Government of South Australia

CORONERS COURT

2018-19 Annual Report

Coroners Court
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Date presented to Minister: 31 October 2019

To:

The Honourable Vickie Chapman MP

Deputy Premier

Attorney-General

This annual report will be presented to Parliament to meet the statutory reporting requirements of *the Coroners Act 2003* and the requirements of Premier and Cabinet Circular *PC013 Annual Reporting*.

This report is verified to be accurate for the purposes of annual reporting to the Parliament of South Australia.

Submitted on behalf of the Coroners Court by:

David Whittle

State Coroner

Date: 31 October 2019 Signature: 

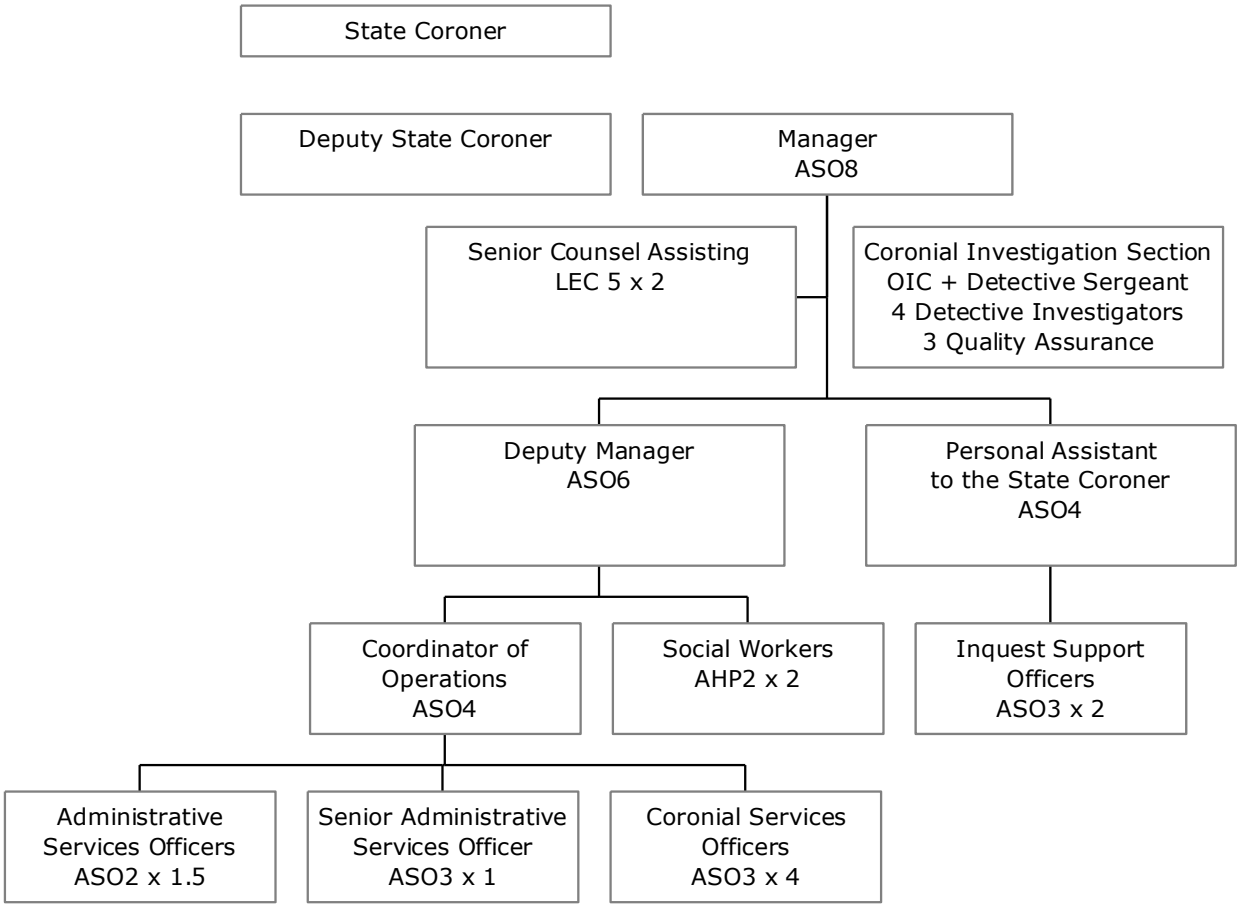
Contents

Overview: about the agency

Our strategic focus

Our Purpose	The Coroners Court of South Australia is established pursuant to the *Coroners Act 2003*, which requires the reporting of deaths occurring in certain circumstances, and creates a system of investigation and adjudication by coroners as to the causes or circumstances of such deaths and provides for the making of recommendations with a view to reducing the numbers of preventable deaths.
Our functions, objectives and deliverables	To receive reports of reportable deaths and make findings as to the cause or circumstances of any death in custody or other reportable death, following any investigation at the direction of, or inquest undertaken by a coroner, and to make any recommendations that may prevent, or reduce the likelihood of a recurrence of an event similar to any efvent which was the subject of an inquest.

Our organisational structure



*the organisational structure denotes the substantive staffing allocation

Additional funding was provided related to resources to undertake four complex inquests:

- Wayne Fella Morrison – death in custody
- Graziella Dailler and Dion Muir – domestic violence
- Alexander Kuskoff – police shooting
- Jorge Castillo-Riffo – workplace death

The funding included the appointment of a Deputy State Coroner, Senior Counsel Assisting, Junior Counsel and administrative assistance. These contract positions are not reflected in the Organisational Structure Chart above.

Coroners

State Coroner – Mark Johns

Deputy State Coroner – Anthony Schapel

Deputy State Coroner – Jayne Basheer

Senior staff

Manager – Michele Bayly-Jones

Senior Counsel Assisting – Naomi Kereru (until 28 June 2019)

Senior Counsel Assisting – Ahura Kalali

Senior Counsel Assisting – Kathryn Waite (until 28 June 2019)

Legislation administered by the agency

Coroners Act 2003

The agency's performance

Performance at a glance

	2014-15	2015-16	2016-17	2017-18	2018-19
Coroners	2	2	2	3	3
Staff	16.2	16.7*	16	18	19.8
Deaths reported	2290	2430	2537	2599	2687
Post-mortems	1683	1391	1344	1355	1482
Inquest matters heard (# deaths)	15	62	53	21	37
Inquest findings delivered	21	29	61	35	39
Court sitting hours	373.5	318.5	276	535	572

* 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.

Agency specific objectives and performance

	2015-16	2016-17	2017-18	2018-19
Total number of finalised cases - civil	2181	1850	2813	2705
Cases finalised in <=12 months	1662	1263	1621	1434
Cases finalised: > 12 months and <= 24 months	393	504	1 071	999
Cases finalised: >24 months	126	83	121	272

Backlog of Inquests

As at 30 June 2019, 108 inquests awaited hearing in the Coroners Court, including 86 cases involving a death in custody.

There were 2274 open cases pending inquiry. This does not represent an increase from the previous year. These open cases are at various levels of investigation. Some may progress to a review by Senior Counsel Assisting, the State Coroner and the SAPOL Coronial Investigation Section (CIS).

As at 30 June 2019 there were 52 cases under high level investigation by Senior Counsels Assisting. This represents a decrease in cases under review by Senior Counsel Assisting when compared to last year.

The SAPOL CIS had 46 Tier 3 cases referred to the Detective Investigators by Senior Counsel Assisting and 392 Tier 2 cases assigned for investigation to CIB and overseen by CIS. SAPOL Patrols reported 1587 Tier 1 cases to the State Coroner which were quality assured by CIS.

Agency performance management and development systems

Performance management and development system	Performance
The administration of the Coroners Court adheres to the policies and practices of the performance management and development system as provided by the Courts Administration Authority based on development and review. Emphasis is on discussions between employees and their manager or supervisor.	The CAA policy provides for each employee to have a written plan in place, reviewed annually, with the manager or supervisor recording the date of the agreed development plan in the CHRIS HRM System.

Workplace injury claims	Past year 2017-18	Current year 2018-19	% Change (+ / -)
Total new workplace injury claims	1	0	-100%
Fatalities	0	0	0%
Seriously injured workers*	0	0	0%

**number of claimants assessed during the reporting period as having a whole person impairment of 30% or more under the Return to Work Act 2014 (Part 2 Division 5)*

Work health and safety regulations	Past year 2017-18	Current year 2018-19	% Change (+ / -)
Number of notifiable incidents (*Work Health and Safety Act 2012, Part 3)*	0	0	0%
Number of provisional improvement, improvement and prohibition notices (*Work Health and Safety Act 2012 Sections 90, 191 and 195*)	0	0	0%

Return to work costs**	Past year 2017-18	Current year 2018-19	% Change (+ / -)
Total gross workers compensation expenditure ($)	$141,230	0	-100%
Income support payments – gross ($)	$49,110	0	-100%

***before third party recovery*

Reporting required under any other act or regulation

Act or Regulation	Requirement
Coroners Act 2003	Section 39- Annual Report (1) The State Coroner must, on or before 31 October in each year, make a report to the Attorney-General on the administration of the Coroners court and the provision of coronial services under this Act during the previous financial year. (2) The report must include all recommendations made by the Coroner's Court under section 25 during that financial year. (3) The Attorney-General must, within 12 sitting days after receiving a report under this section, cause copies of the report to be laid before both House of Parliament.

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 Coroner's Court during the year the subject of this report:

Atkins, Stephen Robert (Coroner Basheer)

I make the following recommendations directed to the Minister for Health:

1) That the initiatives that have been commenced and developed by the South Australian Local Health Network be urgently implemented in their entirety.

2) That the practice of on-call specialist consultants being rostered to cover dual specialities be ceased.

3) A committee or body be established to review the process of information sharing amongst medical and nursing staff with a focus on the handover process, and the use of progress notes as a primary information source.

4) That the proposed changes to the education and training of medical and nursing staff about the dangers of opioid medications be repeated at regular intervals by the implementation of mandatory refresher courses.

Castillo-Riffo, Jorge Alberto (Coroner Johns)

I recommend that the Elevating Work Platforms document dated September 2016 should be distributed on an annual basis electronically and in hard copy to all relevant building industry participants in South Australia. In addition, electronic links to the information sheet should be displayed permanently on SafeWork SA's webpage and be kept current. The associated minimum standard of training document should be brought into line to include references to clear lines of sight.

I recommend that the question of standardising scissor lift controls be given far greater impetus at a State and National level and that it be elevated to the Council of Australian Governments (COAG) for the commissioning of a project to pursue the standardisation of controls in scissor lifts.

I recommend that until the implementation of a system of effective standardisation of scissor lift control configuration across the country, that scissor lifts not be operated unless there is a person on the ground operating as a spotter who is available at all times to take steps to activate the emergency lowering mechanism should that be necessary.

I recommend that SafeWork SA consider whether the balance in the WHS Act and Regulations between safety being managed by risk assessment as opposed to express mandatory rules about what must occur in particular circumstances should be shifted in favour of more express mandatory rules and take that matter up with SafeWork Australia for consideration.

I recommend that SafeWork SA should investigate, consider and report upon the world's best practice engineering solutions to protect workers against the risk of crushing due to overhead surfaces, including the availability and design of secondary protective systems including operator protective alarms and operator protective structures and the options for reform to require that all scissor lifts in use in South Australia have a secondary protection system[1].

I recommend that the Government provide, through the Legal Services Commission, funding to enable families to be legally represented in Inquests, for deaths in custody, and generally. I direct this recommendation to the Attorney-General.

Chaplin, Gray Clyde (Coroner Schapel)

The Court makes the following recommendations directed to the attention of the chief executive or equivalent of the Country Health SA Local Health Network Incorporated, the chief executive of SA Health and the Australian Medical Association (South Australia).

1) That radiological services be made available on weekends and after hours at the Wallaroo Hospital.

2) That suspected rib fractures in the elderly be diagnosed in a timely manner.

3) That in rural settings a diagnosis of multiple rib fractures in the elderly should give rise to immediate consideration being given by medical practitioners to (a) the need to seek advice from the relevant services provided in tertiary hospitals in Adelaide regarding the patient's management, and (b) the need to transfer the patient to a major trauma centre.

4) That education be delivered to medical practitioners, especially medical practitioners working in rural settings and in particular in rural hospitals, concerning the seriousness of multiple rib fractures in elderly patients. The education should relate to matters including but not be limited to:

[1] In the present case it is known that Mr Castillo-Riffo had the guard rails of the machine in very close proximity to the under surface of the third floor slab. I would expect that any effective engineering solution to prevent crushing risk from a scissor lift would have precluded him from being able to get the scissor lift that close to the slab in the first place, thus obviating the use of the scissor lift for the purposes that Mr Castillo-Riffo was using it for on the day. However, that does not mean that I should not recommend the implementation of engineering solutions to protect workers against the risk of crushing from overhead surfaces bearing in mind that is precisely what happened to Mr Castillo-Riffo in this instance.

a) That when dealing with multiple rib fractures in the elderly medical practitioners should act on the assumption that the injuries will likely result in significant pain that will require careful analgesic management, that the injuries will likely compromise the patient's respiration and his or her ability to maintain adequate respiratory hygiene.

b) Modalities of pain management;

c) The type of medical interventions that might be required in order to manage the patient and whether those services are available within the local hospital;

d) The fact that multiple rib fractures in the elderly are a serious injury of themselves and may lead to serious complications;

e) That an elderly person suffering from multiple rib fractures may deteriorate suddenly.

f) That when multiple rib fractures are suspected in the elderly CT imagery is a more ideal modality of diagnosis than X-ray.

5) That a public advertising campaign be instigated in relation to the dangers and possible adverse consequences of use of ladders by the elderly.

McBride, Peter James (Coroner Johns)

I recommend that the Port Pirie Hospital substantially increase the number of active pressure mattresses to reflect the demographics of their patient profile.

I recommend that SA Health promulgate to the general practitioner community a reminder that indwelling catheters double the risk of delirium and promote bed-centred care and that catheter associated urinary tract infections do not require antibiotic treatment when there is no evidence of a more generalised infection. I also draw this recommendation to the attention of the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine.

McRae, Christopher and Pinxteren, Johanna and Higham, Bronte Ormond and Bairnsfather, Carol Anne (Coroner Schapel)

The Court makes the following recommendations directed to the Minister for Health and Wellbeing, the Chief Executive of SA Health and the Heads of Haematology at the Royal Adelaide Hospital, the Flinders Medical Centre and The Queen Elizabeth Hospital:

1. That a State-wide chemotherapy protocol system be developed in relation to the treatment of haematological illnesses. That the system not be individualised in respect of particular hospitals, but apply to all hospitals who provide haematological services. The State-wide protocol development system should encompass the following elements:

    - A State-wide committee be established to govern protocol development and alteration. The committee should comprise the Heads of each hospital's Haematology Department, the chief haematological pharmacist from each hospital and in the case of the disease AML, a specialist consultant with expertise in that disease.
    - The proposed changes to chemotherapy protocol should be discussed at a meeting of the committee prior to any changes being made.
    - Changes to protocol should be presented in draft form to that meeting.
    - Two separate clinicians should review and sign off on the final protocol document.

- The final protocol document should be presented to all haematology specialists and registrars to ensure that all such clinicians are aware of and understand the alterations. These communications should not be made by circular email.
- Any changes to protocol should be based upon documented evidence in support of the change.
- All protocols and alterations to protocols should be uniform across all Haematology Departments in public hospitals in South Australia.
- There should be a State-wide electronic prescription system that is uniform in its operation within all Haematology Departments in public hospitals in South Australia. Electronic prescription templates created by pharmacists should involve checking against the outcome of meetings that have taken place in accordance with the system described above. They should be checked against the written evidence in support of the protocol alteration. The final electronic prescription should be approved by the committee before it is uploaded onto any prescription system. It should be recognised that electronic prescriptions are only as accurate as the information that has been gathered in order for the prescriptions to be created. It should be recognised that electronic prescriptions are not necessarily failsafe. Two independent clinicians should sign off on any prescription.

2. That the current Safety Learning System (SLS) be abandoned and be replaced by an adverse event reporting system that includes the following elements:
   - An adverse event such as the detection of a protocol error or the treatment of a patient in accordance with an erroneous protocol should immediately be reported to the head of the relevant department and immediately be reported to the chief administrative officer of the hospital in question. It should also be immediately be reported to the Chief Executive of the Department of Health and Wellbeing.
   - The fact of the adverse event, a detailed description of the event and of measures taken to rectify any underlying error should immediately be communicated to the chief administrative officers of each tertiary public hospital in South Australia and also be reported to the heads of the relevant departments within those hospitals.
3. That as far as is possible haematology consultants who have a particular expertise in respect of a particular illness should, generally speaking, treat patients who have been diagnosed with that illness. It is to be recognised that this may not always be feasible. I would recommend that if a treating clinician does not have relevant experience in the particular disease in question, they should take advice from consultants who do have such expertise.
4. That email should be regarded as a dangerous means of communication in respect of imparting information regarding protocol changes. I would recommend that email communication be kept to a minimum. Where email communication is utilised, emails should not be sent to large numbers of recipients. They should be sent to batches of recipients, the commonality in the batches being the particular field of professional endeavour of the recipient. For example, one email should be sent to clinicians, another email should be sent to pharmacists and so on. Any such email should display a flag or other warning that it should immediately be read and that any attachment should be so read.
5. That in any open disclosure process wherein an error in treatment needs to be explained to a patient, that an independent entity who has had no responsibility in relation to the promulgation of the error or has any other interest in the outcome of any consequences of the error should conduct and oversee the open disclosure process. The independent person should be involved at the time of such disclosure and also have an involvement in the formulation of a treatment plan in respect of a patient, taking into account the error in treatment. I further recommend that the philosophy underlying any open disclosure system should not be the protection of a person, persons or entities responsible for the error, but the welfare of the patient should always

be the paramount consideration. Disclosure to a patient should be timely, candid, complete and have the capacity to independently inform the patient as to further possible treatment options.

6. That there be a complete overhaul of clinical governance systems as they apply to Haematology Departments within tertiary public hospitals in South Australia. The overhaul should involve as its elements:
    - The identification of suitable clinicians to exercise clinical governance responsibilities taking into account the expertise, experience and, importantly, the character of the individual.
    - The promotion of education in relation to timely, appropriate and candid open disclosure.
    - The creation of timely and effective adverse event reporting systems within the public health system of South Australia.

Nicholson, James (Coroner Johns)

It was Dr Naso's opinion that it would be timely to alert the medical profession generally to the possible psychotic effects of corticosteroid induced psychosis and that steroid induced psychosis is much more common than mood disturbance generated by steroid withdrawal, and it is as well to bear in mind the Occam's razor principle in this context .

I therefore recommend that the Minister for Health publish a reminder to the medical profession of the need to be aware of the risk of steroid induced psychosis in patients in receipt of corticosteroid medication and that the possibility that the symptoms are attributable to steroid withdrawal is much more remote than attributing the symptoms to the introduction of the corticosteroid.

Rollbusch, Graham (Coroner Johns)

I recommend that this State adopt a register of resident to resident aggression in the aged care sector to be supported by a system of mandatory reporting of such incidents, and that it apply regardless of the residents' cognitive status.

I further recommend that the Minister for Health raise with his counterparts the proposition that such registers should be duplicated across the other States and Territories, or better still that there be the adoption of a National register at the Commonwealth Government level.

Ross, Chrystal Jessica (Coroner Johns)

Apart from the burning issue of the need for more mental health beds in this State, Mr Collett, counsel for Chrystal's mother, asked that I say something about funding for families for legal representation in Inquests. Mr Collett has had a long and distinguished association with this jurisdiction. He was involved on behalf of families in the Royal Commission into Aboriginal Deaths in Custody, and has appeared on behalf of families in Inquests over the years since then. Although he did not say so, there is no question that such work, while undoubtedly professionally fulfilling, involves a sacrifice on the part of the practitioners who give of their time to provide representation in these matters, often pro bono. There is no doubt that their contribution provides invaluable assistance to the Court. The Royal Commission into Aboriginal Deaths in Custody recommended that the Government pay for the representation of families in Inquests into deaths in custody . For the same reasons I am of the opinion that Government assistance should be available, through the Legal Services Commission, in all Inquests.

I recommend that the number of mental health beds in this State be radically increased. At a minimum the number should increase four fold. I direct this recommendation to the Minister for Health and Wellbeing.

I recommend that the Government provide, through the Legal Services Commission, funding to enable families to be legally represented in Inquests, for deaths in custody, and generally. I direct this recommendation to the Attorney-General.

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:

Costi, John Steve (Coroner Schapel)

Response from the Department for Correctional Services

Recommendation 1 - That the Department for Correctional Services implement, if it has not already been implemented, the draft revised paragraph 3.3.9 of SOP 90 in the terms set out in paragraph 7.9 in the affidavit of Jane Farrin dated 4 May 2017 and that the requirement contained therein be stated to apply to all prisoners regardless of whether they are HRAT prisoners or not.

- SOP 90 refers to the Management of Prisoners at Risk of Suicide and Self-Harm. At the time of Ms Farrin's affidavit, the SOP stated the following:

  "When an at-risk prisoner returns from court (including Family Court and the use of video conferencing facilities), police escorts, medical appointments, compassionate leave, or are transferred in from other locations, correctional officers are to check the prisoner and if there are any signs of distress or if the officer has any concerns they must immediately report their observations to the Responsible Officers for action."

- This process within SOP 90 has since been modified. The SOP now states:

  "Correctional Officers are to be vigilant for any signs of distress when prisoners, particularly HRAT prisoner, return from any escort, including but not limited to:

  a) Video Conferencing Court;
  b) Police escorts;
  c) Medical appointments;
  d) Compassionate leave;
  e) Court or Parole Board; and
  f) Transfers from other locations.

  If the Correctional Officer has any concerns about a prisoner returning from an escort, they must verbally notify the Responsible Officer and must complete a NOC as soon as reasonably possible."

- The above amendment has been endorsed following an extensive process and is intended to come into effect on Monday, 30 July 2018.
- DCS considers this addresses the area of concern referred to in the Coroner's recommendation, in that any prisoner (remand or sentenced) who returns from court that shows signs of distress will have a NOC (Notice of Concern) raised. The NOC will then result in a risk assessment being undertaken for that prisoner.
- It was acknowledged by both Counsel Assisting and the Coroner during the Inquest, that a mandatory screening and assessment process for all prisoners in the above-described situations could cause some impracticality, as well as resourcing issues for DCS. It is also not an approach undertaken by other any other correctional jurisdictions to DCS' knowledge.
- DCS considers the amended paragraph described above does now make it clearer that not only prisoners under monitoring by the High Risk Assessment Team (HRAT), but any prisoner presenting with any signs of distress receive further assessment as to their risk of self-harm.

Recommendation 2 - That the Department for Correctional Services amend SOP 97 to ensure that observations of prisoners are conducted at intervals no less frequently than one-hourly and are conducted randomly and not

always in the same sequence to avoid becoming predictable. I further recommend that the necessary human resources be made available to the Department for Correctional Services in order to implement this recommendation.

- SOP 97 refers to Prisoner Counts. Section 3.4.1 states that:

  "Patrols should be conducted randomly and not always in the same sequence to avoid becoming predictable and should be conducted at intervals no greater than two hourly."

- As previously raised with the Coroner as part of the Inquiry hearings, and as per the sworn affidavit of Mr Mike Reynolds from Statewide Operations, increasing patrols to a frequency of no less than one-hourly is not considered to be a feasible option within the correctional environment. As Mr Reynolds advised at the time:

  "If the requirement was set for hourly patrols then this would require the officers to commence almost immediately after their last patrol and would restrict the ability for truly random patrols to occur. Correctional Services Officers are also required to patrol the whole of the facility and check all locations and not just the cells. A requirement for hourly patrols could mean that these security checks are compromised due to time constraints."

- Given the Coroner has resolved to make this recommendation, whilst noting the advice provided by Mr Reynolds in relation to this issue, the Department considers it appropriate to give further consideration to this issue.
- Whilst DCS is not able to formally commit to making such an amendment, it intends to undertake a comprehensive review of processes and procedures relating to prisoner counts, including a review of the practices of other jurisdictions, to determine the appropriateness of this recommendation. As previously stated, such a change in process would potentially result in significant resource implications for DCS, a change in work practice and require extensive consultation.

Recommendation 3 - That the Department for Correctional Services ensure that safe-cell design takes into account the hanging point that was used by Mr Costi to hang himself.

- In accordance with interstate practises and previous Coronial recommendations, DCS has determined that the following principles form the basis of 'safe cell' principles:
  - No obvious hanging points;
  - Forced air circulation throughout all cells;
  - All edges are rounded;
  - All knobs and / or 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 in design.
- The Department has established a Major Works Steering Committee (MWSC) with Terms of Reference that require them to consider submissions relating to the procurement of major facilities.
- The committee ensures the design of new facilities meet the requirements outlined in the Department's Policy 39 Prioritisation of Safe Cells, which details the process being undertaken to remove all ligature points across the prison system.
- Minor Works (Renovations) are managed within the Asset Services Branch of the People and Business Services Directorate. The designs and renovations of existing infrastructures are monitored by the Director and Team Leader of that Branch along with all project managers and custodial staff associated with the various facilities.

- This policy documents a tiered approach to the removal of existing infrastructure that is contrary to safe cell principles and ensures that 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 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 or in the interests of the safety or welfare of 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. At this time, approximately 29% of Tier 3 cells have been made 'safe cell' compliant.
- DCS has ensured that future 'safe cell' design takes into account the hanging point that was used by Mr Costi in his death. As was acknowledged by the Coroner, the hanging point used by Mr Costi in this instance was unusual. Mr Costi's suicide involved ripping material from his bed sheet, fastening a ligature around his neck and securing it to the base frame of his bed, prior to lying on the floor and pulling a slip knot together to secure his wrists and then rolled over, tensioning the ligature around his neck, thus asphyxiating himself.
- Since Mr Costi's passing, DCS has modified Unit 4, cell 20 to the safe cell standard and this sets the reference point for modifications for the remaining Tier 3 cells. This standard will also apply to any works conducted in Tier 4 and Tier 5 cells in the future.
- 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' 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 risks associated with prisoner self-harm or suicide within prisons.

Jones, Heath Ryan (Coroner Basheer)

Response from the Department for Correctional Services

Recommendation 1 - That the Department for Correctional Services continue to identify and eliminate hanging points from cells in all South Australian correctional institutions.

Recommendation 2 - That the Tier 3, 4 and 5 Priorities as set out in the Report to the House of Assembly by the Chief Executive of the Department for Correctional Services dated 9 February 2016 be implemented as a matter of urgency.

- The majority of DCS' infrastructure pre-dates the 'safe cell' standard; therefore, the Department has progressively been undertaking updates to those cells to meet the 'safe cell' specifications within existing resources.
- DCS utilises a tiered approach to the removal of existing infrastructure that is contrary to safe cell principles, and ensures that 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 Department's Priority Tiering System has been documented previously, and is summarised as follows:
- TIER 1 PRIORITIES: Observations Cells - cells used for camera or physical observation of prisoners at risk of suicide or self-harm or 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.
- As has previously been reported to the Coroner and Parliament, the Department has completed all Tier 1 and Tier 2 cells and is currently prioritising Tier 3. At this time, approximately 29% of Tier 3 cells have been made 'safe cell' compliant.
- All new infrastructure meets safe cell principles. In this regard, new accommodation units have been designed and constructed to meet the principles of safe cells, including the Banksia Unit at Port Augusta Prison, WaaWoor Unit at Mount Gambier Prison, Opal Unit at the Adelaide Women's Prison and the High Dependency Unit at Yatala Labour 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' conversion.
- The Department's most recent estimate to upgrade all prison cells across the State to be consistent with safe cell principles is in excess of $50m.
- With regards to the hanging point used by Mr Jones, towel rails remain in the east wing of Light Unit, at Mobilong Prison. This is due to this area of the medium security prison falling under Tier 5. Prisoners that are placed at Mobilong Prison have generally progressed through an admitting/induction prison unit prior to transitioning through the system based on behaviour and engagement.
- 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 risks associated with prisoner self-harm or suicide within prisons.

Clavell, Rodney Ian (Coroner Johns)

Response from South Australia Police

Recommendation 1 - In compiling and releasing information to the public about an identified target, police officers must be accurate and precise in describing factual matters. Facts asserted in media releases should only in the rarest of circumstances, if ever, conflict with the findings and outcomes established in a court of law. The use of exaggerated and hyperbolic assertions of fact in media releases should be assiduously avoided.

- SAPOL Media and Public and Engagement Section (MPES) have robust media protocols, supported by the General Order- Media Affairs. SAPOL's General Order – Media Affairs was reviewed in 2017 since the death of Mr Clavell in order to ensure robust protocols, policy and training in providing media releases accords with the Coroner's findings. Training in media protocols and policy is delivered at all levels within SAPOL from Recruit training through to Officer of Police development programs.
- One of the primary underpinning SAPOL media protocols for any high risk situation is that the Police Forward Commander/ Police Commander should advise MPES and request their advice and assistance if media or public information release is required.
- This will ensure that only well researched and factual information is released as suggested by the Deputy Coroner's Recommendation One. The Manager of MPES has an accountability to quality assure what information is released to the public. There is a strict policy that no information will be released which is of personal opinion (not based on fact) or is speculative.
- It would appear that the matter of Mr Clavell referred to by the Deputy Coroner was a rare occasion and that the current media protocols in place are robust and should significantly diminish any future type situations occurring.
- SAPOL's policy and training complies with Recommendation One.

Recommendation 2 - Police internal reports in relation to the previous offending of an individual and to the court outcomes relating to the same should reflect not only the basis upon which the prosecution had presented its case against that individual, but also the factual basis on which the individual was dealt by the court.

- SAPOL agrees with the recommendation as it would constitute best practice. However, current SAPOL information technology systems do not provide an automated method of capturing court outcomes to the extent that the Deputy Coroner has proposed.
- Furthermore, during the 2017/18 financial year, 117,659 charges were lodged in the South Australian courts from more than 65,000 briefs submitted for prosecution. Each one of these contained a report of the basis in which the prosecution initially presented its case. The quantity of cases and nature of court proceedings where factual matters are regularly negotiated at the bar table upon which a plea is entered, or findings of fact are made, does not allow for each and every report to be altered.
- It is not considered feasible to record written reasons for judgment or sentencing remarks made by Judges/Magistrates on SAPOL systems. These are not always provided as a matter of course or may often be quite lengthy. To do so would be an onerous task given the very limited number of occasions this information would be accessed.
- Information concerning the dropping or substitution of charges is recorded and available to SAPOL members. Whilst logistically SAPOL are unable to record each and every alteration, members will be reminded that the allegations within an Apprehension Report may be subject to court processes which could involve the modification or substitution of charges. The reader of these reports will be required to make an individual assessment of the weight placed on initial allegations having regard to any court outcomes.
- Future enhancements are planned within Program Shield which includes the caveat to alert the reader that the factual basis on which the offender was dealt with by the court may differ from the allegations therein.
- Definitive outcomes of factual matters are a matter for court recording.
- SAPOL is taking action to address Recommendation Two to the extent that is feasible.

Recommendation 3 - When considering tactical measures in respect of the apprehension of high risk offenders, consideration should be given, where possible, to obtaining any historical mental health reports or psychological opinions concerning the offender. In some instances it may also be desirable to consult with officers who in the course of a previous incident have acted as negotiators in respect of the particular offender.

- As a matter of standard practice for every high risk incident, police negotiators proactively access historical mental health information (where available) by contacting the Mental Health Triage Service and or where appropriate the Police Corrections or the Department for Correctional Services.
- Such information is regularly sought and utilised pursuant to a MOU with SA Health, Royal Flying Doctor Service and SA Ambulance Service. Opinions of mental health professionals are also sought, where there is a basis to do so. These tactics are time dependant and on the agency or person holding the information to share it. As an adjunct, advice from police psychologists is regularly sought during such incidents.
- Since late 2015, the issue of information / intelligence management and timely communication is considered and is frequently reinforced by SAPOL Special Tasks and Rescue (STAR) management as being critical during operations and also during all training for tactical / deputy tactical commanders, operations section shift managers and on negotiator courses.
- In regards to consulting former negotiators who have dealt with the same offender, SAPOL agree with this aspect of the recommendation. Where assessed by the attending tactical / deputy tactical commander or negotiator as being necessary or appropriate, attempts will be made to contact negotiators who have had previous experience with a particular offender.
- That said, previous negotiators may not be on shift or immediately available, and they may have little or no recollection of the incident. In any case, at the conclusion of every incident attended by negotiators, a Negotiator Incident Report (NIR) is completed and stored on the STAR Intelligence database. This historical information is available to negotiators and/or the tactical commander 24 hours a day.
- SAPOL is complying with Recommendation Three.

Recommendation 4 - Relevant internal reports such as those compiled in respect of a Commissioner's Inquiry should be made available to investigating officers and to those officers who are involved in tactical decision making in respect of the apprehension of high risk offenders.

- A Commissioner's Inquiry was held into the 2004 incident in which Mr Clavell was shot by police. There were learnings with regard to dealing with Mr Clavell from the incident in 2004 which were used to develop the tactics to locate and arrest Mr Clavell in 2014.
- Relevant internal reports, such as those compiled in respect of a Commissioner's Inquiry, will be made available on a 'need to know basis' to investigating officers and officers who are involved in tactical decision making in respect of the apprehension of high risk offenders.
- The Shield software program will soon contain a record against the name of the subject person of the existence of a Commissioner's Inquiry (or Significant Incident Investigation) which can then be made accessible to entitled officers, upon request. This is expected to be implemented by 30 November 2018, which will result in compliance with Recommendation Four.

The Coroners Court has provided an At A Glance summary of staffing and workloads through the year under review. They appear here Coroners Court At A Glance.

Public complaints

Number of public complaints reported

Complaint categories	Sub-categories	Example	Number of Complaints 2018-19
Professional behaviour	Staff attitude	Failure to demonstrate values such as empathy, respect, fairness, courtesy, extra mile; cultural competency	0
Professional behaviour	Staff competency	Failure to action service request; poorly informed decisions; incorrect or incomplete service provided	3
Professional behaviour	Staff knowledge	Lack of service specific knowledge; incomplete or out-of-date knowledge	1
Communication	Communication quality	Inadequate, delayed or absent communication with customer. Clarity of information provided	4
Communication	Confidentiality	Customer's confidentiality or privacy not respected; information shared incorrectly	1
Service delivery	Systems/technology	System offline; inaccessible to customer; incorrect result/information provided; poor system design	0
Service delivery	Access to services	Service difficult to find; location poor; facilities/ environment poor standard; not accessible to customers with disabilities	0
Service delivery	Process	Processing error; incorrect process used; delay in processing application; process not customer responsive	0
Policy	Policy application	Incorrect policy interpretation; incorrect policy applied; conflicting policy advice given	0

Complaint categories	**Sub-categories**	**Example**	**Number of Complaints 2018-19**
Policy	Policy content	Policy content difficult to understand; policy unreasonable or disadvantages customer	0
Service quality	Information	Incorrect, incomplete, out dated or inadequate information; not fit for purpose	0
Service quality	Access to information	Information difficult to understand, hard to find or difficult to use; not plain English	0
Service quality	Timeliness	Lack of staff punctuality; excessive waiting times (outside of service standard); timelines not met	0
Service quality	Safety	Maintenance; personal or family safety; duty of care not shown; poor security service/ premises; poor cleanliness	0
Service quality	Service responsiveness	Service design doesn't meet customer needs; poor service fit with customer expectations	0
No case to answer	No case to answer	Third party; customer misunderstanding; redirected to another agency; insufficient information to investigate	0
		Total	9

Service improvements for period

Service improvements that responded to customer complaints or feedback
Staff provided with standards of information provision and written checklists of what information needs to be provided in order to ensure that the caller has the correct information. Feedback provided to staff about ensuring preparedness for discussions with members of the public. Feedback provided to staff about voice clarity and voice tone and modulation.