ANNUAL REPORT OF THE STATE CORONER
FINANCIAL YEAR 2015-2016

A report to the Attorney General pursuant to section 39(1) of the Coroners Act 2003 on the administration of the Coroners Court and the provision of coronial services under the Coroners Act 2003.

SOUTH AUSTRALIAN CORONERS COURT

Coroners Court
302 King William Street
Adelaide SA 5000

Telephone: (08) 8204 0616
Facsimile: (08) 8204 0615
E-mail: coroner@courts.sa.gov.au

25 November 2016

The Honourable John Rau MP
Attorney-General
Government of South Australia
GPO Box 464
ADELAIDE SA 5000

Dear Attorney-General

In accordance with section 39 of the Coroners Act 2003 I have prepared a report on the administration of the Coroners Court and the provision of coronial services under the Coroners Act 2003 during the financial year ending on 30 June 2016.

The report is forwarded with this letter.

Yours sincerely

Mark Johns
STATE CORONER

ANNUAL REPORT OF THE STATE CORONER

TABLE OF CONTENTS

Annual Report of the State Coroner

Annual Report pursuant to section 39 of the Coroners Act 2003

To the Attorney General

Pursuant to section 39(1) of the Coroners Act 2003 I make the following report to you on the administration of the Coroners Court and the provision of coronial services under the Coroners Act 2003 during the financial year ended 30 June 2016.

1. State Coroner's Overview

I present the eleventh Annual Report of the State Coroner to be tabled in Parliament reporting on the administration and operations of the Coroners Court during the financial year 2015-2016.

The South Australian Coroners Act 2003 provides for the establishment of the Coroners Court and the administration that supports the functions of the Court. The Act defines what constitutes a reportable death, the practice and procedures of the Court, establishes the power of inquiry and of the Inquest and other legal processes that enable the jurisdiction of the Coroner to undertake inquiries and make recommendations.

This report documents the activities and initiatives of the Coroners Court during the year under review. The number of reported deaths has increased from those of previous years with 140 more reported deaths this year than last.

In 2015-2016 2430 deaths were reported and throughout the year 2181 were closed. This represents a clearance rate of 89.8% which is a 16.8% decrease in the rate of closed cases from last year. The backlog indicator of cases that are more than 12 months old has marginally decreased to 35.1% from 35.4%.

Cases that are greater than 24 months old and still open pending inquiries are 11.2% of our cases which is a 1.7% decrease from the year before. The types of cases in this category usually represent the more complex cases requiring specialised investigations, or deaths in custody investigations, SafeWork SA investigations, cases pending charges in other courts and open homicide cases.

The challenges of reviewing and completing cases in a timely manner when our modest resources do not match our workload is ever present. The staff of the Court endeavour to process work without delay however it is diffcult to achieve the balance of meeting the needs of a grieving family with the rigours of the coronial investigation. Cases face delays at each stage of review due to the lack of staff resources available to undertake the time consuming and detailed work of reviewing case investigations.

During this year, as in previous years, administration staff and Counsel Assisting have endeavoured to provide the public of South Australia with a professional and impartial service within the resources available to the Court.

2. Acknowledgements

My colleague, Tony Schapel, Deputy State Coroner, deserves my deepest appreciation and thanks. His knowledge of the law and his ability to analyse complex circumstances of death with skill and compassion is a great asset to this jurisdiction. The Deputy State Coroner has undertaken his duties with dedication and I often rely on his opinion and counsel when considering matters pertaining to this jurisdiction. I am indebted to him for his unwavering support and his ability to distil issues and present recommendations that are in the best interests of community safety and harm prevention.

Although I have had little need to call on the support of the Magistrates Court this year, I nevertheless wish to extend my thanks to the Chief Magistrate Her Honour Judge Mary-Louise Hribal for her interest in and support of the coronial jurisdiction.

I thank Senior Counsels Assisting who have worked for the Court this year. Naomi Kereru has supported both coroners on a full time basis throughout the year and Amy Cacas and Debbie De Palma shared the role of Senior Counsel Assisting until Ms Cacas returned to full time duties in February 2016. I sincerely thank them for their hard work, especially in the face of a large workload and complex cases.

It appears to me that coronial cases have become more complex over time. The issues are multi-factorial often involving a number of government departments and non-government agencies each playing a part in the life of someone who has died in tragic circumstances. Medical cases are extremely sophisticated in the application of medical interventions with multiple medical practitioners attending to treat the patient who is often in an extreme physical condition. Social issues such as illicit and licit drug abuse, 'doctor shopping', long-term mental health conditions, poverty and lack of ability to seek appropriate health care options, coupled with family breakdown, domestic violence and absence of social supports, intertwine to create layered impacts on circumstances of death. Also, accidents involving machinery which is highly technical in design, construction and use are also involved in deaths and the investigation must pursue the nature of such machinery and conclude its involvement in a person's death. The above are just some of the matters that Senior Counsel Assisting are reviewing when deciding whether to recommend a case for Inquest. They must apply their legal analytical skills and uncover complex issues often deeply embedded within the details of a case to ensure that the evidence presented in court is such that a coroner can hear matters that will lead to recommendations that might prevent another person dying in similar circumstances. I commend Senior Counsel Assisting for bringing a number of cases to court this year that are well prepared and presented which is of great benefit to the community in general.

I wish to make special mention of the work that the staff undertake in an efficient and compassionate manner. I have mentioned in a number of previous Annual Reports that I consider the resources allocated to the Coroners Court to be insufficient for the volume and complexity of work undertaken. It is, therefore, a

testament to the staff that they work tirelessly and without complaint about the workload every day of the year (except Christmas Day). I am often reminded through the work that staff undertake that there is a strong culture in this office of placing a priority on assisting families to understand the coronial process. Staff work seamlessly behind the scenes to ensure that the deceased person is returned to their family, via a funeral director, in a timely manner in order for funeral ceremonies to proceed. Whilst some families find the coronial process intrusive and at times very confronting, most families accept that there are necessary procedures to follow. It is my view that the staff of the Coroners Court have a great deal of compassion and loyalty to families who are experiencing trauma and grief and, within the confines of the legalities of the legislation, they go 'above and beyond' to enable families to continue with funeral preparations as quickly as possible.

I thank the SAPOL officers in the Coronial Investigation Section (CIS) for managing reports of death that are provided by SAPOL members who are tasked to attend recent deaths. A proper investigation into a death provides a coroner with a basis for continuing inquiries. It is paramount that police officers approach a coronial inquiry with a mindset that seeks to establish the manner and circumstances of the death, whilst also relating the inquiries to the aim of preventing similar deaths in the future.

During the year under review the staff of the Court continued a positive relationship with Forensic Science SA (FSSA). I thank the forensic pathologists for their expertise and knowledge and for being readily available to myself, the Deputy State Coroner and relevant staff to discuss cases as issues and queries arise. I also extend thanks to the broader scientific and technical staff for the invaluable and sophisticated information they provide to support coronial investigations. During the year under review coronial senior staff and Coroners, and, senior staff and pathologists from FSSA formally met on three occasions to discuss strategic issues pertinent to the development of forensic services to the State Coroner. The value of sound forensic evidence in coronial cases cannot be underestimated. In most cases it is true to say that the basis of the progression of an investigation towards Inquest is a detailed post mortem examination. The adage of learning from the death to inform and protect the living is still relevant in my view.

Following from such a view is my support for forensic pathologists to examine in a detailed and specialised manner the major organs of the body such as brains and hearts, along with other organs that are pertinent to establishing the cause of death. In my last Annual Report I mentioned that FSSA was negotiating with Adelaide University to take responsibility for the examination of brains for coronial post mortems. I report that this alliance was successfully achieved and the process has seamlessly transitioned under the auspices of Adelaide University. The transfer of some staff from the Hanson Institute went a long way to ensuring that the special examination of organs was a success and I make special mention of the work of Jim Manavis in conjunction with the coronial social workers in this area.

I also extend my thanks to Professor Tony Thomas at Flinders Medical Centre for his leadership and expertise in forensic examination of hearts. This specialised form of examination is essential to understanding causes of death in complex heart biology and I rely on the opinion of Professor Thomas to assist both the Deputy State Coroner Schapel and me in understanding the effect of sometimes rare heart conditions in cause of death.

I express my appreciation to the Women's and Children's Hospital (WCH) for providing specialist post mortem advice on paediatric cases.

I acknowledge the contribution made by the team of forensic odontologists who provide the Coroners Court with dental identification analyses in the circumstances where other methods of identification of deceased persons has either not been successful or possible.

This year I would like to pay special tribute to the work of Dr Helen James as the senior forensic odontologist in South Australia. Dr James retired at the end of 2015 and it marked the end of a career of dedication to dentistry, teaching dentistry students through the Adelaide University School of Dentistry and the pursuit of developing the science of forensic odontology. Dr James worked tirelessly to assist the coronial jurisdiction in identifying deceased persons by dental means. Nothing was ever too much trouble for her or her team of local dentists and students. Dr James has been involved in all multiple fatality identification events in Australia and often those overseas over the past 20 years or more. I am indebted to her focus and dedication. Dr Denice Higgins has taken over as the senior forensic odontologist and I welcome her to the role and am sure she will continue with Dr James' excellent work.

Once again I extend my particular thanks and acknowledgement to Michele Bayly-Jones, the Manager of the Court for her hard work, dedication and friendship. Her contribution to the work of the Court is invaluable. She maintains a positive attitude to all aspects of her work in an environment of ever increasing demands coupled with ever shrinking resources. I am in her debt.

3. Reportable Deaths and the Role of the Coroner

The Coroners Act 2003 requires that the State Coroner investigates all reportable deaths.

The role of the Coroner is to investigate any sudden, unexpected or unknown cause of death. The Coroner establishes the cause of death, the identity of the deceased and the circumstances preceding the death.

The Coroners Act 2003 provides an interpretation of what constitutes a reportable death. Regardless of the age of the individual or any subjective opinion of a third party about the death, if the death falls within the definition of a reportable death as defined by the Act, then the death is reportable. There is no discretion to choose whether or not a death is reportable.

The Coroners Act 2003 provides that deaths falling under the following categories are reportable deaths:

- Unexpectedly, unusually or by a violent, unnatural or unknown cause;
- On a flight or voyage to South Australia;
- While in custody;
- During, as a result or within 24 hours of certain surgical or invasive medical or diagnostic procedures, including the giving of an anaesthetic for the purpose of performing the procedure;
- Within 24 hours of being discharged from a hospital or having sought emergency treatment at a hospital;
- While the deceased was a 'protected' person;
- While the deceased was under a custody or guardianship order under the Children's Protection Act;
- While the deceased was a patient in an approved treatment centre under the Mental Health Act;
- While the deceased was a resident of a licensed supported residential facility under the Supported Residential Facilities Act;
- While the deceased was in a hospital or other facility being treated for drug addiction;
- During, as a result or within 24 hours of medical treatment to which consent had been given under Part 5 of the Guardianship and Administration Act;
- When a cause of death was not certified by a doctor.

I have stated in previous Annual Reports, and I reiterate, that there is no penalty for reporting a death that upon closer analysis proves not to be reportable under the Coroners Act. However it is an offence to fail to report the death of a person whose death must be reported.

In investigating the cause and circumstances of a death I rely on a range of professional opinions. Such opinion may extend to how a practice or system should operate and how practices and systems, if changed, may prevent a death in similar circumstances to the one under investigation.

In order to explore these matters I am able to exercise wide powers of inquiry, such as:

- Entering premises and viewing a body;
- Inspecting and removing anything pertaining to the coronial investigation;
- Taking photographs, film, video or other recordings;
- Remove a body;
- Exhume a body (with the consent of the Attorney-General) and;
- To direct a medical practitioner to examine a body and perform any tests that are necessary to establish the cause of death.

The above powers enable coronial investigators to gather information and provide me with evidence on which to base decisions about whether it is necessary or desirable to hold an Inquest.

Extensive work is undertaken by staff in the Coroners Court, as well as by FSSA and SAPOL, to review the circumstances of the death so that a Coroner can receive a recommendation to assess whether a case should proceed to Inquest.

The process of investigating a case from report of death to gathering the necessary information and evidence, and then a decision as to whether to Inquest or finalise the case, can be quite lengthy. The process may take between 9 to 24 months.

A death does not have to be suspicious in order to have it reported to the Coroner. Many of our inquiries pursue information that ultimately reveal that although a person died suddenly, they died as a result of natural causes. This office makes every effort to process these cases in a timely manner. This can be achieved in a case where a post mortem examination is not necessary.

Many people believe that all cases reported to a Coroner are the subject of an Inquest. This is not so. On average approximately 2% of deaths reported to a Coroner in South Australia proceed to the Court for an Inquest. All deaths are investigated to the extent of establishing whether the circumstances of the death warrant the scrutiny of an open Court hearing. Only when the often lengthy investigations are finalised is a determination made as to whether an Inquest is necessary or desirable.

For those cases that do not proceed to Inquest, the Coroner makes a finding as to the cause of death (Coroners Act Part 5 Section 29 (b)). There is no other narrative written about the circumstances of death and no recommendations can be made.

This is sometimes surprising to families who are expecting a formal and detailed description of the circumstances of the death at the end of the process. However, family members are generally permitted to read material held on file including statements and medical and other expert reports that give a very comprehensive picture of the circumstances of their loved one's death, and the thorough investigations that have been carried out by my office.

Section 25 of the Coroners Act 2003 provides that when making findings upon Inquests, the Court may add to its findings any recommendation that might, in the opinion of the Court, prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

In deciding which cases proceed to Inquest, section 25 provides an important benchmark against which to judge and balance the various factors for consideration.

However, an Inquest may be extremely beneficial even if no recommendation is made. The holding of an Inquest can shine a light on events that have given rise to public disquiet or concern and provide an occasion for holding people, from all walks of life and strata of society, to account for the role they may have played in a particular event. The beneficial effects of opening events to public scrutiny, and highlighting events that would otherwise remain hidden from public scrutiny, cannot be overestimated.

4. Matters Arising During 2015-2016

4.1. Domestic Violence Research Project

Since 2011 the position of Senior Research Officer (domestic violence) has assisted this Court in the investigation of deaths occurring in a domestic violence context. This position is the result of an ongoing and productive partnership between the Office for Women and the South Australian Coroners Court and enables this Court to robustly investigate domestic and Aboriginal family violence deaths.

Over the reporting period there have been several key areas of focus for this position both directly related to coronial processes and to broader South Australian initiatives to address domestic violence.

Policy provision - the Office for Women provides policy support and advice across the SA Government. To this end, the SRO has continued to:

- Report regularly to the A Right To Safety Chief Executive Group chaired by the Minister for the Status of Women;
- Attend the A Right To Safety Provision and Protection working group;
- Provide briefings and other advice as required.

Stakeholder engagement - the SRO was a keynote speaker at the National Domestic and Aboriginal Family Violence conference, co-presented at the Emergency Medicine South Australia conference and has made many presentations to community forums and agencies including:

- SA Health Women's Safety Strategy;
- Women's Domestic Violence Legal Service;
- Violence Against Women Collaboration (Mt Gambier);
- Victim Support Service Court volunteer training;
- Women's Information Service volunteer training.

The SRO continues to collaborate and liaise with the SA Child Death and Serious Injury Review Committee.

Investigation of open coronial matters - 26 file reviews were undertaken and presented for coronial consideration during the relevant period. This includes homicide, multiple fatality and single instance suicide deaths.

Support and advice to Inquests involving a domestic violence context - an Inquest into the death of Ebony Napier was heard by the Deputy State Coroner in August and September 2015. The Inquest required weeks of preparation and the Court heard evidence for 15 days resulting in 33 recommendations directed towards improving child protection. The SRO assisted in the review and preparation of this matter as well as providing assistance where required throughout.

National collaboration - the SRO remains an active member of the Australian Domestic Family Violence Death Review Network (The Network). The Network has finalised its homicide consensus statement and national minimum dataset. This underpins the retrospective research conducted by the SRO and enables national consistency in the identification of relevant deaths and national comparability of the data collected regarding domestic and family violence deaths.

The Australian Human Rights Commission has been working in partnership with The Network and individual coronial jurisdictions to advance a platform for national reporting of data relating to domestic violence deaths. This position has provided advice regarding the South Australian Coroner's Court survey responses to this project. The final report from the Australian Human Rights Commission is pending.

Retrospective research in relation to DV deaths in SA - as previously reported this position has undertaken preliminary work and database development to achieve a retrospective analysis of South Australian homicide* deaths which have an identified domestic or Aboriginal family violence context - that is, where there are either or both a relationship between the parties or a background context of domestic violence associated with the homicide. This methodology will enable deaths to be analysed in terms of the context in which they occurred rather than purely on the basis of a relationship between the deceased and the offender (for example - a third party or bystander may be killed in the context of a domestic violence dynamic). The collection and analysis of each death enables the capture of the full extent of homicides relating to domestic violence in South Australia.

As part of the ongoing work in South Australia to reduce violence against women and children, the SA Government announced the development of a specific domestic violence deaths database. The Coronial Domestic Violence Information System (CDVIS) is housed within the coronial jurisdiction and the first two phases of reporting (prevalence and relationship; domestic violence context) are presented below. This data is retrospective from 1 July 2005 and includes only deaths which have been finalised in the coronial jurisdiction.

Data collection is resource intensive involving an in-depth review of each death. While the CDVIS is capable of storing a large range of victim/perpetrator demographics, justice and service responses and risk or vulnerability factors, reporting beyond the scope of the annual report will not be feasible within the current resource allocation of the Court.

To establish a domestic violence context both the relationship type and behavioural dynamic need to be defined and contextualised. For the purpose of this research the Intervention Orders (Prevention of Abuse) Acts SA 2009 provides the legislative scope.

There is no universal definition of domestic violence, however for the purpose of defining a 'domestic violence context' in this research, the central elements relate to an ongoing pattern of behaviour aimed at controlling a person the perpetrator

has a relationship[1] with through fear and the use of threatening and violent behaviour. The violent behaviour is part of a range of tactics to exercise power and control. These behaviours can be criminal and non-criminal. It is widely accepted and legislated that a range of violent behaviours may occur over time and those behaviours can be classified as physical, sexual, emotional, psychological or economic abuse[2].

Limitations of data - As detailed in my last annual report the capture and reporting of this data is a staged process. The CDVIS is capable of collecting qualitative and quantitative data across a range of variables for both the perpetrator and victim. The CDVIS will ultimately house data relating to homicide incident data and proximate victim and perpetrator characteristics. The scope of the CDVIS includes collection of individual demographics, service/systems contact history, mental health history, criminal justice responses and outcomes, domestic violence dynamics - including risk and vulnerability factors and domestic violence dynamics (context) relevant to the case.

The data contained in this report represents the completion of identifying homicide prevalence, the relationship between offenders and victims (Stage 1) and the identification of homicides with a domestic violence context in the background to the homicide incident (Stage 2).

The retrospective research and its collection will continue providing a longitudinal picture of homicides with a domestic violence context. Reporting on these cases can only occur in a de-identified way and where cases have been completed in the criminal or coronial jurisdictions.

Data sources - The CDVIS data set is established by identifying all deaths with the National Coronial Information System (NCIS) coding of 'intent on completion' of the case type as 'assault' which was cross-referenced with South Australian coronial information including electronic case management records and the original coronial case files. For the majority of cases reviewed this included police coronial investigation reports and statements, post mortem/toxicology reports and sentencing remarks or coronial Inquest findings. The identification of further sources of information will occur as the CDVIS data collection evolves.

Data summary - of the 217 identified suspected homicides, 38 (17.5%) were excluded due to assault not being confirmed at the completion of the case, and a further 46 (21%) were not finalised. The remaining 133 (61.5%) of homicides were confirmed. Of the confirmed homicides 21 (16%) did not have an offender identified leaving 112 (84%) of the identified homicides with a confirmed offender enabling an analysis of the victim/offender relationship and domestic violence context.

* The definition of 'homicide' adopted for this research is aligned with The National Network homicide definition and is broader than the legal definition of the term as outlined in the Criminal Law Consolidation Act SA 1935. 'Homicide' includes all circumstances in which an individual's intentional act, or failure to act, resulted in the death of another person.

[1] IPO Act SA Section 8 (8)
[2] IPO ACT SA Section 8 (1) (2) (3) (4) (5) (6) (7)

In eight (7%) of these cases a relationship could not be established on the basis of the information presented. The population of the CDVIS is an ongoing process and additional information added as it comes to hand. Therefore further interrogation of additional information may clarify the relationship status in future reporting.

Where the offender was identified 52 (50%) were identified as non-domestic homicides with no intimate or domestic relationship between the victim and the offender. It is important to note that, while there was a non-domestic relationship identified in these homicides, seven (13.5%) of these homicides occurred in a domestic violence context. Examples of these situations may be that the victims were bystanders (eg member of public) or third parties to an incident (eg police officer or person intervening) or were otherwise involved in the domestic violence context (eg a new partner killed by an ex-partner). The analysis of the domestic violence beyond relationship status is crucial in determining the extent of homicides occurring in a domestic violence context. This has not occurred comprehensively in previous data analysis of South Australian homicide deaths.

The remaining 52 (50%) of confirmed homicides identified an intimate or domestic relationship between the victim and the primary perpetrator. However, when reviewing the context of the relationship, 12 (23%) did not have an identifiable history of domestic violence in the circumstances of the relationship leading to the incident resulting in the death.

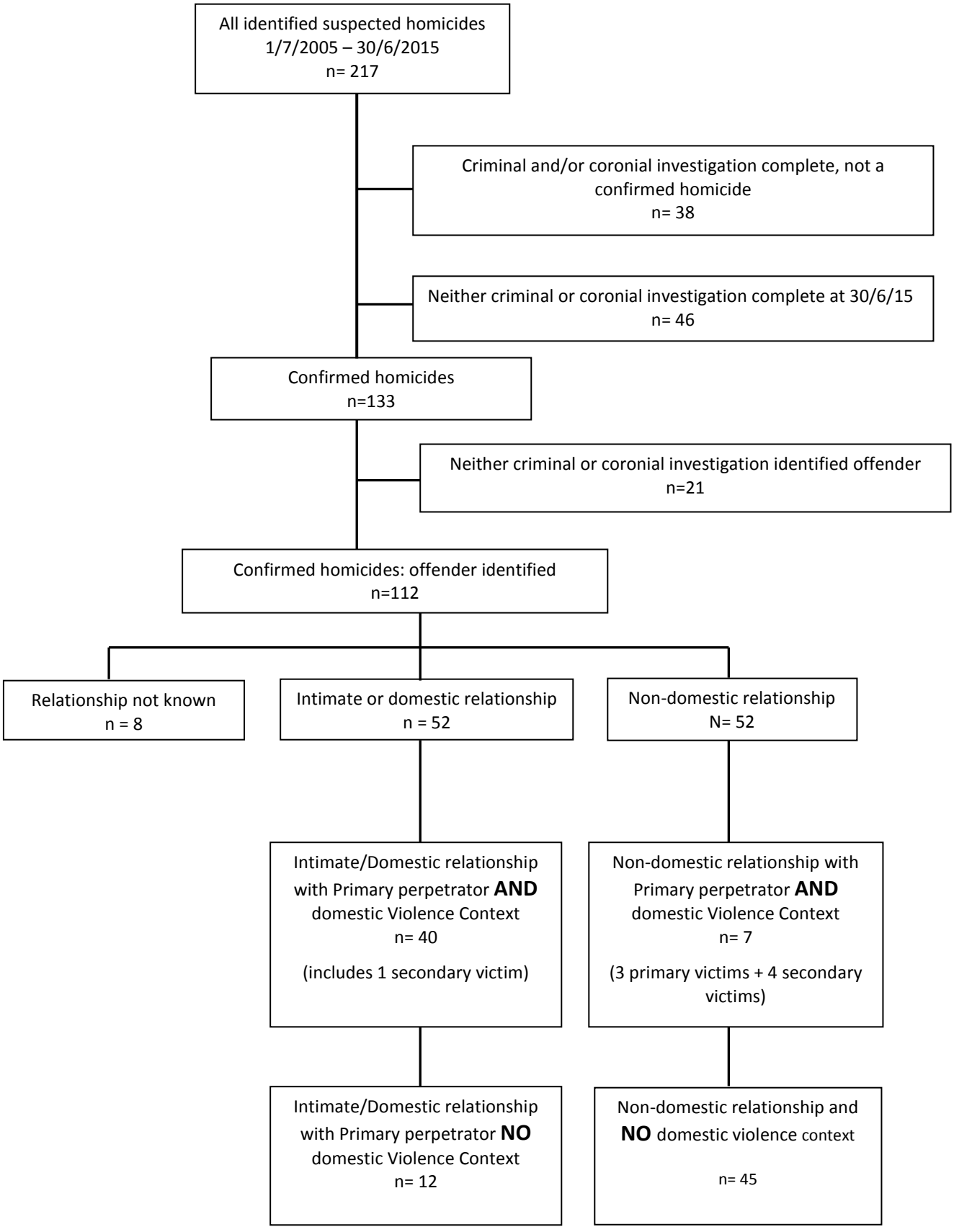
This detailed analysis of South Australian homicides reveals that of the cases included in the CDVIS analysis of domestic violence context, 47 (45%) of the included homicides had a background and circumstances of ongoing domestic violence pre-dating the homicide incident.

Of the 104 included homicides there were 13 (12.5%) identified murder/suicide incidents. These deaths are captured in the CDVIS and an analysis of these multiple fatality incidents reveals that 11 (85%) had an identifiable domestic violence context. For eight (72%) of these multiple fatality incidents the homicide was perpetrated by the (current or ex) intimate male partner, who was also the domestic violence aggressor in the circumstances of the relationship and suicided proximate to the homicide. For the remaining three incidents, two had a domestic relationship and one a non-domestic relationship, but a domestic violence context (bystander).

Based on the coronial cases available for reporting in South Australia since 2005, 47 homicides were identified which had a domestic violence context. If added to the 11 suicide deaths which occurred in proximity to the murder, it provides a current profile of 58 coronial cases with a direct relationship to a history of domestic violence and an escalation to either homicide or homicide/suicide.

The CDVIS also records other victimisation, for example the family structure and children. As the CDVIS data set evolves and the number of closed cases for inclusion grows, de-identified reporting will be possible. Further analysis of the CDVIS will occur over 2016-2017 and will be reported in future annual reports.

South Australian Homicides 2005 – 30 June 2015 - CDVIS data profile



4.2. Research Projects

During the year under review I agreed to participate in a joint project with the Office of the Chief Psychiatrist, SA Health, to develop a classification tool to identify deaths that could be categorised as 'intentional self-harm' *(see section 4.3)*.

I continued to consent to a proposal, in conjunction with FSSA, for the provision of de-identified cardiac MRI scans to a radiologist. This type of project may assist in the identification and treatment of cardiac issues. Cardiac disease is a major health issue in our community and accounts for a large number of sudden deaths that are reported to a coroner each year. I am pleased to support important research work that may contribute to the knowledge of cardiac health and thereby prevent unnecessary and premature death.

In addition to the above, the Coroners Court again approved research access to the Pregnancy Outcome Unit and the Child Death and Serious Injury Review Committee.

I believe that it is important to support research where possible. To this end, where I can collaborate with bona fide and approved researchers to enhance and inform public health and safety, and when it does not impact on my limited staff and budget resources, I am happy to do so.

4.3. Suicide Issues

As mentioned above in section 4.2 of this report, a joint project between the Mental Health Unit and the SA Coroners Court was agreed to look at suicide deaths and categorise each death according to certain common criteria.

Suicide deaths continue to be a major public concern for both government and non-government health agencies and for the community in general. The social cost of suicide is immeasurable and I continue to be dismayed and deeply affected by the number of suicides that are reported to me each week.

The joint project between my office and the Office of the Chief Psychiatrist aims to undertake a pilot and evaluation project to develop an epidemiologically based state suicide registry.

In the 2013-2014 Annual Report I suggested a method of achieving reliable suicide statistics. Namely, the development of a 'common tool, or scoring system, that could be used to provide a consistent approach' and that this statistical/epidemiological analysis could be undertaken separately and in parallel with the coronial process. To this end I have consented to Dr Casey Nottage, Public Health Medicine Registrar, undertaking work to investigate aspects of this proposal.

The pilot project will involve a retrospective review of a 12 month cohort of deaths with the primary objective being the use of the candidate classification tools to

determine a revised suicide statistic for the study year. I look forward to reporting on the results of this project in my next Annual Report.

4.4. Staffing Resources

I am pleased to report that staffing levels have remained the same during the year under review.

I continue to hold the same view as I have expressed in previous Annual Reports and which is that my office is under resourced to cope with the volume of cases that are reported each year. With the resources available the office cannot progress research partnerships, or undertake proactive continuous improvements such as the development of new publications and enhancements to the website, or, the finalisation of the review of the operational procedures manual. Staff are wholly occupied with processing the day to day operational work and can rarely take time 'off line' to develop new processes, policies and practices.

When a decision is made to conduct a lengthy Inquest with far reaching community interest such as the Inquest in the deaths of Chloe Valentine and Zahra Abrahimzadeh my Senior Counsels Assisting are consumed with preparing the Inquest and are then occupied in court for weeks at a time. There is, subsequently, limited time for them to devoted to reviewing other cases that also require analysis and preparation. Ultimately, the coronial process is often cumbersome and results in delays for families in having their matters finalised. I will not apologise for this situation as I am confident that the majority of staff work to full capacity each day to progress cases, and, the system can only operate within the resources that are provided, however, I do regret that families are subjected to lengthy delays in having matters brought to Inquest.

4.5. Infant deaths at the Women's and Children's Hospital

During the year under review it was reported to me that the Women's and Children's Hospital failed to report 8 infant deaths over a period of nine years.

Once advised of this situation I held a number of discussions with the Chief Executive Officer of the Women's and Children's Hospital in order to ascertain how the medical practitioners involved could have misunderstood their obligations under the Coroners Act 2003 to report the deaths.

I am satisfied that the Chief Executive Office of the Women's and Children's Hospital, once she knew of the situation, responded quickly to review and report the deaths. I directed that a Forensic Pathologist specialising in paediatric death review the deceased's case notes and the death certificates as a matter of urgency. I also asked that each family be contacted by a senior officer from the W&CH to ensure that a personal explanation was provided with information about why the death was not reported at the time of death and the reason as to why the death was a reportable death to the State Coroner.

At the time of writing this report I believe that most families involved in this matter have been contacted by both the Women's and Children's Hospital and the Coroners' Court. I am informed that there are still two families who have not been contacted due to difficulties in locating them given the passage of time. I am assured that efforts will continue to be made to contact these families if at all possible.

As a result of the inquiries into these reportable deaths I am able to report that the Forensic Pathologist who reviewed the hospital case notes and death certificates concurred with the medical practitioner's opinions as to causes of death and I did not find any adverse events or systemic problems in treatment and care of the infants. I thank Professor Roger Byard, FSSA, for responding quickly to my request to have the case notes relating to the infants reviewed so that the disclosure to the families could occur without delay. I also express my thanks to Helen Paues, Deputy Registrar, Births, Deaths and Marriages for her advice and cooperation during this review of the certificates of cause of death.

Whilst I am satisfied that the Women's and Children's Hospital acted quickly to remedy the situation once it was known I must comment that any death that is not reported when it is required to be reported has serious ramifications for the necessary and required investigations into the death. The ability to investigate a death in a hospital once a body is disposed of and after a lengthy period of time passes results in any evidence being almost invisible. I do not consider that this is how the community would want deaths to be reported to a coroner. Any coronial analysis of possible systemic issues is very difficult under such circumstances. I believe that the Women's and Children's Hospital has established measures that will avoid a similar occurrence in the future.

It is incumbent on medical practitioners to know and understand their obligations under the Coroners Act 2003 and if it is not clear to them then SA Health should take measures via their Risk Management departments to provide training and guidance regarding reportable deaths. It is quite common for medical practitioners in hospitals to call the Coroner's Office and seek direction from staff as to whether a death is reportable. Whilst the Coroners Court staff are knowledgeable and efficient in their jobs, they are relatively junior administrative officers. It is not reasonable for a medical practitioner to expect a clerical officer to give advice about a medical reportable death. Coroners Court staff have been instructed to only give information about reportable deaths by directly quoting from the Coroners Act 2003. They are employed to receive and process reports of death and not to give advice to medical practitioners whose responsibility is clearly to make their own professional judgement after becoming aware of a death that is or may be reportable. The medical practitioner must also give his or her opinion as to the cause of death to the Coroner if he or she treated the person or examined the person after death.

4.6. Death Report to Coroner Medical Practitioners Deposition

After the death of a person in a hospital the medical practitioner who has been responsible for the treatment of the person must complete a 'Death Report to

Coroner Medical Practitioners Deposition' form. I have mentioned in previous Annual Reports that I consider the quality of the completion of these forms to be poor. Often, sections of the form are not even completed and the clinical progress summary is often illegible, with brief information. This year, the Deputy State Coroner and I have noticed a worrying trend which is to have a medical intern complete the form. Often the intern has barely treated the patient which results in a deposition that is difficult to understand and may lead to the direction for post mortem which may not have been necessary if a senior practitioner who had experience of the patient had completed the form and given me the benefit of their clinical expertise. This is not a reflection on the interns themselves, I support their ongoing education and experience and this responsibility places them in a difficult position, however, it is fundamental to the quality of a process that when a patient dies and is reportable to a coroner that the medical practitioner who had knowledge of and responsibility for the patient completes the form giving a coroner the benefit of their knowledge of the patient presentation, diagnosis, treatment, interventions and ultimate events that lead to the patient's demise.

4.7. Section 32 under the Guardianship and Administration Act 1993

The Coroners Act 2003 prescribes that a death in custody means the death of a person where there is reason to believe that the death occurred, or the cause of death, or possible cause of death, arose, or may have arisen while the person was detained or being apprehended or escaping apprehension.

Within that interpretation detention means any person within the State who is detained under any Act or law. This includes those persons who die whilst being detained under Section 32 of the Guardianship and Administration Act 1993 as a protected person and under an advance care directive.

All deaths in custody are the subject of a mandatory Inquest, which is a hearing in open court. A death in custody investigation is a specialised process undertaken by SAPOL and requires intensive review, meetings and a detailed final report to the Coroner.

Section 32 deaths in custody are usually characterised by the detention of a person who is aged or mentally ill and who needs to be detained in order to administer medical treatment. In most cases, under this type of detention, the person dies of natural causes.

Over the past year it has come to my attention that there are a number of such cases being reported and they require large amounts of resources, both Court and SAPOL, to investigate and resolve. In addition to this, it is quite upsetting to the family who find that the death of their elderly relative with dementia with psychiatric features is the subject of a long investigation and then Inquest. The period of waiting for resolution of the case may be up to two years. The family may assume that a Coroner is investigating the death because 'something went wrong' and then expect that the Inquest will publicly reveal issues about the treatment of their loved one. In reality the Inquest is usually uneventful and comments on the medical cause of death and then closes. The family are left

wondering why the Inquest took so long to resolve, and if no circumstances were revealed as adverse then what was the purpose.

It is my view that these types of deaths should not necessarily be the subject of a mandatory Inquest. They should have a SAPOL death in custody investigation that is tailored to the specific circumstances. Having said that I maintain the discretion to hold an Inquest in to the death if I decided that it was desirable or necessary.

Throughout this year a number of Affidavit only Inquests were held with the aim of efficiently dealing with Section 32 deaths in custody of elderly persons where behaviour associated with dementia is the feature of the detention.

4.8. Strategic services with Forensic Science SA

Coroners and senior staff from the Coroners Court, and the Director and senior staff of FSSA meet quarterly to discuss issues relating to policy and service provision to the coronial jurisdiction. This liaison has proven to be a positive initiative in our mutual work and enables pathologists to directly discuss high level forensic issues with the State Coroner and Deputy State Coroner and Counsels Assisting.

This year the pertinent issues discussed included:

- The ability of the EPAS system to deliver readily understandable case documents that will satisfy the requirements of a forensic pathologist undertaking a coronial post mortem and the requirements of the Coroners Counsel Assisting when reviewing a case for Inquest.
- The community increase in the use of Fentanyl in 'designer drug' use and the extreme dangers in such use due to the potency of the drug.
- Extension of sample types for DNA analysis for identification of deceased.

4.9. Hierarchy of Senior Next of Kin

During the year under review I have received a number of letters from Members of Parliament on behalf of their constituents who do not have senior next of kin status seeking to receive information about deceased relatives. Such overtures from relatives demand time and resources in managing disputes and resolutions about who gets to access information from a case file. I have adhered to the policy position that only the senior next of kin is eligible to receive information about the deceased. Another party is only able to access the same information with the written permission of the senior next of kin. This office does not have the resources to engage in inquiries into the merits of a family dispute and whether an individual with a poor relationship history, either with the deceased when they were alive or the senior next of kin, should be entitled or disentitled to have information about the deceased.

It might be suggested that it would be possible to set up a dispute resolution process to deal with these issues. However, any dispute resolution process would

have to be thorough as a cursory attempt to unravel a delicate and complicated set of relationships and longstanding grievances would do more harm than good. The Coroners Court does not have the social work resources to manage a dispute resolution process to arbitrate between parties who may never agree on who has the right to information.

There is an exception to the policy. In some cases members of a family are contacted and informed about post mortem results. That occurs where the Forensic Pathologist recommends in a post mortem report that family members be tested for a hereditary or genetic medical problem that the deceased was found to have. When such a recommendation is made a Social Worker from the Coroners Court contacts family members and advises them of the results of the post mortem and suggests that they seek medical advice.

The Coroners Court Rules 2005 provide an interpretation for 'senior available next of kin' and is as follows:

Senior available next of kin means-

(a) in relation to a child, the first in order of priority of the following persons whose contact details are known to the Manager:
    (i) a parent of the child;
    (ii) a brother or sister, who has attained the age of 18 years, of the child;
    (iii) a guardian of the child; and
(b) in relation to any other person, the first in order of priority of the following persons whose contact details are known to the Manager:
    (i) the spouse of the person;
    (ii) the de facto partner of the person;
    (iii) a son or daughter, who has attained the age of 18 years, of the person;
    (iv) a parent of the person;
    (v) a brother or sister, who has attained the age of 18 years, of the person.

Spouse includes domestic partner in keeping with the Family Relationships Act 1975. For the purposes of the Coroners Act domestic partner will include *de facto* partner who on the date of the deceased's death was cohabiting with the deceased in a close personal relationship and so cohabited with that other person as the husband or wife (*de facto*) of the deceased person continuously for the period of three years immediately preceding the date of death, or, during the period of 4 years immediately preceding that date so lived with that other person for periods aggregating not less than 3 years, and/or there is a child/ren of which the domestic partner (*de facto*) and the deceased were the parents.

This interpretation refers to Division 2 - Inquests in the Coroners Court Rules and applies to the service on relatives of notice of intention to hold an Inquest.

It is a matter of policy that the Coroners Court also applies the hierarchy of senior available next of kin to requests for access to information and approval to access items such as tissue samples for DNA testing. If the designated senior next of kin chooses/agrees to another person also having senior next of kin status that will be determined with the Coroners Court Social Worker in consultation with the Manager, Coroners Court.

5. Statistical Information

There were 13 300 deaths registered with the Registrar of Births, Deaths and Marriages in 2015-2016, a decrease compared to the previous year. Of these, 2 430 deaths were reported to the State Coroner, an increase when compared with last year.

In 2015-2016, 62 Inquests were held into individual deaths, of which 47 related to deaths in custody. The significant increase in the number of Inquests held this year has been a result of an increase in mandatory death-in-custody Inquests where the deceased was the subject of orders under the *Guardianship and Administration Act 1993* requiring the deceased to be, or remain at, a residential facility specified by a guardian. With the ageing of the population it is expected that this trend will continue.

Ten Inquests were part-heard at the time of reporting and will continue in 2016-2017. There were 8 584 pages of transcript produced.

There were 29 Inquest findings delivered during 2015-2016. This figure is the actual number of findings delivered, regardless of the number of deaths per Inquest. Court sitting hours for the period were 318.5 hours.

During the year under review there was one Inquest held in regional South Australia (Mount Gambier).

5.1. Cases Reported by Local Case Management (LCM) Cause of Death Code

Cause	Deaths	Cause	Deaths
Aircraft	0	Industrial Accident	7
Aspiration of Vomitus	2	Marine	1
Burns	2	Natural	688
Death in Custody	48	Other	7
Death in Institution	357	Pending PM Report	163
Dehydration	1	Petrol Sniffing	0
Disease	2	Poison	1
Domestic Accident	11	Refer back	0
Drowning	13	SIDS	1
Drug Overdose	46	Skeletal Remains	0
Fall	36	Suicide	202
Homicide	21	Undetermined Cause	61
Hospital	654	Vehicle Accident	105
House Fire	5		

* *Please note that the LCM Cause of Death code is a 'snapshot' of broad categories as each death must be coded in one major 'cause' category, eg death in custody must be recorded as the primary code even if the death was as a result of suicide.*

5.2. Year in Review

During the year under review 2,430 deaths were reported to the State Coroner and 2,441 cases were finalised (finalised cases includes cases that were opened in previous years).

At A Glance	2012-13	2013-14	2014-15	2015-16
Number of Coroners	2	2	2	2
Number of Staff	16.7*	16.2	16.2	16.7
Number of deaths reported	2200	2248	2290	2430
Number of post mortems	1289	1339	1683	1391
Inquest findings delivered	35	35	21	29
Number of Court sitting hours	421.5	421.5	373.5	318.5

** From 2015-16 staffing numbers are based on AFTE (Average Full Time Equivalent) which includes vacancies and locum social workers. Staffing establishment has not changed.*

5.3. Case Statistics - Operational

Pending Matters	2013-14	2014-15	2015-16
Lodgements pending completion <12 mths old	1390	1128	1330
Lodgements pending completion >12 mths old and <24 mths old	265	394	490
Lodgements pending completion >24 mths old	207	225	230

Clearances and Backlogs	2013-14	2014-15	2015-16
Case clearance rate	90.9%	106.6%	89.8%
Total cases pending finalisation	1862	1747	1723
Backlog (% >12 months)	25.3	35.4	35.1
Backlog (% >24 months)	11.1	12.9	11.2
All cases - lodgement to finalisation	2044	2441	2214

6. Backlog of Inquests

As at 30 June 2016, 54 Inquests awaited hearing in the Coroners Court, including 48 cases involving a death in custody. There were 1 723 open cases pending inquiry. This represents an increase from the previous year taking into account the similar number of reported deaths. These open cases are at varying levels of investigation. Some may progress to a review by Counsel Assisting the State Coroner and the Coronial Investigation Section.

As at 30 June 2016 there were 55 cases under high-level investigation by Senior Counsels Assisting. This represents an increase in cases under review by Senior Counsel Assisting when compared to last year.

During the year under review the SAPOL CIS had 60 Tier 3 cases referred to the Detective Investigators by Senior Counsel Assisting, and 393 Tier 2 cases assigned for investigation to CIB and overseen by CIS. SAPOL patrols reported 1 495 Tier 1 cases to the State Coroner which were quality assured by CIS.

7. Professional Presentations of State Coroner and Deputy State Coroner

State Coroner

Member

- SA Indigenous Justice Committee
- Heads of Jurisdiction, Courts Administration Authority

Presentations

- Presenter & panelist - Criminal Justice Seminar (2016 Governor's Leadership Foundation Program
- Aged and Community Services SA & NT Inc Residential Care Forum
- Panel member on discussion related to child protection for Dr Jeremy Sammut, Centre for Independent Studies

Deputy State Coroner

Member

- Magistrates Association of South Australia Executive

Presentations, etc

- SAPOL - Detective's Training Course
- Bar Readers Course
- Law Society - Graduate Diploma Legal Practice, Trial Advocacy

The State Coroner participated in an interview with Andrew Denton on the subject of euthanasia which formed part of a podcast series.

8. Inquests for the Year 1 July 2015 to 30 June 2016

- Alcock, Ross Matthew
- *Baartse, Leila Marijke*
- Bannister, Alfred Geoffrey
- *Bradley, Dwayne Scott*
- Brown, Leon McLaren
- Cailes, Kevin Arnold
- Cambpell, Robert
- Cameron, George William
- Clayton, James Edmund
- *Cooper, Alfred Henry*
- Corbo, Antonio
- Danielsen, Jens Thomas
- D'Arcy-Evans, Andrew Eyre
- Dilettoso, Giuseppe
- Dorman, Frank
- Falkenberg, Malcolm David
- Fallon, Peter John William
- Frederick, Geoffrey Lachlan Hogarth
- Graetz, Clifford Ralph
- Hazlett, Steven William
- Hearne, Alistaire William
- Heneker, Scott Maxwell
- Hewlett, Betty Lorraine
- Hopkins, Ronald William
- *Hunt, Ian James*
- Issacson, David Jacob
- Kalme, Dearne Lee
- Keane, Shaun Martin
- *Kelbin, William Thomas*
- Kellett, Samuel Zachary
- Kennedy, Brian
- *Klingberg, Briony Caitlin*
- *Kuskoff, Alexander Peter*
- Lambropoulos, Andreas
- Larizza, Guiseppe
- MacMillan, Kay Meredith
- Maddern, Raymond Oliver
- Maheras, Haralambos
- *Mayell, Edward John*
- McAteer, John Desmond
- *McConnal, Brenton Winton*
- McShane, Robert Ian
- Milera-Ashford, Bailey Trent Richard
- Mitton, Rodney Lyle
- Napier, Ebony Simone
- Noakes, Geoffrey Scott
- Ong, Hock An
- Osang, Roswitha Maria
- Pertz, Zvonka
- Putsey, Doreen Mary
- Qasem Adballa, Saeed
- Ramm, Gladys Maud
- Reed, William Matthew
- Roberts, Brian Matthew
- Said, David Patrick
- Schulz, Bertha Anna
- Shirra, James Angus
- Shueard, Braydon Adrian
- Smith, Colin Peter
- Smordowski, Edmund
- Way, Dennis Martin
- Williams, Jeremy Todd

** *Italics denote that the matter is part heard and will resume in the 2016-2017 financial year.*

8.1. Inquests Held During the Year 1 July 2015 to 30 June 2016

No	Name	Date of Death	Inquest Number	Inquest Start Date	Finding Delivered	Period (mths) From DOD	Period (mths) From Inquest
1	MACMILLAN, Kay Meredith	25/02/13	7/2015	15/03/16	-	-	-
2	CLAYTON, James Edmund	3/03/13	9/2015	7/07/15	-	-	-
3	McATEER, John Desmond	9/03/13	10/2015	10/07/15	22/09/15	31	2
4	LARIZZA, Guiseppe	3/10/12	11/2015	10/07/15	22/09/15	36	2
5	CAMBPELL, Robert	26/09/12	12/2015	28/07/15	19/05/16	44	10
5	WILLIAMS, Jeremy Todd	26/09/12	12/2015	28/07/15	19/05/16	44	10
6	HEWLETT, Betty Lorraine	22/01/13	13/2015	4/08/15	22/09/15	32	2
7	LAMBROPOULOS, Andreas	30/11/13	14/2015	16/11/15	-	-	-
8	SMORDOWSKI, Edmund	16/06/12	15/2015	20/07/15	-	-	-
9	NAPIER, Ebony Simone	8/11/11	16/2015	18/08/15	28/01/16	51	5
10	MADDERN, Raymond Oliver	31/08/12	17/2015	24/07/15	-	-	-
11	OSANG, Roswitha Maria	1/10/13	18/2015	17/08/15	11/04/16	31	8
12	KELBIN, William Thomas	28/12/12	19/2015	6/10/15	-	-	-
13	KELLETT, Samuel Zachary	8/02/14	21/2015	29/09/15	-	-	-
14	FALLON, Peter John William	2/02/13	22/2015	13/10/15	09/06/16	41	8
15	SAID, David Patrick	4/04/12	23/2015	4/11/15	30/06/16	52	8
16	KEANE, Shaun Martin	15/07/12	24/2015	27/10/15	-	-	-
17	NOAKES, Geoffrey Scott	20/02/13	25/2015	15/09/15	-	-	-
18	SHUEARD, Braydon Adrian	11/03/13	27/2015	27/10/15	-	-	-
19	RAMM, Gladys Maud	20/04/13	28/2015	27/10/15	-	-	-

No	Name	Date of Death	Inquest Number	Inquest Start Date	Finding Delivered	Period (mths) From DOD	Period (mths) From Inquest
20	FREDERICK, Geoffrey Lachlan Hogarth	28/05/13	29/2015	25/11/15	-	-	-
21	MITTON, Rodney Lyle	8/06/13	30/2015	18/11/15	05/05/16	35	6
22	FALKENBERG, Malcolm David	27/06/13	31/2015	18/11/15	05/05/16	35	6
23	DANIELSEN, Jens Thomas	3/07/13	32/2015	18/11/15	05/05/16	35	6
24	REED, William Matthew	23/08/13	33/2015	18/11/15	-	-	-
25	CORBO, Antonio	11/09/13	34/2015	25/11/15	-	-	-
26	GRAETZ, Clifford Ralph	16/09/13	35/2015	25/11/15	-	-	-
27	SHIRRA, James Angus	22/09/13	36/2015	25/11/15	09/12/15	27	0
28	CAMERON, George William	29/09/13	37/2015	25/11/15	-	-	-
29	KUSKOFF, Alexander Peter	16/09/15	38/2015	20/10/15	-	-	-
30	McSHANE, Robert Ian	8/01/13	39/2015	7/12/15	-	-	-
31	BAARTSE, Leila Marijke	1/10/15	40/2015	14/12/15	-	-	-
32	ONG, Hock An	22/07/13	1/2016	11/03/16	-	-	-
33	KALME, Dearne Lee	14/10/13	2/2016	16/02/16	-	-	-
34	SCHULZ, Bertha Anna	22/10/13	3/2016	16/02/16	-	-	-
35	CAILES, Kevin Arnold	25/12/13	4/2016	16/02/16	-	-	-
36	WAY, Dennis Martin	15/12/13	5/2016	16/02/16	-	-	-
37	QASEM ADBALLA, Saeed	12/10/13	6/2016	11/03/16	-	-	-
38	PERTZ, Zvonka	2/02/14	7/2016	11/03/16	-	-	-
39	ROBERTS, Brian Matthew	22/03/14	8/2016	11/03/16	-	-	-
40	BROWN, Leon McLaren	5/04/14	9/2016	11/03/16	-	-	-
41	HENEKER, Scott Maxwell	7/08/12	10/2016	29/04/16	-	-	-
42	MAYELL, Edward John	5/10/14	11/2016	23/05/16	-	-	-

No	Name	Date of Death	Inquest Number	Inquest Start Date	Finding Delivered	Period (mths) From DOD	Period (mths) From Inquest
43	HUNT, Ian James	26/02/16	12/2016	24/03/16	-	-	-
44	ISSACSON, David Jacob	9/04/14	13/2016	14/04/16	-	-	-
45	KENNEDY, Brian	30/04/14	14/2016	14/04/16	-	-	-
46	SMITH, Colin Peter	15/04/14	15/2016	14/04/16	-	-	-
47	HOPKINS, Ronald William	20/04/14	16/2016	14/04/16	-	-	-
48	ALCOCK, Ross Matthew	23/02/14	17/2016	3/05/16	-	-	-
49	MAHERAS, Haralambos	15/05/14	18/2016	6/05/16	-	-	-
50	DILETTOSO, Giuseppe	20/05/14	19/2016	6/05/16	-	-	-
51	COOPER, Alfred Henry	6/07/14	20/2016	6/05/16	-	-	-
52	BRADLEY, Dwayne Scott	22/07/14	21/2016	6/05/16	-	-	-
53	DORMAN, Frank	29/07/14	22/2016	6/05/16	-	-	-
54	MILERA-ASHFORD, Bailey Trent Richard	12/07/13	23/2016	11/05/16	-	-	-
55	KLINGBERG, Briony Caitlin	18/01/15	24/2016	1/06/16	-	-	-
56	MCCONNAL, Brenton Winton	15/12/15	25/2016	17/05/16	-	-	-
57	HAZLETT, Steven William	26/07/14	31/2016	24/06/16	-	-	-
58	PUTSEY, Doreen Mary	11/08/14	32/2016	24/06/16	-	-	-
59	D'ARCY-EVANS, Andrew Eyre	12/08/14	33/2016	24/06/16	-	-	-
60	HEARNE, Alistaire William	22/08/14	34/2016	24/06/16	-	-	-
61	BANNISTER, Alfred Geoffrey	2/11/14	35/2016	24/06/16	-	-	-

8.2. Recommendations

Section 25(2) of the Act provides that the Court may add to its findings any recommendations that might, in the opinion of the Court, prevent or reduce the likelihood of a recurrence of an event similar to the event that was the subject of the Inquest. Where a recommendation is made pursuant to section 25, the recommendation must be included in this annual report (section 39(2)). The following is a list of recommendations made by the Coroners Court during the year the subject of this report (excluding deaths in custody):

Sophie Ann Schulz (Coroner Schapel)

The Court would like to apologise to the family of Sophie Ann Schulz for omitting the recommendations made following the Inquest into her death from the 2012-2013 Annual Report to the Attorney-General. The recommendations from this Inquest were as follows:

I make the following recommendations:

1) That these findings be drawn to the attention of Standards Australia and that Standards Australia consider researching and implementing a Standard whereby massage tables with exposed lowering mechanisms should be required to have guards attached in order to prevent accidental access by a person to the working mechanism;

2) That SafeWork SA issue a further Safeguard to the effect that in no circumstances should a child be present within a room in which a massage table of this kind resides, except in the case of an age appropriate child who can be accommodated within a playpen.

The Court would also like to apologise for the incorrect spelling of Sophie's middle name in sections 8 and 8.1 of the 2012-2013 report.

Marjorie Irene Aston (Coroner Schapel)

The Court makes the following recommendations:

1) That these findings and recommendations be brought to the attention of the Chief Executive Officer of the Royal Australian College of General Practitioners, the Chair of the South Australian State Committee of the Royal Australian College of Physicians and the President of the Australian Medical Association (SA);

2) That consideration be given to revision of the practice whereby specialist medical practitioners in the first instance prescribe warfarin in the expectation that a general practitioner will thereafter manage the patient's warfarin therapy. Consideration should be given to the issue as to whether the general practitioner, on the advice of the specialist, should both initiate and manage the patient's warfarin therapy;

3) That specialists be advised not to place undue reliance on the patient him or herself advising the general practitioner that warfarin therapy has been initiated by the specialist;

4) That in circumstances where the specialist initiates warfarin therapy but does not intend to manage that therapy, the specialist should immediately advise the patient's general practitioner, by the most efficient method of communication available, that warfarin therapy has been initiated and that the general practitioner is expected to manage that therapy. In this regard the practice of communicating with general practitioners by way of ordinary post should be curtailed and be replaced by a means of communication that would

include email and/or facsimile transmission. Any such communication should contain a request that the general practitioner, by return, acknowledge the communication. It may be necessary in some cases for the specialist to communicate with the general practitioner by phone;

5) That in cases where warfarin therapy may be indicated, general practitioners who refer patients to a specialist should advise the specialist that they expect to be informed of the initiation of warfarin therapy by the most efficient and rapid means available. They should also advise the specialist that they expect to be copied into any INR test results that have been obtained by the specialist;

6) That medical specialists initiating warfarin therapy and who also initiate INR testing ensure that the patient's general practitioner is copied into the results of any INR test;

7) That general practitioners be reminded that where patients who are undergoing warfarin therapy display unexplained bleeding, especially in cases where INR monitoring has not been conducted on a satisfactory basis, there is a need to carefully consider whether the patient should undergo reversal of anticoagulation at the earliest possible opportunity. In cases of doubt the general practitioner should seek a second opinion;

8) That medical practitioners be advised to include in request forms for INR testing all information relative to any clinical presentation that the patient might exhibit and which is consistent with possible excessive anticoagulation, and also to include information that no previous INR testing has taken place where that may be the case.

Robert Campbell and Jeremy Todd Williams (Coroner Johns)

I recommend that mental health nurses, particularly those in Emergency Departments, should have mandatory ongoing training in respect of their powers and duties under the Mental Health Act 2009.

I recommend that records relating to such training should be maintained centrally with the Chief Psychiatrist for monitoring purposes.

I note that I made the following recommendation as a result of the Inquest into the death of Damian Kay[3]:

> 'That a junior doctor or a mental health nurse should not discharge a suicidal patient, particularly one brought in by police under section 57(1)(c) of the Mental Health Act 2009, from an Emergency Department without having sought advice from a senior medical colleague - either an Emergency Department senior registrar or consultant, or else a psychiatric registrar or consultant on-call;'

Having considered the matter I now do not regard it as adequate to permit a discharge by a junior doctor or a mental health nurse unless the patient has consulted with a psychiatric registrar or a psychiatric consultant. Nothing less than this is sufficient in the case of a patient brought in by police under section 57 of the Mental Health Act 2009, and I so recommend.

I recommend that the clinical review process within Northern ACIS be amended to require that the person who carried out the assessment in the first instance should be present at the review to present the case to the consultant psychiatrist. Given that the ACIS system of treating persons in the community appears to be designed to cut costs, this is one cost cutting bridge

[3] Inquest 15/2012

too far. The very least that can be expected is that the person who actually saw the patient will make the presentation to the psychiatrist and I so recommend.

The Northern ACIS file was mistakenly transferred away from Mr Davies. The mistake was not discovered by some systematic process, but rather randomly by Ms Mullins[4] who is a fellow mental health nurse, not someone in any position of authority and who took it upon herself to randomly check the scheduler because she was aware of just how unreliable it was. I have no confidence that there is a systematic process to audit the system to pick up such mistakes and I recommend that there be a review of the operation of the scheduler system to prevent a recurrence of this unforgivable mistake.

So far as the possible role played by Duromine in the case of Mr Williams, I make the recommendation that when a person presents to his or her general practitioner with mental health issues for the first time, the practitioner should make a check of any current medication to ascertain if there are any contraindications to the taking of such medication in the setting of a psychiatric condition and I direct that recommendation to the Royal Australian College of General Practitioners and the Australian Medical Association.

Marie Janet Ford (Coroner Johns)

I recommend that the South Australian Minister for Health, the South Australian Minister for Ageing and the Commonwealth Minister for Health and Aged Care consider this finding and work together to consider the possible adoption of a protocol under which nursing facilities would refer patients following falls resulting in minor head injuries to hospital for assessment, and that hospitals receiving such patients should give consideration to the carrying out of a CT scan for at least those patients who are on anticoagulation therapy.

Ebony Simone Napier (Coroner Schapel)

I make the following recommendations directed to the attention of the Minister for Education and Child Development, the Chief Executive of the Department for Education and Child Development, the Minister for Child Protection Reform, the Minister for Health, the Chief Executive of the South Australian Department for Health and Ageing, the Minister for Police and the Commissioner of Police.

I repeat the recommendations made by the State Coroner of South Australia in the matter of the death of Chloe Lee Valentine[5] to the extent that those recommendations are relevant to the death of Ebony Simone Napier, namely Recommendations numbered 22.3, 22.4, 22.5, 22.7, 22.8, 22.11, 22.12, 22.13, 22.14, 22.15, 22.16, 22.18, 22.19, 22.20 and 22.21 (and would add that Recommendation 22.21 be extended in its operation to the supervisors of social workers if a supervisor is not a qualified social worker). By referring to a select number of the State Coroner's recommendations that this Court adopts, I do not mean to imply that the remaining recommendations should not be implemented.

I recommend the implementation of a uniform national child protection structure that would comprise the following elements:

a) A nationwide database in respect of all information that has been and will be gathered in relation to child protection cases throughout the entire country. The national database should be immediately accessible by workers within the child protection authorities of each individual State and Territory, thereby obviating the need for specific inquiries to be made

[4] Exhibit C47
[5] Inquest 17/2014

as between one State child protection authority and another State child protection authority, or by the use of interstate liaison officers. For example, a child protection worker employed within Families SA should be able to have immediate access to information about the child protection history of an individual whose history is contained within records created and kept in another Australian State or Territory. I further recommend that insofar as it is necessary, legislation should be introduced to facilitate such nationwide access to child protection information in order to overcome any privacy considerations;

b) In circumstances where an individual moves from one State or Territory to another there should be automatic transfer of guardianship, custody, parental responsibility and like orders as between the States and Territories of Australia;

c) That where a State child protection authority loses contact with a child who is the subject of a child protection matter within that State, the authority should immediately place an alert that informs all other State and Territory protection authorities of the fact that contact has been lost with the child in question.

I recommend that the Minister for Health and the Chief Executive of the South Australian Department for Health and Ageing take steps to ensure that where members of the staff of health services have detected drug abuse in a family environment in which children are present, that such drug abuse be immediately reported to the Families SA Child Abuse Report Line. This should occur both in cases where Families SA have an existing notification in respect of a child or children of such a family and in those cases where they do not.

I recommend that it be recognised that an essential element of any investigation into a notification to Families SA in respect of a child is a thorough investigation into the background of the parents of the child or of any person in loco parentis to a child. This is particularly necessary in circumstances where the family concerned has come to this State from another State or Territory and little is known about the family. It is also particularly necessary in cases in which one or both parents, or a person in loco parentis to the child, is him or herself under the guardianship of a Minister responsible for child protection in another State or Territory (or is of equivalent status). It should be assumed, unless demonstrated otherwise, that a person who is under the guardianship of the Minister responsible for child protection in another State or Territory (or is of equivalent status) and who has come to this State without the knowledge or permission of the authority administering child protection in the State or Territory from which the person has come, has come to this State in order to avoid the regime that his or her interstate child protection status has imposed.

I recommend that the Child Protection Service, Families SA and SAPOL recognise that an investigation strategy in respect of an injury to a child comprises more than a bare assessment as to whether the injury is consistent in a mechanical sense with an explanation proffered for that injury. An investigation needs to take into consideration the background and propensities of persons connected with the child and the intrinsic likelihood or otherwise of the explanation having regard to all of the relevant circumstances. A person should not be regarded as having been 'cleared' of having deliberately caused an injury to a child except in circumstances where the investigators are satisfied with some certainty that the injury was not deliberately caused.

I recommend that the Child Protection Service recognise that an investigation conducted by the Service should take into account the medical opinions of all physicians involved in the child's matter, including but not limited to the opinions of radiologists who have conducted or reported on radiological investigations.

I recommend that in the following circumstances the closure of notifications and files within Families SA in respect of child protection matters should only be authorised by an officer superior in rank and position to that of Supervisor:

i) in cases where physical harm has been sustained to a child in respect of whom a notification has been made, or in cases where such physical harm has been reported;

ii) where domestic violence has occurred or has been reported within a family, where such domestic violence has not necessarily involved the specific child to whom the notification relates;

iii) in cases where there has been a reported disengagement by the family from health and other services which to that point in time have been provided.

I recommend that all other Families SA file closures be reported to an officer of higher rank than Supervisor as and when those files are closed.

I recommend that in cases where the family of a child who is the subject of a notification to Families SA has disengaged with health and other services, that such disengagement be immediately reported to Families SA by way of further notification or otherwise, and that in such circumstances a Families SA worker should immediately be dispatched to the home of that family to investigate the reason for disengagement from services. In all such cases the family should be warned, both in person and in writing, that any further disengagement from services might well involve the taking of action against that family pursuant to the Children's Protection Act 1993. I further recommend that Families SA thereafter continue to monitor on a regular basis the engagement of that family with health and other services, and to insist upon regular reports from those services concerning the engagement or otherwise of that family with those services. I recommend that under no circumstances should a file ever be closed where reported disengagement from health and other services has taken place.

I recommend that the Minister for Education and Child Development, the Minister for Child Protection Reform, the Chief Executive of the Department for Education and Child Development, the Minister for Health and the Chief Executive of the South Australian Department for Health and Ageing conduct a full reassessment of the manner in which health services, including the Women's and Children's Hospital, the Children, Youth and Women's Health Service, and Child and Family Health Services and Families SA interact in cases involving child protection matters.

I recommend that Families SA ensure that there are systems in place that will result in the escalation of Families SA scrutiny and oversight of notified matters in circumstances where the subject family has been reported as having disengaged from services.

I recommend that Families SA instruct all staff that the closure of a notification file does not of itself relieve Families SA of the responsibility for the care and protection of the relevant child. Families SA should urge staff not to place undue emphasis on the formality of file closure, but rather to examine the substance of any further information that comes to hand regarding the risks posed to a child who was the subject of the original notification. I further recommend that Families SA implement a system that would, in cases that have involved high risk to a child, facilitate the continued monitoring and scrutiny of families notwithstanding the closure of a notification file.

I recommend that Families SA introduce requirements and measures that would ensure that where due to a lack of resources any matter is not being adequately managed or investigated, the matter is immediately drawn to the attention of the Chief Executive of the Department for Education and Child Development.

I recommend that staff members of services such as Children, Youth and Women's Health Service and Child and Family Health Services be trained in specific child protection issues and that they be encouraged to have regard to the need in given cases to assertively engage with families. Families who disengage from services should be reported to Families SA as and when such disengagement occurs.

I recommend that where a family has been engaged with health or other services, and where Families SA intends to close its file, that the various service entities be advised of that intention before closure actually occurs.

I recommend that regular formal inter-agency liaison meetings occur as between the various service providers and Families SA to discuss families at risk.

I recommend that the Minister for Police and the Commissioner of Police ensure that data retention systems are in place such that reported incidents involving the same family are together collated. Such a system should enable police officers to ascertain immediately whether a family in respect of whom they are conducting an investigation has been the subject of any previous interaction with police or has been the subject of any notification to Families SA.

Roswitha Maria Osang (Coroner Johns)

I recommend that the Cardiac Society of Australia and New Zealand, in conjunction with the Royal Australian College of General Practitioners, consider whether it is necessary to alert the general practice community to the risks involved in the prescription of Sotalol in untreated heart failure.

Mellanie Joanne Paltridge (Coroner Schapel)

The Court makes the following recommendations directed to the Chief Executive of SA Health, the Chief Executive Officer of the Women's and Children's Hospital, the Chief Executive Officer of the Country Health SA Local Health Network, the President of the Australian Medical Association (SA), the Chair of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (SA), and the Chair of the Royal Australian College of General Practitioners (SA):

1) That educational and professional development strategies be directed to the medical profession, including medical practitioners and nursing and midwifery staff, concerning the condition of ruptured splenic artery aneurysm. Such measures should include reference to (a) the proposition which appears to be generally accepted that a diagnosis of ruptured splenic artery aneurysm should be considered in any pregnant patient who complains of sudden onset of severe left upper-abdominal pain regardless of whether pain or shock is prominent at the time of evaluation, (b) the symptomatology of the condition, (c) the fact that patients who are experiencing a ruptured splenic artery aneurysm will not necessarily present in the first instance in shock, (d) the fact that practitioners should be alive to the possibility that false reassurance might be derived for a period of haemodynamic and other stability following the initial episode, (e) the fact that limited diagnostic reassurance can be derived from a patient's positive response to analgesia, (f) the issue as to whether or not the absence of abdominal guarding and rigidity is of diagnostic significance, (g) the diagnostic measures that are available and appropriate to diagnose a ruptured splenic artery aneurysm, and (h) the need for urgency in the conducting of diagnostic measures in cases where a differential diagnosis of ruptured splenic artery aneurysm is involved;

2) Presentations of a pregnant woman who complains of a sudden onset of severe left upper abdominal pain, especially with evidence of loss of consciousness at the time, should immediately be referred to, as far as is possible, a consultant obstetrician and gynaecologist or other medical practitioner at consultant level, including an Emergency Department consultant or surgical consultant;

3) That such patients be the subject of continual and detailed observation, and that such observation should be supervised by a medical practitioner at consultant level;

4) The recommendation of the Victorian Coroner's Court in respect of the death of Michelle Johnson is endorsed, namely:

> 'Intra-abdominal haemorrhage (e.g. ruptured splenic artery aneurysm, ruptured liver) should be considered as part of the differential diagnosis when a pregnant woman presents with severe abdominal pain especially if she requires narcotic analgesia.'

5) That consultations between consultant medical practitioners and radiologists regarding the appropriateness or otherwise of conducting CT scans of pregnant women in circumstances where ruptured splenic artery aneurysm is a part of a differential diagnosis be encouraged to take place routinely;

6) In cases where ruptured splenic artery aneurysm is part of a differential diagnosis, but where other preferred or more likely diagnoses need to be explored, that all diagnostic measures in respect of those other diagnoses be conducted urgently and at the first available opportunity;

7) That the services currently provided at the Women's and Children's Hospital be co-located with the Royal Adelaide Hospital.

8.3. Recommendations - Deaths In Custody

Where a recommendation is made in relation to a death in custody, the Minister responsible for the agency or instrumentality of the Crown to which a recommendation is directed must, within eight sittings days of the expiration of six months after receiving a copy of the findings and recommendations, cause a report to be laid before each House of Parliament giving details of any action taken or proposed to be taken in consequence of the recommendations, and forward a copy of the report to the State Coroner. During the year under report the following recommendations were made in cases of deaths in custody:

Judith Beverley O'Leary (Coroner Schapel)

It is suggested that when an order is made pursuant to section 32 that includes orders that the protected person reside in such place as the guardian from time to time thinks fit, and an order that the protected person be detained in such place as the guardian shall from time to time determine, an order should also be made that such direction or determination of the guardian in that regard be reduced to writing. I direct this recommendation to the President of the South Australian Civil and Administrative Tribunal which entity now has responsibility in relation to the imposition of orders pursuant to the Guardianship and Administration Act 1993.

8.4. Response to Recommendations - Deaths In Custody

During the year the subject of this report, the following reports detailing any actions taken or proposed to be taken in consequence of recommendations made in the case of a death in custody, were received by the State Coroner:

Shane Rene Blunden (Coroner Schapel)

Recommendation 1 - That the Department for Correctional Services continue to identify and eliminate hanging points from cells in all South Australian correctional institutions and, in particular, to replace all ventilation grilles, air-conditioning vents and similar with anti-ligature vents.

- The Department continues to identify and eliminate hanging points from cells and ensure safe cell designs are applied throughout prison systems. Resources are targeted towards those accommodation areas that hold prisoners presenting the greatest risk of suicide or self-harm, and newly admitted prisoners of whom DCS has limited knowledge.

  The majority of the Department's infrastructure pre-dates the 'safe cell' standard introduction. However, since this incident, the Department has strengthened its approach to this practice and has issued a policy that ensures renovations and upgrades of existing prison cells are undertaken in accordance with a risk based approach.

  As resources are allocated to renovate cells to 'safe cells' standards, the Department refers to the following Priority Tiering System:

  TIER 1 PRIORITIES:
  Observations Cells - cells used for camera or physical observation of prisoners at risk of suicide or self-harm in the interests of the safety or welfare of the prisoners, separated under section 36(2) of the Correctional Services Act 1982 (the Act).

  TIER 2 PRIORITIES:
  Management cells - cells used to manage prisoners separated under section 36(2) of the Act that are not specifically observation cells as defined above.

  TIER 3 PRIORITIES:
  Admission/Induction cells - Secure prison cells in the Admission/Induction Unit.

  TIER 4 PRIORITIES:
  Secure cells in High Security Prisons with Secure zones as first priority and Residential zones as second priority.

  TIER 5 PRIORITIES:
  Secure cells in Medium Security Prisons with induction units as first priority and all other secure cells as second priority.

  The Department has completed all Tier 1 and Tier 2 cells and is currently prioritising Tier 3.

  An audit has also been conducted on cells considered in Tier 1 and Tier 2 across the system and against the Principles of Safe Cells. The audit also saw resources allocated to complete a full detailed site audit of all cells inclusive of photos of every cell and prescribing compliance or non-compliance to the principles of Safe Cell Principles, Targeting High Risk areas first.

In recent years, additional cell accommodation units have been designed and constructed to meet the principles of safe cell. This includes Banksia Unit at Port Augusta Prison and the WaaWoor Unit at Mount Gambier Prison.

The cost to remove ligature points from prison cells varies from prison to prison and cell to cell. Variable costing factors include existing style of showers, toilet facilities, beds, storage facilities and hand basins. Noting prison cells have different infrastructure, it is not possible to indicate a generic cost for a full 'safe cell'[6] conversion.

The Department continues to alter prison cell infrastructure through funding from the annual provisions capital budget. This work is ongoing recognising the importance of the Department reducing risk associated with prisoner self-harm or suicide within prisons.

All new build secure prison cell accommodation meets 'safe cell' specifications.

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

- Within South Australia there are nine prison facilities of which eight are managed by the Department and one is managed by private contractor arrangements. Of these prisons, six[7] are deemed 'reception' prisons meaning they admit prisoners from either South Australia Police or Court custody. The other three[8] prisons do not admit prisoners however provide a transfer option for prisoners moving through the system.

  The Admissions area of each prison is equipped with space for an Officer to induct the prisoner into the facility inclusive of assessing potential stress factors. To assess level of risk or stress related factors the Officer can access a range of JIS information (inclusive of case notes and warning flags), a Prisoner Stress Screening Form is completed, and any information which may be provided by South Australia Police through their SHIELD electronic platform is reviewed[9].

  Each of the admitting prisons operate slightly differently during the admission process however they each acknowledge Officers are not rostered to this position until a level of competence has been achieved. Ongoing support and work shadowing opportunities are some methods in which Officer confidence can be developed. Additionally, within the maximum security prisons Supervisors are allocated to the Admissions area and are able to assist / manage the induction / assessment process.

  Each departmental employee is granted access to JIS.

[6] In accordance with interstate practices and Coronial recommendations, DCS has determined that the following principles form the basis of 'safe cell' design principles: no obvious hanging points or ligature points, forced air circulation throughout all cells, all edges are rounded, all knobs / taps are sloped, safety screws used throughout, wall fixtures sit flush with walls, all joins are sealed, and all lighting is recessed or anti-ligature design.

[7] Prisons include; Adelaide Remand Centre, Yatala Labour Prison, Adelaide Women's Prison, Port Augusta Prison, Port Lincoln Prison and Mount Gambier Prison.

[8] Prisons include; Adelaide Pre Release Centre, Cadell Training Centre, and Mobilong Prison.

[9] The SHIELD generated report is only available if the prisoner was processed through a SAPOL charging station.

JIS user access permission levels are determined by the employee role which is cross referenced to the JIS Security Profile Specifications Version 1.51 May 2015.

JIS Security Profile Specifications for "Custodial Correctional Officers" enables employee access to the following JIS functions:

- **Case Management** including; All Enquiries Record / Modify / Browse Case notes, Manage Home detention, Manage offender plan menu, Create Program Plan, Schedule Case Review, Record Case Review, List Case Officer Tasks
- **Reports** including Institution Reports (Batch), Prisoner Reports, Assessment reports, Sentence Plan reports
- **Basic Pay Functions** including; Activity Assignment menu and Activity Attendance menu
- **Offender Enquiries**
- **Prisoner Information System (Main Menu)**
- **Manage Prisoner Details** including; Interview and Security rating and all other Prisoner details
- **Urinalysis** including Modify Drug Test
- **Movements** including; Manage incoming / outgoing Prisoners, Maintain movements (including modify / delete), Manage Leave Plans (including modify / delete), Manage Court Appointments (including modify /delete), Modify / Delete prisoner Placement
- **Basic Visits** including record / modify visit appointment and also Delete Nominated Visitors
- **High Risk Offenders** including; Enquiry access for Serious Offender, High Risk of Re-offending, Suicidal Self Harm, HRAT, Gang Member, Prison Gang Member
- **Incidents** including; Incidents Prison General, Incidents General Full
- **Prison Photographs** including; Add prisoner photograph, Delete Prisoner Photograph, Print Prisoner Photograph Documents, Enquire Prisoner Photographs (Local)

Of particular importance to the Coronial findings, confirmation is given that Custodial Correctional Officer user permission level authorises access to the following:

- HRAT case notes (current and historical);
- Prisoner Warning Flags (both current and historical); and
- All JIS case notes are available regardless of the time in which they were written (for instance case notes for a prisoner from 5 years earlier from a separate incarceration period remain visible to a level 2 Correctional Officers).

In relation to Officer training, new Correctional Officers must complete an initial 12 week training program. During this period, six weeks is allocated to 'classroom' type training and the other six weeks is allocated to 'in-house' training within the prison whereby the Officer 'shadow' staff to enhance their learnings. The training modules provided within the program target the development of skills which pertain to prisoner management inclusive of JIS training. Post the initial twelve week period Officers continue their learning within a prison and must continue to evidence their learnings through a range of activities within the Workplace Assessment Guide (WAG). These activities must be observed or reviewed by a senior Officer and witnessed by signature that the person is deemed competent in that specific area. Activities include ability to access electronic information inclusive of JIS case notes.

Officers have a 12 month period to complete their WAG and demonstrate competence to be eligible for Certificate III in Correctional Practice. During this period quarterly performance

reports are provided to Executive level staff which monitor the Officers progression and enable the opportunity for Managers to address concerns which may arise. Within these performance reviews evidence of JIS case noting is required. Once the Officer is successful in obtaining their Certificate III they may progress to the next level which enables them to perform duties of an Officer independently within the prison[10].

Recommendation 3 - That the Chief Executive of the Department for Correctional Services ensure that all documentation that is received at the time of the arrival of a prisoner at a correctional institution in this State is seen and examined by the admitting officer and that a copy of all such documentation is placed within the prisoner's case management file. A copy of the entirety of the documentation should be provided to the Prison Health Service upon admission of the prisoner. No document should be removed from the bundle of documentation that is received at the time of admission. An inventory listing all individual documents that are intended to accompany the prisoner to a DCS institution should be created by SAPOL before the prisoner is removed from SAPOL custody. The inventory should also accompany the prisoner. A further inventory should be created by DCS staff when the SAPOL documentation arrives at the DCS institution.

- Since Mr Blunden's death in 2011, a number of process changes have occurred within the Department and interrelated processes with other Justice Agencies.

  Of particular significance is the implementation of the South Australia Police (SAPOL) SHIELD generated report titled Detainee Transfer Report (DTR) and legislative changes regarding the release of information between DCS and SAPHS.

  On 15 October 2013, SAPOL commenced the introduction of its SHIELD program. The SHIELD program was implemented over a 12 month period and included consultation with DCS. As a general overview, if an offender is processed through a SAPOL charging station prior to being transferred to a prison, a DTR will be provided (via the SHIELD electronic system) to the receiving Officer. The DTR summarises a range of critical information areas including the offence, warrant details, welfare, care plan, risk assessments, detention log, property, and detainee flags / cautions (for instances self-harm or suicide risk).

  The DTR is produced electronically and replaces all previously issued Police Information Management System (PIMS) documentation (which were utilised at the time of Mr Blunden's admission).

  Communication with DCS employees regarding the new SHIELD system occurred via a Deputy Chief Executive Instruction (DCEI) 98-13 *Prisoner Admission, SAPOL Custody Forms and Prisoner Stress Screening Forms*, a range of teleconferences and ongoing support to Admissions Officers from central office Safety and Security Services Unit. This DCEI also referenced the importance of documentation being shared with SAPHS. In particular the DCEI stated "*Complete copies of the Detainee Transfer Report (DTR) paperwork and / or PIMS documentation are to be placed in the prisoner's case file and a copy must be provided to Prison Medical Staff*".

  Noting the change from the former police documentation to the DTR may cause some additional stress for staff in identifying any risk factors, a document titled *Detainee transfer report comparison* was emailed to staff via their General Managers. The *Detainee transfer*

[10] Working independently does not exclude recognition that specific positions within a prison such as Admissions Officer may require additional site training / supervision.

report comparison provided staff with the title of previous SAPOL documents received at the point of admission and the location of this information within the new singular DTR.

The advancement from numerous SAPOL forms over to a singular SHIELD produced report significantly reduces the risk of 'misplaced' SAPOL forms. It is important to note that only those offenders coming into a prison via SAPOL custody will have an accompanying DTR. Those offenders being admitted directly from a court hearing will only be admitted with a document such as Warrant of Commitment or Sentencing Advice form which outlines the Judge's / Magistrate's decision.

With regard to prisoner records management, Executive Directors Instruction (EDI) 65-12 Prisoner Documentation was issued on 13 March 2012. This Instruction stated "*Effective immediately, General Managers are to ensure any documentation which pertains to a prisoner is kept and filed either in the prisoners Case File of Dossier. This documentation is to include but not restricted to all Movement Orders, Court Return Advice Slips, SAPOL Authority to Remove a Prisoner Request Form and any other appointments or Hospital Escorts including appointment schedules. Upon release of the prisoner all documentation is to be retained and sent to Microfilm for archiving*".

To ensure compliance with the above EDI, DCEI and the Departments Standard Operating Procedures (SOPs) prisons have implemented reviews of random prisoner case files within the site Operational Compliance Framework. These compliance reviews check prisoner case files to ensure documentation is contained as prescribed. Outcomes of these compliance checks (for instance incomplete documentation) form part of the sites monthly report to the Audit and Risk Team.

Recommendation 4 - That the Chief Executive of the Department for Correctional Services ensure that there are procedures in place at all correctional institutions in South Australia to ensure that at the time of admission of prisoners aged below 20 years of age, enquiries are made in respect of the behaviour of the prisoner during any period of the prisoner's interaction with the juvenile justice system, and in particular to ascertain whether any information in respect of risk of self-harm is contained within records held within juvenile custodial institutions.

- On 28 April 2014 a Memorandum of Administrative Arrangement (MoAA) was enacted between DCS and the Department for Communities and Social Inclusion (Youth Justice) (DCSI YJ) with a one year review notation.

  The MoAA outlines "*information exchange arrangements to enhance the capacity of the Department for Communities and Social Inclusion (Youth Justice) and the Department for Correctional Services to provide coordinated services and support young people making a transition between youth and adult, or adult and youth correctional settings".*

  The MoAA included a standard template for correspondence requests between the two agencies. The request for information is emailed to a designated mail box and a response must be provided within 24 hours.

  Whilst this Coronial Recommendation specifically outlines request for information for those prisoners admitted aged below 20 years of age, both Departments agreed to use 25 years of age as the threshold for the MoAA in line with DCSI YJ definitions of a "young person".

  In consideration of making every attempt to capture information regarding a young person's level of risk within current resources, both agencies decided whilst the age for

information sharing would be set at prisoners 25 years or younger, applications for information would be restricted to those young people admitted to prison where identified risk factors have led to a Notification of Concern (NOC) being raised[11]. This standard enables the Department to obtain information from DCSI YJ for a wider age group population than recommended by the Deputy Coroner, however an initial risk assessment must be made by the admitting officer before a request for information is actioned (as to avoid a 'blanket' approach which may saturate staff with information and potentially increase risk of information not being appropriately assessed).

To communicate the ability for DCS to obtain information from DCSI YJ, DCEI 106 – 14 *Information Sharing with Youth Justice – Young People Admitted to DCS Custody* was issued on 21 May 2014.

The DCEI stated the MoAA between DCSI and DCS had been signed and effective immediately. It advised when a prisoner is admitted into an adult prison facility for the first time, is aged between 18 and 25 years, and has presented with vulnerabilities / risks which led to a NOC being raised, the individual responsible for conducting the Suicide Assessment Manual for Inmates (SAMI) must submit a request to DSCI YJ for additional information. DCSI YJ will provide the information to the DCS worker within a 24 hour period. The DCSI YJ report must then be placed in the Prisoner Case File. The responsible Manager for this process is the Manager Offender Development and / or the HRAT Chair allocated to the specific prison.

Within the past few months the MoAA has been reviewed (noting one year review period) and reissued to Senior Managers across both DCS and DCSI YJ agencies on 15 September 2015. The revised MoAA essentially remains as previous document with changes occurring to logistic operations, such as the request of information template and ability for DCSI YJ to seek information from DCS (noting young offenders can cross over both agency jurisdictions)

Recommendation 5 - That the Chief Executive of the Department for Correctional Services ensure that all newly admitted prisoners below the age of 20 years are assigned a case officer, regardless of whether the prisoner's period of imprisonment is expected to exceed a period of 28 days or not and regardless of whether the prisoner is a remanded prisoner or sentenced prisoner.

- With regard to Mr Blunden, the Coroner wrote; *The SOP also describes a requirement in respect of the assignment of a case officer to a prisoner if the prisoners' period of imprisonment was expected to exceed 28 days from the time of admission, regardless of whether the prisoner is a sentenced prisoner or a remanded prison. In this particular case it is understood by the Court that no case officer was assigned to Mr Blunden, or if there was, that person has not been identified. In any case there was no expectation that Mr Blunden*

[11] To aid the Departments prediction of workload impact, and in consideration of risk management, DCS gathered the following data:

- On 1 May 2015 across prison populations there were twelve (12) eighteen year olds, twenty six (26) 19 year olds and fifty seven (57) twenty year olds. A total of 95 prisoners, within the system on this day, aged 20 and below.
- One hundred and fifteen (115) prisoners aged 18 years were admitted between 1 May 2014 and 1 May 2015.
- One hundred and fifty one (151) prisoners aged 19 years were admitted between 1 May 2014 and 1 May 2015.
- One hundred and eight seven (187) prisoners aged 20 years were admitted between 1 May 2014 and 1 May 2015.

In summary between 1 May 2014 and 1 May 2015 a total of four hundred and fifty three (453) prisoners aged 20 and below were admitted.

would necessarily be in Yatala for a period of 28 days as his remand date was 23 September 2011 (Point.5.7 page 21).

In consideration of the above it is assumed the intent of the Deputy Coroner with this recommendation was to have a process which allocates a specific DCS position / employee to a prisoner upon admission as an additional measure in which prisoner risks may be identified in the event they were not captured during the initial admission process. If this is a correct assumption, then the position of Case Management Coordinator (CMC) would be better placed to provide this support. The role of CMC is a five (5) day per week position which offers increased stability for the prisoner when compared with a Correctional Officer who may work across three shift periods over a seven (7) day roster.

SOP 001A section 3.13.1 states: *The CMC that is responsible for the unit / wing area in which a prisoner is accommodated, must assign themselves to that prisoner within 4 days of a prisoners admission or transfer into the accommodation unit. This must be undertaken for all prisoners regardless of status or expected length of the imprisonment period.*

Of particular significance in terms of accountability, the allocation of a CMC to a prisoner is measured against a four (4) day window period; compared with the allocation of a Correctional Officer, which by current standards, must occur within 28 days (Refer to Standard Operating Procedure (SOP) 001A *Custodial Admission – Case Management*).

Recommendation 6 - That the procedure whereby a newly admitted prisoner is mandated to undergo shared accommodation within the first seven days be continued, and that a renewed prisoner stress screening process be conducted in respect of all prisoners at the conclusion of that seven day period, taking into account all further information that may have been gathered in the intervening period about that prisoner's risk of self-harm.

- Prisoner placement is considered once a prisoner has been assessed by the Admission Officer and SAPHS (where available). Whilst shared cell accommodation is an option, single cell placement remains an additional option for those individuals where location prescribes (for instance, G Division at Yatala Labour Prison or the management wing at the Adelaide Women's Prison) or where risk factors may be increased if the prisoner is co-celled. For instance if a prisoner is being admitted and risk factors for self-harm or suicide are present, the assessing staff may determine that the prisoner needs to be placed on camera observation or in a management unit whilst opportunity is provided for additional assessments (for instance social work , psychological or medical) which would necessitate single cell placement. The key element in prisoner cell placement is managing risk and a specific option (single or shared cell accommodation) may be preferable for that individual need at that time.

  On 11 June 2014, DCS commenced the roll-out of an automated email warning system to alert officers to an offender's prior self-harm or HRAT status during the admission process. As a result of this change, the admitting institution is sent the following automated message when a prisoner is admitted to prison with prior self-harm or HRAT status: "*An offender has been admitted to your prison who has a JIS record of self-harm / suicide warnings (either DCS and / or SAPOL).* Further investigation will be required to ascertain current level of risk and if the raising of a Notification of Concern is required". This automated email is sent immediately, once the officer has placed the prisoner name on JIS as being in custody. The automated email is to be used as a prompt for further investigation to ascertain if a NOC is required (the email does not constitute an automatic NOC).

Further to this DCSI 107 – 14 *Prisoner Admission and JIS Warning Flags* was issued on 26 May 2014. This DCSI advised of two changes to JIS being implemented (on 11 June 2015) to enhance the Department's assessment process. The first new process occurs when an Admissions Officer enters the name of a prisoner being admitted to custody. At this time a list of JIS Warnings will appear on the screen before the officer can progress to any other JIS screen. This change enables the admitting officer to recognise any warning flags associated with risk such as self-harm / suicide and ensure the prisoner is prioritised for SAPHS assessment prior to placement within the prison (or may be placed under observation in the holding cell). The second JIS change implemented on this date relates to JIS warning flags for self-harm / suicide and HRAT. Once entered, these warning flags will always remain on the warning screen, with and end date notation if the flag is no longer current. Prior to this change, if a prisoner was removed from HRAT the warning flag would be deleted. With the new changes the warning flag remains with an end date notation.

Within the first week of incarceration prisoners are placed under 'seven day observations' which requires the Officer to make contact with the prisoner regarding their welfare and ensure a JIS case note is completed which summarises their contact. The seven day observation forms are contained within the Prisoner Case File. If any concerns are noted during this seven day period Officers will advise the relevant person (i.e. Social Worker or SAPHS) and request assistance for the prisoner. In particular Standard Operating Procedure 001A Case Management – *Admission – Case Management* states the following:

7-Day Observations commenced:

a) The 7-Day Observation Form (F001/007) is commenced during the induction interview or within 24 hours of placement in an accommodation unit. This form will be used as part of the assessment process.

b) 7-Day Observations do not need to be commenced for prisoners if they are:

i) Admitted directly to the infirmary for medical observation and/or treatment.

ii) Placed in an observation cell where continual monitoring occurs.

iii) Placed in a management cell under section 36 of the Correctional Services Act 1982.

c) Once medical treatment, continual monitoring in an observation cell or placement in a management cell is complete or no longer required, and the prisoner is placed in an accommodation area, 7-Day Observations must commence.

Case notes must be entered onto the JIS detailing any issues/concerns and interventions that have taken place or that have been recommended to take place by DCS, the SAPHS and the Intervention Team within the prison or any external provider over this 7-day period.

Recommendation 7 - That the Chief Executive of the Department for Correctional Services ensure that no prisoner is placed in single accommodation in any cell that contains an obvious hanging point, and in particular in a cell that contains a ventilation grille of the kind that was utilised by Mr Blunden.

- As outlined in the response to recommendation one, DCS continues to amend infrastructure to remove or modify potential hanging points based on an assessment of risk. All newly constructed secure custody cells meet 'safe cell' specifications.

  DCS is committed to providing safe accommodation for all prisoners. The Department strives to protect prisoners from self-harm / suicide and provide support mechanisms to

aid prisoners to address their personal trauma whilst learning effective decision making skills, emotional regulation, resilience and hope for their future as a positive community member.

Recommendation 8 - That in no circumstances should a prisoner who is removed from the HRAT regime be immediately accommodated in single cell accommodation.

- As outlined in recommendation six, cell accommodation options are important tools for staff to manage risk and support the prisoner. When a prisoner is placed onto HRAT, an assessment would determine where they are best placed (for instance single cell or shared accommodation). For some prisoners the ability to share a cell is positive whilst for another prisoner it may enhance stress / anxiety / paranoid thoughts etc.

  When a prisoner is placed on HRAT weekly meetings are conducted with a range of key staff to discuss the prisoners wellbeing. Attendees may include Social Workers, psychologist, SAPHS, Aboriginal Liaison Officer, Accommodation Managers, Supervisors and unit staff. This multi-disciplinary team make decisions regarding the prisoners current assessment, risk factors, protective factors, placement and what interventions will be implemented to support the prisoner. The intervention / assessment agreed upon actions are then documented, actioned over the next seven days then reviewed the following week.

  When a prisoner is monitored by HRAT, staff endeavour to collate as much information as possible from a range of sources to assist with risk management and assessment. It is this forum which decides placement suitability for the individual prisoner and this is reviewed weekly. In the event a member of HRAT or staff member would like the accommodation to be reviewed outside of the weekly HRAT meeting, this can occur in consultation with a selection of HRAT members.

  A key factor with regard to prisoners being placed into shared cell accommodation to assist with managing risk factors, is the importance of ensuring the prisoner remains with another prisoner at all times. For instance, if Mr X is placed into a cell with Mr Y, and Mr Y must attend court or the health centre, staff need to have measures in place to ensure another prisoner is placed into the cell with Mr X to maintain accommodation status. Prisons which utilise the sharing of cells as a mechanism to assist with prisoners who are monitored by HRAT have been reviewed to ensure a site process is in place to assist staff to easily identify those prisoners who must remain 'doubled up' and how this is managed in absence of the co-celled prisoner.

Recommendation 9 - That the Chief Executive of the Department for Correctional Services ensure that when a prisoner is placed in single cell accommodation, a prisoner stress screening procedure is conducted afresh. Such a process should obligate the officer performing the prisoner stress screening to make the necessary Justice Information System enquiries and to identify all information that is or may be relevant to the prisoner's risk of self-harm. This process should apply to, but not be limited to, prisoners who have applied to be accommodated in F Division in single cell accommodation.

- The Deputy Coroner's recommendation has been considered in depth with particular focus upon daily operational functions and principles which underpin SOP 090 *Management of Prisoners at Risk of Suicide or Self Harm*, inclusive of the Prisoner Stress Screen Form (PSSF).

  With regard to the PSSF, a review of this documentation was undertaken in July 2014 to ensure the document effectively assessed risk in consideration of evidence based practice. Post the review an extensive consultation process followed (including members of

institutional High Risk Assessment Teams, Correctional Officers, Regional Working Groups, Aboriginal Services Unit, Sentence Management Unit, Rehabilitation Programs Branch, Case Management Coordinators, Safety and Security Services Unit, Managers Offender Development, South Australian Prison Health Services and Forensic Mental Health Services).

Significant findings from the review included:

1) An over-reliance on offender's self-report for information that could perhaps be more accurately assessed from official records
2) A lack of scoring consistency on the current form with a number of risk factors being assessed in multiple questions
3) The presence of items on the current form does not appear to be linked to evidence based practice.

Following the consultation process and consistent with the aim of using an evidence based approach to identify prisoners at risk of suicide on their admission to prison, data analysis was conducted to examine the predictive validity of the proposed revised PSSF. A trial of the revised PSSF will commence during the 2015–2016 financial year.

The PSSF provides the Department with a guide to potential risk factors for the prisoner. The 'reuse' of this form when a prisoner is placed into a single cell would not necessarily be a predictive indicator of additional risks (noting within the prison environment risk factors change rapidly and not necessarily in response to a specific change of events).

The Department acknowledges prisoner risk factors can change rapidly, for instance following a distressing family phone call, a family member not arriving for visits, children ceasing contact and so forth. These ongoing risks may surface at any point during a person's incarceration; therefore risk assessment cannot solely rely upon a single 'form' at a specific time. To assist staff identify potential risks, for instance changing in behaviours, the Department is committed to ensuring additional training regarding suicide and self-harm (inclusive of refresher training) is delivered to all correctional institutional staff. This training will increase the Officers skill base which will strengthen confidence and ability to identify risk as a fluid ongoing need.

In addition to the ongoing review and development of the PSSF the Department implemented (in January 2014) a new *Stress Screen on Transfer Form*. This form was designed to highlight risk factors which are related to the prisoners internal transfer (in addition to providing detail on any known historical risks).

Recommendation 10 - That the Chief Executive of the Department for Correctional Services ensure that prisoners admitted to F Division are in the first instance accommodated in double cell accommodation within that division.

- The General Manager Yatala Labour Prison has advised all prisoners who are transferred into F Division are required to be accommodated in a 'double-up' cell. When single cell accommodation vacancies arise within F Division, the Supervisor / Manager will review prisoner length of time, behaviour, compliance, mental health issues and so forth before making a decision as to who will move into the single cell.

  Whilst the above process has been occurring since the death of Mr Blunden, formal documentation referred to as the Local Interpretation Statement (LIS) outlining this practice standard remains in draft at the site level. Once discussions have finalised the LIS will be endorsed within the site Local Consultative Committee and published as a final document.

Recommendation 11 - That the Chief Executive of the Department for Correctional Services ensure that there is complete and immediate access to all information gathered about a prisoner by the Department for Correctional Services and within the juvenile justice system.

- In summary of the above 10 recommendations which support access to prisoner information across the Department for Correctional Services and the Department for Communities and Social Inclusion, I offer the following key points.
    - Level 2 Correctional Officers can access a range of information held within JIS which includes case notes, offender enquiries, prisoner interview details, security ratings, urinalysis results, court appointments, prisoner placements, visitors (for instance restrictions and appointments), Warning Flags (including Serious offender, High Risk of Reoffending, Suicidal Self-Harm, HRAT, and Gang Member), incidents, and prisoner photographs.
    - Admissions Officers will receive a DTR from the South Australia Police if the offender was processed via police charging station. This singular report replaces former documents and significantly reduces the risk of information not being communicated across to the Department for Correctional Services. The DTR will be placed in the prisoner's case file and a copy is to be provided to SAPHS.
    - A MoAA has been enacted between DCS and DCSI YJ which enables reciprocated release of information with regard to a prisoner who is admitted into prison, is aged between 18 and 25 years, and has presented with vulnerabilities / risks which led to a Notification of Concern being raised. DCS will forward a request to DSCI YJ for additional information to aid the risk assessment process. This information must be provided within a 24 hour period.
    - The use of a PSSF for each new admission and prisoner transfer received provides the Department with a guide to potential risk factors for the prisoner thus enabling intervention strategies to be implemented to mitigate these risks.

  Information sharing enhancements which have occurred with Health SA, since Mr Blunden's death, are reported within response to recommendation 14 and 15.

Recommendation 12 - That the Chief Executive of SA Health ensure that there are proper and appropriate procedures for the conveyance of Prison Health Service files in respect of a prisoner from one correctional institution to another.

- An electronic database was introduced in 2012 to monitor the movement of patient health records between correctional institutions. All SA Prison Health Services (SAPHS) administrative staff have access to the database and a clear process is in place for requesting the transfer of files. Given increased prisoner occupancy and movements between correctional institutions over the past couple of years, a review of this system is currently being undertaken and is planned to be completed in early 2016..

Recommendation 13 - That the Chief Executive of SA Health establish an electronic database, whether included in EPAS or not, that enables Prison Health Service staff to view the entire health records of a prisoner, regardless of the institution or institutions in which that prisoner has been previously accommodated and regardless of whether the previous institution was an adult institution or a juvenile justice institution,

- SA Health is committed to investing in EPAS to deliver an electronic health record providing access to health information irrespective of juvenile or adult institutional setting. The

current program is focussed on ensuring that the core foundations are in place before extending to services such as SAPHS. In the interim, work is underway to create a Prison Health Service episode within the Community Based Information System (CBIS) electronic system, the SA Health supported system for mental health care planning. This will provide access to prisoner health records regardless of the (adult) institution and will also be capable of recording the unique Justice information System (JIS) number. This will be ready for piloting at the Adelaide Women's Prison in late 2015, ahead of the planned roll out to all sites.

Recommendation 14 - That the Chief Executive of the Department for Correctional Services and the Chief Executive of SA Health establish procedures whereby staff of the Prison Health Service have access to the Justice Information System, particularly in relation to information contained on that system regarding the risk of self-harm of a particular prisoner.

Subsequent action by SA Health

- SA Health is progressing work on a Memorandum of Understanding between SA Health and the Department for Correctional Services (DCS) on information sharing protocols. This includes the development of an interface between the JIS and CBIS to ensure the accurate sharing of prisoner information between SA Health and DCS staff. All SAPHS site staff currently have read only access to the JIS, which includes access to information regarding the risk of self-harm of prisoners.

Subsequent action by the Department for Correctional Services

- In June 2011 the Department created a JIS access levels titled SAPHS Prison Medical Service Security Profile thus enabling prison related health care professionals access to the JIS.

  The JIS Security Profile given to SAPHS employees allows for staff (at both the SAPHS Corporate office and prison) to review comprehensive prisoner information. Access permission includes the ability to view general prisoner and institution reports, and details in relation to high risk offenders. SAPHS staff can also view the JIS Warning Flags which may include HRAT and suicide / self-harm warnings (historical and current).

  DCS is satisfied with the current level of JIS access granted to SAPHS staff and believes that the provision of this access was a significant improvement in the enhancement of information sharing between the two agencies. As of June 2015, 258 SAPHS employees have the JIS Prison Medical Service Security Profile.

  In addition to JIS access, developments have been made to “required information technology infrastructure” at Health Centres and Health Clinics in the prison system. The technological development enables SAPHS staff to create and access electronic health records for prisoners, as well as view community based mental health information through the Community Based Information System (CBIS). Access to the prisoners’ health information is both historical and current thereby addressing the risk where health staff used to wait for hard copies of prisoner health records to be forwarded, a delay which may increase prisoner risk.

  SAPHS staff are also included on daily HRAT email Distribution Lists at each prison. This allows for any NOC, Initial Response Plans (IRP) or other HRAT information to be emailed direct to those staff members on a daily basis.

SAPHS staff can further access current and historical HRAT details through review of meeting minutes (at the relevant institution). These meetings are held on a weekly basis and demonstrate joint decision making to the prisoners management plan.

Recommendation 15 - That the Chief Executive of the Department for Correctional Services and the Chief Executive of SA Health together establish procedures relating to the sharing of information between DCS officers and PHS staff who are involved in the admission process of prisoners in DCS institutions in this State to determine whether, at the time of admission, information recorded in the DCS Prisoner Stress Screening Form is consistent with information given by the prisoner to PHS staff.

Subsequent action by SA Health

- SAPHS has collaborated with DCS on the development and implementation of new procedures for the management of prisoners identified at risk of suicide and self-harm. In 2013, the new SAPHS 'Stage 1 and Stage 2 assessment' document was introduced across all sites. This has improved the identification of health risks upon admission, including the risk of suicide and self-harm. The assessment tool ensures that the DCS Prisoner Stress Screening score is recorded, that CBIS and the OASIS clinical information system are checked, and that all relevant SAPOL paperwork is received and documented.

Subsequent action by the Department for Correctional Services

- DCS and SAPHS continue to work collaboratively to enhance assessment and service delivery to prisoners in recognition that the management of a prisoners' risk of suicide or self-harm is a shared multi-disciplinary responsibility from the prisoner's admission until discharge.

  Enhancements between the two agencies include the following;

  - In February / March 2012 the MoAA between DCS and SAPHS titled *The Administration of Healthcare Services to those detained under the Correctional Services Act 1982 'The Act' at the City Watch House 'CWH'* was enacted. This MoAA operates in conjunction with the *Memorandum of Understanding Between the Central Northern Adelaide Health Service and the Department for Correctional Services Regarding the provision of Prisoner Health Care Services* executed on 2 January 2008 (referred to as the 2007 MOU).
  - One of the key changes for the Department in relation to information sharing is the legislation enacted on 31 August 2012 now requiring staff operating under the *Health Care Act 2008 and / or the Mental Health Act 2009* to disclose relevant health information with DCS.
  - Following this legislative amendment, DCS and SAPHS jointly created the *Protocol for the Exchange of Information between SA Health and the Department for Correctional Services for the Treatment, Care or Rehabilitation of a Prisoner* (referred to as 'the Protocol').
  - The Protocol provides a guideline to information disclosure, in addition to detailing the correct processes that staff must use. The Protocol also extends to a prisoner's contact with the SA Ambulance Service and or health services external to the prison (such as Forensic Mental Health Services / James Nash House, and public hospitals). At this time, the final version of the Protocol is in the final stages of approval.
  - The Protocol will complement the existing Joint System Protocols between DCS and SAPHS (approved in May 2010). Both these documents address the roles and functions

of each organisation and the importance and need for sharing information between both agencies.

- In relation to the admissions process, DCS acknowledges its responsibility with regard to the provision of effective systems and cross agency collaboration, to assess and manage prisoners (upon their admission) who are identified as being at-risk of immediate and / or ongoing risk of suicide or self-harm.
- DCS is satisfied that the current use of the PSSF and NOC process (as prescribed by the Department's *Standard Operating Procedure 090 – Management of Prisoners at Risk of Suicide or Self Harm*) provide appropriate opportunity for SAPHS and DCS staff to accurately record (and review for consistency) any detail in relation to a previous self-harm, or current thoughts of self-harm.
- A prisoner's score on the PSSF informs subsequent decision making by DCS custodial staff on whether to raise a NOC on a prisoner. SAPHS can also raise a NOC based on their own separate assessment. This would then lead to a more thorough risk-assessment by the HRAT and management by multi-disciplinary staff from DCS and SAPHS.
- When a prisoner is admitted the PSSF stipulates that any SAPOL documentation is copied and forwarded to SAPHS with the original being placed in the Prisoner Case File. SAPHS then use the information forwarded as a reference for their assessment (in relation to any additional information provided by DCS Admission Officer for instance a NOC being raised).
- Both agencies are provided with an opportunity at the time of admission to capture (any known or disclosed) detail in relation to a prisoner's risk of self-harm.
- To further enhance the processes used to assist in the identification of at risk prisoners at the time of admission, the Department has also:

    a) Developed and implemented (in January 2014) a new *Stress Screen on Transfer Form*. This form was designed to highlight separate risk factors related to prisoners moving from one institution to another in addition to providing detail on any known historical risks).

    b) Undertaken a review of the PSSF. This review is aimed at ensuring the use of the PSSF allows for better targeting of resources to ensure at-risk prisoners receive increased assessment, treatment and supervision from the time of admission. A draft revised PSSF has been developed following a comprehensive literature review and included consultation across DCS and with representatives from SAPHS and SA Forensic Mental Health Services. The Department will undertake a pilot of the revised form during 2015–2016 to ensure it adequately addresses noted areas of concern prior to implementing the document state wide.

    c) In February 2015, DCS commenced a review of SOP 090. It is expected that a draft updated SOP will be released for consultation towards the end of 2015. Consultation includes liaising with SAPHS.

Jeremy Godfrey Harding-Roots (Coroner Schapel)

Recommendation 1 - I recommend, as the State Coroner has recommended in the matter of the death of Mrs Zahra Abrahimzadeh, that all aspects of domestic violence policing be characterised by a sense of curiosity, questioning and listening. Risk assessment must be actually applied, not merely recited as a mantra.

- On 25 September 2015, SAPOL implemented amendments to General Order – Domestic Abuse which included 'a sense of curiosity' within the philosophies outlined in the General Order. The 'sense of curiosity' philosophy was included in the 'Policing Domestic Violence 2015' training that was delivered to all sworn members, Call Centre Operators and Client Services Operators in cycle 2 of the Corporate Training Cycle, delivered between 9 March 2015 and 26 April 2015.

Recommendation 2 - I further recommend that in cases such as these, which for the purposes of SAPOL General Orders may not necessarily be characterised as involving violence or potential violence of a domestic nature, that all complaints of a similar nature be referred to police officers who have training in domestic violence risk assessment. At the very least, all such complaints should immediately be drawn to the attention of an officer of the rank of Sergeant or above.

- All sworn SAPOL members are trained in the management of DV-related incidents and DV risk assessments. The 'Policing Domestic Violence 2015' corporate training included DV risk assessments and included the use of 'professional judgement' which can effectively override a risk rating if, in the opinion of the assessing member, the circumstances warrant management of that investigation or incident with greater urgency irrespective of the risk rating. Furthermore, any incident which is recognised as being DV-related is subject to oversight by the submitting member's line manager who is of or acting at the rank of Sergeant. The line manager vets the report prior to it progressing to the Family Violence Investigation Section (FVIS), where the FVIS manager, who allocates the reports, reassesses the reports risk rating. The FVIS manager is of or acting at the rank of Detective Sergeant..

Recommendation 3 - I further recommend that within SAPOL General Order Domestic Violence the definitions of 'Domestic partner' and 'Close personal relationship' be amended to encompass circumstances akin to those that existed between Ms Rankine and Mr Harding-Roots.

- At the time of Mr Harding-Roots death on 24 July 2011, the relationship between Mr Harding-Roots and Ms Rankine would not have been defined as a domestic relationship under the Domestic Violence Act 1994, which was operative at that time. However, in December 2011, the Intervention Orders (Prevention of Abuse) Act 2009 (the Act) commenced to replace the Domestic Violence Act 1994. The new Act broadened the scope of the relationships determined to be domestic relationships and whereby an act of abuse became an act of domestic abuse. The definition of 'domestic relationship' contained in General Order - Domestic Abuse is taken directly from the Act and includes a 'domestic partner' under the Family Relationships Act 1975. The General Order also contains a working definition of 'intimate domestic relationship' to determine which matters are managed by SAPOL FVIS staff. In the Harding-Roots matter, the relationship would clearly now be classified as a domestic relationship and, further, as an intimate domestic relationship. This recommendation is covered in the current General Order.

Recommendation 4 - I further recommend that police be directed to carefully consider whether in a complaint made in the context of a domestic situation involves the commission of a criminal offence. I further recommend that investigations into offences committed in that context be given priority.

- General Order Domestic Abuse outlines that DV/DA incidents are to be treated as a priority, including specific instructions in relation to management of DV incidents assessed as 'high risk'. The investigation of identified criminal offences is considered and prioritised pursuant to General Order Domestic Abuse, and General Order Crime investigation particularly. Furthermore, the primacy of serving Intervention Orders on defendants is detailed in General Order Intervention and Restraining Orders.

Mark William Payne (Coroner Johns)

Recommendation - I recommend that the Department for Correctional Services assign a dedicated officer(s) for the purpose of twenty-four hour constant, continuous monitoring of vision streamed by the cameras responsible for monitoring at risk prisoners in the observations cells of G Division. This recommendation is directed to the Minister for Correctional Services, the Chief Executive of the Department for Correctional Services and the Chief Executive of Yatala Labour Prison.

- Immediately following the death of Mr Payne, the Department's Standard Operating Procedures were revised to ensure that vision streamed by the cameras responsible for monitoring at risk prisoners in G Division were under constant, twenty-four hour monitoring.
- The 'five in thirty' camera observation procedure was discontinued immediately following Mr Payne's death, and the installation of a standalone monitor for camera observation in G Division occurred in the days immediately following his death. The 'five in thirty' camera observation procedure has therefore not been in operation at any departmental facility since June 2011.
- Further, the Department is continuing to identify and complete the necessary works required to make prison cells 'safe cells'. This includes removing any ligature points within secure custody cells. In addition, all newly constructed secure custody cells meet 'safe cell' specifications.
- The majority of DCS' infrastructure pre-dates the 'safe cell' standard introduction. Therefore, the Department has progressively been undertaking updates to those cells to meet the 'safe cell' specifications within existing resources.
- Since this incident, the Department has strengthened its approach to this practice and has issued a policy document that ensures renovations and upgrades of existing prison cells are undertaken in accordance with a risk, tier based approach. Policy 39 - Prioritisation for Implementing Safe Cells provides a consistent approach to decision making in relation to 'safe cell' designs and renovations across departmental prison sites.
- Resources are therefore targeted towards those accommodation areas that hold prisoners presenting the greatest risk of suicide or self-harm, and newly admitted prisoners of whom DCS has limited knowledge.
- In recent years, and with regard to targeting the highest risk areas in a planned and staged manner, to date, a number of cell refurbishments have occurred in the identified highest risk areas. G Division has had a total of 24 cells upgraded to meet safe cell standards.
- Since this incident, and specifically during 2014, modifications in G Division have included:

- camera coverage being modified from colour to black and white, to improve the viewing of prisoners in G Division cells. Keeping the camera in black and white mode provides a more consistent and clearly defined image of prisoners under observation;
- cell lighting above camera height has been moved to minimise glare issues for the viewing of images displayed via cell cameras; and
- corner mounted camera covers have been professionally cleaned of built up grime, dust and cigarette smoke deposits.

- The construction of a 26 bed High Dependency Unit and new Health Centre facility at Yatala labour Prison is also close to completion. This unit will provide inpatient mental health assessment and treatment services (and the continuum of care), for prisoners presenting with multiple and complex needs. The new Health Centre will meet all the primary health care needs for up to 12 prisoners. This new infrastructure will also comprise six state of the art observation cells. It is expected that the Unit will be completed by late 2015. Following a four week commissioning period, it is anticipated that prisoners will commence being transitioned into the Unit as appropriate from mid-January 2016.
- The Department is committed to continuously improving processes and procedures for managing prisoners who are at risk of self-harm. In this regard, DCS will continue to review and consider the monitoring arrangements at all of its facilities.

Theodoras Joannas Simos (Coroner Schapel)

The Court makes the following recommendations directed to the Minister for Mental Health and Substance Abuse:

Recommendation 1 - The Court echoes the recommendation made by Dr Joyner as follows - '*There should be ongoing awareness by Rural and Remote Consultants of the need to assess carefully risk/safety factors and the limitations of rural hospitals in managing acutely psychotic and violent patients in rural SA; Reinforcement to transport and retrieval services to carefully risk manage/assess acutely psychotic patients in rural hospitals with a view to early transport where possible (I should also say that I am well aware that these recommendations form part of current policies of these organisations but that does not prevent me from stating them here).*'

- All consultant psychiatrists and rural and remote staff have been advised of the Coroner's recommendations and the findings were presented at the Transport Working Group meeting of 12 May, 2015. The group is comprised of representatives from MedSTAR, Royal Flying Doctor Service (RFDS), South Australian Ambulance Service (SAAS) and Country Health SA Local Health Network (CHSALHN). It is attended by other key agencies as required, such as SA Police. The recommendations were reinforced with transport and retrieval services.
- The Rural and Remote Emergency Triage and Liaison Service, including access to an on-call psychiatrist, provides advice and services seven days a week, 24 hours a day. An audit process is used to investigate the appropriate use of medications to achieve both improvement in patient well-being and safe transport.
- The third edition of the Transportation of Mental Health Patients from Country South Australia to Metropolitan Services document is currently in draft revision" This edition reflects the Coroner's recommendations and includes sedation protocols and guidelines for providing advice to local hospitals. The sedation protocols were endorsed by the Statewide Mental Health Clinical Network.

- The introduction of the new Integrated Mental Health Inpatient Units and Community Rehabilitation Services are expected to increase capacity and reduce waiting times; these were not available at the time of Mr Simos's death.
- Digital Telehealth Network video conferencing equipment is to be located in the MedSTAR Emergency Operations Centre to enable advice and supprn1 for those awaiting transport. Training has been rolled out to clinical staff in local hospitals to upskill them in the use of videoconferencing facilities to improve their utility in such situations.

Recommendation 2 - That in according priority to the transportation of mentally ill patients, that priority be given, wherever possible, to the transport of patients who are the subject of inpatient treatment orders under the Mental Health Act 2009 or who are the subject of other measures that have been invoked under that Act.

- An improved system of clinical oversight was implemented in the SAAS Emergency Operations Centre in late 2010. All rural mental health patient transport requests are centrally assessed in the SAAS Emergency Operations Centre and awarded an appropriate priority after consultation with Rural and Remote Mental Health. This is procedurally embedded via a flow chart of the process utilised by the nurse retrieval consultant when dealing with a regional mental health patient transport request.
- Priority coding is provided to the RFDS at the time a request to transport is made and RFDS conduct the transfer of the patient to an agreed response time" The response times for each priority coding are detailed in the Inter Hospital Fixed-Wing contract between SAAS and RFDS.

9. Manager's Report

9.1. Registry Report

I am pleased to report on the activities and administration of the Coroners Court this year.

Firstly, I would like to offer my thanks and appreciation to the staff of the Coroners Court. All staff share the common goal of assisting the State Coroner fulfil his duties to investigate deaths. Staff aim to achieve that goal by ensuring that all required documents are received, coded and placed on file. Furthermore, staff critically analyse cases to ensure that information is only released to an eligible party and that all necessary reports are case managed and followed up within a suitable timeframe. In addition to their responsibilities to the coroners they are keenly aware of the needs of grieving families and make every effort to deal with paperwork and requests as efficiently as possible. Staff derive a great deal of personal and professional satisfaction from assisting a family to progress with funeral arrangements and receive the necessary documents to manage subsequent issues such as estate matters. At times, due to the rigours of the investigation, staff are unable to resolve the concerns and needs of the family yet they unfailingly impart this news to the next of kin with compassion and tact.

The main areas of continuous improvement this year include:

- Continuation of the arrangements for country conveyance of deceased persons;
- Review of the policy of carers' rights to information in conjunction with the Department Education and Child Development;
- Review of the criteria for recognition of domestic partners as senior next of kin;
- Review of forms and Directions as specified by the Coroners Act 2003;
- Review of the operations manual (ongoing);
- In conjunction with SA Health, progressing the introduction of an identification statement embedded in the medical deposition form;
- Review of the business continuity plan;
- Introduction of standardised letters for families to provide to insurance companies that may assist the family to secure an insurance/superannuation payment.

Staff participated in the following development activities:

- Presentation by DonateLife SA explaining the donation process for *donation after cardiac death*;
- Presentation - StandBy Response Service (SA Country, South) spoke to staff about the StandBy service. StandBy is a suicide post-vention service to support people who have been bereaved by suicide;
- Resilience and change readiness;
- Ethics awareness;
- Foundation training for supervisors;
- Performance management and development;
- Practical hazard management.

Again this year I mention the challenge the Coroners Court faces with records management. We have no space to store documents, closed cases and medical case-notes. There is no budget allocation to assign staff to undertake the specialised task of consigning files to State Records and the problem grows each year. This year I also raised the issue under the auspices of the Occupational Health, Safety and Welfare audit by Galpins Accountants and Auditors.

Over a number of years the Coroners Court has had the benefit of distributing to families bereaved through suicide a very useful folder of information funded by the Commonwealth Government. The folder of information gave families bereaved through suicide a wide range of information and referrals for support and assistance. We have been informed that this folder is no longer being printed as it will now be online. The SA Coroners Court has exhausted its supply and regrets that the information will no longer be distributed in hard copy.

Team leaders from the Coroners Court and FSSA meet bimonthly to discuss issues of relevance to both agencies. This meeting focuses on operational issues between the Coroners Court registry and the FSSA mortuary. The issues discussed this year included improvements in efficiencies in transporting bodies, operational issues concerning neuropathology, odontology, family viewings of bodies and liaison with hospitals. These meetings are valuable in analysing and improving processes and are the foundation of our good relationship with FSSA technical staff and I sincerely thank them for their cooperation. I particularly thank Kim Williams and Simon Moretta for their responsive attitude to our many requests.

The Manager is a member of the following committees:

- Court Services Executive;
- Systems Management Committee;
- CAA Operational Leadership Team;
- Security Steering Group;
- State Disaster Victim Identification;
- State Human Disease;
- International Framework for Court Excellence;
- A Women's Right to Safety.

During the year the Manager and the Social Workers negotiated with Flinders University to host a social work student on placement. The student will begin the placement during the next financial year.

The Court has met all of its occupational health, safety and welfare requirements this year after a rigorous audit by Galpins Accountants and Auditors in preparation for a review in the next reporting period by Deloitte Australia.

As Manager I have continued to be available to outside agencies such as hospitals, health related professionals and students along with attending various seminars and conferences as a guest speaker. These sessions enable the Court to educate the community and health care professionals about the Coroners Act and the coronial process. During the year under review I attended eight speaking engagements and addressed approximately 200 people.

I would like to express my thanks to Danielle Hutchison, Executive Director, Court Services, for the support and guidance she has given to me throughout this year. I also thank the Coroners for their accessibility to staff on a daily basis, their interest in the staff and their willingness to join staff on social occasions such as morning teas. The accessibility and friendliness of our Coroners is pivotal in maintaining our motivated and dedicated team.

I wish to record my thanks and gratitude to the State Coroner for his personal support and professional guidance and leadership.

9.2. Social Work Service

The South Australian Coroners Court employs two senior social workers. They provide first contact calls to families as well as providing ongoing social work services to senior next of kin throughout the coronial process. The social work services include providing information and updates about the coronial process, arranging formal identification, facilitating viewing of deceased persons with family members when appropriate, supporting next of kin to view closed files, and referral to external services.

For most of the last financial year social work services were delivered by two permanent social work staff. This stability allowed for the planning of longer term projects, including a co-operative project with Forensic Science SA and also with the social work faculty of the University of South Australia. The Bachelor of Social Work now includes a segment on the South Australian Coroners Court as part of the curriculum and the Coroners Court social workers have a particular interest in providing students with an interactive and educational experience in order to enhance their on-campus learning.

The social workers make themselves available to government and non-government services who deal with families and individuals experiencing grief. They attend speaking engagements and staff development sessions to explain the role of the Coroner and the social work service.

9.3. Organ Retention

The Coroner is responsible for the investigation of the cause and circumstances of reportable deaths in South Australia. In certain deaths however, an autopsy does not always reveal the cause of a person's death. In these situations further investigations and tests are required. These investigations and tests can involve the retention of organs and tissue. The Court's social workers advise the senior next of kin of the decision to retain one or more organs, and ensure the release or disposal of organs are consistent with the wishes of the senior available next of kin.

9.4. Disaster Victim Identification

The Manager of the Coroners Court is a member of the State Disaster Victim Identification Committee. The Committee is responsible for the coordination of the identification of the victims of any single incident where the number of fatalities is more than three.

There were no DVI incidents in South Australian during the year under review. The Manager attended one Disaster Victim Identification meeting this year.

The Manager and a Senior Social Worker attended three meetings of the State Recovery Committee following the Pinery Bushfire and the tragic death of two people.

10. Staff Roles and Organisational Chart

The Business Unit is structured according to the following organisational chart: