



## **ANNUAL REPORT OF THE STATE CORONER FINANCIAL YEAR 2010-2011**

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.



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31 October 2011

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 2011.

The report is forwarded with this letter.

Yours sincerely

**Mark Johns**  
STATE CORONER

# ANNUAL REPORT OF THE STATE CORONER

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# **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 2011.

### **1. State Coroner's Overview**

I present the sixth Annual Report of the State Coroner to be tabled in Parliament reporting on the administration of the Coroners Court and the provision of coronial services under the Coroners Act 2003 during the financial year 2010-2011.

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.

The Coroners Act provides for the legislative base upon which to investigate the circumstances of a death. However, in a contemporary society, the Coroner's Office and staff must provide a broad service to the community by recognising the need to assist bereaved families to understand the coronial investigation process and its many exacting and sometimes intrusive features. Alongside an objective investigation into a death sits the imperative for a Coroner to recognise that families require support and information.

The cornerstone of coronial inquiry in South Australia is to provide a thorough and impartial service to the community when investigating the circumstances in which people die. It goes without saying that each individual death is unique in features and circumstance. Similarly, each family reacts to the impact of a traumatic and or sudden death in a variety of ways. For instance, some families want to know a great deal about the circumstances of the death, whilst others are unprepared for graphic detail and only require the essential information in order to plan the next steps such as a funeral.

Some families petition vigorously for an investigation and Inquest, whilst others want to move beyond this distressing time in their lives and keep their family matters private. Some families rally together in their grief to support and nurture each other. Yet others struggle with the family dynamic amidst overwhelming change and sorrow pulling them apart and exposing fragilities in

relationships that may have been held together by the common bond of a person who is now deceased.

The Coroner's staff deal with these family dynamics on a daily basis and are always diligent in noting the views and reactions of family members. Notwithstanding family opinions and reactions, it is incumbent on the coronial jurisdiction to manage every death with an objective inquiry. Therefore, whilst a Coroner will consider the views of a family, it is the legislative responsibility of a Coroner to seek answers about the circumstances in which a person died regardless of the opinion of the family. The Coroner may proceed to an in-depth inquiry or may, on considering the evidence, decide that no further inquiry is warranted. A family's view will be considered to a certain point during the inquiry, however the final determination for further investigation and, ultimately, an Inquest, is the sole decision of the State Coroner and Deputy State Coroner.

In each Annual Report I have acknowledged the patience and fortitude of families who have lost loved ones. I have attempted to explain in the preceding narrative that the coronial process can sometimes meet the expectations of a family and at other times may not do so. In each case I give careful consideration to the circumstances in which a person dies and I take seriously my role as the person who can seek answers on behalf of those who are no longer able to speak for themselves. I thank each family who comes into contact with the Coroners Court for the privilege of being allowed to know their private information so that systems, practices and products may be improved in the future so as to protect and keep safe other people in our community.

Coronial inquiries serve to safeguard the wider community and provide a unique opportunity to influence public health and safety.

## 2. Acknowledgements

Throughout my period as the State Coroner I have been fortunate to work with the Deputy State Coroner, Anthony Schapel. It is rare to experience such a harmonious working relationship over a long period of time. Within our own individual approaches to our work, there is respect, a willingness to share ideas and responsibilities and a genuine dedication to the coronial jurisdiction. Deputy State Coroner Schapel has completed a number of complex Inquests throughout the year and his findings and recommendations are thoughtfully considered and display respect for, and an intricate knowledge of, the law. It is a privilege and a pleasure to work with him each year.

Once again I wish to acknowledge the dedicated work of the Counsel Assisting. I appreciate the work of Senior Counsel Assisting Amy Cacas who began 12 months maternity leave in March of 2011. I also thank Amanda Taylor who agreed to extend her contract to work with us for another year as Counsel Assisting whilst Mrs Cacas was on leave. I welcomed the return of Naomi Kereru as Acting Senior Counsel Assisting. The Counsel Assisting have provided excellent advice to both myself and the Deputy State Coroner, and have worked consistently to ensure that all files are case managed, reviewed and acted upon in a timely manner. Counsel Assisting have displayed skill in briefing expert witnesses and in providing information about the content and structure of an Inquest to families who are attending Court. I am aware that they have worked to improve the case review and investigation procedures and have worked well with the SAPOL Coronial Investigation Section. I am grateful that in South Australia we have a specialised 'in-house' counsel to the Coroners Court. The jurisdiction is better able to maintain a high degree of skill and impartiality by having in-house counsel at its disposal to manage and direct inquiries on behalf of the Coroner. Having said that, I would prefer that both Counsels were remunerated at the Senior Counsel Assisting classification level as I firmly believe that the coronial Inquest demands a high degree of skill in research, case management, advocacy and cross examination.

I wish to express gratitude and thanks to the staff of the Coroners Court for their skill and dedication to the work of the Coroners Court. Each staff member has a strong work ethic and value base. They value the work they do to assist families during emotional and difficult times. Most staff are not formally trained in counselling, however each staff member brings a compassion to the plight of families and a level of resilient maturity that one might expect from more formally qualified professionals.

The registry work continues to be unrelenting in volume. The daily complexity of issues increases yet staff manage to provide a level of service that is compassionate and timely. On a few occasions during the year under review staff members have been threatened with physical harm by members of the public. On two occasions a police report was lodged to ensure the safety of a staff member. Staff members are to be congratulated for their consistency in

providing high levels of service even when faced with some clients who express their grief as aggression and rudeness.

I acknowledge the tremendous support given to this office by the SAPOL Coronial Investigation Section. Even though, at times, the staffing levels have been low over the past year the senior staff have not tired in working to improve the quality of police investigations and documentation to the Coroners Court. The improvements in the taking of statements are noticeable and I congratulate Detective Senior Sergeant Jeff Brown for his leadership of this group along with the support of Detective Sergeant Cameron Georg and Detective Sergeant Mark McEachern. These three officers have provided leadership to their team that has resulted in improved systems and relationships with the coronial staff. They have been most responsive to Counsels Assisting in progressing investigations.

I express my thanks to Chief Magistrate Elizabeth Bolton who has supported the Coroners Court when asked to assign a Magistrate to oversee the coronial jurisdiction when both the Deputy State Coroner and I are unavailable, or where cases are not able to be considered by either one of us.

The work of the Coroner relies on the skills, knowledge and expertise of a number of other disciplines and to that end I must extend my gratitude and thanks for the work of other Government agencies who contribute to building the knowledge and evidence base of the investigation. I acknowledge the highly professional work of Forensic Science SA (FSSA). The pathologists and technical mortuary staff provide a responsive and highly specialised service to the Court. Their camaraderie with my staff is consistent and always good natured and responsive. I value the opinions of the Forensic Pathologists and always find them willing to discuss cases and answer questions. Their appearances in Court as expert witnesses are well prepared and objective.

I thank the Hanson Institute for their work in special brain examinations and in keeping the timeframes for such examinations to a minimum in order to alleviate further worry and distress for families.

I would particularly like to acknowledge Michele Bayly-Jones, the Manager of the Coroners Court, for her tireless dedication and excellent work. The Court is very fortunate to have the services of this officer who combines skilful management with compassion and good humour at all times.

### 3. **Role of Coroner**

The role of a 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 inquires into the circumstances preceding the death.

The Coroners Act 2003 provides an interpretation of what constitutes a reportable death. No matter the circumstances of death, age of the individual or subjective opinion of a third party who may be assessing 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.

I have stated in previous Annual Reports, and I reiterate, that there is no penalty for reporting a death that ultimately may not be reportable under the Act, however it is an offence to dispose of the remains of a person whose death must be reported to a Coroner.

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.

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 the 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 - 24 months.

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 become the subject of an Inquest in Court. All deaths are investigated to the extent of establishing whether the circumstances of the death warrant the scrutiny of an open Court hearing. When the often lengthy investigations are finalised, the determination usually results in a finding as to the cause of death without a Court sitting or recommendations being made.

Section 25 of the Coroners Act 2003 stipulates 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 to present in Court it is Section 25 that provides the benchmark against which to judge the merit of the case and the inherent importance and public interest to the community.

It is in this section of the Act that the role of the Coroner and the Coroners Court is truly defined for all who are involved in the investigation, case review process, appearance in Court and the community at large.

However, it must never be forgotten that 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 stratas 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 2010-2011**

##### **4.1. Senior Research Officer (Domestic Violence)**

This position is a result of an election commitment made by the South Australian Government in 2010 to fund a research position specifically dedicated to domestic violence related deaths. To advance this commitment the South Australian Attorney General's Department's Office for Women and the South Australian Coroners Court have undertaken a 4-year partnership to research and investigate domestic violence related deaths.

The position of Senior Research Officer (Domestic Violence) was recruited in January 2011. This position, while employed through the Office for Women, is predominantly based within the South Australian Coroners Office and provides a specific domestic violence perspective which contributes to the process of Coronial investigation and provides Coronial Inquest support.

The resourcing of this position is significant for South Australia and represents a real opportunity for a sustained and extended coronial focus on the cause and circumstance of deaths identified as having a domestic violence context. The development of similar domestic violence focussed positions within the coronial jurisdictions of Victoria, New South Wales and Queensland also creates the potential for this work to be advanced by interstate partnership and collaboration.

This position reviews and investigates currently open coronial cases and retrospectively researches closed coronial cases where a domestic violence context can be identified.

The scope of deaths for investigation and/or review is deliberately broad and includes single instance homicide, single instance suicide and multiple fatalities eg. homicide-suicide.

The development of a retrospective research agenda arising from this position is expected to be determined in the coming year.

In open coronial matters, this position works as part of the South Australian Coroners Office investigation team to:

- Identify domestic violence contexts, issues and relevant service systems to assist in the investigation of the adequacy of system responses;
- Identify systemic issues and/or inter-agency approaches which may assist in the prevention of deaths which occur within a domestic violence context;
- Provide advice which builds the capacity of the Coronial Inquest to explore and inquire into system responses to domestic violence; and recommend improvements with a preventative focus;
- Develop data collection systems to enable the provision of advice to coronial processes and enable the identification of demographic or service trends, gaps or improvements.

In retrospectively researching closed coronial matters with a domestic violence context, the position will conduct specific research projects utilising access to information from a range of sources including the existing coronial investigation files or Inquest documents, as well as the National Coronial Information System (NCIS).

In the short space of time that this position has been in place there has been significant progress towards the identification and investigation of matters where domestic violence has been identified. Work continues with key stakeholders to formalise these processes within coronial reporting and investigation. The initial identification and investigation frameworks will be further developed and implemented to extend the capacity of coronial investigation to address areas of prevention in relation to domestic violence deaths.

This position has also provided review, advice and support across two Coronial Inquests where domestic violence was a feature of the deaths. At the conclusion of Inquest proceedings in May, the Deputy State Coroner issued a preliminary finding and recommendation that the Family Safety Framework process be implemented in the Murray Mallee Police region. This was a direct outcome from the specific evidence heard and advice provided regarding the potential benefit from inter-agency collaboration in the management of high risk domestic violence matters.

At a national level, the National Family Domestic Violence Death Review Network was established in April 2011. This network enables the coronial jurisdictions undertaking this work to share information, align investigation processes and collaborate on best practice at a national level. There is significant future potential in this alliance as a formal national network.

I look forward to expanding upon the range of outcomes resulting from this initiative and the extension of South Australian coronial contribution to the prevention of deaths resulting from domestic violence.

#### 4.2. Odontology Services

Forensic odontology is the application of dental science to the administration of the law. The scope of forensic odontology is wide and is often integral to the identification of victims of trauma such as gunshot wounds, incineration, decomposition and mass fatality.

At the end of 2010 it was announced that SAPOL would no longer fund the specialist service that was the Forensic Odontology Service within the School of Dentistry, Adelaide University. It was the first dedicated service of its kind in Australia and one of only a few worldwide at the time. South Australia was a leader in this field.

I made special mention of the service in my Annual Report of 2009-2010 and emphasised that I believed that a dedicated resource in this State was essential

to providing accurate and timely identifications of facially traumatised bodies. Further, I remain of the belief that South Australia should not lose the skills of such a dedicated team of professionals who have national and international respect.

When the funding was expected to cease I made my views known to the most senior officers of SAPOL and other senior Government officials. Unfortunately, my entreaties, and those of peak professional bodies, were unsuccessful and the service was closed.

One of the rationales for ceasing to fund the service was that other forms of identification could be used to identify deceased who were not visually identifiable by reason of trauma or natural process. I outline the following options:

- *Visual Identification* - not available because those bodies identified through dental examination are not visually identifiable;
- *Fingerprint Identification* - not all people have a fingerprint record, or the fingerprint is compromised;
- *DNA Profile Analysis* - this can usually be achieved by taking samples from the deceased to compare with samples from biological relatives, or samples from a reference sample from the deceased such as blood or tissue, or a sample from a personal item such as a toothbrush or razor, etc. This process is accurate, but is also time consuming (especially for families who are waiting for the release of the body) and expensive.
- *Circumstantial Identification* - when all other methods of identification have been exhausted, this process collects information about the deceased. The process relies on statements from those who may have last seen the deceased alive and who can attest to the physical attributes of the deceased person, or other evidence such as credit cards or letters and identification material such as a drivers licence. Cumulatively, this circumstantial evidence taken as a whole may suggest the identity of a person. Lack of sightings of the person or access to bank accounts might also suggest that the deceased person is an identified person

Contrary to the popular view derived from television shows and Hollywood movies, DNA is not the fast and simple 'silver bullet' answer to the question: 'who was this deceased person?'. DNA results can, and do, take 3 weeks to produce after the reference samples have first been obtained. By contrast, forensic odontology produces fast and accurate results. In one case, whose DNA identification had taken 3 weeks, a simple comparison was undertaken. At around 11:00am of the day of DNA result arrived (at which time the deceased's remains were released so there was no further delay) a forensic odontologist was asked to carry out a dental ID. The result came in at 3:00pm that same day. This meant that if the odontology service had not been discontinued, that family could have been reunited with their loved one 3 weeks earlier.

There have been incidents during the year when it would have been sensible and convenient to have the Forensic Odontology Service at our disposal. One such example was the repatriation of a deceased soldier from Iraq. All diplomatic and consultative measures were seamlessly undertaken between my Office and the Australian Defence Force. The main hindrance to releasing the body from the jurisdiction of the Coroner to the family was the process of establishing correct identification. Fortunately, SAPOL and FSSA were able to work together to engage one of the forensic odontologists on a 'once-off' basis to undertake the dental analysis. The dental examination was done promptly once funding approval was given. I am grateful that one of the Forensic Odontologists made himself available at short notice to complete this task.

I am concerned that difficulties may arise in circumstances where there are multiple fatalities and accurate and timely identifications must occur rapidly. The longer this service is left unfunded the greater the difficulty in reconstituting the service as staff become occupied with other work.

I do wish to acknowledge the special efforts of the individual members of the SAPOL Coronial Investigation Section in their efforts to compensate for SAPOL's termination of the Forensic Odontology Service. The Coronial Investigation Section coordinates identification of deceased for the Coroner. Since the dental identification service was stopped they have assisted to the best of their ability to coordinate circumstantial identifications. I particularly mention the work of Detective Investigator Shaun Osborne who has displayed special initiative in coordinating circumstantial identifications by gathering evidence such as photographs of distinctive tattoos and prosthetic limbs, etc. Such attention to detail gives a Coroner greater confidence when approving circumstantial identifications.

#### 4.3. Comments on Suicide

The Coroners Annual Report 2009-2010 reported that I was concerned by the high number of suicides each year. In fact the suicide rate has marginally increased each year from 2005, although in 2006-2007 it rose sharply to 205, then dropped back in 2007-2008, and has since continued to rise.

This year we recorded 202 reports of death attributed to suicide, however that figure does not include deaths of single vehicle and single occupant road fatalities, some drug overdose fatalities or suicides in custody.

I have continued to be concerned by suicides in our community. I have publicly spoken about this issue on three occasions during the year under review including:

- An interview with The Advertiser for an Opinion article in July 2010 which was entitled 'We Need to Talk About Suicide'. This article assisted in opening a healthy debate about whether or not suicides should be more widely reported by media and whether this could assist in helping to reduce the nearly 200 such deaths in South Australia each year. I was grateful for the

advice of Emeritus Professor Robert Goldney, who is the Professor and Head of the Discipline of Psychiatry at the University of Adelaide. Professor Goldney is recognised as one of the world's most foremost researchers on suicide and depression, receiving a number of international awards for his work

- Following on from the article in The Advertiser, I participated in an interview with ABC891 radio and discussed further the need for suicides to be afforded the attention given to road deaths and the opportunity for media to be able to responsibly report suicides in an attempt to promote public consciousness of the issues surrounding mental health.
- In May 2011 I participated in an informal Round Table convened by the Australian Press Council to discuss media standards in relation to the reporting of suicide. The Round Table was intended to assist the Australian Press Council's reconsideration of its guidelines in this area, including consideration of guidelines from other sources in Australia and overseas. It was attended by approximately 15 individually invited participants drawn from the ranks of mental health experts and senior media representatives. The Australian Press Council's revised draft guidelines have since been issued.

#### 4.4. SafeWork SA

During the year under review I heard an Inquest into the death of 18 year old apprentice, Daniel Madeley, who died in June 2004 in a workplace accident. He was caught in a horizontal boring machine he was operating at his workplace.

I found that the death was entirely preventable. The Inquest could not be commenced until the completion of the criminal prosecution of the employer, which took 6 years and resulted in a plea of guilty. It therefore meant that Daniel's mother's first opportunity to hear representatives of the company he worked for explain what happened, was more than 6 years following his death. I was concerned about the lack of timeliness in the prosecution process and the fact that an audit of similar machinery was not conducted by SafeWork SA until the Inquest commenced.

I made a number of recommendations (*see page 24 of this report*).

I intend to maintain an interest in industrial deaths.

#### 4.5. National Coronial Information System Review

In December 2010 the NCIS Board of Management commissioned a review of the governance of the NCIS. The review aims to examine the NCIS' governance and strategic direction, with a report from the review to be considered by the Board in July 2011. This review should also clarify protocols surrounding data supply and custodianship.

The review is being undertaken by the Victorian Department of Justice and reports to the NCIS Board of Management.

I provided feedback to the review and now await the outcome of the final report.

#### 4.6. Staffing Resources

Staffing levels have remained the same during the year under review. The loss of a 0.5FTE during the previous year due to budget savings is beginning to place a strain on the work that can be achieved in the registry. Certain tasks have had to be rationalised and staff have attempted to implement work efficiencies with as little disruption to families as possible.

I fear that further budget savings will negatively impact on the level of service the office will be able to provide in the future. Certain services will need to be curtailed and I am concerned that this will result in longer waiting times for families when receiving correspondence and updates. Other services the Coroner's Office has provided to Government agencies, such as release of documents, notifications about status of cases and access to research information, may be ceased if the resources of the office are further eroded. I do not wish this to happen, but I cannot ask the staff to continually provide a high level of service with reduced resources and diminishing staff numbers.

The work pressure continues to be immense. I commend the staff for their dedicated work in this jurisdiction. Even with the cuts we have already suffered, staff continue to attempt to cover all duties and process the volume of work that presents itself relentlessly. I am fortunate that the staff, from all areas of the office, attend to their duties with skill, compassion and loyalty.

#### 4.7. Medical Practitioner and Ancillary Staff Reports of Death

During the year under review issues arose within the public hospital setting regarding an instruction from the A/Chief Executive of SA Health to medical staff to seek the authorisation of the Chief Executive Officer of the incorporated hospital to provide statements to the Coroners Court. There was a general understanding within the public hospital system that statements could only be given with the direct and express approval of the Chief Executive of the Department of Health. This was clearly, in my view, a cumbersome, obstructive and unhelpful approach to providing timely information to a Coroner about a patient in hospital care. After a meeting between myself and the Chief Executive of the Department of Health, David Swan, the matter was resolved productively although somewhat belatedly.

It is essential that there be a willingness to cooperate with the coronial jurisdiction from within the public hospital system and for the public health system to provide leadership across the hospital system in demonstrating transparency and openness to scrutinise treatment, practice and health outcomes.

## 5. Statistical Information

There was a slight increase in the number of deaths reported to the State Coroner in 2010-2011 compared to the previous year.

There were 12,849 deaths registered with the Registrar of Births, Deaths and Marriages. Of those, 2,148 deaths were reported to the State Coroner.

There were 43 Inquests held into individual deaths in the 2010-2011 year. Of these, 23 were death in custody matters. Of these 43 Inquests, there are 7 matters which are part-heard and will continue sitting in the 2011-12 financial year.

The number of Inquest findings (33) was almost the same as for 2009-2010. There was a significant decrease in the number of Court sitting hours (360) compared to 532.5 in 2009-2010. This is attributed to a number of complex matters which were heard in 2009-2010, requiring an increased number of witnesses and sitting hours.

During the year under review one Inquest was held in a country region, that being Berri.

### 5.1. Cases Reported by NCIS Cause, Manner and Place of Death Code

Cause	Deaths	Cause	Deaths
Aircraft	1	Industrial Accident	9
Aspiration of Vomitus	2	Marine	1
Burn	0	Natural	617
Death in Custody	13	Other	13
Death in Institution	244	Pending Post-Mortem	54
Dehydration	3	Petrol Sniffing	0
Disease	0	Poison	0
Domestic Accident	16	Refer back	2
Drowning	12	SIDS	1
Drug Overdose	69	Skeletal Remains	0
Fall	26	Suicide	202
Homicide	27	Undetermined Cause	45
Hospital	664	Vehicle Accident	123
House Fire	4		

## 5.2. Year in Review

During the year under review 2,148 deaths were reported to the State Coroner and 2,075 cases were finalised (closed cases includes cases that were opened in previous years).

<b>At A Glance</b>	<b>2007-08</b>	<b>2008-09</b>	<b>2009-10</b>	<b>2010-11</b>
Number of Coroners	2	2	2	2
Number of Staff	17	17	16.5	16.5
Number of deaths reported	1899	2099	1929	2148
Number of post mortems	1221	1571	1242	1146
Number of Inquest findings delivered	38	33	31	33
Number of Court sitting hours	465	339	532.5	360

**6. Backlog of Inquests**

As at 30 June 2011 there were 31 Inquests awaiting hearing in the Coroners Court, including 21 cases involving a death in custody. This is a decrease in the category of deaths awaiting Inquest compared to the previous year. There were 1,542 open cases pending inquiry. These 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 2011 Senior Counsel Assisting and Counsel Assisting had 65 cases under high-level investigation with an additional 21 cases under investigation by the Coronial Investigation Section.

## 7. Professional Presentations of State Coroner and Deputy State Coroner

### State Coroner

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#### *Member*

- SA Indigenous Justice Committee

#### *Presentations*

- Army Reserve - The Role of the Coroner
- SAPOL - Inspectors Qualification Course - Investigation Model
- Asia Pacific Coroner's Society Conference in Auckland NZ - Chair of Session, Recent Developments in Coronial Case Law

### Deputy State Coroner

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#### *Member*

- CAA Community Relations Committee

#### *Presentations*

- SIDS and KIDS Conference, Sydney - Co-Sleeping Inquests
- Law Society of South Australia - Suppression orders and dealing with the media
- Australian & New Zealand Assoc of Psychiatrists, Psychologists & Lawyers - Suicide - A Coroner's Perspective
- University of South Australia and SA Health - Keynote Speaker, Risk Assessment and Management Symposium

### 7.1. 2010 Asia Pacific Coroner's Society Conference

The 2010 Asia Pacific Coroners Society Conference was held in Auckland, New Zealand. The theme of the conference was 'What can a modern coronial system do to speak for the most vulnerable members of our society - Our mokopuna (our children)'.

The conference focussed on comparisons between coronial systems in England and Wales, with a focus on case law and the issues relating to sudden unexpected death in the young, such as SIDS and SUDI. The conference also heard from speakers on the issue of youth suicide, in particular the media coverage of youth suicide.

Much debate also occurred in relation to the post mortem examination, retention of tissue and organs and notification of next-of-kin and the considerations of cultural imperatives.

During our time in Auckland the tragedy that was the Pike River Coal Mine explosions unfolded. The responsibilities of the coronial jurisdiction in such disasters was keenly felt by all attending the conference and, as the news continued to suggest that there was no chance of survivors, the conference attendees were deeply saddened for the New Zealand hosts.

8. **Inquests for the Year 1 July 2010 to 30 June 2011**

☞ Amos, Mark Geoffrey	☞ Miller, Allan Kenneth
☞ Anderson, Rosemary Joy	☞ <i>Mitton, Paul Laurie</i>
☞ Bais, Jamie Stuart	☞ Morris, Julia Hisae
☞ Ballard, Margaret Dawn	☞ <i>Penniall, David</i>
☞ Binch, Joyce	☞ Piro, Barbara Mary
☞ Blythe, Dorothy Josephine	☞ Porter, John Bruce
☞ Brown, Lance Clive	☞ Pretty, Gregory William
☞ Burns, John Arthur	☞ Raphael, Daniel Buddy
☞ Dubbioso, Roberto	☞ Richardson, Margaret Joan
☞ Durance, Edwin Raymond	☞ Rigney, Vincent Norman
☞ Elliott, Stephen Brian	☞ Ryan, Rhys Allan Gerard
☞ Fry, Lindsay Allan	☞ Semmler, Howard Malcolm
☞ Hayward, Robyn Eileen	☞ Silland, Asta
☞ Henschke, Jake Spencer	☞ Tatchell, Melissa Jay
☞ Hillman, Glenys Anne	☞ Tilka, Susan Marie
☞ Hiscock, Stephen West	☞ Trengove, Ian
☞ Hynes, Simon Christopher	☞ Walker, Moyston Edward Kerry
☞ Jast, Raymond Glenn	☞ Wanganeen, Derick Terence Lee
☞ Jorkowski, Natassja Alexandra	☞ Wyatt, David James
☞ Kromwyk, Shane Andrew	☞ Wyatt, Jakob James
☞ Lawrence, Rebecca	☞ Xu, Yan Yi
☞ Leonard, Emily Ruth	

\*\* *Italics denote that the matter is part heard and will resume in the 2011/2012 financial year.*

8.1. Inquest Statistics relating to Inquests held during the Year 1 July 2010 to 30 June 2011

No	Name	Date of Death	Inquest Number	Inquest Start Date	Finding Delivered	Period (mths) From DOD	Period (mths) From Inquest
1	TATCHELL, Melissa Jay	08/10/07	20/2010	12/08/10	22/06/11	45	10
2	BINCH, Joyce	17/01/09	21/2010	12/07/10	-	-	-
3	<i>MORRIS, Julia Hisae</i>	23/10/08	22/2010	06/09/10	08/06/11	32	9
4	<i>JAST, Raymond Glenn</i>	25/03/09	22/2010	06/09/10	08/06/11	27	9
5	FRY, Lindsay Allan	22/03/09	23/2010	30/07/10	-	-	-
6	BURNS, John Arthur	17/09/06	24/2010	17/08/10	-	-	-
7	TRENGOVE, Ian	30/03/08	25/2010	13/09/10	22/06/11	39	9
8	RIGNEY, Vincent Norman	25/04/09	26/2010	21/09/10	-	-	-
9	PIRO, Barbara Mary	22/10/08	27/2010	29/09/10	-	-	-
10	BAIS, Jamie Stuart	02/11/08	28/2010	06/10/10	-	-	-
11	XU, Yan Yi	28/12/08	29/2010	12/10/10	-	-	-
12	ELLIOTT, Stephen Brian	19/11/08	30/2010	19/10/10	-	-	-
13	RICHARDSON, Margaret Joan	31/01/09	31/2010	03/11/10	-	-	-
14	DUBBIOSO, Roberto	07/03/09	32/2010	07/12/10	-	-	-
15	ANDERSON, Rosemary Joy	27/04/09	33/2010	02/12/10	-	-	-
16	BLYTHE, Dorothy Josephine	10/05/09	34/2010	02/12/10	-	-	-
17	BROWN, Lance Clive	07/04/09	35/2010	01/12/10	-	-	-
18	HISCOCK, Stephen West	24/06/09	36/2010	11/11/10	-	-	-
19	<i>RYAN, Rhys Allan Gerard</i>	25/03/09	37/2010	07/12/10	17/02/11	23	2
20	<i>HENSCHKE, Jake Spencer</i>	25/03/09	37/2010	07/12/10	17/02/11	23	2
21	HYNES, Simon Christopher	03/05/07	1/2011	18/01/11	-	-	-
22	RAPHAEL, Daniel Buddy	02/06/06	2/2011	08/02/11	06/05/11	60	3

No	Name	Date of Death	Inquest Number	Inquest Start Date	Finding Delivered	Period (mths) From DOD	Period (mths) From Inquest
23	WANGANEEN, Derrick Terence	06/05/09	3/2011	20/01/11	17/02/11	22	1
24	BALLARD, Margaret Dawn	02/01/09	4/2011	15/02/11	-	-	-
25	SEMMLER, Howard Malcolm	14/11/08	5/2011	03/03/11	-	-	-
26	MILLER, Allan Kenneth	17/11/07	6/2011	15/03/11	-	-	-
27	SILLAND, Asta	08/06/09	7/2011	24/02/11	24/02/11	21	0
28	PORTER, John Bruce	10/07/09	8/2011	25/02/11	-	-	-
29	TILKA, Susan Marie	13/01/08	9/2011	21/03/11	-	-	-
30	LAWRENCE, Rebecca	04/11/08	10/2011	24/05/11	22/06/11	32	1
31	<i>HILLMAN, Glenys Anne</i>	25/11/08	11/2011	07/04/11	-	-	-
32	<i>LEONARD, Emily Ruth</i>	18/07/09	11/2011	07/04/11	-	-	-
33	<i>PRETTY, Gregory William</i>	16/01/10	12/2011	11/03/11	18/03/11	14	0
34	<i>WALKER, Moyston Edward Kerry</i>	16/01/10	12/2011	11/03/11	18/03/11	14	0
35	MITTON, Paul Laurie	19/01/09	13/2011	10/05/11	-	-	-
36	<i>HAYWARD, Robyn Eileen</i>	27/02/09	14/2011	03/05/11	-	-	-
37	<i>DURANCE, Edwin Raymond</i>	27/02/09	14/2011	03/05/11	-	-	-
38	JORKOWSKI, Natassja Alexandra	10/06/09	15/2011	10/06/11	-	-	-
39	KROMWYK, Shane Andrew	14/03/09	17/2011	09/06/11	-	-	-
40	AMOS, Mark Geoffrey	20/04/09	18/2011	23/06/11	-	-	-
41	<i>WYATT, David James</i>	16/03/09	19/2011	23/05/11	-	-	-
42	<i>WYATT, Jakob James</i>	16/03/09	19/2011	23/05/11	-	-	-
43	PENNIAL, David James	04/04/09	23/2011	28/06/11	-	-	-

## 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):

### **Allan, Vera (Coroner Johns)**

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The Court has jurisdiction to make recommendations pursuant to section 25(2) of the Coroners Act 2003. I acknowledge the helpful submissions of Mr Knight in making the recommendations that follow:

- 1) That Flinders Medical Centre ICU staff who are involved in the care of patients following cardiac surgery, should attend the regular mortality and morbidity meetings held by the Cardiac Unit;
- 2) That Cardiac Unit and ICU heads, together with Flinders Medical Centre senior management, address questions raised in relation to communication issues between the Cardiac Unit and ICU<sup>1</sup>;
- 3) It should be mandatory for ICU staff to confer with members of the surgical team at any point at which they determine it is necessary or appropriate, to alter a drug regime chosen by the surgical team that is still being administered at the point of handover to ICU;
- 4) That Flinders Medical Centre protocols and policies on communication between junior ICU staff and consultant intensivists should be reviewed with the aim of improving patient care and continuity of care;
- 5) That Flinders Medical Centre protocols and policies in relation to the attendance of consultant intensivists at ICU should be reviewed with a view to requiring a consultant intensivist to attend a patient admitted to ICU in circumstances where they are not otherwise present at handover;
- 6) That it should be mandatory for the on-call consultant intensivist to be directly involved in a patient's management plan on admission, whether by telephone or in person (depending upon the complexity and seriousness of the patient's condition upon admission);
- 7) That Flinders Medical Centre protocols and policies in relation to completing the Death Report to Coroner should be reviewed to ensure that the medical practitioner who was directly involved in the patient's care completes the deposition;
- 8) That Flinders Medical Centre protocols and policies should be reviewed as to record keeping, particularly in respect of anaesthetic and ICU charts in order that ambiguities

<sup>1</sup> The evidence of Mr Knight made it quite plain that as Head of the Cardiac Unit he felt that there was a lack of communication and that his input into patient care in ICU was not welcomed. Dr O'Callaghan was not of the same opinion. Nevertheless, the fact that the Head of the Cardiac Unit might hold that view is, in itself, a sufficient basis on which to address the issue.

and handwritten records that are later required to be interpreted by other persons, including the Coroner, can be minimised and that, in particular, records of drugs administered in precisely the dosages at precisely the times administered, should be recorded clearly on all such charts;

- 9) That Flinders Medical Centre protocols and policies should be reviewed in relation to the use of Swan-Ganz catheters;
- 10) That all Flinders Medical Centre ICU staff should receive training on the insertion of Swan-Ganz catheters with the aim of ensuring that patients who require haemodynamic monitoring get the level of care required;
- 11) That the adequacy of Flinders Medical Centre's credentialling of existing doctors and other medical staff should be reviewed and the circumstances surrounding Flinders Medical Centre's credentialling of doctors and other medical staff in late 2009 should be investigated by an appropriate independent authority.

**D'Agostino, Antonia (Coroner Schapel)**

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I make the following recommendations:

- 1) That these findings be drawn to the attention of the Chief Executive Officers or equivalent of the Department of Health, the South Australian branch of the Australian Medical Association and the South Australian Medical Board.
- 2) That the said Chief Executive Officers or their equivalent draw to the attention of members of the medical profession the findings in this matter.
- 3) That the said Chief Executive Officers or their equivalent advise members of the medical profession that in cases similar to this where faecal peritonitis is suspected in a patient, they should have regard to the following matters:
  - a) the need to avoid or minimise delay in surgery,
  - b) the need to identify a point in time at which optimal resuscitation has been achieved and at which further resuscitation would be futile,
  - c) the risk of acute deterioration in an otherwise apparently stable patient,
  - d) the need to consider a worst case scenario,
  - e) the need to consider admitting or transferring the patient, prior to surgery, to a hospital that has an intensive care unit,
  - f) the need to consider obtaining a second medical opinion as to the appropriate clinical management of the patient.

**Daly, Michael Barry (Coroner Schapel)**

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I make the following recommendations:

- 1) That the Minister for Mental Health and Substance Abuse cause the continued development of protocols relating to treatment centres under the Mental Health Act 2009 to ensure that detained patients who are considered to be at risk of absconding from treatment centres are prevented from doing so;

- 2) That the Minister for Mental Health and Substance Abuse consider introducing an amendment to the Mental Health Act 2009 to empower a member of the police force to apprehend, or take into his or her care and control, a patient at large who has absconded from an approved treatment centre during the currency of a period of detention, notwithstanding that that period of detention has expired;
- 3) That the Commissioner of Police amend police General Orders in the following manner:
  - a) to direct police officers not to remove a wanted missing flag and the active detention order flag at any time prior to it being established that the person has been returned to the approved treatment centre;
  - b) to require staff of a police custodial facility to conduct a check when releasing a person in custody as to whether that person has been reported as missing and whether an active detention order flag is in existence in respect of that person;
  - c) to ensure that officers responsible for compiling and maintaining missing persons reports communicate with staff of a police custodial facility when it is revealed that the missing person has been taken into police custody;
  - d) to ensure that missing persons reports are immediately vetted by a more senior officer and, in any case, vetted during the period in which the person is still regarded as missing.
- 4) That the Commissioner of Police review the desirability or appropriateness of civilian staff performing duties that might more appropriately be performed by trained and sworn police officers.

**Haselgrove, Harvie Frederick (Coroner Johns)**

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I recommend that the Minister for Road Safety consider the introduction of compulsory roadworthy inspections for heavy vehicles.

I recommend that the inspections should be carried out at least once per year.

I recommend that when a heavy vehicle is involved in a fatal crash, or a potentially fatal crash (in the present case Mr Haselgrove did not die at the scene, but in hospital the next day), SAPOL impound the vehicle in a safe and secure location where police mechanics can conduct a thorough inspection without feeling undue pressure through the need to restore traffic flows and other distractions associated with roadside inspections, and where proper equipment is available to assist in the examination.

I recommend that when a heavy vehicle is involved in a fatal crash SAPOL should carefully consider who, apart from the driver, may be accountable in some way for what has occurred. In particular, the owner of the vehicle should be looked at with a view to determining whether the vehicle has been adequately maintained.

I recommend that when a heavy vehicle is involved in a fatal crash SAPOL should investigate the existence of any defect notices applicable to the vehicle, or in the case of a vehicle comprising more than one component, to any components of the vehicle, and take proper enforcement action immediately.

In this case, the prosecution against Wilson was not resolved until nearly the end of 2009, with the result that the Inquest could not be held until after that time, nearly four years after

the crash. I recommend that SAPOL investigate how this prosecution took such an unacceptably long time to resolve.

**Heath, Dawn Patricia (Coroner Schapel)**

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I make the following recommendations:

- 1) I repeat the recommendation that I made at the conclusion of the Inquest, namely, that any facility that chooses to permit its residents to smoke on the premises should ensure that in the case of each individual smoker the risk of harm to the resident, having regard to the level of dementia, the loss of manual dexterity of the resident and other matters relevant to the ability of the resident to smoke safely, and thus the need for and level of supervision, is properly assessed. Such an assessment should take place on an ongoing basis having regard to the possibility of deterioration in the level of cognitive ability and dexterity of the individual over time. All staff responsible for care and their supervisor should be made aware of such an assessment;
- 2) That in any circumstance in which the safety of the smoking activity of a resident in an aged care facility becomes problematic, that procedures be put in place within the facility to ensure that any decision made or practice that is maintained within the facility regarding that resident's habit of smoking, is made known to, discussed with and approved by the resident's representatives and/or family;
- 3) That in formulating or altering any resident's care plan, the involvement of the resident him or herself and/or their respective representatives and/or family members, should be secured;
- 4) That aged care facilities create procedures whereby concerns about the wellbeing of residents, as raised by visiting family members, are properly documented at the time and that the concerned family member is given the opportunity to read and acknowledge what is in fact documented;
- 5) That within aged care facilities carers, including agency staff, be required to attend handovers of shifts of staff, or participate in other briefings, in order to familiarise themselves with any adverse issues concerning the current wellbeing of a resident in their care.
- 6) That within aged care facilities it be a mandatory practice for all carers to acknowledge in writing the fact that they have read changes to the care plan of a resident, especially changes that may be relevant to the safety of a resident.
- 7) I direct that a copy of these findings and recommendations be furnished to the relevant Commonwealth and State aged care authorities for dissemination to all aged care facilities.

**Infant Co-Sleeping (Kade, Nelson, Cleland, Phelan & Francis) (Coroner Johns)**

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I recommend that the Minister for Health consider these findings and consider the promulgation of a pamphlet such as Exhibit C71c with an appropriate adjustment of the age referred to therein from 6 months to 12 months.

**Lawrence, Rebecca Mary (Coroner Schapel)**

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I make the following recommendations directed to the Director of the Emergency Department and Director of Critical Services at the Royal Adelaide Hospital:

- 1) That reconsideration be given to including within the RAH Acute Coronary Syndrome - Management Guidelines for Patients Presenting to Emergency Department (Chest Pain) specific reference to risk factors such as diabetes and, in addition, to the quality and duration of chest pain as being important considerations in assessing whether patients are at very low risk;
- 2) That instructions be given to all medical staff working within the Royal Adelaide Hospital Emergency Department that (a) the requirements and protocols set out within the Guidelines should be strictly adhered to and, in particular, that a direction be given to such staff to strictly adhere to the requirements of the very low risk criteria, and (b) that regardless of whether the very low risk criteria are satisfied, medical staff should only discharge patients where there is in existence an alternative explanation for their chest pain and where the explanation has a high degree of certainty;
- 3) That ongoing training and education be provided to medical staff regarding chest pain management, including ECG interpretation;
- 4) That a direction be given to junior medical staff, including registrars, that a patient who has presented with chest pain should not be discharged by virtue of the very low risk pathway unless and until (a) the patient has been examined by a medical practitioner at consultant level and (b) any ECG examination or examinations have been sighted and evaluated by a practitioner at consultant level;

I direct the following recommendations to Telehealth Services, GP Solutions and the Chief Executive Officers of any other organisations that provide similar services:

- 1) That telephone operators providing advice to callers or who arrange locum medical services for callers, should advise callers who seek advice about chest pain to immediately call an ambulance or take themselves to hospital and that they should do so regardless of whether there has been any recent presentation to hospital.

**Madeley, Daniel Nicholas (Coroner Johns)**

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I make the following recommendations:

- 1) I recommend pursuant to section 25(2) of the Coroners Act that the SafeWork SA Advisory Committee, established under the Occupational Health, Safety and Welfare Act 1986, examine the practices of SafeWork SA in the period preceding 5 June 2004 in order to consider the adequacy of the inspection regime that was then in place.
- 2) I recommend pursuant to section 25(2) of the Coroners Act that SafeWork SA Advisory Committee examine the practices of SafeWork SA in the period after 5 June 2004 in order to consider the adequacy of the inspection regime that has been in place since then.
- 3) As a matter of law reform, I suggest that the Government consider a major reform of the current system of criminal prosecution for fatal industrial accidents. In my opinion it is just wrong that the prosecution of Diemould took 5 years to arrive at a plea of guilty.

There must be a way to improve that. It seems to me that the family of a person killed in a workplace accident may be better served by seeing an open public inquiry convened within 12 to 18 months of the accident, than a criminal prosecution which might never result in the public hearing of any evidence, and which takes more than three times that long to even start. I suggest that consideration be given to a reform of the law which would enable the following things to happen:

- a) Coroner intimates that, were no charges to be laid against any person in connection with the accident, an Inquest would be held;
- b) Family elects whether they would prefer that the matter be the subject of an Inquest, or the subject of the usual criminal process;
- c) If the family elects that they would prefer that there be an Inquest, the prosecuting authorities (including the DPP) would be empowered to intimate that no person or company would be prosecuted under the Occupational Health, Safety and Welfare Act or any other law. Such an intimation would then operate as a bar against future prosecution and, accordingly, no person would be exposed to the risk of self incrimination in answering questions at the Inquest, with the result that the Court could insist that answers be given, notwithstanding that they might otherwise be refused on that ground.

This is a suggested law reform, not a recommendation under section 25(2) of the Coroners Act. That is because of the way section 25(2) is framed, being limited to recommendations that might prevent or reduce the likelihood of events similar to the event the subject of the Inquest. If section 25(2) permitted recommendations concerning the administration of the law, as the corresponding provision in the Coroners Acts of some other jurisdictions do, I would have made this suggestion a recommendation<sup>2</sup>.

**Morris, Julia Hisae and Jast, Raymond Glen (Coroner Johns)**

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I make the following recommendations:

- 1) That the Attorney-General consider the amendment of the Firearms Act to require that commercial range operators, including firearms clubs, be obliged to install suitable tethering and/or bullet proof screening for use by persons who are not the holder of a firearms licence or member of a club. The requirement should be subject to such exceptions as may be prescribed, including the provision of training to security organisations where the trainees may not hold firearms licences. There may be other necessary exceptions;
- 2) That the Attorney-General consider the material contained in this finding with a view to deciding whether it is necessary to amend the Firearms Act to make the situation clearer regarding the application of the prohibition order regime to mental health notifications.

<sup>2</sup> See generally *Saraf v Johns* (2008) 101 SASR 87 where Debelle J noted the limitation on the recommendation making power in the Coroners Act, but made his own suggestion for reform of the law, a practice that has long been adopted by courts of law

**Natt, Katherine Michelle (Coroner Johns)**

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In view of the recent indications that the Commonwealth Government may be considering measures to deal with problem gamblers and poker machines following negotiations with the Independent Member for Denison (Mr Wilkie, MP), I have decided simply to recommend that a copy of this Finding be provided to the Prime Minister's Office, and to the Office of the Member for Denison, together with a copy of such other material tendered at the Inquest as either of those Offices may request.

**Raphael, Daniel Buddy (Coroner Schapel)**

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I make the following recommendations that I direct to the attention of the following entities:

- The Minister for Transport;
- The Minister for Road Safety;
- The Commissioner of Police;
- The Registrar and Deputy Registrar (Manager of Licensing) of Motor Vehicles;
- The Secretary or other responsible person of the Australian Transport Council;
- The Secretary or other responsible person of the National Transport Commission;
- The Secretary or other responsible person of Austroads;
- The President of the Australian Medical Association;
- The Chief Executive Officer of the Royal Australian and New Zealand College of Ophthalmologists;
- The Chief Executive Officer of the Royal Australian College of General Practitioners.

That the abovenamed entities confer and consider the following measures:

- a) That in respect of the issuing of a driver's licence, monocular persons be assessed pursuant to the commercial standards as set out in the Assessing Fitness to Drive guidelines as a matter of course;
- b) That monocular persons be required to undergo testing for visual acuity and visual fields more frequently than every 3 years, particularly where the condition of monocularity is due to an underlying disorder such as diabetes which may have affected the vision of the remaining eye. In particular, it should be mandatory for visual fields of a monocular person to be measured using an automated static perimeter and/or other sophisticated testing measures regardless of whether it is suspected that the person has a visual field defect;
- c) That in respect of the issuing or renewal of any driving licence to a monocular person that information be sought from and provided by that person as to the circumstances in which the person will be driving a motor vehicle including, but not limited to, information concerning whether the vehicle is being driven for any commercial purpose, information as to the times of the day or night at which the vehicle is driven and the duration of any task of driving; and that conditions be imposed upon the person's licence in accordance with the person's driving task;

- d) That the medical review unit of the driving licence authority in South Australia review every such application made by a monocular person;
- e) That in respect of the issuing or renewal of any driving licence to a monocular person that the driving and accident record of that person be obtained and that it be taken into consideration in assessing whether a licence should be issued or renewed;
- f) That the Registrar of Motor Vehicles ensure that certificates furnished by medical practitioners accurately reflect the requirements within the Assessing Fitness to Drive guidelines;
- g) That the AFTD guidelines be amended as necessary in accordance with the above.

**Stemmer, Jessica Lee and Mahar, Thomas William (Coroner Schapel)**

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I make the following recommendations:

- 1) That the Minister for Health and the Medical Board of South Australia draw these findings and recommendations, and in particular those relating to the circumstances surrounding the death of Jessica Stemmer, to the attention of the wider medical community;
- 2) That the Royal Australasian College of Physicians draw these findings and recommendations to the attention of its members, and in particular those members who are neonatologists;
- 3) That the Royal Australasian College of Physicians promulgate and circulate for the benefit of its members a College Statement that replicates that of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists document dated July 2009 and entitled 'Prevention Detection and Management of Subgaleal Haemorrhage in the Newborn';
- 4) That the Royal Australasian College of Physicians draws to the attention of its members, and in particular neonatologists, the following matters:
  - a) That practitioners should recognise that subgaleal haemorrhages can behave in unpredictable ways and can have devastating consequences;
  - b) That undue reliance should not be placed upon a clinical picture of haemodynamic stability alone as the clinical picture may be falsely reassuring;
  - c) That regular monitoring of acidosis and haemoglobin levels, among other parameters, is essential;
  - d) That upon a diagnosis of a subgaleal haemorrhage in a neonate, practitioners should have regard to the potential need for cross matched blood transfusion and transfusion of fresh frozen plasma and that they should immediately take the necessary steps to ensure that cross matched blood and fresh frozen plasma is available to be administered at short notice;
  - e) That if a decision is made to administer a blood transfusion or a transfusion of fresh frozen plasma that practitioners should ensure that it is administered without delay.

- 5) I draw recommendation d) to the attention of the Minister for Health for transmission to the Chief Executive Officers of all hospitals in South Australia that provide obstetrics services, be they Level 1 or Level 2 hospitals;
- 6) That the Chief Executive Officer of the Women's and Children's Hospital take the necessary steps to ensure that in future, assurances given to medical practitioners as to the availability of cross matched blood are met.

**Tatchell, Melissa Jay (Coroner Schapel)**

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I make the following recommendations:

- 1) That the Chief Executive Officer of the Australian Health Practitioner Regulation Agency cause advice to be given to all medical practitioners supervising the training of overseas medical practitioners working in general practices, that they should specifically supervise and oversee the prescription of opiate based medication that an overseas practitioner might wish to prescribe, especially in circumstances where the overseas practitioner lacks familiarity with the relevant medication. In this regard such overseas medical practitioners, during the course of their training, should be instructed to seek the advice of their supervisor before any such prescription is made;
- 2) That the Chief Executive Officer of the Australian Health Practitioner Regulation Agency advise all registered psychologists to be vigilant in identifying, in clients, signs of overmedication and that if they do identify such a client, they should consider advising the referring general practitioner to those circumstances;
- 3) That the Director of the Emergency Department and Director of Critical Services at the Royal Adelaide Hospital consider instructing medical staff within the Royal Adelaide Hospital Emergency Department, in circumstances where the patient is kept within the Emergency Department for an extended period, to review the medication requirements of a patient, particularly where the patient has been prescribed opiate based medications and has exhibited signs of excessive sedation;
- 4) That the Director of the Emergency Department and Director of Critical Services at the Royal Adelaide Hospital instruct nursing and medical staff of the Emergency Department to sight any medication in the possession of a presenting patient and to remove any medication from the possession of the patient in circumstances where the patient is admitted either to a general ward or to the Short Stay Ward;
- 5) That the Director of the Emergency Department and Director of Critical Services at the Royal Adelaide Hospital ensure that the necessary steps are taken to prevent patients within the Emergency Department Short Stay Ward from self medicating;
- 6) That the Director of the Emergency Department and Director of Critical Services at the Royal Adelaide Hospital ensure that clinical staff are made aware of the need to avoid erroneously advising patients that they may break slow release medications such as oxycontin before consumption.

**Trengove, Ian (Coroner Schapel)**

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I would recommend that St Andrews Hospital ensure that patients with pelvic fractures who present in an anticoagulated or over-anticoagulated state be subject to the closest observation possible. This should include regular monitoring of the patient's vital signs, regular observation of the person's renal function, fluid balance observations and recording, regular testing of a person's haemoglobin and state of anti-coagulation and constant observation as to the patient's clinical presentation.

**Whyte, Mark Anthony (Coroner Schapel)**

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I have no recommendations to make in this matter other than to refer to the recommendations made in my findings delivered on the same day in the matter of the deaths of Rhys Allan Gerard Ryan and Jake Spencer Henschke<sup>3</sup>.

**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:

**Bais, Ricky James (Coroner Schapel)**

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I make the following recommendations:

- 1) That the Minister for Health consider ensuring that the outpatient mental health service of the Noarlunga Health Service (known as the Adaire Clinic) and the Emergency Department of the NHS are housed within the same building so as to eliminate or minimise the opportunity for patients detained at the Adaire Clinic to abscond before they are examined within the Emergency Department of the Noarlunga Health Service;
- 2) That the signatories to the Mental Health Memorandum of Understanding together continue to develop practices and procedures that promote a collaborative culture in respect of the detention, apprehension and restraint of persons with a mental illness. I direct that recommendation to the Minister for Health, the Chief Executive Officer of the Department of Health, the Chief Executive Officer of the South Australian Ambulance Service, the Chief Executive Officer of the Royal Flying Doctor Service, the Minister for Police and the South Australian Police Commissioner;
- 3) That the Minister for Health ensure that mental health services are, at short notice and at any time of the day or night, made available to assist police in the execution of their duties in respect of the apprehension of persons with a mental illness.

<sup>3</sup> Inquest 37/2010

- 4) That the Commissioner of Police take the necessary steps to ensure that officers are provided with specific and detailed training, orders and instructions regarding their duties and responsibilities when apprehending or restraining persons with a mental illness. Such training, orders and instructions should deal with the circumstances in which the services of the entities who are party to the Mental Health Memorandum of Understanding should be sought and utilised.
- 5) That the Commissioner of Police takes the necessary steps to ensure that officers of the rank of Inspector or above are made aware of instances where junior officers are required to exercise their powers of apprehension and restraint pursuant to the Mental Health Act 2009 at the time that those instances occur.

**Lee, Troy Thomas and Matthews, Scott Leslie (Coroner Schapel)**

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Whether or not DCS officers should actually be professionally trained to recognise and manage 'at risk' home detainees is a matter that is not free from difficulty. One matter that would require consideration in this regard is whether it would be appropriate for such officers to assume such a high duty of care. In this case there is insufficient evidence to suggest that such formal training would, or might, have altered the outcome in either of these two cases. However, the need for such training is a matter that the Minister for Correctional Services and the Chief Executive of the Department for Correctional Services should consider and I recommend that they do so.

**Parker, Laura (Coroner Schapel)**

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I make the following recommendations:

- 1) That the Minister for Health and the Minister for Correctional Services cause a database to be established that contains the medical histories of all prisoners who have been held both in police custody and custody within correctional institutions and that the database be accessible by authorised personnel of SAPOL, the Department for Correctional Services and the Prison Health Service;
- 2) That the Department for Correctional Services and the Prison Health Service so far as is considered necessary for the proper management of a prisoner, develop protocols and procedures for the sharing of information between those entities regarding the medical histories and clinical presentations of individual prisoners in Department for Correctional Services custody;
- 3) That the Minister for Health and the Minister for Correctional Services introduce such legislation as may be necessary to overcome confidentiality considerations in respect of the implementation of Recommendations 1) and 2);
- 4) That the Prison Health Service develop a protocol for the clinical management of prisoners who are known to suffer from epilepsy;
- 5) That in respect of prisoners who have a diagnosed condition and history of epilepsy, that the Prison Health Service conduct a medical review of each such prisoner upon his or her induction into a Department for Correctional Services custodial facility. The review should include an assessment of the efficacy of their anticonvulsant medication, a review

of recent history of seizures and an assessment of risk having regard to known risk factors for epileptic seizure including disturbed sleep patterns, failure to take prescribed medication and recent history of seizure;

- 6) That officers of the Department for Correctional Services be made aware of an individual prisoner's diagnosis of epilepsy and any adverse risk assessment regarding risk of seizure in respect of an individual prisoner;
- 7) That officers of the Department for Correctional Services be trained in relation to epilepsy and its possible fatal consequences, and in respect of the risk factors that may exist in relation to seizure;
- 8) That Department for Correctional Services Standard Operating Procedures be amended to include a separate and specific direction to correctional services officers that any episode of unconsciousness or unresponsiveness exhibited by an individual prisoner should be regarded as a medical emergency requiring immediate intervention and the provision of medical treatment without delay;
- 9) That Department for Correctional Services officers be reminded both verbally and in writing that the calling of any Code Black, or the identification of any medical emergency, requires the immediate notification of medical staff and an immediate assessment of the need to call emergency services;
- 10) That Department of Correctional Services officers be advised both verbally and in writing that they should not resist or otherwise question clinical decisions made by staff members of the Prison Health Service in respect of an individual prisoner and that they should facilitate without delay all such clinical decisions;
- 11) That medical staff, including medical practitioners and nurses, employed by the Prison Health Service in custodial institutions be equipped with Department for Correctional Services radios to enable them to be advised of a Code Black as and when it is called;
- 12) That the Minister for Correctional Services introduce such legislation that would amend section 36 of the Correctional Services Act be so as to prohibit the delegation of section 36 powers and responsibilities to officers of the Department for Correctional Services below the position of General Manager of a custodial institution or a person acting in that position or capacity;
- 13) That the Minister for Correctional Services introduce such legislation that would amend section 36 of the Correctional Services Act so as to require both the said Minister and the Chief Executive Officer of the Department of Correctional Services to be regularly informed of the current circumstances of a prisoner in respect of whom an order has been made that the prisoner be kept separately and apart from all other prisoners;
- 14) That Department of Correctional Services Standard Operating Procedures be amended so as to contain a requirement that the General Manager of a correctional institution regularly review the circumstances of a prisoner to whom section 36 of the Correctional Services Act applies.

**Ryan, Rhys Allan Gerard and Henschke, Jake Spencer (Coroner Schapel)**

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I make the following recommendations:

- 1) That the Commissioner of Police define and exemplify the expression 'minor traffic matters' as utilised within the current General Order relating to police high risk driving, and provide police with some guidance within the document, as well as general training, relating to the need to avoid conducting high risk driving including pursuits in the investigation of offences of driving an unregistered and uninsured motor vehicle;
- 2) That the Commissioner of Police amend the said General Order by including specific reference to the need to avoid conducting high risk driving including pursuits on unfounded supposition that the pursued vehicle might be stolen or that the occupants of the vehicle might be engaged in illegal activity;
- 3) That the Commissioner of Police amend the said General Order by including specific reference to the need, in any risk assessment when conducting a pursuit, for the pursuing police officer and any incident controller to consider the real possibility that the driver of the pursued vehicle may have an impaired driving ability by reason of that person's consumption of alcohol or drugs and that a pursuit should not be conducted where there is a suspicion that the driver of the pursued vehicle is so impaired, unless there are exceptional circumstances where the need to apprehend the driver of the pursued vehicle, or its occupants, outweighs the danger that may be presented by a pursuit;
- 4) That the Minister for Transport initiate such public awareness campaigns designed to draw the attention of the general public to the folly connected with, the extreme dangers presented by, the futility of and the likely tragic outcomes associated with intoxicated drivers of motor vehicles endeavouring to evade police.

**Wallace, James William (Coroner Schapel)**

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I would recommend that the Medical Director of the SAAS consider issuing a guideline that describes a method of administration in accordance with the evidence given by Professor Jason White, in particular that set out in paragraph 5.5 herein.

**Wanganen, Derrick Terence Lee (Coroner Schapel)**

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I have no recommendations to make in this matter other than to refer to the recommendations made in my findings delivered on the same day in the matter of the deaths of Rhys Allan Gerard Ryan and Jake Spencer Henschke<sup>4</sup>.

<sup>4</sup> Inquest 37/2010

#### 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:

##### **Bais, Ricky James (Coroner Schapel)**

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**Recommendation 1** - That the Minister for Health consider ensuring that the outpatient mental health service of the Noarlunga Health Service (known as the Adaire Clinic) and the Emergency Department of the NHS are housed within the same building so as to eliminate or minimise the opportunity for patients detained at the Adaire Clinic to abscond before they are examined within the Emergency Department of the Noarlunga Health Service.

- The Adaire Clinic is unique in being located in the Noarlunga Health Service's precinct, and co-located with primary health and hospital services. This enables significant service collaboration across different services.
- To further enhance the health precinct principle, Adaire Clinic will move into a purpose built Community Mental Health Centre co-located with the GP Plus Super Clinic. This will move the Adaire Clinic closer to the Noarlunga Health Service and Emergency Department. This co-location will enable further development of improved procedures to manage agitated patients and those requiring detention.
- In the interim, Southern Mental Health has updated procedures to include increased use of security staff when patient agitation can be anticipated, and will work with all community mental health centres to develop standardised procedures to safely contain and transport patients who require detention.

**Recommendation 2** - That the signatories to the Mental Health Memorandum of Understanding together continue to develop practices and procedures that promote a collaborative culture in respect of the detention, apprehension and restraint of persons with a mental illness. I direct that recommendation to the Minister for Health, the Chief Executive Officer of the Department of Health, the Chief Executive Officer of the South Australian Ambulance Service, the Chief Executive Officer of the Royal Flying Doctor Service, the Minister for Police and the South Australian Police Commissioner.

- (*Minister for Health*) SA Health, SAAS, the Royal Flying Doctor Service and the South Australia Police continue to work together to develop practices and procedures that promote a collaborative culture in respect of the detention, apprehension and restraint of persons with a mental illness. The Mental Health and Emergency Services Steering Group (MHESG) meet regularly for this purpose, as do local liaison groups throughout metropolitan and country South Australia.
- The Mental Health and Emergency Services Memorandum of Understanding (MOU) was updated in 2010 to reflect the provisions of the new Mental Health Act 2009.
- SA Health, in consultation with the other signatory agencies, has developed information and training resources to inform staff of how the changes in the new MOU will impact partnerships, practice, communication, and documentation. The resource material includes a Power-point presentation, e-Learning CD and a poster comparing roles and powers.

- Information sessions began across the State in September 2010. One hundred and eighty training resource CDs have been distributed to emergency departments, mental health teams and country hospitals. The MHESG is kept informed of the roll out of the information sessions and will be alerted to operational changes or policy matters that may need to be addressed at a local level.
- (*Minister for Police*) The 2010 Mental Health & Emergency Services Memorandum of Understanding (MHMoU) superseded the 2006 agreement and was signed by the Chief Executive Officers of SA Health, SA Ambulance Service, Royal Flying Doctor Service and the Commissioner of the South Australia Police in July 2010 .
- The MHMoU promotes a collaborative culture and approach to the apprehension, restraint and detention of persons with mental illness. This is exemplified in the foreword of the MHMoU which states in part:
 

‘The MHMoU commits the signatory parties to work in cooperation to promote a safe and coordinated system of care and transport, and defines the roles and accountabilities of the agencies throughout the process of ensuring access to assessment and treatment. Successful implementation and operation of this MHMoU and the Mental Health Act 2009 requires a commitment from all participating and signatory parties to work cooperatively to develop protocols and procedures which address local needs. This includes the provision of ongoing education and the development and review of policies.’
- Meetings are held every two months and include representatives of each of the signatory agencies to facilitate ongoing collaboration.
- The MHMoU will be evaluated on a six monthly basis and will remain in effect unless it is revoked, varied or modified in writing by signatory parties.

**Recommendation 3** - That the Minister for Health ensure that mental health services are, at short notice and at any time of the day or night, made available to assist police in the execution of their duties in respect of the apprehension of persons with a mental illness.

- SA Police are able to call the Mental Health Triage (MHT) at all times, including overnight, to request assistance with people with a mental illness.

**Recommendation 4** - That the Commissioner of Police take the necessary steps to ensure that officers are provided with specific and detailed training, orders and instructions regarding their duties and responsibilities when apprehending or restraining persons with a mental illness. Such training, orders and instructions should deal with the circumstances in which the services of the entities who are party to the Mental Health Memorandum of Understanding should be sought and utilised.

- In addition to the Coroner's recommendation, a Commissioner's Inquiry following the death of Mr Bais recommended that consideration be given to improving police training in relation to members' understanding of the Mental Health MoU.
- In response, an all SAPOL e-mail was circulated on 7 May 2009 directing the need for members to have an understanding of the then 2006 Mental Health MoU, along with the Mental Health Act 1993, General Order Mental Incapacity, Section 269 of the Criminal Law Consolidation Act 1935, and Incident Management and Operational Safety Training (Mental Health Training Packages). It also directed that members should sight any documents of authorisation when attending a request from other agencies for assistance.

Additional instruction was included on the SAPOL intranet sites. On 20 May 2009 the e-mail directions were ratified by notice in the SA Police Gazette.

- The revised Mental Health Act 2009 came into operation on 1 July 2010.
- Prior to its commencement, an extensive information package was developed as a Significant Communication Strategy for formal presentation to all operational members of SAPOL. It outlined the provisions of the new legislation and detailed the procedures and use of documentation as agreed to in the 2010 MHMoU. Presentation to members was completed in October 2010, and is available as a reference source on SAPOL's intranet. This information has also been integrated into the Constable Development Program.
- In late 2007 SAPOL delivered a corporate training package regarding Mental Incapacity and Mental Disorders to 3300 police members. This training package, which was written by SAPOL Psychology Unit, provided statistical information as to the extent of mental illness in Australia, the types of mental illnesses police were likely to encounter and the effects these illnesses had on the affected persons. In particular, focus was placed on mental illnesses police were likely to encounter as part of their operational duties. The presentation provided police with information to assist them in distinguishing between persons suffering from mental illnesses from those exhibiting antisocial behaviour or experiencing the effects of psycho-stimulant toxicity. Further, the training provided police with techniques to intervene, communicate and deal with situations involving mentally disturbed persons and how to avoid the use of force or confrontation if possible. Further, information literature entitled Mental Health First Aid prepared by the Department of Human Services Mental Health Unit has also been disseminated. Members wishing to refresh their knowledge in relation to the content can access the training sessions on the SAPOL Training Gateway intranet site.
- All police trainees (cadets) are required to complete an assessable course of 16 lessons delivered by Police Psychologists encompassing the same issues as previously mentioned.
- Incident Management and Operational Safety Training is delivered annually to all operational police members. This covers subjects relating to mental health issues, disability, suicide awareness, dementia, Alzheimer's, positional asphyxia and excited delirium. The course also recounts issues raised in the Mental Health training listed above, and goes further in terms of physical handling of these persons to avoid death through positional asphyxia and excited delirium. The training packages are also available on the SAPOL Training Gateway intranet site.
- SAPOL's General Order Mental Incapacity is currently being rewritten, including a training package for all members and will include procedural advice on the issues raised in recommendation 4.
- SAPOL will undertake an evaluation of the training delivered to members in relation to the handling of mentally incapacitated persons after the training package for the revised General Order Mental Incapacity has been delivered to operational members.

**Recommendation 5** - That the Commissioner of Police takes the necessary steps to ensure that officers of the rank of Inspector or above are made aware of instances where junior officers are required to exercise their powers of apprehension and restraint pursuant to the Mental Health Act 2009 at the time that those instances occur.

- SAPOL's General Order *Mental Incapacity* is being rewritten to include additional supervisory oversight at mental health incidents where apprehension and restraint is involved. It will require officer/s to obtain authority from a supervisor prior to an arrest or, if this is not practicable, to advise the supervisor as soon as possible after the incident. The General Order will also require the supervisor to attend at the incident where reasonably possible.
- The Coroner's recommendation requiring an inspector to be notified has been examined by SAPOL but, because that person would very likely be physically remote from the incident, was considered to provide only limited practical benefit to the overall safety of those involved. Instead, greater safeguards and control would more likely follow from the presence and influence of an on-road supervisor.

**Daly, Michael Barry (Coroner Schapel)**

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**Recommendation 1** - That the Minister for Mental Health and Substance Abuse cause the continued development of protocols relating to treatment centres under the Mental Health Act 2009 to ensure that detained patients who are considered to be at risk of absconding from treatment centres are prevented from doing so.

- The Mental Health Act 2009 is guided by the principle that mental health services should be provided in the least restrictive way and in the least restrictive environment that is consistent with their efficacy and public safety. Accordingly, there has been a trend towards 'opening' previously secured acute admission units within mental health services in South Australia.
- Individual inpatient units will review and update local procedures and guidelines for locking doors when there is a patient who is a significant absconding risk, and also for dealing with patients who do abscond, in line with the provisions of the Mental Health Act 2009.
- As new facilities are built to accommodate mental health patients, they are purposefully designed to create an environment that reconciles safety and security measures with a protective and homely domestic setting conducive to therapy. For example, units within the new Glenside facility have implemented the following measures to prevent absconding:
  - Enhanced physical environment. The design of the new Glenside facility creates privacy and autonomy for consumers whilst maintaining safety and security. Points of access and egress converge to allow consumers and carers to more readily engage and enable better opportunity for observation of those at risk.
  - Ongoing clinical care and leadership (including observation levels assigned to patients of high risk).
  - Transferring patients who require this level of intensive care to a Psychiatric Intensive Care Unit.
  - Continued utilisation of local procedures and guidelines for closed wards and absconding patients.

**Recommendation 2** - That the Minister for Mental Health and Substance Abuse consider introducing an amendment to the Mental Health Act 2009 to empower a member of the police force to apprehend, or take into his or her care and control, a patient at large who has

absconded from an approved treatment centre during the currency of a period of detention, notwithstanding that that period of detention has expired.

- Section 57 of the Mental Health Act 2009 empowers a police officer to take a person into their care and control for the purpose of transporting them to a treatment centre or other place for medical examination if:
  - it appears that the person has a mental illness; and
  - the person has caused, or there is a significant risk of the person causing, harm to himself or herself or others or property; and
  - the person requires medical examination.
- A police officer is not required to exercise any medical expertise in order to form an opinion about the apparent mental status of the person. The Mental Health Act 2009 states that the police officer may form such an opinion based on the officer's own observations of the person's behaviour or appearance or on reports about the person's behaviour, appearance or history obtained from a third party.
- Accordingly, if a person has absconded from an approved treatment centre during a period of detention, but the detention and treatment order has expired by the time the person comes into contact with police, a police officer may take the person into their care and control on the basis of a report provided to them by the approved treatment centre regarding the person's behaviour or history. In this situation, the person would be transported to a treatment centre or other place for medical examination, at which point they could be placed under a new detention and treatment order if this was deemed necessary.

#### **Dobrijevic, Sofija (Coroner Schapel)**

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**Recommendation 1** - That the Department of Health continue to develop and implement risk management strategies that, in an assessment of risk of self-harm, take into account the patient's entire mental health history as it is known at the time of assessment.

**Recommendation 2** - That the Chief Executive Officer of the Department of Health instruct clinical staff employed in acute and chronic mental health facilities that concerns expressed by members of a patient's family or by a patient's associates should be communicated to, and be properly evaluated by, the patient's treating psychiatrist or psychiatric registrar.

- Letters were sent to the Regional Chief Executive Officers (CEOs) on 24 May 2010 requesting that they:
  - ensure all staff are made aware of the findings and recommendations and be advised of steps undertaken
  - undertake a review of and implement strategies to improve current systems (including policies, protocol and staff training)
  - all clinical staff employed in acute and chronic mental health facilities ensure that concerns expressed by members of a patient's family, or by a patient's associates are communicated to, and be properly evaluated by the patient's treating psychiatrist or psychiatric registrar.
- Regional CEOs were advised of the 'Mental Health Assessment Modules', a new assessment tool, which was implemented on 1 July 2010 which aims to:

- ensure consumers have access to individually appropriate and evidence-based treatment and rehabilitation and support services, which aim to prevent relapse and promote recovery
- monitor and evaluate the appropriateness and effectiveness of interventions and reassess, as necessary, to ensure optimal outcomes of treatment, rehabilitation and support services
- ensure care management systems facilitate continuity of care across service components, according to individual needs
- identify and apply strategies for relapse prevention in collaboration with other community and Government organisations.
- The Regional Health Services have advised that:

#### Adelaide Health Service (AHS)

- A new assessment module, part of the Community Based Information System Mental Health Client Management Engine, is being rolled-out for all mental health consumers. The module breaks down 'risk assessment for self harm' to include past history of self harm, current actual risk, and static risk, which enables clinicians to make an improved judgement of the self harm risk of the consumer.
- A formal process is underway to educate all clinical staff about the improved assessment tool.
- Clinical Directors have been asked to ensure that appropriate action occurs when family members raise concerns.
- AHS procedure, which details the process of documenting formal communication between clinical staff and significant others will be revised to emphasise the importance of this occurring. It will then be communicated to staff to highlight the concerns raised in the Inquest.

#### Children, Youth and Women's Health Service

- Child and Adolescent Mental Health Service (CAMHS) has:
  - Tabled the findings and recommendations, at the Clinical Quality, Safety and Risk Meeting and the Medical Co-ordinating Committee Meeting, in July 2010.
  - The CAMHS Clinical Risk Assessment and Management, including Complex Care Review Committee Procedure, was reviewed and updated:
    - All but one of the Deputy State Coroner's recommendations was included in the procedure, however, clearer wording was included to expand the points raised in the recommendations. The following was added 'Ensure that concerns expressed by the patient and/or expressed by members of a patient's family, or by a patient's associate are communicated to, and that risk be assessed and evaluated by the patient's treating psychiatrist/psychiatric registrar. Where there is no treating psychiatrist or psychiatric registrar allocated to the patient/client the clinician will discuss the information with a team manager/chief clinician, with the intention of discussing the clinical situation with a team psychiatrist/registrar or psychiatrist on-call .
    - The procedure now includes the recommendation that all clinical staff employed in acute and chronic mental health facilities, ensure that concerns expressed by members of a patient's family or by a patient's associates are communicated to, and be properly evaluated by the patient's treating psychiatrist or psychiatric

registrar. Not all CAMHS clients have a psychiatrist allocated to their care, so at those times, the recommendation has to be assigned to the clinician responsible or the manager.

- CAMHS evidence-based care plan and initial consultation process has been evaluated and improved over the past two years and evaluations have shown an improvement in the assessment process. CAMHS care plans ensure that the carer is involved in the assessment process where appropriate, and the genogram conducted on each client provides the opportunity to assess any other underlying or family related issues.
- CAMHS staff have been trained in initial consultation, assessment and risk assessment. Staff also underwent extensive training in conducting an initial consultation, assessment and risk assessment when the new Clinical Risk Assessment and Management Procedure was endorsed.
- CAMHS constantly reviews the evidence-based interventions available for children and adolescents, as well as where possible, implements strategies to improve the services provided.
- In line with the National Standards for Mental Health Services, case reviews are conducted quarterly or more frequently, as appropriate. A care plan is updated at each review. If a case is deemed to be a complex case, then the case can be presented to the Complex Care Review Committee.
- National Outcomes and Casemix Collections are conducted on clients at assessment, review and closure. Strengths and Difficulties Questionnaires are offered at assessment, review and closure.
- Electronic care plans are available to CAMHS staff across the service. Therefore, if the client/patient presents to the emergency department, staff in the emergency department can access the latest care plan for the client electronically.
- Clients receive a Keeping Well Plan, which enables them and others to access consented information in the event of a relapse or an emergency.
- Clients are also given copies of their Consumer Discharge/Closure Care Plan, which they can provide to others as needed. This is also electronically available to other CAMHS services and the emergency department.

#### Country Health SA (CHSA)

- Senior clinical staff within CHSA Mental Health Services have been advised of the Deputy State Coroner's recommendations.
- CHSA Mental Health Services will shortly implement the risk screen component (Module 5) on the Community Consolidated CME database. Clinical mental health staff have undertaken training to ensure that they are competent in using the risk screen to assess a consumer's level of risk.

#### **Lee, Troy Thomas and Matthews, Scott Leslie (Coroner Schapel)**

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**Recommendation** - Whether or not DCS officers should actually be professionally trained to recognise and manage 'at risk' home detainees is a matter that is not free from difficulty. One matter that would require consideration in this regard is whether it would be appropriate for such officers to assume such a high duty of care. In this case there is insufficient evidence to suggest that such formal training would, or might, have altered the outcome in either of these two cases. However, the need for such training is a matter that the Minister for Correctional

Services and the Chief Executive of the Department for Correctional Services should consider and I recommend that they do so.

- The above recommendation is particularly relevant to issues that were already being explored by the Department for Correctional Services at the time the findings were handed down.
- A Crisis Intervention and Support Service project commenced in December 2010.
- The intention of the project being to develop a consistent approach to responding to offenders who have been identified as being at risk of self harm and/or suicide.
- This large project has been broken into two phases; the initial phase, which was focused on prisoners within the custodial setting; and the second phase, focused on the management of offenders subject to community based supervision.
- Although processes have already been established to raise and manage concerns about a prisoner identified as being at risk of self harm or suicide, this project plans to extend these processes out into the community so that community based resources can be arranged to best support the offender upon their release.
- The Community Corrections component aims at:
  - developing processes to support the timely and efficient communication of offender management details across directorates when the offender is released into the community, returned to custody, or remains in the community under supervision;
  - developing processes for escalating the management of offenders experiencing a crisis; and
  - developing and providing training to Community Corrections staff in exercising the outcomes of this project.
- Established processes from the initial phase will enable relevant information to be sent to the appropriate location in a timely manner. In cases where the offender is returned to prison, information from the community will be easily accessible by the relevant location.
- The development of a staff training package is currently being finalised, with the delivery of this training package scheduled to commence in mid September 2011. The training will include the use of a Risk Escalation Matrix that has been developed to guide staff in determining priority actions when presented with an offender at risk of self-harm or suicide.
- 32 of 43 Home Detention officers have now been provided the Department's training in Suicide Awareness. The remaining 11 staff will attend future training sessions when it is available to ensure all Home Detention officers have this level of training.
- Once staff training is completed, the outcomes will be presented to the department's Executive.
- In conclusion, although the Department is committed to progressing this initiative in order to maximise the support that can be offered to offenders both in prison and in the community, the Deputy Coroner has acknowledged that the matter of professionally training staff to recognise and manage 'at risk' home detainees is a matter that is not free from difficulty, and that consideration must be given to whether it is appropriate for officers to assume such a high duty of care. He further quite rightly notes that there is little evidence to suggest that such training would, or might have altered the outcome in either of these two cases.

**Recommendation 1** - That the Minister for Health and the Minister for Correctional Services cause a database to be established that contains the medical histories of all prisoners who have been held both in police custody and custody within correctional institutions and that the database be accessible by authorised personnel of SAPOL, the Department for Correctional Services and the Prison Health Service.

- *(Minister for Health)* SAPHS is in the process of introducing computers into the health centres along with a patient information management program to establish an electronic health record. Initial meetings have been held with the Department of Correctional Services (DCS) to identify procedures for information sharing with health professionals between both organisations.
- SAPHS have been provided read only access to the DCS Prisoner Information System (PIS) and have also applied for the use of computer programs, such as Community Based Information System (CBIS) and Open Architecture Clinical Information System (OACIS).
- Currently, no consideration has been given to the sharing of information with SAPOL via electronic database, however, all information related to medical issues during SAPOL care is relayed to health staff for noting and action during the initial nursing admission assessment. This forms part of the comprehensive admission process.
- *(Minister for Correctional Services)* The South Australian Prison Health Service is responsible for the provision of health and medical services for prisoners in custody in this State.
- SA Prison Health Service is under the Department of Health.
- Some issues raised during the Inquest related to the lack of information sharing across agencies, specifically SAPOL, Health and the Department for Correctional Services. For example, Ms Parker reportedly had a history of epilepsy though this information was not widely known. Additionally, access to community mental health information was not known by DCS or SAPHS.
- In response to the first recommendation, SAPHS staff now have access to the electronic Justice Information System used by the Department for Correctional Services that contains comprehensive prisoner information.
- The access is seen to be a significant improvement in the information sharing between the two entities.
- In addition, I understand it is the intention of SAPHS to introduce computers into the prison health centres to establish an electronic health record for prisoners.
- Also SAPHS has been approved access to community based mental health information through the Community Based Information System (CBIS). The installation of associated information technology infrastructure to facilitate the access has commenced.
- To further respond to the recommendation, information related to medical issues of prisoners identified during custody with SAPOL is communicated to SAPHS staff as part of the comprehensive prison admission process.
- Given the strengthened initiatives now in place and the responses to recommendations two and three, a specific database of the kind referred to in recommendation one will not be progressed further by Correctional Services at this time.

**Recommendation 2** - That the Department for Correctional Services and the Prison Health Service so far as is considered necessary for the proper management of a prisoner, develop protocols and procedures for the sharing of information between those entities regarding the medical histories and clinical presentations of individual prisoners in Department for Correctional Services custody.

- *(Minister for Health)* The Joint Systems Protocol between DCS and the Department of Health was created in April 2007 with the aim of improving health and wellbeing of prisoners. The protocol describes:
  - How relevant information regarding prisoners is shared between agencies?
  - How a shared decision-making model of working together is established and sustained?
  - The openness and transparency about the decisions that are reached.
  - Where necessary, the recording of decision by agency staff.
  - The process of managing and resolving differences and disputes between agency staff.
  - The most appropriate joint governance arrangements for this collaborative exercise.
  - Complex case management.
- SAPHS and DCS meet quarterly to discuss joint procedures via an Operations Committee. This group reports to the Prison Health and Justice Steering Committee and have been tasked to review and update the Joint Systems Protocol.
- The requirement to define the process, to share information between entities, is currently being reviewed as part of enhancing communication processes and once completed will determine agreement on the type of information that can be shared when a patient provides informed consent and the processes for ensuring DCS are informed of changes in health status.
- *(Minister for Correctional Services)* In response and in addition to actions specified under recommendation one, the Department for Correctional Services has developed a Standard Operating Procedure (SOP) on the management of prisoners at risk of suicide or self harm. This document underwent a comprehensive consultation between February and October 2010 and a trial of the SOP commenced at the Adelaide Remand Centre on 26 November 2010. Following recent further consultation, it will commence use at Port Augusta Prison in May 2011 and will subsequently be rolled out to all other prisons .
- Further, the Joint Systems Protocol between SAPHS and the Department for Correctional Services was reviewed and formally signed off in May 2010. The significant changes are the incorporation of Forensic Mental Health and SA Dental as signatories with SAPHS and DCS, and comprehensive sections outlining information sharing and shared care for prisoners requiring complex case management.
- In that context, the updated version of the Joint Systems Protocol formalises the processes that have been in place since February 2009 for the management of complex prisoner behaviour. During 2009 the revised procedures and processes have already been used in the management of a number of prisoners presenting with complex risks and needs.
- Some of the improvements to manage prisoners with complex risks and needs include:
  - a requirement for prisoners detained under the Mental Health Act 2009 to be treated as a medical emergency and transported from prison by ambulance;

- the Adelaide Women's Prison (AWP) provision of Borderline Personality Disorder training to forty eight custodial staff members in May 2009;
- the development of a Local Operating Procedure (LOP) at the AWP that outlines the procedure for the multi-disciplinary review of prisoners accommodated in the management wing at the AWP;
- the updating and implementation in May 2009 of the AWP LOP for the operational management of prisoners demonstrating physical or mental distress;
- the development of a Local Interpretation Statement (LIS) at the AWP ensuring that the booking and presence of professional visitors, such as community mental health workers, are communicated to the prison intervention teams and Case Management Coordinators (CMC's); and
- strengthening the policies and procedures of both DCS and SAPHS that provide for risk assessments and admissions processes for prisoners that present upon admission to prison as having challenging behaviour.
- Some other improvements to enhance information sharing between and across agencies include:
  - ongoing discussions at the Statewide Mental Health Committee relating to the through care of community mental health services;
  - ongoing negotiations with the Courts Administration Authority regarding the sharing of information when courts request psychiatric reports on a prisoner (DCS and SAPHS are not privy to types of reports requested and in the case of psychiatric reports, the request is made by the Court directly to James Nash House);
  - the approval for SAPHS to access community based mental health information through the Community Based Information System (CBIS). The installation of associated information technology infrastructure to facilitate the access has commenced; and
  - changes to the Parole and Probation Guidelines and the Community Corrections Quality Standards in order to further increase information sharing opportunities and collaborative working relationships.
- The implementation of recommendation three will further strengthen the information sharing processes.

**Recommendation 3** - That the Minister for Health and the Minister for Correctional Services introduce such legislation as may be necessary to overcome confidentiality considerations in respect of the implementation of Recommendations 1) and 2).

- (*Minister for Health*) The Department of Health has reviewed S.93 of the Health Care Act 2008, which became operational on 1 July 2008 and S.34 of the Mental Health Act 2009, which became operational on 1 July 2009. Between the two Acts there are a number of identified exceptions to where confidential information may be disclosed:
  - if authorised by the Chief Executive
  - with the consent of the person concerned
  - to a health or other service provider if the disclosure is reasonably required for the treatment, care or rehabilitation of the person to whom the information relates
  - if it is reasonably required to lessen or prevent a serious threat to the life, health or safety of a person, or a serious threat to public health or safety.

- In the event that a patient does not give SAPHS informed consent to share medical information with the DCS, the health practitioner may make a clinical decision as to what is important for DCS to know and relay this information.
- Risk assessment processes have been implemented to assist in this process to ensure the safe management of patients whilst in custodial care and to ensure the patients' health needs are met.
- As a result of the above opportunities, the Department of Health do not foresee any changes that are required to existing legislation.
- (*Minister for Correctional Services*) Since the death of Ms Parker, the Health Care Act 2008 and the Mental Health Act 2009 became operational. Both Acts contain a number of identified exceptions to enable confidential information to be disclosed .
- In addition, the Joint Systems Protocol between SAPHS and DCS has significantly enhanced information sharing across Agencies.
- Notwithstanding, in September 2010, Cabinet approved the drafting of a range of proposed amendments to the Correctional Services Act 1982.
- Accordingly, the Correctional Services (Miscellaneous) Amendment Bill 2011 (the Bill) is in progress.
- To directly respond to the Deputy State Coroner's recommendation, it appeared prudent to include an extra provision in the Correctional Services Act 1982 to strengthen the legislative requirements for the sharing of health related information between the Department of Health and the Department for Correctional Services regarding the medical histories and clinical presentations of individual prisoners in Department for Correctional Services' custody.
- Support to include such amendments in the current Bill was sought from the Department of Health and the Minister for Health and consultation undertaken.
- Accordingly, a new provision is included in the Correctional Services (Miscellaneous) Amendment Bill 2011. It is anticipated that the new provision, once approved and enacted, will entirely satisfy the Deputy State Coroner's recommendation.

**Recommendation 4** - That the Prison Health Service develop a protocol for the clinical management of prisoners who are known to suffer from epilepsy.

- (*Minister for Health*) SAPHS have established procedures in place to identify patients who have a history of epilepsy and for the emergency management of seizures. With patient informed consent this information is made available to DCS. Where consent is refused, the health practitioner may make a clinical decision regarding sharing of this information.
- A copy of the medical instruction form, which is completed by nursing staff and signed by the patient, is given to DCS to place in the patient's file. This instruction can be commenced or cancelled at any time. The information is then placed on the Joint Information System and Corrections Officers can access as required.

**Recommendation 5** - That in respect of prisoners who have a diagnosed condition and history of epilepsy, that the Prison Health Service conduct a medical review of each such prisoner upon his or her induction into a Department for Correctional Services custodial facility. The review should include an assessment of the efficacy of their anticonvulsant medication, a review of recent history of seizures and an assessment of risk having regard to known risk

factors for epileptic seizure including disturbed sleep patterns, failure to take prescribed medication and recent history of seizure.

- *(Minister for Health)* SAPHS has a process to fully assess all patients on admission. Patients, who are known to suffer from epilepsy, will undergo a medical review upon admission and will be further assessed by a medical officer in the health centre as soon as practicable. The patient's current medication regime will be continued.
- The review is likely to include an assessment of the efficacy of their anticonvulsant medication, a review of recent history of seizures. Any known risk factors for epileptic seizure for the patient will also be documented.
- The Operations Group is currently working on the establishment of a Joint Protocol for assessing and managing epileptic patients and a Joint Information Sheet will be developed and made available to DCS staff.

**Recommendation 6** - That officers of the Department for Correctional Services be made aware of an individual prisoner's diagnosis of epilepsy and any adverse risk assessment regarding risk of seizure in respect of an individual prisoner.

- *(Minister for Health)* This recommendation is in place at all sites with the exception of the Adelaide Remand Centre and Port Augusta Prison.
- Negotiations are continuing with both the Adelaide Remand Centre and Port Augusta Prison General Managers for radios to be supplied to the health centre staff. Monitoring of the progress of the purchase of radios is occurring at the DCS Custodial Services meeting.
- For those sites that have radios, they are held by the senior nurse or Team Leader and used to improve the timeliness of health response to Code Black (Medical Emergency).
- *(Minister for Correctional Services)* Individual prisoner's diagnoses of epilepsy and risk of seizure is routinely captured upon admission to prison through the DCS Health admissions form provided to DCS.
- Notwithstanding, all admissions paperwork is currently being reviewed by the Department for Correctional Services in an effort to further strengthen procedures.
- To further strengthen staff awareness and response staff training and reaccreditation in Senior First Aid has been given priority in all institutions. It is now a requirement that all new custodial staff have a Senior First Aid Certificate.
- In addition, an information sheet about Epilepsy has been placed on the Department's intranet site along with a link to the Epilepsy Association. Email access was enabled for all DCS employees in May 2011, which will allow the information sheet to be emailed directly to all DCS prison staff.

**Recommendation 7** - That officers of the Department for Correctional Services be trained in relation to epilepsy and its possible fatal consequences, and in respect of the risk factors that may exist in relation to seizure.

- *(Minister for Correctional Services)* As reported in the response to recommendation six, it is anticipated that all DCS custodial staff will have a Senior First Aid Certificate as staff training and reaccreditation in Senior First Aid has been given priority in all institutions.
- The Senior First Aid Certificate training includes instruction in Epilepsy and other seizure response.

- In May 2011, email access was facilitated for all DCS staff. This will strengthen and reinforce the delivery of departmental information and enable an information sheet on Epilepsy from the Epilepsy Association to be emailed to all DCS prison staff.

**Recommendation 8** - That Department for Correctional Services Standard Operating Procedures be amended to include a separate and specific direction to correctional services officers that any episode of unconsciousness or unresponsiveness exhibited by an individual prisoner should be regarded as a medical emergency requiring immediate intervention and the provision of medical treatment without delay.

- *(Minister for Correctional Services)* In response, the Department's Standard Operating Procedure that relates to Medical Emergency (Standard Operating Procedure 20A) clearly states any episode of unconsciousness constitutes a 'Code Black - Medical Emergency'.
- The same SOP outlines the responsibilities of all staff attending such an emergency, including administering first aid and/or attempting to resuscitate the person. The SOP also provides for the attending officer(s) to continue attempts at resuscitation of the person until such time as a qualified medical person arrives with resuscitation equipment.
- SAPHS staff now have access to radios at all prisons. The access to radios will further strengthen a response to a code black. This will allow immediate notification to SAPHS should a code black be called.
- In addition, the AWP Local Operating Procedure (LOP) that outlines the emergency procedure when a code black is raised has been amended to reflect that an immediate response is required taking into consideration Occupational Health and Safety requirements e.g. the use of personal protective equipment. This response includes checking vital signs where a prisoner is not conscious and if no vital signs registered, then cardiopulmonary resuscitation must commence immediately.

**Recommendation 9** - That Department for Correctional Services officers be reminded both verbally and in writing that the calling of any Code Black, or the identification of any medical emergency, requires the immediate notification of medical staff and an immediate assessment of the need to call emergency services.

- *(Minister for Correctional Services)* In response, staff in all prisons have been provided with training in regard to incident management. This includes requirements around completion of incident reports, commencement and maintenance of incident logs and case noting, and responses to code blacks and the requirement for SAPHS to be immediately notified (Director's Memorandum number 27) .
- Additional information for supervisors about emergency code training has been incorporated into the Supervision in Prison manual and provides for supervisor's responsibilities in code black emergencies in detail.
- Additionally, the DCS relevant correctional officer job and person specification has been amended to reflect the requirement to have a first aid certificate.
- Adelaide Women's Prison (AWP) is also recruiting and training staff for a local Emergency Response Group (ERG). This will allow AWP access to additional support should it be required.
- Some SAPHS staff at prisons have been provided with radios to carry on their person and have been trained in the use of them. This will allow immediate notification to SAPHS should a code black be called. The relevant Standard Operating Procedure (SOP) related to radio security has also been updated to include that employees issued with radios must

ensure that they maintain absolute control of the radio at all times and use the authorised radio swivel pouch and keep the item secured by the issued belt loop.

- As documented under recommendation eight, the AWP Local Operating Procedure (LOP) that outlines the emergency procedure when a code black is raised has been amended to reflect that an immediate response is required taking into consideration Occupational Health and Safety requirements e.g. the use of personal protective equipment. This response includes checking vital signs where a prisoner is not conscious and if no vital signs registered, then cardiopulmonary resuscitation must commence immediately.
- Further, a review of all AWP document control has been completed to ensure correct, up to date version control is in place, through the establishment of a register and management procedure. The Local Interpretation Statement regarding medical emergency is held in the control room in hard copy, is up to date and correct and is subject to regular compliance activity checks.
- AWP staff are also participating in frequent emergency contingency testing including code black response.

**Recommendation 10** - That Department of Correctional Services officers be advised both verbally and in writing that they should not resist or otherwise question clinical decisions made by staff members of the Prison Health Service in respect of an individual prisoner and that they should facilitate without delay all such clinical decisions.

- (*Minister for Correctional Services*) In response I can advise that Department for Correctional Services' staff will comply with all reasonable requests wherever possible where resources permit.
- The Department's Standard Operating Procedure that relates to Medical Emergency (Standard Operating Procedure 20A) clearly outlines the responsibilities of all staff attending the emergency. Attending correctional officers are responsible for the administration of first aid until qualified medical personnel arrive. Medical personnel assume responsibility once on the scene.
- The SOP also provides at 3.3.3 that responding officers must assist with first aid if required.
- Additionally, the Department for Correctional Services' Executive Director's Instruction 10-09 provides clear instruction to all staff that any prisoners detained under the Mental Health Act must be treated as a medical emergency and transported by ambulance.
- To further respond to the recommendation, the Joint Systems Protocol refers to joint SAPHS and DCS decision making processes for case escalation and roles and responsibilities of both agencies.
- DCS and SAPHS will meet to determine and identify the rare situations where recommendation ten is not realistic or feasible in an effort for both agencies to have a clear understanding of when this recommendation might not be effected but reiterate that DCS staff will comply with all reasonable requests wherever possible.

**Recommendation 11** - That medical staff, including medical practitioners and nurses, employed by the Prison Health Service in custodial institutions be equipped with Department for Correctional Services radios to enable them to be advised of a Code Black as and when it is called.

- (*Minister for Correctional Services*) As documented in the response to recommendations eight and nine, SAPHS staff at all prison sites now have access to radios, including some

SAPHS staff being provided with radios to carry on their person. Staff issued with radios have been trained in the use of them. This will allow immediate notification to SAPHS should a code black be called.

- The relevant Standard operating Procedure (SOP) related to radio security has also been updated to include that employees issued with radios must ensure that they maintain absolute control of the radio at all times and use the authorised radio swivel pouch and keep the item secured by the issued belt loop.

**Recommendation 12** - That the Minister for Correctional Services introduce such legislation that would amend section 36 of the Correctional Services Act be so as to prohibit the delegation of section 36 powers and responsibilities to officers of the Department for Correctional Services below the position of General Manager of a custodial institution or a person acting in that position or capacity.

**Recommendation 13** - That the Minister for Correctional Services introduce such legislation that would amend section 36 of the Correctional Services Act so as to require both the said Minister and the Chief Executive Officer of the Department of Correctional Services to be regularly informed of the current circumstances of a prisoner in respect of whom an order has been made that the prisoner be kept separately and apart from all other prisoners.

- (*Minister for Correctional Services*) The Deputy State Coroner found that the formal separation order for Ms Parker was completed appropriately at the site and served upon Ms Parker, but the formal order was not forwarded to the then Minister for Correctional Services for review in accordance with legislation.
- Separation involves the temporary placement of a prisoner in a cell, apart from other prisoners .
- The Correctional Services Act 1982 provides for the separation of prisoners for various reasons including prisoner safety, security of the institution and investigation of offences alleged to have been committed by the prisoner.
- At the time of Ms Parker's death, the legislative provisions for the notification of prisoner separations was administratively cumbersome; the Act required the Minister to be advised as soon as reasonably practical of every prisoner separation. The Minister was then required to confirm or revoke the decision.
- Because of the short term nature of many separations, most were not considered by the Minister until after the prisoner had been removed from separation. In addition, the process placed an immense administrative requirement on the prison to forward every separation notice for preparation for the Minister's review.
- Since that time, changes to the Correctional Services Act 1982 have seen the Chief Executive or delegate be responsible for confirming temporary separations of less than 5 days while separations exceeding 5 days remain the responsibility of the Minister.
- The change has strengthened the administrative processes, enhanced scrutiny of separations greater than five days and improved timely notification to the Minister.
- The Department's SOP relating to prisoner separations has been updated accordingly and has clear requirements for the separation of a prisoner, including that within 24 hours of the separation occurring, the General Manager/delegate must ensure:
  - a written direction to separate the prisoner, including the appropriate Separation Direction is completed;

- the direction is served on the prisoner and that the prisoner is provided an opportunity to sign the "Proof of Service" section;
- that the officer serving the direction completes the "Proof of Service" section;
- a copy of the completed direction is given to the prisoner;
- a case note is made in relation to the prisoner's separation;
- a business unit file is created for all separations;
- the original direction and all documentation associated with the separation is attached to a local business unit file; and
- a completed copy of the Direction to Keep a Prisoner Separate and Apart is forwarded to the Department's head office on the same day as the proof of service is completed.
- The Chief Executive's powers to separate a prisoner in accordance with Section 36 is currently formally delegated to General Managers, Operations Supervisors and Unit Managers. Notwithstanding, to entirely respond to recommendation 12, the delegation will be amended to give the power to General Managers only in the latter half of 2011 to further ensure the appropriate use of the Section in regards to all prisoner separations.
- The various proposed amendments to the Correctional Services Act 1982 that are currently in progress has necessitated the review of all delegations and will require various changes to be made as a result should the amendments be passed and enacted. The change to the delegation in regards to Section 36 will be included in the wide-ranging delegations review anticipated to be finalised in the late 2011.

**Recommendation 14** - That Department of Correctional Services Standard Operating Procedures be amended so as to contain a requirement that the General Manager of a correctional institution regularly review the circumstances of a prisoner to whom section 36 of the Correctional Services Act applies.

- (*Minister for Correctional Services*) In response, the Department's SOP in relation to Prisoner Separations (SOP 12) has been reviewed and approved in September 2010.
- The reviewed SOP has clear instructions for the daily review of every separated prisoner to ensure all prisoners placed on separation are monitored.
- The SOP also contains further instructions for the weekly assessment of prisoners separated for a week's duration, including ensuring separated prisoners are visited by a Visiting Inspector in accordance with Section 20 of the Act, and the Minister notified.
- The SOP also provides for General Managers to be responsible for citing evidence to justify the continued separation of a prisoner within the terms of the direction made and ensuring that each Review of Separation including any attached written comments from the prisoner is attached to the local business unit file.

#### **Wallace, James William (Coroner Schapel)**

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**Recommendation** - That the Medical Director of the SAAS consider issuing a guideline that describes a method of administration in accordance with the evidence given by Professor Jason White, in particular that set out in paragraph 5.5 herein.

- (*Minister for Police*) The topic 'excited delirium' has been included in the 2011 curriculum for the Incident Management and Operational Safety Training course (IMOST). This will provide police with the necessary knowledge to identify the signs and symptoms of excited delirium and the appropriate action for them to take. The IMOST programme is a

compulsory 2 day annual course of instruction for all operational police officers, and will be an appropriate forum to ensure implementation of the Coroner's recommendation.

- *(Minister for Health)* The Chief Executive Officer of SA Ambulance Service has confirmed that the teaching regarding the use of midazolam is in line with the recommendation, and the Clinical Practice Guideline for Acute Behavioural Emergencies will be updated to incorporate the requirement to administer midazolam 0.5mg to 1 mg IV to a maximum of 3mg at a rate no faster than 1 mg over 30 seconds allowing adequate time to observe the clinical effects and onset of effective sedation.
- The Minister for Mental Health and Substance Abuse wrote to the Minister for Police on 30 November 2010, providing a copy of the Deputy State Coroner's findings and suggesting that the findings be distributed to all police officers so that they may be better informed about excited delirium and the possible effects of substances, such as cocaine, on a person's behaviour.

## 9. Manager's Report

### 9.1. Registry Report

The Manager of the Coroners Court has responsibility to oversee the financial and administrative functions of the office. The Manager also has a number of responsibilities delegated from the Coroner in order to manage a range of quasi judicial functions as designated by the legislation.

There are 14.5 full time-time equivalent (FTE) administrative staff plus 2 FTE Counsels Assisting attached to the Coroners Court. Once again the Court has experienced an almost 100% retention rate with staff. The 0.5 FTE in reception remains the most difficult position to recruit and retain.

The role of coronial staff is to support the State Coroner and the Deputy State Coroner to undertake their inquiries with accurate and timely information. The office also provides a support service for families and provides access to information to certain approved parties, such as lawyers and insurance companies and medical practitioners.

The staff are to be congratulated for another year of dedicated and diligent work. They are knowledgeable about their work and are extremely loyal to the coronial jurisdiction. The staff demonstrate great pride in assisting families through very difficult times. Unfortunately there are occasions when members of the public believe staff are obstructing their requests for information or taking too long to release final paperwork. Unfailingly, the staff provide clear and impartial advice and assistance to all senior next-of-kin (SNOK) (SNOK as defined by the Coroners Court Rules 2005). Staff members regularly go out of their way to provide excellent service delivery and, even though staff are criticised by members of the public, there are also many occasions when family members send thank you emails and letters to acknowledge that staff assist as much as they can within the parameters of the legislation and policies.

Major achievements of the office during the year include:

- Improving information to families about the coronial process;
- Development of a business case to support the development of a new case management system to modernise business practices, improve functionality and extract meaningful statistics;
- Development of a 2011-2013 Business Plan;
- Audit of files on a 6 monthly basis improving the targeting of investigations and improving timeliness of case development;
- Quarterly meetings with FSSA mortuary staff to improve communications and systems between the agencies.

The Manager has continued to be available to outside agencies such as hospitals, health related students and general interest groups for speaking engagements.

These sessions enable the Manager to educate the community and health care professionals about the Coroners Act and the coronial process. During the year under review the Manager attended 16 speaking engagements.

During June 2011 all staff participated in the development of the 2011-2013 Coroners Court Business Plan. The major objectives for the future include:

- A review of case management procedures;
- Finalisation of the Business Continuity Plan;
- Reviewing correspondence procedures and reviewing efficiencies in administration procedures;
- Update procedure manuals;
- Review public information on the CAA website;
- Finalisation of the Coroners Court Case Management Business Case to support funding approval for the implementation phase;
- Progression of Domestic Violence Project objectives.

As well as working to achieve the Business Plan objectives, all staff will continue to participate in staff development and training (both formal and informal), Performance Development meetings and Occupational Health, Safety and Welfare awareness.

## 9.2. Counselling Service

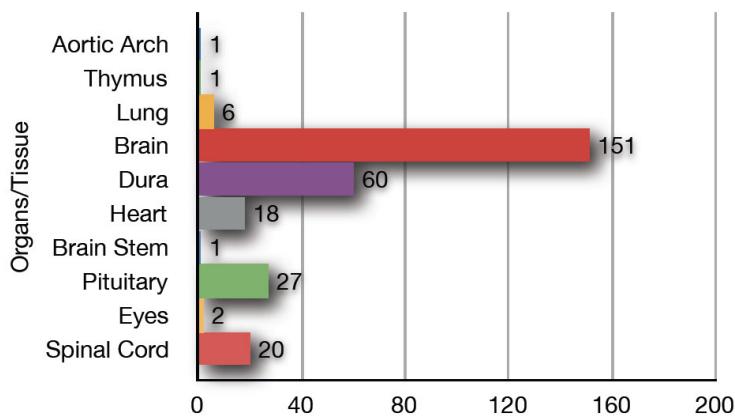
The South Australian State Coroners Court employs two senior social workers. They provided first contact calls to families as well as providing coronial social work services for the State Coroner and the Deputy State Coroner. Both social workers had an additional 1,000 families added to their case load over the last financial year.

The introduction of an electronic case management system (date yet to be determined), may go some way to capture quantitative data of social work activities.

## 9.3. Organ Retention

The Court is responsible for the investigation of the cause and circumstance of reportable deaths in South Australia. The cause of a death is almost always determined via a post mortem examination. In certain deaths however, a post mortem does not always reveal the cause of a person's death. In these situations further investigations and tests are carried out. These investigations and tests can involve the retention of organs and tissue. The Court's social workers have primary responsibility to inform and seek the views from the deceased's senior next-of-kin with respect to organ retentions.

For the 2010/2011 financial year there were 153 deaths that involved the

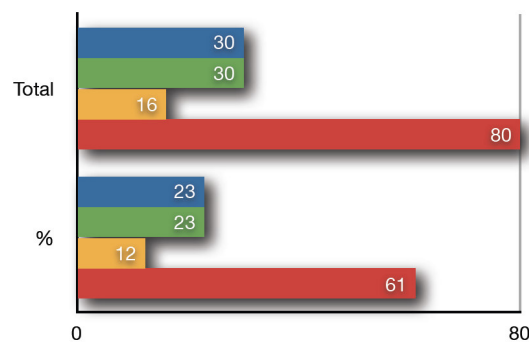


retention of one or more organs or tissue for specialist tests. This accounted for about 6% of all reported deaths. This number is up by more than 20 on the previous financial year.

In total there were 287 human organs and tissue retained during

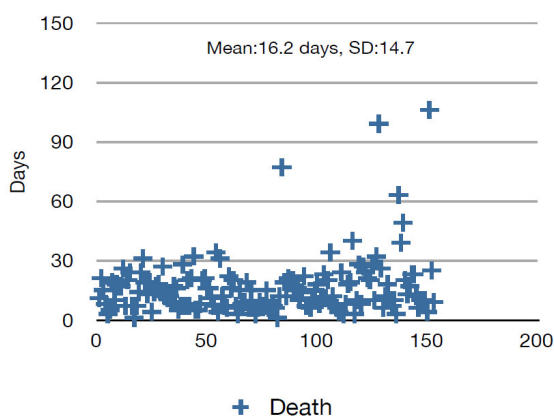
the 2010/2011 financial year. **Figure 1** shows that about 80% of all organs and tissue retained were brains.

Once specialist tests on organs and tissue are completed, the deceased's senior next-of-kin are able to direct the Court on how to dispose of their loved one's organs or tissue. **Figure 2** is breakdown of the method of disposal of organs and tissue.



At the expressed direction of the senior next-of-kin, over half (61%) of organs and tissue were donated to research. This figure is up by 10% on the previous year. Approximately 23% choose to have the retained organ or tissue returned to their funeral director. The funeral director would either have the organ or tissue cremated, or returned to the deceased's grave. About 23% of organs and tissue were returned to the deceased's body prior to the body being released to a funeral director. Only 12% directed the FSSA to respectfully dispose of the retained organs or tissue via cremation.

Retained organs and tissue must be kept in preserving chemicals before



kept in preserving chemicals before specialist tests can begin. Human brains, for example, are kept in formalin for approximately two to three weeks before a neuropathologist can undertake any micro and macro neuropathology examinations. This whole process may affect timeframes related to when families can bury or cremate their loved one. **Figure 3** shows the time taken for the organ retention process to be completed.

The mean time was 16.2 days and the standard deviation was 14.7 days.

#### 9.4. Disaster Victim Identification

The Manager of the Coroners Court is a member of the State Disaster Victim Identification Committee. This 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.

During May, senior staff from the Coroners Court attended the DVI 'Exercise Construct' meeting which provided information about the Christchurch, New Zealand, earthquake disaster victim recovery and identification. That information was then translated to an Adelaide scenario and lessons were applied to a facility that would be used should Adelaide experience a large scale disaster event.

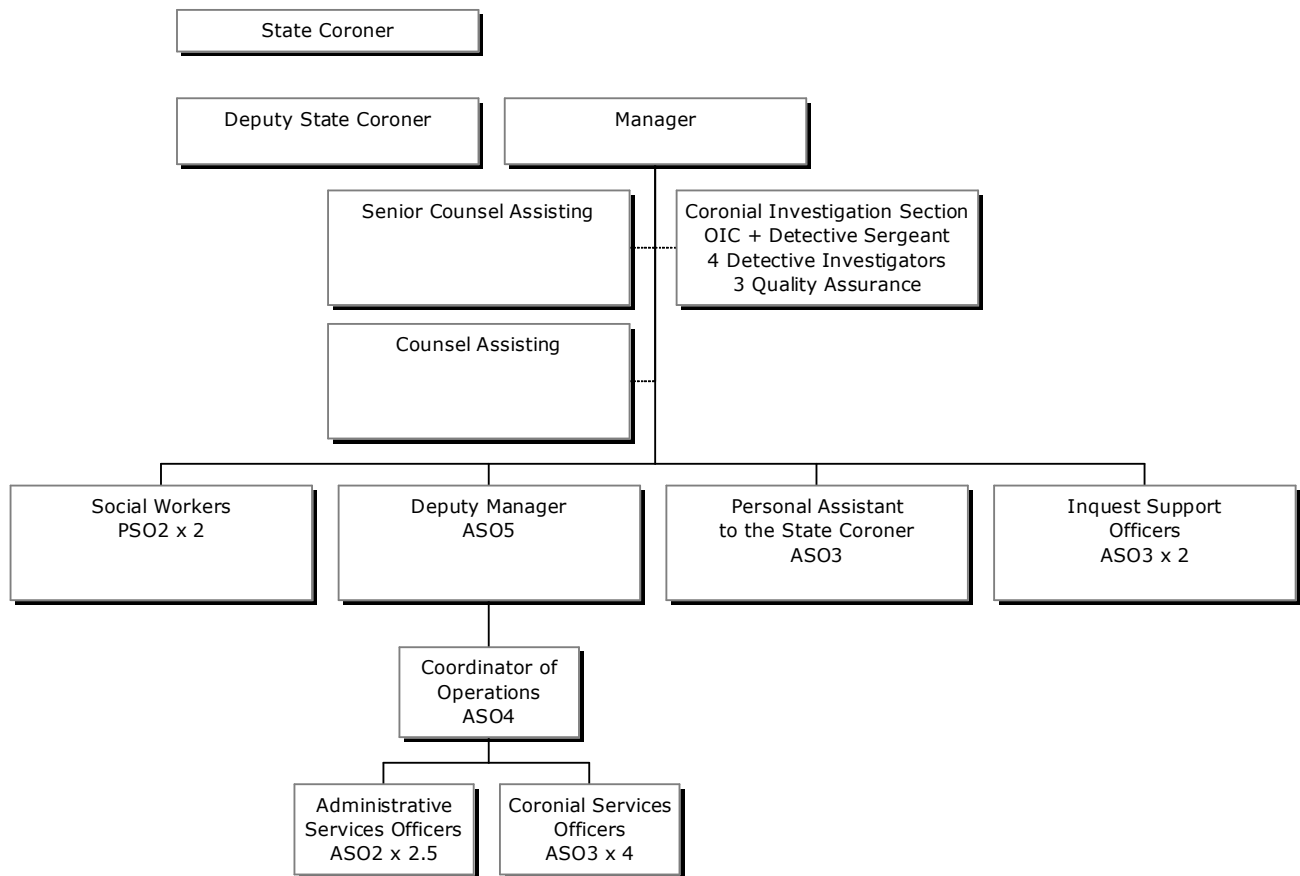
#### 9.5. Training of Staff

Staff participated in a variety of training programs throughout the year. Training activities are documented below:

<b>Type of Training</b>	<b># Staff</b>
Chief Justice Forum	1
Chief Magistrate Forum	2
Client Service Forum, Challenging Issues in Client Service with Grief and Loss	5
Client Service Forum, Dealing with Grief and Loss	2
Contact Person, Role and Responsibilities	2
Courts Operation Programme	1
Creating Structured Procedure Manuals and Help Files	2
DVD - Amy's Story (Domestic Violence Issues)	13
Managing for High Performance	1
Medical Terminology	2
Performance Development Briefing	2
Performance Development Training	3
Public Sector Financial Management	1
SAPOL Taser Demonstration	5
Staff Forum at Forensic Science SA	4

## 10. Staff Roles and Organisational Chart

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



**Management Team** consists of the Manager, Deputy Manager, Operations Coordinator and the Social Workers. This group provides strategic direction to the administration team and provides leadership in the areas of Business Planning, Business Continuity Planning, OHSW, human resource management and the general day to day functions of the registry.

**Coronial Services Officers and Administration Officers** in the Registry receive reports of death from SAPOL, hospitals and aged care facilities. The role also involves coordinating initial investigations, reporting matters to the State Coroner, referring matters for investigation and authorising and arranging the conveyance of deceased persons within the State. This section of the business unit also attends to correspondence, manages reception duties, and provides a 'quality assurance' service to the data entered into the national coronial database.

**Social Workers** provide initial grief and crisis counselling during the time immediately following the death, they provide specific information about the coronial process and assist families in preparing to attend an Inquest. The

Social Workers also provide referrals to those who are bereaved to longer term services, both counselling and support groups. The Social Workers play an important role in talking to families about the post mortem process, particularly where tissue/organs have retained for further examination.

**Inquest Support Officers** provide assistance to Counsel Assisting in preparing Inquests and issuing Court documents, notifying and liaising with stakeholders and next-of-kin and ensuring appropriate information is recorded and provided to relevant parties. They provide a confidential administrative service to Senior Counsel Assisting/Counsel Assisting the State Coroner and Deputy State Coroner by typing from manuscript or digital Dictaphone, conducting file management on a large number of files and exhibits and responding to various correspondence. They also provide information pertaining to the conduct of coronial Inquests by liaising with administration, counsel and the public and other interested parties regarding documents and other information requested and provision of appropriate responses and action.

**Personal Assistant to the State Coroner** provides a confidential and efficient typing, clerical, secretarial and administrative service to the State Coroner and provides general support to Inquest Support Officers as required.

**The Counsel Assisting the State Coroner and Deputy State Coroner** works to provide legal services to the State Coroner and Deputy State Coroner, preparing matters for Inquest, ensuring that matters are listed for Inquest in an orderly and efficient manner to make the best use of the Court's resources. This position also prepares legal matters pertaining to complex investigations and formulates advice to the State Coroner that will assist in determining whether an Inquest is necessary or desirable.

There are two Counsels Assisting assigned to the State Coroner and Deputy State Coroner and they are assisted in the preparation of Inquests by two Inquest Support Officers.

The major responsibilities of Counsels Assisting are:

- Liaising with the State Coroner, Deputy State Coroner, Senior Counsel Assisting and other personnel in relation to all coronial functions;
- Preparation of matters for Inquest which are of a complex and sensitive nature;
- Conducting cases considered complex and sensitive in nature as Counsel Assisting the State Coroner and Deputy State Coroner at Inquests;
- Providing verbal and written legal advice to the State Coroner and Deputy State Coroner;
- Liaising with investigators from SAPOL, Workplace Services and other agencies, witnesses and members of the public as required;

- Ensuring that in dealing with all issues pertaining to social, ethnic and cultural sensitivities, the dignity and rights of those involved in coronial Inquests are preserved.

The role of Counsel Assisting demonstrates the values of the Courts Administration Authority by practising law with integrity and professionalism and by respecting, the Coroners, the Court and their legal colleagues. Counsels Assisting provide a service to the South Australian community by inquiry into circumstances of death in order to advise the Coroners so that they may make recommendations that will prevent the likelihood of a similar occurrence in the future.

#### **Senior Researcher (Domestic Violence)**

This project is in response to an election commitment made by the South Australian Government. To advance this commitment, the Office for Women and the South Australian Coroners Court have undertaken a 4-year partnership to research and investigate domestic violence related deaths. The position of Senior Researcher (Domestic Violence) was created and recruitment finalised in January 2011.