THE *CORONERS ACT 2003* (SA) AND THE PARTIAL IMPLEMENTATION OF RCIADIC: CONSEQUENCES FOR PRISON REFORM

Christopher J Charles*

The Royal Commission into Aboriginal Deaths in Custody ('RCIADIC') recognised, in its *National Report* of 1991, that coronial reform was among the suite of measures necessary to address the high rate of Aboriginal deaths in custody, which the Royal Commission itself had investigated. The crisis that had led to the Royal Commission being established was the complaint of Aboriginal families that there were too many unanswered questions about deaths in custody.[1] In volume 1 of the *National Report*, RCIADIC acknowledged the pivotal role that State and Territory coroners could play in providing to families and to the community at large findings that were authoritative and clear as to the cause and circumstances of individual deaths in custody.

More importantly RCIADIC recommended substantial measures to strengthen the coronial jurisdiction. These would be directed at ensuring that deaths in custody were investigated by a competent and impartial body, accountable to the coroner, which left no stone unturned in its investigations. Coroners should be assisted by counsel who would superintend investigations and, at the conclusion of each case, coroners should be empowered to make recommendations to governments, even on topics outside the parameters of the instant case. These recommendations would address systemic failures in prison and police practices and so prevent further deaths in custody. Governments would also be made more accountable for implementing coronial recommendations. In that way prisons and police would also become more accountable for the care of their charges. The incidence of Aboriginal deaths in custody would gradually be reduced. In addition, because the coronial system works through time, on a case-by-case basis, it could provide incremental impulses for reform and change arising out of individual cases, well into the future.

At the time of the Royal Commission, major prison reform and improvements had only just been achieved in South Australia. Indeed, Commissioner Johnston QC, who headed RCIADIC, acknowledged that the Clarkson Royal Commission into South Australian prisons of 1980 and 1981 had had enormous influence in reforming the South Australian prison system, stating that it 'was a very important catalyst for important changes in the law relating to penal institutions in South Australia.'[2] Reforms included the replacement of the *Prisons Act 1936* (SA) with the *Correctional Services Act 1982* (SA) and wholesale reform of prison medical services. In addition, Commissioner Johnston noted that:

> The recommendation by Commissioner Clarkson that the Act [*Correctional Services Act 1982* (SA)] or the Regulations thereunder should establish and set out the responsibilities of prison officers in relation to care of prisoners has not been but should be put into effect.[3]

To this day, almost 20 years after Commissioner Johnston's comments were made, and almost 30 years after the Clarkson Royal Commission's original recommendation was made, the responsibilities of prison officers for prisoner care have not been defined in South Australian legislation or regulations. Most authorities and responsibilities in relation to prisoners' welfare and management reside in the chief executive officer or the manager of the prison in question. They are subject to complex and crosscutting systems of delegation by Standard Operating Procedures and Managers' Rules. Fundamental

reforms of the kind recommended by both Commissioners Clarkson and Johnston to the structure of the *Correctional Services Act 1982* (SA), giving individual officers direct statutory responsibility for the welfare of prisoners, have not been implemented, despite adverse comment by the State Coroner.[4] One of the questions this report leaves unanswered is whether the coronial system is a suitable vehicle to drive major structural reform of the prison system and the *Correctional Services Act 1982* (SA) or whether a major inquiry, or other means, is needed for that purpose.

Following RCIADIC a number of authors wrote on the effects that it had had on South Australian prisons and coronial processes. Dr John Dawes, the former South Australian Public Advocate and former head of the Department for Correctional Services,[5] noted that of the 14 deaths by suicide in South Australian prisons between 1980 and 1993 one was not inquested, some had coronial findings which were quite cursory and only four resulted in coronial recommendations.[6] Aboriginal and Torres Strait Islander Social Justice Commissioner Michael Dodson released a monumental study[7] discussing and reanalysing Aboriginal death in custody cases, including those subject to inquest by the South Australian Coroner's Court, from the period 1989 to 1996. The study referred to and commented upon relevant RCIADIC recommendations which had or had not been implemented, and provided an individual commentary upon each of the cases. Ultimately, the study sought to answer this question: had the RCIADIC caused a significant change to custodial practices?

This report also seeks to answer this question, in the South Australian context, by looking at post-RCIADIC legislative reforms and providing case studies of inquests in South Australia. It covers the implementation of RCIADIC recommendations 6 to 18 and examines the influence the RCIADIC reforms of the coronial system have had on South Australian prison reform. The report begins by discussing legislative reforms that have fully implemented RCIADIC recommendations. The breadth of the coronial jurisdiction generally and the recommendation-making power, as defined under the *Coroners Act 2003* (SA), is then discussed in relation to the relevant RCIADIC recommendations. The report then looks at the impact RCIADIC has had on the duty of care owed by correctional officers to prisoners. Following this, the discussion moves to the topic of screening hanging points, which was really brought to the fore by RCIADIC, and which is a corollary of the enhanced duty and standard of care which RCIADIC had engendered. Lastly, the report provides an analysis of government accountability in relation to the implementation of coronial recommendations, specifically in respect of ministerial responses to coronial recommendations following an inquest into a death in custody. It is concluded that, while some positive reform of the South Australian prison system has been achieved in the wake of RCIADIC, this reform has only partially implemented some of the RCIADIC recommendations relevant to prisons.

I Legislative Reforms that have Fully Implemented RCIADIC Recommendations

As independent judicial officers under the Crown, coroners serve the public by impartially examining deaths under their jurisdiction in a public forum. The findings give an authoritative statement of how and why the death occurred. The recommendations made as a result of a coronial inquiry provide instructive advice to government on how to prevent a further occurrence of a preventable death. As this report will show, their implementation is crucial to preventing future deaths.

The original version of the *Coroners Act 1975* (SA) did not make it mandatory that deaths in custody be subjected to coronial inquest, although the 1975 Act was amended in 1988 to make inquests into deaths in custody mandatory.[8] Of the South Australian deaths investigated by RCIADIC, some, particularly those that occurred during the currency of the Royal Commission itself, were inquested in great detail.[9] Others were subject to superficial coronial inquests,[10] and some had not been inquested at all.[11] It is apparent that the defects of the South Australian death in custody inquests before the RCIADIC were among the issues considered in the drafting of the recommendations to improve the coronial process.

RCIADIC recommendation 12 recommends:

> That a Coroner inquiring into a death in custody be required by law to investigate not only the cause and circumstances of the death but also the quality of the care, treatment and supervision of the deceased prior to death.[12]

This recommendation addresses the issue of the standard of prison care, which includes accommodation and its relationship to the suicide of prisoners – all matters that had

been agitated at length before the Royal Commission itself and are the subject of many of the individual reports as well as volume 3 of the *National Report*.[13]

Coroner Hope of the Coroner's Court of Western Australia has endorsed recommendation 12, commenting that 'the quality of supervision and treatment' of the deceased prior to death should be thoroughly examined at an inquest into a death in custody.[14] Such coronial investigations have the potential to address deficiencies and to initiate improvements in the standard of prisoner accommodation and the way prisoners, particularly Aboriginal prisoners, are managed by correctional authorities. The standard of prison accommodation has been identified by several research projects as being vital in determining 'the prison experience for the prisoner'.[15] It has long been recognised that Aboriginal prisoners have culturally specific needs.[16]

Positively, recommendation 12 has been very thoroughly implemented in South Australia, but by judicial and coronial interpretation, not by the legislation adopting the RCIADIC criteria. Under s 21(1) of the *Coroners Act 2003* (SA), a coroner has a mandatory jurisdiction to ascertain the cause or circumstances of a death in custody and a number of other deaths or events. Coroners have taken a broad view of their jurisdiction, consistent with Supreme Court authority. In *WRB Transport v Chivell*,[17] Lander J said of the breadth of the South Australian coronial jurisdiction generally:

> The inquiry will not be limited to those facts which are immediately proximate in time to the deceased's death. Some of the events immediately proximate in time to the death of the deceased will be relevant to determine the cause of the death of the deceased. But there will be other facts less proximate in time which will be seen to operate, in some fact situations, as a cause of the death of the deceased. That is a factual inquiry which only has as its boundaries common sense.[18]

His Honour continued:

> Not only does the Coroner have jurisdiction to determine the cause of the deceased's death he also has jurisdiction to determine the circumstances of the death of any person. ... There may be some circumstances surrounding the death of the deceased which, although not operating directly as a cause of the death of the deceased, are relevant for the coroner's inquiry.
>
> Those circumstances might explain the origins of the causes of the death of the deceased or the interaction between a number of causes of death.
>
> The circumstances surrounding the death of the deceased may be important, for the purposes of the coroner adding to his or her findings recommendations which might prevent or reduce the likelihood of a recurrence of the death.[19]

In addition to the broad scope for coroners to inquire into deaths, including into deaths in custody, the definition of 'death in custody' itself is broadly defined under s 3 of the *Coroners Act* 2003 (SA). Instances of deaths in custody under the Act's definition include deaths that arise while a person:

- was being detained under any Act or law (this includes home detention[20] and instances where a person is in the custody of an escort);
- was in the process of being apprehended, or was being held, by a person authorised to do so under South Australian law;
- was evading being apprehended; or
- was escaping or attempting to escape from custody.[21]

It may be observed that this definition satisfies the recommendation as to the breadth of jurisdiction found in RCIADIC recommendation 6.[22] It seems likely that the definition would cover police shootings of persons who may or may not have been formally arrested at the time of their deaths, and that the uncertainty as to breadth of jurisdiction in the old *Coroners Act 1975* (SA)[23] has been resolved in favour of the broader RCIADIC criteria.

II The Coroner's Jurisdiction and Power to Make Recommendations

From the analysis of the cases discussed below, this author suggests that the rather narrow recommendation-making power in the *Coroners Act 2003* (SA) has had serious consequences for South Australian prisons and prisoners. These consequences have manifest, in part, because of the confluence of two factors: firstly, the South Australian Department for Correctional Services was not required to respond to the Coroner's concerns, expressed in 2000, over the doubling up of prisoners in cells;[24] and secondly, an increased use of that practice, as a means to deal with a dramatic increase in prisons population, has occurred since that date.

This author suggests that the coronial jurisdiction and recommendation-making power should be broadened still further to cover events that occur around and after the time of the discovery of a death that may be relevant to coronial investigation,[25] and events that arise from the circumstances of the custody of the deceased but are outside the present recommendation-making power. RCIADIC recommendation 13 should be implemented in South Australia. Recommendation 13 is:

> That a Coroner inquiring into a death in custody be required to make findings as to the matter which the Coroner is required to investigate and to make such recommendations as are deemed appropriate, with a view to preventing further custodial deaths. The Coroner should be empowered, further, to make such recommendations on other matters as he or she deems appropriate.[26]

A The Lindsay Inquest

A ruling was made by the former State Coroner, Mr Chivell, on 31 May 2004 in the inquest into the death of T M Lindsay.[27] Although that was a case under the *Coroners Act 1975* (SA), the point remains apposite. In that case, various matters concerning the conduct of police towards members of the deceased's family were not considered by the Coroner because they were not evidence in relation to the cause or circumstances of the death. Rather, they were matters relating to what occurred immediately after the death, and thus were not relevant to the primary jurisdiction of the Coroner. The Coroner commented as follows:

> This is the type of issue which has given rise to recommendations, for example in the Royal Commission into Aboriginal Deaths in Custody, the Coroner should have the power to make recommendations about issues which are incidental to a death, rather than directly causally relevant to it. In several States of Australia, Coroners now have that power, ie, to make a recommendation which is associated with a death, but not directly causally relevant to it. That power does not exist in South Australia and in my opinion, it would be inappropriate for me to exercise my power to force an officer to answer questions about issues that are irrelevant to my Inquiry.[28]

It is clear from former State Coroner Chivell's statements that, though he was mindful of RCIADIC recommendation 13, he felt limited by the South Australian coronial legislation, which prevented him from making recommendations associated with, but not causally relevant to, the death in question.

B The Carter Inquest

In the inquest into the death of M F Carter, the findings of which were delivered by the State Coroner on 16 June 2000,[29] questions arose about the breadth of the recommendation-making power. This was a tragic case of a young Aboriginal man who had been transferred from a youth training centre to E Division of Yatala Labour Prison. In the inquest, the evidence disclosed and the Coroner found that the young man had died in his cell of a drug overdose. While the circumstances of his incarceration, which included being in an overcrowded doubled-up cell with another Aboriginal prisoner who had an infectious disease, received comments from the Coroner, they could not be the subject of recommendations. In addition, the Coroner had to deal with the vexed question, arising from the Royal Commission itself, of whether it was desirable for Aboriginal prisoners to be doubled up in a cell. The State Coroner said:

> A basic problem is that the chronic over-crowding in South Australian prisons requires multiple occupation of cells. One only has to look at photographs of cell 302 [the cell of the deceased] to realise the miserable and over-crowded conditions in which these prisoners lived. The lack of privacy and hygiene involved in sharing toilet and hand-washing facilities in the cell, and the fact that there is only one small desk and a couple of plastic trays for their private possessions, create a negative impression of conditions endured by these prisoners. ... Carter so disliked sleeping on the top bunk that he used to take his mattress and put it on the floor and sleep there next to the toilet bowl each night ...[30]

Sadly, those comments are as relevant to prison conditions in South Australian prisons now as they were in 2000. Problems of overcrowding in South Australian prisons are more chronic now than they were then.

The Coroner also stated:

> it is highly inappropriate that prisoners who have a communicable disease should be 'doubled up' with prisoners who do not. The health risks are obvious. If a prisoner does develop a communicable disease as a result of this process, then the Department [for Correctional Services] will have to bear the consequences. In this particular case, however, I am

> unable to find that .... Carter died as a result of this policy. I am therefore unable to make a recommendation pursuant to Section 25(2) of the Coroners Act on this topic.[31]

The Coroner's conclusion about the breadth of the recommendation-making power under s 25(2) of the *Coroners Act 1975* (SA) is undoubtedly correct. As in the Lindsay inquest, it is clear that, for all the reasons the Coroner enumerates, there should have been a power to make recommendations on events and issues that arose either after the death itself or which were not 'similar to the event that was the subject of the inquest'.

In addition the evidence in the Carter inquest raised an alarming statistic on the rate of infectious diseases in the prison system. Evidence given at the inquest disclosed that the number of prisoners in E Division of Yatala Labour Prison with communicable diseases was about 80 per cent.[32] Clearly such a statistic in itself called for immediate reform and steps to alleviate its effects, yet the Coroner could do no more than note the evidence and the obvious connection between the doubling up of prisoners and the high rate of infectious disease.[33]

C The *Saraf* Case

The recent decision of the South Australian Supreme Court in *Saraf v Johns*[34] dealt with the recommendation-making power under the *Coroners Act 2003* (SA) and the question of the coronial power to determine the jurisdictional fact, namely, what constitutes a reportable death? In relation to the recommendation-making power Debelle J took an approach similar to that which had been taken by the former State Coroner in the Lindsay and Carter inquests. His Honour stated:

> the power to make recommendations is not at large but is limited to 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.[35]

His Honour then discussed the use of the recommendation-making power in the case at hand:

> The power of the Coroner to make recommendations was limited by s 25(2) [of the *Coroners Act 2003* (SA)]. That power included the power to make recommendations relating to both the cause of death of Mrs Wells and to the circumstances in which she died. It, therefore, extends to circumstances that are not a direct cause of death. Nevertheless, the power to make a recommendation extends only to such matters as might prevent or reduce the likelihood of recurrence of a death in like circumstances to those in which Mrs Wells died or to prevent death from the same or like causes to those from which she had died.[36]

His Honour also concluded that the appellate jurisdiction of the Supreme Court in hearing appeals from the Coroner's Court included jurisdiction to overturn recommendations:

> The Coroner's Court and any Coroner exercising the jurisdiction of that court has authority to exercise only the powers and functions conferred on the court by the Coroners Act. Conduct that is not authorised by the Act is invalid. As each of these recommendations falls outside the power in s 25(2), the Coroner had no power to make them and each is invalid.[37]

In the inquest subject of the decision in *Saraf v Johns*, as in the Carter and Lindsay inquests, the recommendation that the Coroner was not permitted to make was an eminently reasonable and desirable one.[38] Debelle J considered the question of law reform, but limited his observations to the reform of the jurisdictional fact problem, to clarify the law on the coronial jurisdiction to determine what was a reportable death.

Unfortunately, Debelle J did not comment upon the need for law reform to widen the recommendation-making power itself. The present s 25(2) *Coroners Act 2003* (SA) is in substantially the same form as s 25(2) of the *Coroners Act 1975* (SA), and it stipulates:

> 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.

When the Coroners Bill was before the Parliament between 2000 and 2003, the Aboriginal Legal Rights Movement and the Law Society of South Australia had actively lobbied parliamentarians and had supported the amendments to the Bill proposed by Mr Gilfillan MLC. Three of Mr Gilfillan's amendments that were passed became ss 25(4), 25(5) and 39 of the *Coroners Act 2003* (SA). However, one of Mr Gilfillan's

amendments that was not incorporated into the final Bill or the *Coroners Act 2003* (SA) was for a further subsection 25(3), which provided that '[a] recommendation may be made under sub-section 2 despite the fact that it relates to a matter that was not material to the event the subject of the inquest.'[39] Because the Gilfillan amendment was not passed, a significant opportunity for coronial reform was passed up.

III The Royal Commission and an Enhanced Duty of Care

RCIADIC had delivered its final report in 1991 and inevitably the State Coroner's findings on inquests into deaths in custody in South Australia after RCIADIC reflected the impulses and changed perspectives on duty of care which it had engendered. This section will cover the ways in which South Australian coroners have dealt with death in custody cases from South Australian prisons and their recognition of the enhanced duty of care owed to prisoners since RCIADIC.

A The Henry and Bonney Inquests: Reaction Times to Incidents in a Cell

In the inquest into the death of P A Henry,[40] the State Coroner found that the deceased had lit a fire in his cell in F Division of Yatala Labour Prison. The alarm was raised almost immediately but correctional officers were unable to release him from his cell till some 14 minutes later, by which time he had suffered irreversible brain damage. A coronial recommendation was made that the time for accessing the master key from the Yatala Labour Prison central control tower be reduced to three minutes. Failing this, it was recommended the Department for Correctional Services should consider introducing electronically operated cell doors.[41] In the subsequent inquest of Bonney, which was an investigation into the death by hanging of Mr Bonney in E Division of Yatala Labour Prison, the recommendation for electronic doors was repeated, but was again rejected by the Department for Correctional Services.[42]

The State Coroner's findings in the Bonney inquest display a robust debate between the Coroner and the then head of the Department for Correctional Services, Ms Sue Vardon. Whilst the State Coroner noted Ms Vardon's response that a three minute reaction time cannot always be guaranteed, he repeated the specific recommendation from the Henry inquest. He pointed out that three minutes was the maximum time which can elapse between the cutting of the blood supply to the brain and the onset of permanent brain damage. Despite the objections of the Chief Executive of the Department, the Coroner stood firm on the principle of the three minute minimum standard for reaction times in accessing a prisoner locked down in a cell when the master key is kept in another part of the institution.[43]

The Coroner, having explained what the consequences were of not meeting the three minute time limit, was upholding the principle of duty of care, and setting a standard of care.[44] It may be noted that one of the most important benchmarks set by the Royal Commission is that there is a fundamental duty on custodial authorities to attempt to rescue those in peril, even those – and indeed especially those – in peril by their own conduct.[45]

Other steps had been taken by the Department since the Henry inquest to reduce the reaction time in getting the master key to a prisoner's cell. This included the introduction of a special safe to hold the master key, and a chute from the central control tower down which the master key might be sent in order to hasten the process of rescue.[46] The State Coroner remained sceptical.[47]

What is apparent, though unstated, from the coronial findings in the Bonney and Henry inquests is a fundamental issue of prison design. Yatala Labour Prison is a 19th century institution. The central control tower, where the master keys are kept, is a considerable distance from the Divisions where prisoners are held. The real determinant of reaction time is the geography and layout of an antiquated and outmoded institution which needed then, at the time of the Bonney and Henry inquests, and needs now to be replaced. The dilemma for South Australian coroners and the parties who appear before them was and continues to be the ongoing risk to prisoners housed in Yatala Labour Prison, which is not due for replacement until at least 2010–12.[48]

For the purposes of this report, it is noteworthy that the written response of Ms Vardon in the Bonney inquest had been made to the State Coroner in part as a result of the recommendations in the Henry inquest. It is also worth noting that Ms Vardon's response in Bonney indicated that the policy issues raised by the Coroner in the Henry inquest were treated seriously by her Department. There were, however, fundamental and intractable disagreements about the question of electronically operable doors.[49]

The State Coroner noted in the Bonney inquest that some of the departmental correspondence had been sent to him as a result of a departmental review flowing from the death subject to inquest.[50] That such correspondence had been entered into and was tendered discloses that both the State Coroner and the Department for Correctional Services saw the policy questions involved in the prevention of future deaths in custody as vitally important and requiring dialogue between them. In the opinion of this author, such robust dialogue is a good thing. In fact, it anticipated the implementation of RCIADIC recommendation 15, which was ultimately put into effect by the formal processes set out in ss 25(4) and 25(5) of the *Coroners Act 2003* (SA).

The recommendation concerning reducing the reaction time in Yatala Labour Prison to three minutes was also relevant to the later Varcoe inquest, where the correctional officers' statements disclosed that the time between discovery and opening of the cell was three minutes.[51] The Coroner had been heeded.

The Bonney and Henry inquests disclose that robust dialogue between the Coroner and departmental authorities is not new and that coronial recommendations are always contextualised to the institution under inquest. Sometimes the recommendations of a coroner point to one end: that the institution needs to be replaced.

B Hanging Points and Coronial Implementation

The removal or screening of hanging points in cells is a vexed topic in South Australian prisons. It had not been a topic of concern until RCIADIC, but subsequently it very graphically illustrated the limitations of South Australian correctional institutions in dealing with an enhanced duty of care to prisoners. In a 2007 submission to the Correctional Services Advisory Council,[52] the Aboriginal Legal Rights Movement had identified 20 inquests into deaths by hanging in South Australian prisons between 1994 and 2004. This in itself was not new; the aforementioned study by Dr John Dawes[53] disclosed that, in the period from 1980 to 1993, of the 38 deaths in custody in South Australian prisons, 14 cases were found to have been suicides, with hanging the usual method.

The State Coroner had begun commenting on the removal of hanging points as long ago as 1995 in the Wakely[54] inquest concerning B Division of Yatala Labour Prison. In that case he made a recommendation, consistent with the original RCIADIC recommendation 165, that steps should be taken to screen hanging points in police and prison cells:

> That DCS urgently reconsider its policy of reliance upon the detection of 'at risk' prisoners, and instigate a program of refurbishment of the cells in B Division so that hanging points are minimised to the greatest extent possible consistent with the safety, dignity and comfort of the prisoner.[55]

The Coroner's recommendations for retrofitting and upgrading prison cells was extended to E Division in the Bonney inquest and in many other inquests through the 1990s. Refurbishment had been costed, at the time of Bonney in 1997, to be about $3000 per cell, a total of about $168 000 for E Division of Yatala Labour Prison.[56]

One may reflect upon the estimated costs involved in 1997 for screening hanging points in E Division of Yatala Labour Prison compared to the human costs subsequently, and the fact that inquests continued to be held regarding E Division.

1 The Varcoe Inquest

The death of A K Varcoe was inquested by the former State Coroner Mr Chivell in 2003. It was a tragic case of a vulnerable young Aboriginal man, overcome by his circumstances. He was found hanged in his cell in E Division of Yatala Labour prison.[57] The Coroner stated that it was 'perfectly obvious from the photographs of Mr Varcoe's cell ... that there were many "hanging points" he could have used.'[58] It was another tragic case where proper screening of hanging points, in accordance with RCIADIC recommendation 165 and the Bonney recommendations, might have prevented the death. The Coroner had had put before him evidence of a study from Victoria on safe cell design, the Building Design Review Project, which had developed a 'prototype cell' that would be free of hanging points.[59] These documents later became the subject of a specific coronial recommendation, the Coroner recommending that a comprehensive review, similar to the Victorian study, be undertaken, not only of cell design in E Division of Yatala but in all older cells in the South Australian prison system.[60] On the topic of cell design, the findings disclose that the State Coroner was, unfortunately, becoming accustomed to repeating his recommendations. He had made a similar recommendation for the screening and removal of hanging points from cells some seven years earlier in the Bonney inquest.[61] The Coroner also referred to a

specific recommendation made three years earlier in another inquest, the Nobels inquest, for the removal of hanging points from bunk beds. The Coroner had recommended that, if hanging points could not be removed from bunk beds, bunk beds should be removed from cells.[62]

The Varcoe inquest had taken place well before the *Coroners Act 2003* (SA) came into operation, so the Minister and the Department for Correctional Services did not have to formally respond to the Coroner on the specific recommendation regarding a comprehensive review of safe cell design. Nevertheless it was becoming apparent that the State Coroner was not afraid of repeating coronial recommendations and the reference to hanging points on double bunks remained an issue of continuing concern, as will appear later in this report.

Although it is beyond the scope of this report to consider them in detail, the Victorian safe cell design principles that emerged from the Building Design Review Project represent part of a new and apparently comprehensive architectural and design solution to suicide prevention in prisons. They are based around three principles: that cells should be fireproofed and that fire response times should be sufficient to allow the rescue of prisoners trapped in cells on fire;[63] that prison cells should not have hanging points which might be used in an attempt at suicide by hanging; and that prison cells should be part of a living environment for prisoners that is conducive to mental health and stability and that includes an element of human interaction. They were developed with knowledge of coronial findings and recommendations. The authors were also aware of the need for policy makers to balance safety and security and at the same time to optimise the human element in design. It is beyond the scope of this report to evaluate or discuss the architectural and engineering merits of the safe cell design principles, however it is noted that to date they have received comparatively little academic comment or criticism.[64]

Given Mr Chivell's comments in the Carter inquest, quoted above, concerning double bunking of prisoners, it is noteworthy that the safe cell design principles for a multiple occupancy cell include two single beds, toilet and shower facilities screened from the sleeping area and an overall floor space for a double cell of 13.53 square metres.[65] This should be borne in mind in considering the South Australian Department's response to increased prisoner numbers; that is, of doubling up existing single cells with safe double bunks.

IV The Impact Of RCIADIC on the *Coroners Act* and the Accountability of Government

RCIADIC in its *National Report* of April 1991 proposed a detailed system of government accountability to the Coroner over recommendations to prevent future deaths in custody. In summary RCIADIC recommendations 13 to 18[66] had recommended, as well as an enhancement of the recommendation-making power, that Ministers responsible for departments and agencies affected by coronial recommendations should receive copies of findings and recommendations and be obliged to respond to the Coroner of the relevant inquest with a response. In addition coroners should be empowered to call for such further explanations or information as they consider necessary, including reports as to further action taken in relation to the recommendations. The State Coroner should also make an Annual Report to the Attorney-General to be tabled in Parliament, which would contain each of the coronial recommendations made throughout the year regarding the prevention of further deaths in custody.

These recommendations were partially implemented in the *Coroners Act 2003* (SA) and part of the history of that legislation has been related above. The relevant sections of the Act are 25(4), 25(5) and 39:

> 25 – Findings on inquests
>
> ...
>
> (4) The Court must, as soon as practicable after the completion of the inquest, forward a copy of its findings and any recommendations:
>
> (a) to the Attorney-General; and
>
> (b) in the case of an inquest into a death in custody:
>
> (i) if the Court has added to its findings a recommendation directed to a Minister or other agency or instrumentality of the Crown – to each such Minister, agency or instrumentality of the Crown; and
>
> (ii) to each person who appeared personally or by counsel at the inquest; and
>
> (iii) to any other person who, in the opinion of the Court, has a sufficient interest in the matter.
>
> (5) The Minister or the Minister responsible for the agency or other instrumentality of the Crown must, within 8 sitting days of the expiration of 6 months after

receiving a copy of the findings and recommendations under subsection (4)(b)(i):

(a) 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 those recommendations; and

(b) forward a copy of the report to the State Coroner.

39 – Annual report

(1) The State Coroner must, on or before 31 October in each year, make a report to the Attorney-General on the administration of the Coroner's Court and the provision of coronial services under this Act during the previous financial year.

(2) The report must include all recommendations made by the Coroner's Court under section 25 during that financial year.

(3) The Attorney-General must, within 12 sitting days after receiving a report under this section, cause copies of the report to be laid before both Houses of Parliament.

RCIADIC recommendation 15 requires a three month response period from the Minister for the recommendations as to a death in custody. Section 25(5) of the Act stipulates a six month period for the Minister to respond and to advise of any action taken. Any sense of urgency could be lost in this six month reporting period. Given that many departments, in particular the South Australia Police and the Department for Correctional Services, conduct internal inquiries into deaths in custody in parallel with the coronial investigation, it can rarely be said that the departments concerned are likely to be surprised by coronial recommendations.[67] More importantly, the 2003 Act does not empower coroners to requisition further explanations or information from responsible Ministers in relation to the implementation of recommendations.

What follows is a case study on the operation of the new principles of accountability placed on the Government. The context is continuing coronial recommendations on the implementation of the Victorian safe cell design principles to South Australian prisons.

A The Turner and Glennie Inquest

The matter of Turner and Glennie[68] was a 2006 joint inquest into two deaths by hanging at the Adelaide Remand Centre. In her findings delivered on 18 October 2006, the Coroner spoke of the safe cell principles and of the Government response to recommendations for their implementation. The Coroner referred to a previous coronial recommendation, made in the 2005 Cook inquest,[69] for the adoption of the safe cell principles. The Coroner then quoted from the Minister responsible for the Department for Correctional Services' response, provided in 2006, to that recommendation:

> Safe cell design principles are incorporated in all new cell accommodation. The refurbishment of existing cell accommodation to safe cell standards is beyond the current resources of the Department.
>
> The financial priorities of the Government are related to issues of health, education and police. The cost associated with upgrading all prison cells so they are consistent with 'safe cell' principles would be in excess of $40m. Expenditure of such proportions would reduce the ability of the Government to provide the wider community with better security, education and health related services.
>
> ...
>
> It is unfortunately not possible to change all existing cells to include 'safe cell' principles.[70]

In light of this response, the Coroner in the Turner and Glennie inquest made the following recommendation:

> on the assumption that the Government has no intention in the foreseeable future of providing funding for the upgrade of prison cells to comply with 'safe cell' principles, the Minister for Correctional Services [should] seek funding to convert a portion of the existing facilities in such a way as to provide safe and humane 'special needs' units in each custodial institution for the accommodation of those prisoners requiring this type of management.[71]

It is a matter of concern that in this instance the Coroner saw fit to modify her recommendation, from a recommendation for 'safe cells' to a recommendation for 'special needs units', as she herself put it, 'on the assumption that the Government has no intention in the foreseeable future of providing funding for the upgrade of prison cells to comply with "safe cell" principles.' The Ministerial response to safe cell principles in the Cook inquest had been made formally, pursuant to s 25(5) of the *Coroners Act 2003* (SA).

The rather robust response made by the responsible Minister in the Cook inquest is an assertion by the Government of its right and responsibility to allocate funds and resources as it sees fit. As such, the Cook and Turner and Glennie cases show quite starkly the limits of persuasion that can be achieved by coronial recommendations. The purposes of RCIADIC recommendation 15 had been to encourage governments to respond favourably to coronial recommendations and to inform the Coroner of progress in implementation. It is thus noteworthy that the Parliament did not see fit to enact a provision implementing RCIADIC recommendation 16 – which calls for the empowerment of coroners to request further explanations and information from Ministers – so as to require even greater accountability of government to the Coroner.

The *Annual Report* of the State Coroner for the financial year 2006–07, as required by the new s 39 of the *Coroners Act 2003* (SA), discloses that the Government response to the recommendations in the Turner and Glennie inquest had rejected even the modified recommendations.[72]

B Reports to Parliament upon the Inquests of Johnson and Smith

On 29 April 2008, two reports were tabled in the Parliament regarding Department for Correctional Services' responses to death in custody findings and recommendations. Those were the responses, made pursuant to s 25(5) of the *Coroners Act 2003* (SA), to the inquests of Johnson and Smith.[73]

The inquest into the death of R A Johnson had been held in September 2007. It was a case of hanging in E Division of Yatala Labour Prison. The State Coroner Mr Johns had found that the ligature point was the double bunk in his doubled-up cell. The State Coroner said:

> it is a simple matter for a person to take his own life in the general environment at Yatala Labour Prison. Many previous Inquest findings have drawn this same conclusion and I simply adopt and reiterate previous recommendations in that regard without specifically setting them out again. It is a sad fact that the double bunk used by Mr Johnson to take his own life is still in use in Yatala Labour Prison today. It has not been modified, and could be used in precisely the same manner as it was by Mr Johnson at any time.[74]

In the response to this statement from the Johnson inquest, the following was said by the Chief Executive of the Department for Correctional Services:

> The modified bunk bed designs reflect varying layouts for different cell block configuration at individual locations. Designs range from a new top bed to a replacement bunk bed. Installation of the new beds has been completed in B Division at Yatala Labour Prison. Installation has also commenced in E Division at Yatala Labour Prison and at both Port Augusta Prison and Port Lincoln Prison. The beds will also be installed at the Adelaide Remand Centre. ...
>
> The Department has, and continues to address the issue of ligature point removal from cells. As advised in reports of the Minister previously tabled in Parliament, a departmental audit resulted in the removal of hanging points and the refurbishment of certain existing cells in accordance with available funding.
>
> The Government has also announced that new prison infrastructure will comply with 'safe cell' standards, as will any new cell accommodation in existing facilities. The new standards are the benchmark for future prison construction and have been adopted by all States and Territories for new facilities. Cells constructed under the 'safe cell' standards are free of ligature points.[75]

This response may be seen as a partial mollification of the State Government's approach to the Cook and Turner and Glennie inquests. Yet it should be noted that the response to the Cook inquest detailed above had, of itself, been a major recognition of safe cells. While the Government had not committed itself to refurbishing existing cells to make them safe, it had nevertheless acknowledged the importance of safe cell design principles and had indicated an intention to implement them in all new prison cell accommodation.

To put that in context, the Government of South Australia had in November 2007 announced a public-private partnership for the development of new prisons to replace Yatala Labour Prison, James Nash House (a correctional psychiatric institution) and the Northfield Prison Complex, consisting of the Adelaide Women's Prison and the Adelaide Pre-Release Centre. This was costed in excess of $500 million.[76]

The response to the Johnson inquest was thus an important concession and recognition of the requirements for securing ongoing cell safety, even in the period leading up to the

replacement of Yatala Labour Prison. The references to refurbishment of cells in B and E Divisions at Yatala, the Adelaide Remand Centre, and also at both Port Augusta and Port Lincoln Prisons, represents a significant recognition of the enhanced standard of care required in existing correctional institutions, flowing from RCIADIC.

Yet these responses also represent a pragmatic approach by the Department to the continuing problem of overcrowding in prisons. The Department's *Annual Report* for 2006–07 discloses that there has been a 15 per cent increase in South Australia's prison population in the last five years. During 2006–07 the average number of prisoners in South Australian prisons was 1686, compared to 1469 in 2002–03.[77]

Doubling up of existing single cells in most South Australian prisons has been the Department's response to the increase in prisoner numbers in South Australia. Since single cells needed to be refitted to allow for doubling up of prisoners, the fitting of double bunk beds could be done in a way that removed hanging points from the double bunks – as was announced by the Chief Executive. It is, however, a partial response. It does not appear to deal with the ligature points in E Division of Yatala which were mentioned in the Bonney and Varcoe inquests.

In that context the somewhat ambiguous response to the Smith inquest[78] (concerning a coronial recommendation for the removal of towel rail hanging points) assumes greater importance. The response to the Smith inquest was in similar terms to that which had occurred in the Johnson inquest, with this additional statement:

> In response to the Coroner's recommendations, the Department has been able to remove some of these fixtures, but many of the rails are an integral part of the plumbing fixtures and would be extremely difficult to remove without substantial refurbishment of each cell.
>
> The Department has and continues to address the issue of ligature point removal from cells. Cells are refurbished to safe cell design standards through an holistic approach that incorporates bed, shelving and associated cell requirements. This approach is preferred over focusing on removing one item (eg, towel rails) from cells whilst leaving multiple other ligature points available.[79]

On 27 August 2008, the Director of Custodial Services of the Department for Correctional Services provided the author with the following additional information:

> The Department for Correctional Services is committed to providing a safe, secure and humane prison system. Currently the Department is experiencing an unexpected increase in prisoner numbers. This has required that the Department look for ways to manage these extra prisoners safely within the current infrastructure until the construction and commissioning of new prisons are completed in 2011–2012. Most of the increase in prison numbers has been managed by doubling up existing cells. Any cell that has been doubled up has had a safe cell design bunk fitted. These bunks are designed without ligature points.
>
> A number of ligature points in both the doubled up and single accommodation cells have been identified, and will be removed progressively as funding becomes available.[80]

C Doubling Up and Cross-Infection of Communicable Diseases

Doubling up of prisoners has the attendant danger of cross-infection of communicable diseases, as was discussed by the former State Coroner in the Carter inquest, when he specified, but could not formally recommend, that infected and uninfected prisoners not be doubled up. In the view of this author, it has still not been adequately addressed.

The issue has been raised with the Chief Executive Officer over the last several years by the Aboriginal Legal Rights Movement at Prevention of Aboriginal Deaths in Custody Forums. These forums are held by the Department for Aboriginal prisoners in all South Australian prisons. They are an important response to RCIADIC, since they allow Aboriginal prisoners, institutional and departmental managers, and service organisations to meet regularly in each (by turn) of the South Australian prisons. Their purpose is to discuss matters of concern to Aboriginal prisoners and their support agencies in relation to the prevention of Aboriginal deaths in custody.

In a letter to the author in August 2008, the Department for Correctional Services outlined its response to the problem of cross-infection from sharing cells. The Department referred to the difficulty presented by anti-discrimination legislation, which, the Department stated, 'essentially precludes the

Department ... from separating prisoners on the basis of their communicable disease status.'[81] Problems were also noted by the Department in actually ascertaining the communicable disease status of prisoner, the Department stating that:

> Self reporting is problematic, communicable disease testing is not mandatory and confidentiality of voluntary testing is maintained by Prisoner Health Staff, except in cases where prisoners are identified as engaging in behaviours that pose a risk to prisoners or staff.[82]

The Department concluded:

> These factors, combined with bed space management issues and the cultural imperative to have indigenous offenders share cells, rules out separating prisoners with communicable diseases as a means of dealing with cross infection.
>
> The Department for Correctional Services is very aware of the need to address the spread of communicable disease through cross infection for the protection of individuals and the community. Currently the risks of cross infection in prisons is addressed through induction, education, testing and counselling provided to prisoners by Department for Correctional Services and Prisoner Health staff.[83]

There has been, since the time of the Carter inquest in 2000, an urgent need to address the issue of cross-infection of communicable diseases in shared cells. This report suggests that there needs to be improved policy formation, as between the Department and the Prison Medical Service on this issue, but it is also acknowledged that the Department is in a difficult position under current laws.

V Summary and Conclusion

The reform of the South Australian *Coroners Act* has given rise to greater accountability of government to coronial recommendations arising from death in custody inquests. This increased accountability has coincided with improvements being announced to South Australian prisons, whether by way of replacement of antiquated institutions or upgrading of those institutions pending their replacement. Such improvements are consistent with the enhanced duty and standard of care which RCIADIC had required. RCIADIC had also recommended that the coronial recommendation-making power should itself be enhanced so as to extend beyond issues arising from the cause and circumstances of individual deaths. This enhancement was not adopted when the *Coroners Act 1975* (SA) was repealed and replaced by the *Coroners Act 2003*(SA). The consequence in South Australia has been a limitation on the effectiveness of coronial recommendations as a means to encourage improvements to prisoner health, welfare and safety. Further reform of the South Australian prison system is needed, not least to deal with problems that have arisen from overcrowding. A suitable impulse to drive such reform is contained in RCIADIC recommendations 328 to 331,[84] which recommend the introduction of a National Standards Body for corrections, giving proper consideration to prisoners' rights and developing specific guidelines directed to the needs of Aboriginal prisoners.

---

* Christopher J Charles is the General Counsel of the Aboriginal Legal Rights Movement of South Australia. He acted as solicitor for some of the families in the South Australian cases before RCIADIC and as counsel for the National Aboriginal and Islander Legal Services Secretariat. He has also acted for the families of death in custody victims in South Australian coronial inquests. In writing this report the author acknowledges the memories of all those Aboriginal people who have died in police and prison custody in South Australia. Their families still have to live with their loss and so this report is dedicated to the survivors as well. The author acknowledges the assistance of Dr Elizabeth Grant of the University of Adelaide on prison design and policy issues and of the South Australian Department for Correctional Services generally.

1 See Commonwealth, Royal Commission into Aboriginal Deaths in Custody ('RCIADIC'), *National Report* (1991) vol 1, [1.1.2]. The Commissioners said: 'This Royal Commission was established in October 1987 in response to a growing public concern that deaths in custody of Aboriginal people were too common and public explanations were too evasive to discount the possibility that foul play was a factor in many of them.'

2 Commonwealth, RCIADIC, *Report of the Inquiry into the Death of Gordon Michael Semmens* (1990) [4.4].

3 Ibid.

4 Concerns about the use of Standard Operating Procedures ('SOP') in relation to prisoners at risk of self-harm were raised in detail by the State Coroner in the Bonney inquest (discussed below). Prison officers were found to have been unaware of the requirements of the relevant SOP. The Coroner considered that

prison officers should be required to acknowledge in writing their receipt and comprehension of an SOP that applied to their work. *Inquest into the Death of Bonney* (Unreported, SA Coroner's Court, State Coroner Chivell, 26 August 1997) 17–20.

5 John Dawes, 'Deaths in Custody: Moving Beyond a Statistical Analysis' (Paper presented at the 3rd National Outlook Symposium on Crime in Australia, Canberra, 22–23 March 1999) (copy on file with author).

6 Ibid 22, table 6.

7 Aboriginal and Torres Strait Islander Social Justice Commission, *Indigenous Deaths in Custody 1989 to 1996* (1996).

8 *Coroners Act Amendment Act 1988* (SA), s 2. This anticipated RCIADIC recommendation 11, which requires that all deaths in custody be formally inquested by a coroner in public hearings: Commonwealth, RCIADIC, *National Report*, above n 1, vol 1, [4.74].

9 Commonwealth, RCIADIC, *Report of the Inquiry into the Death of Keith Edward Karpany* (1991) [4.3]. Commissioner Johnston relied on the inquest findings after an inquest that sat for 19 days. The standard of that inquest received favourable comment from the Commissioner.

10 See Commonwealth, RCIADIC, *Report of the Inquiry into the Death of the Woman Who Died at Ceduna* (1990) [4.3]. Commissioner Johnston said: 'An inquest based only on the documents is not a satisfactory inquest into a death in custody.' See also Commonwealth, RCIADIC, *Report of the Inquiry into the Death of Malcolm Buzzacott* (1990) [5.3], in which the Royal Commissioner said: 'It must be said that the inquest had all the weaknesses of the investigation which preceded it other than what appears to be a careful investigation as to whether the deceased was lawfully in custody. Both reflected the very narrow approach to the investigation of such deaths which is now repudiated by both the Police Department and the State Coroner.'

11 Commonwealth, RCIADIC, above n 2, [4.3]. The Semmens death in custody was not inquested because it was not then authorised due to the fact that criminal charges had been laid. In fact the criminal charges were resolved without the cause of death being determined and the Royal Commissioner raised the question of 'whether in circumstances such as here occurred there should be an obligation on the coroner to conduct a coronial inquiry after the result of the criminal proceedings is known.'

12 RCIADIC, *National Report*, above n 1, vol 1, [4.74].

13 Ibid, vol 3. See particularly recommendations 122 to 167 (custodial health and safety) and recommendations 168 to 187 (the prison experience).

14 Alistair Hope, 'Coronial Best Practice' (Paper presented at the Australian Institute of Criminology Best Practice Interventions in Corrections for Indigenous People Conference, Adelaide, 13–16 October 1999) <http://www.aic.gov.au/conferences/indigenous/hope.pdf> at 20 November 2008.

15 Elizabeth Grant, *Submission to Correctional Services Advisory Council Review of the Correctional Services Act 1982* (2007) 5 (copy on file with author).

16 Elizabeth Grant and Paul Memmott, 'The Case for Single Cells and Ways of Viewing Custodial Accommodation for Australian Aboriginal Peoples' (Paper presented at the 20th Annual Conference of the Australian and New Zealand Society of Criminology, Adelaide, 23–26 September 2007) 14 (copy on file with author).

17 SASC [1998] 7002.

18 Ibid [21].

19 Ibid [22], [24]–[26].

20 For an example of an inquest into a death that occurred during home detention, see *Inquest into the Death of D J Lynd* (Unreported, SA Coroner's Court, State Coroner Johns, 30 March 2007) <http://www.courts.sa.gov.au/courts/coroner/findings/index.html> at 20 November 2008.

21 *Coroners Act 2003* (SA), s 3.

22 Recommendation 6 recommended an expansion of the categories of death subject to coronial inquest, including to: juvenile deaths in custody, deaths in custody resulting from traumatic injuries caused by a lack of proper care, deaths of persons who police or prison officers are attempting to detain, and deaths that occur where a person is escaping (or in the process of escaping) from custody or detention. See Commonwealth, RCIADIC, *National Report*, above n 1, vol 1, [4.74].

23 *Inquest into the Death of G A Wanganeen* (Unreported, SA Coroner's Court, Coroner Chivell, 9 October 2002) <http://www.courts.sa.gov.au/courts/coroner/findings/index.html> at 20 November 2008. This was an inquest into a police shooting under the *Coroners Act 1975* (SA), and the Coroner said (at [1.5]) of the jurisdiction point: 'It is arguable whether the deceased's death constitutes a "death in custody" within the meaning of Section 12(1)(da) of the Coroner's Act, 1975. A protocol for investigation into deaths in custody has been developed between my office and the Commissioner of Police, and this treats such cases as deaths in custody. Since I decided that an inquest into the death was desirable in the public interest, the strict definition is somewhat academic in the circumstances of this case. There is no doubt that the investigation was of the standard required in such cases in any event.'

24 'Doubling up' is the practice whereby cells have double bunks fitted and the prison cell is used to accommodate two prisoners rather than one.

25 On one view of the *Coroners Act 2003* (SA), coroners have an inherent jurisdiction to investigate and make findings about

the adequacy or otherwise of coronial investigations, which necessarily occur after the death.

26 Commonwealth, RCIADIC, *National Report*, above n 1, vol 1, [4.74].

27 For the final findings of the inquest, see *Inquest into the Death of T M C Lindsay* (Unreported, SA Coroner's Court, State Coroner Chivell, 22 July 2004) <http://www.courts.sa.gov.au/courts/coroner/index.html> at 20 November 2008.

28 Transcript of Proceedings, *Inquest into the Death of T M C Lindsay* (Unreported, SA Coroner's Court, State Coroner Chivell, 31 March 2004).

29 *Inquest into the Death M F Carter* (Unreported, SA Coroner's Court, State Coroner Chivell, 16 June 2000) <http://www.courts.sa.gov.au/courts/coroner/index.html> at 20 November 2008.

30 Ibid [8.15].

31 Ibid [8.32].

32 Ibid [8.19].

33 Ibid [8.15]–[8.23].

34 *Saraf v Johns* [2008] SASC 166.

35 Ibid [36].

36 Ibid [37] (citations omitted).

37 Ibid [40].

38 The State Coroner had made the following recommendation: 'that the Attorney-General consider the introduction of a Bill to amend the Cremation Act 2000 by extending the prohibition in section 6(5) to cover the certification of deaths in a nursing home in which a medical practitioner has a financial or proprietorial interest. In considering this measure, the Attorney-General may wish to consider other interests which might disqualify a doctor from certifying a person for cremation in particular cases.' See *Inquest into the Death of G R Wells* (Unreported, SA Coroner's Court, State Coroner Johns, 7 February 2008) [11.3] <http://www.courts.sa.gov.au/courts/coroner/index.html> at 20 November 2008.

39 Coroners Bill (SA) proposed by Ian Gilfillan, quoted in ALRM, *Submission to Select Committee on the Offices of DPP and Coroner* (2004) (copy on file with author).

40 *Inquest into the Death of P A Henry* (Unreported, SA Coroner's Court, 3 November 1994).

41 Ibid 25 (recommendation 2).

42 *Inquest into the Death of Bonney* (Unreported, SA Coroner's Court, State Coroner Chivell, 26 August 1997) 13–15

43 Ibid 15. The use of master keys in Yatala Labour Prison is a security measure that ensures that any given prison cell cannot be opened without both the cell key and the master key together. Both are required to lock and unlock any given cell. For security reasons the master key is always stored in a very secure and central point in the institution.

44 Commonwealth, RCIADIC, *National Report*, above n 1, vol 1, [3.3.7]: 'On general principles, the duty of care would appear to extend to protection against risks which are reasonably foreseeable and the standard of care to be that which the reasonable person would regard as reasonable in all the circumstances of the particular case.'

45 See ibid, vol 1, [3.3.81]. The Royal Commissioner noted that, in the individual reports, emergency response training, including in resuscitation, had been found to be defective both for police and correctional officers, and that '[a]dditionally, deficiencies were noted in emergency response procedures generally resulting in delays in the provision of medical assistance once it was determined that such was necessary.' See also below references to RCIADIC recommendation 165 that hanging points in police and prison cells should be screened.

46 *Inquest into the Death of Bonney* (Unreported, SA Coroner's Court, State Coroner Chivell, 26 August 1997)14.

47 Ibid 15.

48 In a ministerial statement to the House of Assembly, the Hon Kevin Foley, Deputy Premier and Treasurer, stated: '[T]oday, I can advise the house of the government's decision to announce new commissioning dates for the prisons and secure facilities projects. The new commissioning dates are: for the men's and women's prison, 2013–14 (previously 2011–12, a delay of two years); for the forensic mental health centre, 2013–14 (previously 2010–11, a two-year delay); and for the secure youth training centre and pre-release centre, 2011–12 (previously 2010–11, a 12-month delay). ' See South Australia, *Parliamentary Debates*, House of Assembly, 30 October 2008, 754 (Kevin Foley, Deputy Premier and Treasurer).

49 It is beyond the scope of this report to discuss the controversy that exists in the prison design literature about electronically operated doors. It is amply discussed in the history of the tragic Jika Jika deaths, written by Bree Carlton. See Bree Carlton, *Imprisoning Resistance: Life and Death in an Australian Supermax* (2007).

50 *Inquest into the Death of Bonney* (Unreported, SA Coroner's Court, State Coroner Chivell, 26 August 1997) 17.

51 *Inquest into the Death of A W K Varcoe* (Unreported, SA Coroner's Court, State Coroner Chivell, 20 March 2003) [2.1]–[2.2] <http://www.courts.sa.gov.au/courts/coroner/findings/findings_2003/varcoe.finding.htm> at 20 November 2008.

52 ALRM, *Submission to Chairperson, Correctional Services Advisory Council SA*, 26 February 2007. This Council, which has a monitoring and supervising responsibility over the Department and the Act, was established under div 2, pt 2 of the *Correctional Services Act 1982* (SA).

53 Dawes, above n 5.

54 *Inquest into the Death of D Wakely* (Unreported, SA Coroner's Court, State Coroner Chivell, Inquest number 7 of 1995). Wakely is the first inquest the author has been able to find in which screening of hanging points was specifically recommended by the Coroner for SA prisons.

55 Ibid.

56 See *Inquest into the Death of Bonney* (Unreported, SA Coroner's Court, State Coroner Chivell, 26 August 1997) 16–17: 'I consider this to be a reasonable measure to try and reduce the incidence of prisoner suicide, and I would urge the Department to consider making these modifications.'

57 *Inquest into the Death of AWK Varcoe* (Unreported, SA Coroner's Court, State Coroner Chivell, 20 March 2003) [2.1]–[2.3] <http://www.courts.sa.gov.au/courts/coroner/findings/findings_2003/varcoe.finding.htm> at 20 November 2008.

58 Ibid [8.13].

59 Ibid [8.14]–[8.15].

60 Ibid [9.2].

61 Ibid [8.17], [9.2].

62 Ibid [8.18].

63 Cf *Inquest into the Death of P A Henry* (Unreported, SA Coroner's Court, 3 November 1994), and see discussion above.

64 Victorian Department of Justice, 'Cell and Fire Safety Guidelines', February 2004. See also Grant, above n 15, 5, wherein the author notes that the safe cell design principles have not yet been evaluated .

65 Victorian Department of Justice, above n 64, 20 (multi-occupancy floor plan).

66 Commonwealth, RCIADIC, *National Report*, above n 1, vol 1, [4.74].

67 The South Australian Department for Correctional Services regularly conducts departmental inquiries into deaths in custody and the reports are tendered to the Coroner. Correspondingly the South Australian Police have an internal process of 'Commissioner's Inquiry', which is regularly tendered as part of the coronial brief .

68 *Inquest into the Death B M Turner and T M Glennie* (Unreported, SA Coroner's Court, Coroner Sheppard, 18 October 2006) <http://www.courts.sa.gov.au/courts/coroner/findings/findings_2006/turner_and_glennie.finding.htm> at 20 November 2008.

69 *Inquest into the Death D J Cook* (Unreported, SA Coroner's Court, Deputy State Coroner Schapel, 27 September 2005) <http://www.courts.sa.gov.au/courts/coroner/findings/findings_2005/cook.finding.htm> at 20 November 2008.

70 *Inquest into the Death of B M Turner and T M Glennie* (Unreported, SA Coroner's Court, Coroner Sheppard, 18 October 2006) [20.1] <http://www.courts.sa.gov.au/courts/coroner/findings/findings_2006/turner_and_glennie.finding.htm> at 20 November 2008.

71 Ibid [21.2].

72 State Coroner of South Australia, *Annual Report of the State Coroner for South Australia: Financial Year 2006–2007* (2007) 30–1 <http://www.courts.sa.gov.au/courts/coroner/Annual_rpts/AR_2006-2007.pdf> at 20 November 2008.

73 See, eg, South Australia, *Parliamentary Debates*, Legislative Council, 29 April 2008, 2446.

74 *Inquest into the Death of R A Johnson* (Unreported, SA Coroner's Court, State Coroner Johns, 26 September 2007) <http://www.courts.sa.gov.au/courts/coroner/index.html> at 20 November 2008.

75 SA Department for Correctional Services, 'Report on Actions Taken Following the Coronial Inquiry into the Death in Custody of R A Johnson', 29 April 2008 (copy on file with author). See also South Australia, *Parliamentary Debates*, Legislative Council, 29 April 2008, 2446.

76 SA Department for Correctional Services, *New Prisons: Corrections Infrastructure* <http://www.corrections.sa.gov.au/welcome.htm> at 20 November 2008.

77 SA Department for Correctional Services, *Annual Report 2006–07* (2007) 69 <http://www.corrections.sa.gov.au/annual_report/2006-2007/DCS_Annual%20Report_2006-07.pdf> at 20 November 2008.

78 *Inquest into the Death of A C Smith* (Unreported, SA Coroner's Court, State Coroner Johns, 19 September 2007) <http://www.courts.sa.gov.au/courts/coroner/index.html> at 20 November 2008.

79 SA Department for Correctional Services, 'Report on Actions Taken Following the Coronial Inquiry into the Death in Custody of A C Smith', March 2008 (copy on file with author). See also South Australia, *Parliamentary Debates*, Legislative Council, 29 April 2008, 2446.

80 Letter from the Director of Custodial Services, SA Department for Correctional Services, to the author, 27 August 2008 (copy on file with author).

81 Letter from the Manager of Custodial Programs, SA Department of Correctional Services, to the author, 26 August 2006 (copy on file with author).

82 Ibid.

83 Ibid.

84 Commonwealth, RCIADIC, *National Report*, above n 1, vol 5, pt G, 'Recommendations'.