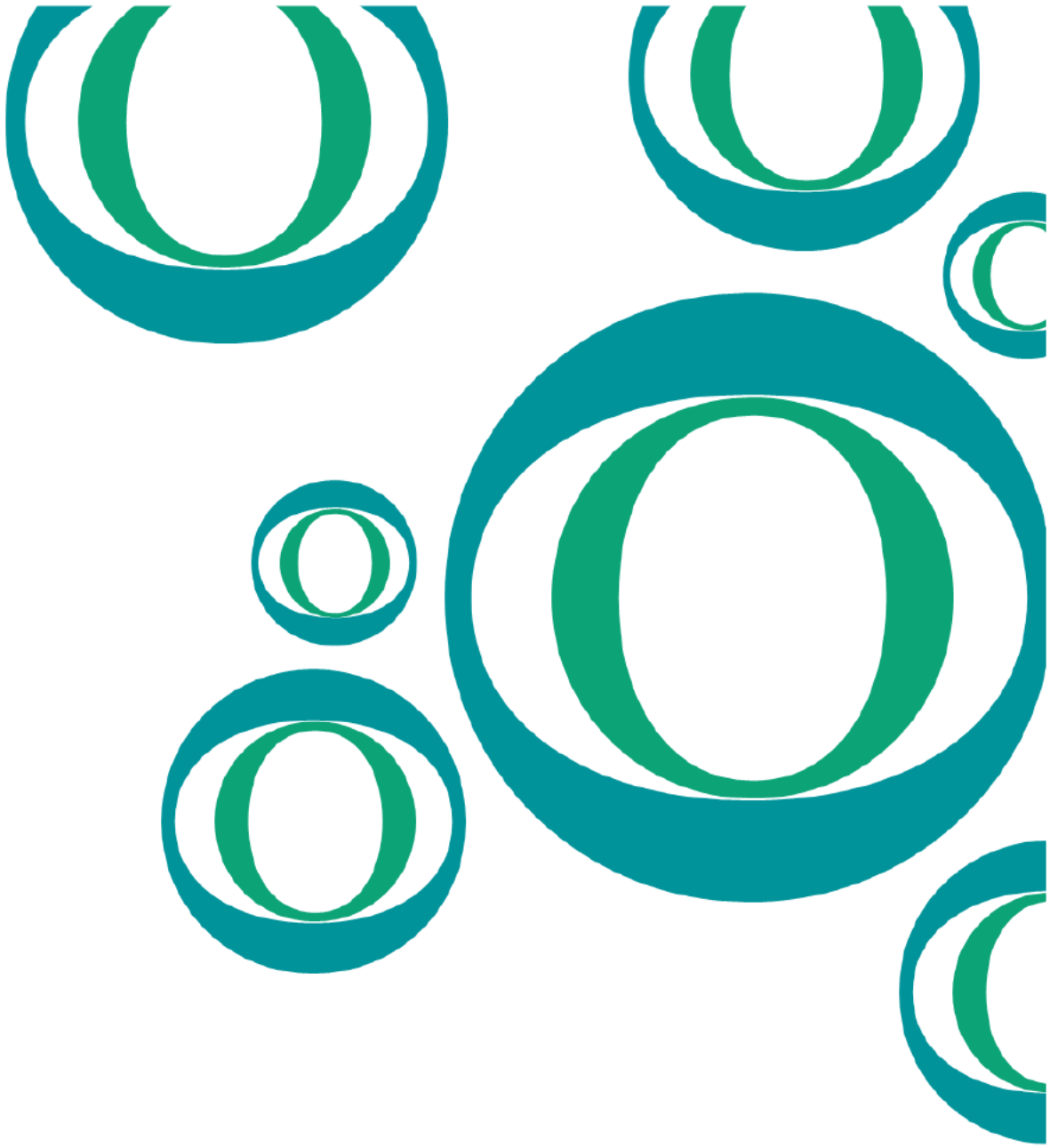

OmbudsmanSA

Ombudsman SA

Ombudsman's own initiative investigation in relation to issues surrounding the death in custody of Mr Wayne Fella Morrison | August 2020

OmbudsmanSA

Investigation under section 13(2) of the *Ombudsman Act 1972* concerning the Department for Correctional Services.

Ombudsman ref: 2016/07705

Department agency ref: CEN/16/1235

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Introduction

In late 2016, I decided of my own initiative to make enquiries and subsequently conduct a full investigation in relation to various issues surrounding the death in custody of Mr Wayne Fella Morrison.

It is important to note at the outset that I have not investigated the incident immediately preceding Mr Morrison's death. The death itself is the subject of a coronial enquiry. The focus of my investigation has been on the department's administrative practices.

While they are not the complainants in this matter, I am grateful to Mr Morrison's mother, Ms Caroline Andersen and his sister, Ms LaToya Rule for allowing me to interview them at length and for the thoughtful submissions provided on their behalf.

This report includes a number of serious criticisms of the department. While I accept that it is easy in hindsight for me to criticise the actions of the department in dealing with an unexpected and high-stress situation, it is essential for the purposes of good administrative practices that I continue to hold the department to a high yet achievable standard.

It concerns me that there appeared to be some initial reluctance by Mr Brown to acknowledge that the department's dealings with Mr Morrison's family could have been better handled. For the reasons set out in this report, I consider that there were serious shortcomings in the department's dealings with Mr Morrison's family, and that the situation could have been better handled.

That said, I acknowledge that the department ultimately provided acknowledgement that certain matters could have been better handled and has outlined steps taken by the department to improve its processes. The most recent responses from the department have evidenced a detailed and genuine engagement with the issues raised.

Finally, in considering this matter, I have had regard to the Royal Commission into Aboriginal Deaths in Custody Report. In my view, it is essential that the issues identified in that report continue to be considered, monitored and addressed on an ongoing basis.

Procedural fairness

I prepared a provisional report and provided it to the following parties for comment:

- Ms Andersen
- the department
- Aboriginal Legal Rights Movement
- The State Coroner.

In response to my provisional report both the department and legal representatives for Ms Andersen provided comprehensive submissions which I address in detail in the body of this report.[1] Ms Andersen's submissions largely addressed the making of further recommendations. While I have not made all of those suggested recommendations formally (for reasons explained in this report), I consider it important that those submissions be included in this report[2] and that the department give them careful consideration.

[1] Neither ALRM nor the State Coroner provided any comment on my provisional report.

[2] A number of proposed recommendations which I consider fall outside the scope of this investigation have not been included in this report.

I authorised the department to provide [the ALO] and [the G4S Officer] with my draft final report. [The G4S Officer] provided a response through Group 4 Services which I have addressed in the body of this report.

In response to my draft final report, the department initially requested that I delay issuing my final report awaiting the outcome of the Coronial enquiry. The department made detailed submissions on potential commonalities between my investigation and the coronial enquiry and consequences following from that. Having carefully considered those submissions, I informed the department that I did not consider it necessary to delay my report further.

The department subsequently provided detailed and thoughtful submissions on my proposed recommendations which I address in the body of this report. It is to the department's credit that it has meaningfully engaged with, accepted most of my foreshadowed recommendations. I am pleased to note that some of those recommendations have already been implemented or are in the process of being implemented.

Legal representatives for Ms Andersen responded to my draft final report, raising a number of further issues and proposed further recommendations. While I consider that most of the issues raised were outside the scope of my investigation (some issues relating directly to the incident itself, or issues that were not considered), I have addressed other issues raised by Ms Andersen as appropriate in the body of this report. I also sought the department's view on a further proposed recommendation in light of Ms Andersen's further submissions.

Jurisdiction

The matter is within the jurisdiction of the Ombudsman under the *Ombudsman Act 1972*. I have conducted an investigation of my own initiative pursuant to section 13(2) of the Ombudsman Act, in response to media reports of Mr Wayne Morrison's death in custody.

Investigation

My investigation has involved:

- seeking information from the Department for Correctional Services (**the department/DCS**) department
- seeking further information from the department
- considering submissions made to the Select Committee on Administration of SA's Prisons
- viewing the CCTV footage made available to the State Coroner
- interviewing:
  - Mr Morrison's mother, Ms Caroline Andersen
  - Mr Morrison's sister, Ms Latoya Rule
  - Mr David Brown, Chief Executive of the department
- seeking a further written response from Mr Brown
- seeking a written response from [the ALO], Aboriginal Liaison Officer for the department
- considering the department's:
  - *Standard Operating Procedure 001A – Custodial Admission* (**SOP 001A**)
  - *Standard Operating Procedure 006A – Prisoner Death or Critical Injury* (**SOP 006A**)
  - *Standard Operating Procedure 013 – Prisoners at Hospital* (**SOP 013**)
  - *Standard Operating Procedure 090 – Management of Prisoners at Risk of Suicide or Self Harm* (**SOP 090**)
- considering the department and the Department of Health Joint Systems Protocol (**Joint Systems Protocol**
- considering the *Correctional Services Act 1982*
- considering the *State Records Act 1997*
- considering the Royal Commission into Aboriginal Deaths in Custody report
- preparing a provisional report and providing it to the following parties for comment:
  - Ms Andersen
  - the department
  - Aboriginal Legal Rights Movement
  - The State Coroner
- providing my draft final report to the following parties for comment:
  - Ms Andersen
  - the department
  - [The G4S Officer]
  - [The ALO]
- providing the department with a further opportunity to comment on recommendations
- preparing this report.

Standard of proof

The standard of proof I have applied in my investigation and report is on the balance of probabilities. However, in determining whether that standard has been met, in accordance with the High Court's decision in *Briginshaw v Briginshaw* (1938) 60 CLR 336, I have considered the nature of the assertions made and the consequences if they were to be upheld. That decision recognises that greater care is needed in considering the evidence in some cases.[3] It is best summed up in the decision as follows:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issue has been proved

[3] This decision was applied more recently in *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 110 ALR 449 at pp449-450, per Mason CJ, Brennan, Deane and Gaudron JJ.

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Background

1. Mr Wayne Morrison was remanded in custody on 19 September 2016 in relation to a number of criminal charges. Mr Morrison died following an incident at Yatala Labour Prison (**Yatala/YLP**) which occurred on 23 September 2016 (**the incident**). In referring to 'the incident' in this report, I am referring to the alleged conduct of Mr Morrison and his restraint and subsequent removal to G Division at Yatala by Correctional Officers. While I provide details of the incident later in this report, it is important to note that I am not investigating the incident itself, which is subject to a coronial inquest. Before turning to the incident, I have outlined below various issues concerning Mr Morrison's assessment and induction when first taken into custody.

2. Mr Morrison was an Aboriginal person. At the time he was admitted to Yatala, however, Mr Morrison was not formally identified and recorded as an Aboriginal person (other than by South Australian Prison Health Service (**SAPHS**)). I also discuss that issue in detail in the body of my report.

3. I have addressed the issues in chronological order, from the time of Mr Morrison's admission to Yatala on 19 September 2016 to his death at the Royal Adelaide Hospital (**RAH**) on 26 September 2016.

Health issues identified in the SAPOL Detainee Transfer Report

4. For the purposes of considering whether the department appropriately followed up issues in relation to Mr Morrison, I have considered the information provided to Yatala staff by SA Police (**SAPOL**) when he was first admitted to Yatala.

5. It appears that while in SAPOL custody, Mr Morrison stated to a doctor that he had been assaulted prior to being taken into the department's custody. It appears likely that the assault occurred during an incident which resulted in Mr Morrison's arrest.

6. The department responded to my investigation that the SAPOL Detainee Transfer Report (**Transfer Report**) indicates that at the time of his arrest, Mr Morrison stated that he was not suffering from any illness or injury. Further, the department has stated that in the course of its internal investigation, the department was advised that the SAPOL Custody Officer's observations were that Mr Morrison did not appear to be suffering from any physical or mental condition. The department submitted that the doctor 'did not appear to identify any serious issues'.

7. According to a risk assessment undertaken by SAPOL on 17 September 2016 (as recorded in the Transfer Report), Mr Morrison answered 'No' to a number of questions which relevantly included the following:
   - Do you have any concerns about being in police custody?
   - Do you have any illness or injury?
   - Are you taking or supposed to take any tablets or medication?
   - Are you suffering from any mental health problems or depression?
   - Have you ever tried to harm yourself?
   - Do you have any drug/alcohol dependencies?

8. The SAPOL custody officer recorded the following observations:

> A1. Has the detainee attempted or implied an intention to self-harm since arrest? No
> If yes, give details:
> A2. Has the detainee's behaviour indicated they may be at risk of self harm? No
> If yes, give details:

A3. Was force used before arriving in detention? Handcuffs
Give details: TO FRONT FOR SAFETY
A4. Was First Aid or Medical Treatment given prior to arrival at police cells? No
If yes or Treatment refused, give details.

and:

C1. Is the detainee apparently suffering from any physical or mental condition? No
Comments:
C2. Are there signs the detainee has caused harm to themselves? No
Comments:
C3. Does the detainee appear to be under the influence of alcohol or drugs? No
Comments:
Alco/BA Conducted: Yes result: 0.000 Time: 17/09/2016 20:48
C4. Does the detainee appear to be suffering alcohol or drug withdrawal? No
Comments:
C5. Based on the responses above, does the detainee need immediate medical treatment? No
Comments:
C6. Do any of the responses above indicate the need to add a Caution? No
If yes, give details:
Injury Details: none No7.

9. According to the Transfer Report, on 18 September 2016, a SAPOL officer made a request that Mr Morrison see a doctor, the reason being that Mr Morrison was complaining of a headache.

10. Under the heading 'Welfare Information', the Transfer Report included the answer 'No' in relation to the following questions:
    - Did the detainee display any intention of endangering himself whilst in custody?
    - Is the detainee likely to cause self-harm or be suicidal?
    - Has the detainee self-harmed or displayed tendencies to self-harm in the past?
    - Has the detainee been psychiatrically examined whilst in custody?
    - Is the detainee in possession of medication?
    - Does the detainee need to be kept separate from other detainees?
    - Does the detainee's property contain any 'sharps'?

11. The Welfare Information also noted on 19 September 2016 that a medical examination at hospital had occurred and that Mr Morrison was 'fit for custody'.

12. Form PD348 included with the Transfer Report is entitled 'Medical Examination of Detainee'. That form indicates that a doctor briefly examined Mr Morrison on 18 September 2016. The doctor's notes state:

Assaulted yest –
? Sunstroke from other day Medn [appears to state 'nil req]
-Vomited last night, eating ok today
- Headache
[indecipherable] BP 140/80 L neck anterior abrasion
Small bruise
Grab mark.

13. The doctor recommended that Mr Morrison be prescribed Celebrex, Panadeine Forte and Diazepam.

14. The Joint Systems Protocol relevantly provides that the department has the following obligations:

- The SAPOL Prisoner Screening Forms, when provided on admission to a prison, must be received by the responsible Admitting Officer. During the admissions process, the Admitting Officer must read and take note of the following forms:
  - South Australian Police Custody Transfer Form (PD346)
  - Prisoner Screening Form (PD331)
- When reviewing the SA Police Custody Transfer Form, one must ensure that any box/s ticked in the section 'Prisoner Welfare Information' is taken into consideration when determining the appropriate placement/regime of the prisoner.
- The Admitting Officer must ensure that all forms provided and/or listed below are given to medical staff as soon as possible:
  (1) Prisoner Screening Form PD331
  (2) SA Police Custody Transfer Form PD346
  (3) Prisoner Risk Assessment PD331A
  (4) Medical Examination of Prisoner PD348A[4]
  (5) SA Police Prisoner Medication Advice PD348A
  (6) Record of Prisoner Inspection, Contact and Risk Assessment Review PD465
  (7) Prisoners Medical Record PD465A
  (8) Record of Prisoner Inspection, Contact and Risk Assessment Review (Supplement) PD466
- The Admitting Officer does not need to read or take note of information contained within the forms listed 4-8 in the section above as these will be considered by SAPHS staff and where applicable, DCS Intervention staff.
- The prisoner is to see SAPHS staff with a copy of the Prisoner Stress Screening Form, in addition to all available health information (e.g. SAPOL Prisoner Screening Form and reports from external doctors and hospitals).
- DCS admission staff are to record a case note explicitly stating Prisoner Stress Screening Score and ensure that SAPHS have been provided with all other available health information.
- The Prisoner Health Information Sheet is placed into the prisoner's Case Management file and a case note recorded on JIS regarding any/potential issues.

The induction process at Yatala

15. The department's Standard Operating Procedure 001A (SOP001A) prescribes procedures to be followed by department employees when undertaking the admission of prisoners. SOP001A requires completion of various forms as part of the induction process.

16. The department provided my investigation with the following forms which were completed by Correctional Officer [redacted]:
    - Form F001/001 – Admission Checklist (**the Admission Checklist**)
    - Form F001/002 – Specific Needs Assessment (**the Specific Needs Assessment Form**), although only page 3, Communicable Disease and Drug and Alcohol Information for New Prisoners was provided
    - Form F001/003 – Prisoner Stress Screening Form (**the Stress Screening Form**)
    - Form F001/004 – Prisoner Interview (**the Prisoner Interview Form**).

17. It appears from those forms that Mr Morrison was not identified as an Aboriginal person by Officer [redacted] and that no health issues or injuries were identified. The fact that Mr Morrison's father and uncle had committed suicide, and that Mr Morrison had made a suicide attempt in the past were, however, identified.

18. I provide more detail of pertinent information included on the relevant forms below.

[4] The reference in the Joint Systems Protocol to the Medical Examination of a Prisoner being form PD348A appears to be a typographical error as the form provided to my investigation is Form PD348.

The Admission Checklist and the Prisoner Interview Form

19. The Admission Checklist included a number of tick boxes underneath the statement '[t]he Supervisor Operations/OIC is to ensure that the following are undertaken on the day of the prisoner's admission into custody'. The only box not ticked was 'ALO notified of the admission/transfer of an Aboriginal/Torres Strait Islander prisoner'. An 'ALO' is an Aboriginal Liaison Officer.

20. The Prisoner Interview Form designated Mr Morrison's 'Cultural Group' as 'OTHER AUS, UK, NZ, USA, CAN, IRE, S AFR.' That form also included the answer 'NO' in relation to the question 'Do you have any physical injuries?'

21. Mr Morrison was, however, identified as an Aboriginal person on a form entitled 'Admission Nursing Assessments PHS02 Stage 1' (**the ANA form**) which was subsequently completed by SAPHS.

The Stress Screening Form

22. The Stress Screening Form in use at the relevant time[5] comprised 26 questions for a prisoner with tick boxes to reflect the prisoner's answers. The form also included five questions to record the reviewing officer's observations. The reviewing officer was expected to tally the answers in column A to arrive at a 'stress screening score'.

23. The Stress Screening Form relevantly included the following information:
    - Mr Morrison's father and uncles had committed suicide '20 yrs ago'
    - Mr Morrison answered 'no' to the question 'do you feel that you have a lot to look forward to in the future?'
    - while Mr Morrison answered 'yes/maybe' to the question 'have you thought about deliberately harming yourself since you were arrested?' he answered 'no' to the question 'do you feel like that now?'
    - Mr Morrison answered 'yes' to the question 'have you ever tried to intentionally hurt yourself?' and it was recorded that Mr Morrison 'tried to hang himself 20 yrs ago'
    - Officer [redacted] answered 'no' to the following questions in relation to his observations:
        - Did the prisoner appear to show marked signs of depression? (e.g. were they tearful or emotionally flat?)
        - Did the questioning appear to have a markedly negative emotional effect on the prisoner?
        - Did the prisoner appear overly anxious, afraid, angry, agitated or confused?
        - Did the prisoner appear to be speaking and/or acting in a strange way, such as an inability to focus attention, inability to understand the questions, hearing or seeing things that were not there?
        - Did the prisoner appear to be under the influence of drugs or alcohol?
    - The following boxes were left unticked:
        - SAPOL transfer docs received, 331 & 346 self harm indicators noted, copy to SAPHS and Case File
        - SAPOL transfer documentation received – copy to SAPHS and Case File
        - No transfer documentation received
    - In the box titled 'Concerns/Advice', Officer [redacted] wrote 'Prisoner bit unsure on [sic] his feeling now he is in prison'.

24. According to the Stress Screening Form, a Notification of Concern must be raised if:

    1. Score is 9 or more; or
    2. Any of the shaded items [sic] questions 21 to 23 are ticked; or

[5] The Stress Screening form has since been reviewed.

3. PD 331 & PD346 SAPOL Prisoner Screening Form identified prisoner to be at-risk of suicide or self harm within previous 7 days
4. Regardless of the score, the interviewing officer feels a further opinion is warranted.

25. A Notification of Concern was not raised.

26. On 19 September 2016 a case note was recorded by Officer [redacted] as follows:

> [M]orrison scored 8 on his stress score – he said he not quite sure where his head is at now that he is in jail but told me he should be ok and should be out on friday – i gave him two phone calls to his mum in which he left messages on her message bank – this seemed to relax him.

27. The Stress Screening Form indicates that Mr Morrison scored an 8 on his stress score. Officer [redacted] ticked 'Yes' to Question 2 under the 'Notification of Concern', presumably on the basis that Mr Morrison answered 'yes/maybe' to question 21 ('Have you thought about deliberately harming yourself since you were arrested?') and question 23 ('Have you ever tried to intentionally hurt yourself?').

28. The department's SOP 090 as in place at the relevant time addressed the management of prisoners at risk of suicide or self harm.

29. SOP 090 relevantly provided:

> 3.3.1 – A correctional officer who becomes aware of a prisoner at risk or observes the behaviour or presentation of a prisoner as indicating an increase in risk of suicide or self-harm must ensure that the Responsible Officer is notified verbally and must complete a Notification of Concern Form – Part 1 (F090/001) immediately (emphasis in original).
>
> 3.3.2 – The staff member completing the [F090/001] must:
>
> - list all the relevant information that indicates the prisoner at-risk of suicide or self-harm;
> - sign and specify the date and time of the notification;
> - forward the [F090/001] to the Responsible Officer as soon as the form is completed;
> - make a JIS case note indicating that a [F090/001] has been completed and;
> - take all reasonable steps to ensure that the prisoner's safety is maintained until appropriate placement of the prisoner has been determined.
>
> 3.3.3 – A prisoner is to be considered at risk and [F090/001] must be completed if
>
> (a) A prisoner on admission presents with:
> - a score of 9 or greater on the Prisoner Stress Screen Form; and/or
> - has a history of recent (within previous 7 days) deliberate suicidal or self-harm behaviour (e.g. through the SAPOL Prisoner Screening Form (PD331)…); or
>
> (b) If a prisoner is presenting at any time with:
> - acts of attempted suicide or self-harm or;
> - threats of attempted suicide or self-harm.

30. The department submitted that the initial health assessment completed by SAPHS did not identify any mental health issues, nor was any at risk information received from other agencies.

31. My investigation sought a response from the department as to why a Notification of Concern was not raised in relation to Mr Morrison. The department initially responded:

> Upon admission, Mr Morrison's Prisoner Stress Screen Form (F001/003) indicates that he had thought about deliberately harming himself since he was arrested, and that he had tried to intentionally hurt himself 20 years ago. Positive indication to these questions requires that a Notification of Concern be completed.
>
> As such it is reasonable to conclude that SOP 90 should have applied.
>
> At this time it remains unclear as to whether the Admitting Officer and/or SAPHS allayed any concerns they may have had about Mr Morrison's risk through further discussions with him and/or each other, such that they were satisfied that a management plan in accordance with SOP 090 was not necessary.
>
> The Department will make further enquiries with staff concerned to illicit any further information relevant to this question and I will update you accordingly.

32. The department subsequently provided a further response which confirmed that a Notification of Concern was required to be raised. That response stated:

> SOP 001A requires that a copy of the Prisoner Stress Screen form be handed directly to the SA Prison Health Service [**SAPHS**] admitting nurse. The DCS Investigation could not establish whether [redacted] provided the SAPHS with a copy of Mr Morrison's Stress Screen form, or whether the SAPHS saw the form, however the Investigator is satisfied that there was a discussion between [redacted] and the SAPHS admitting nurse in relation to Mr Morrison. The Investigator ascertained that it was [redacted] normal practise to discuss any prisoner who expresses thoughts of self-harm and/or provides a history of intentionally hurting himself with the SAPHS nurse. The SAPHS notes in relation to Mr Morrison contains an entry that an SAPHS nurse "liaised" with a DCS officer. It is reasonable to assume that this officer was [redacted]
>
> Mr Morrison was interviewed by an SAPHS nurse who obtained a history that Mr Morrison had contemplated suicide by hanging when he was 14 years of age but had stopped himself. The nurse recorded that Mr Morrison denied having thoughts of self-harm and suicide. This history is consistent with that obtained by [redacted]. The SAPHS nurse noted that a NOC and a High Risk Assessment Team [**HRAT**] review was not initiated as a result of the SAPHS assessment.
>
> The SAPHS nurse recommended that Mr Morrison be accommodated in a double cell.
>
> When interviewed, [redacted] advised that he could not remember his discussion with Mr Morrison or with the SAPHS nurse. Consequently, I cannot categorically state why [redacted] did not raise a NOC.
>
> Whilst conferring with SAPHS is always appropriate including in circumstances when a DCS Officer has discretion to raise a NOC, it is not a substitute for complying with SOP 090 when a NOC is mandatory as it was in Mr Morrison's case.
>
> I can advise that the Prisoner Stress Screening form has been reviewed and the revised forms were implemented at all sites on 30 April 2018 (attached). SOP 90 has also undergone comprehensive review and an implementation plan is being finalised, which should see the SOP operational around the end of July 2018. The amended SOP is attached for your information.

33. I address the changes to the Stress Screening Form and SOP 90 later in this report.

SAPHS assessment

34. On 19 September 2016, after his admission to Yatala, Mr Morrison was assessed by SAPHS.

35. The Joint Systems Protocol relevantly provides that SAPHS has the following obligations:

- Receive [Forms 1-8] and consider/action, where appropriate
- Review all admission documents and place them in the prisoner's medical files
- Place copies of the Prisoner Stress Screening Form in medical files
- Forward completed Prisoner Health Information Sheet to DCS admissions staff
- Schedule a subsequent Comprehensive Health Assessment (a more extensive assessment of chronic health problems e.g. identification of risk factors including family history for diabetes and ischemic heart disease in Indigenous prisoners)
- Undertake initial health risk assessments, including (1) mental state examination (2) screening to determine a person's ongoing needs in relation to physical and psychological issues and refer, as necessary, to appropriate health professionals. This assessment identifies prisoners potentially at risk. This occurs if the prisoner stress screening score is 8 or greater, highlighted questions on the Prisoner Stress Screen are positively scored or as otherwise indicated (3) drug and alcohol intoxication or withdrawal (4) acute medical conditions (5) immediate medication requirements.
- Follow up on issues that have been identified during the admission process
- When indicated, liaise with, or refer:
    - Immediately to Medical Practitioner or hospital regarding acute health problems
    - To appropriate disability services
    - Aboriginal prisoners to ALOs and Indigenous specific special care services
    - To Opioid Substitution program
- Notify DCS verbally of urgent health problems requiring immediate action
- Complete Prisoner Health Information Sheets, including recommendations for placement or ongoing management.

36. The ANA form was completed by SAPHS. On the ANA form:
    - Mr Morrison was identified as an Aboriginal person
    - the 'no' box was ticked in relation to 'Recent Hospital Admission Injury/Illness'
    - no other health issues or injuries were identified.

37. The ANA form included a box entitled 'Suicide Risk Assessment on Admission' which included the following information:[6]

STAGE 1- ENTRY/ADMISSION TO PRISON ASSESSMENT
SUICIDE RISK ASSESSMENT ON ADMISSION
At Risk documentation received from external agencies YES NO✓ *Describe:*
Self Harm Assessment: Previous Self Harm attempts: YES✓ NO Multiple Attempts: YES NO✓ Loss of conscious YES NO✓ Whilst incarcerated YES NO✓ Date of last attempt: Recent (< 6 months) *Describe:* 14.y.o →home, tried to hang self; rope around neck; but stopped himself, no one else knew
Family History of Suicide YES✓ NO *Describe:* father when he's 5 year [sic] old; hang self + [at?] wrist High notoriety prisoner YES NO ✓
Recent Grief/Loss Traumatic Events YES NO✓ *Describe:*

[6] The format has been changed to assist readability in this report.

38. The Suicide Risk Assessment recorded on the ANA form also included answers of 'NO' to the following issues:
    - current thoughts of:
        - self harm
        - suicide
        - homicide
        - plans
    - current feelings of:
        - hopelessness
        - guilt
        - shame
        - anger
        - anxiety
        - other
    - current observation of:
        - depression
        - mania
        - psychosis
        - impulsivity
        - agitation
        - situational crisis
        - impaired judgement/cognition
        - intoxication
        - substance withdrawal.

39. Under the heading 'Patient perception of imprisonment', no concerns were identified. The box entitled 'High Likelihood of Self Harm/Harm to Others based on this nursing assessment' was not ticked. Mr Morrison was not identified as a High Risk prisoner and no Notification of Concern was raised by SAPHS.

40. In relation to 'Placement Recommendations', the 'YES' box for 'routine' and 'routine double up' was ticked, and the 'NO' box was ticked for:
    - single cell
    - camera observation
    - constant observation
    - canvas
    - health centre inpatient.

41. In response to enquiries made by my Office, the department stated:

> The SAPHS work in concert with DCS during the admission process. This involves the active sharing of relevant risk and need information and joint planning where necessary for any immediate response.
>
> In the event that a Correctional Supervisor was not satisfied with the proposed response to those risks and needs, escalation can be undertaken to the Duty Manager. In the event of a medical emergency they, and their staff, would render first aid and would call an Ambulance. There is no information to suggest that the Correctional Supervisor saw a need to escalate any concerns with the management of Mr Morrison or to indicate dissatisfaction or concern with the SAPHS assessment or their involvement in the admission process.

42. When interviewed on oath, Mr Brown stated:

> In preparing for this morning I have reviewed the material again. I think there's a couple of points I would note. It's clear to me that, based on the source material and the investigation, internal investigations, that the department has undertaken, that the stress screening form was completed by the acting correctional supervisor at the time, he was

> Supervisor [redacted] and it's also clear that the immediate health assessments were completed by the South Australian Prison Health Service. Both officers identified those historical factors concerning the history of attempting to harm himself, which was self-reported as being 20 years ago and in the event that the notification of concern had been raised by the supervisor or the nurse, it would in all likelihood, have been the responsibility of those two officers to develop the initial response plan pursuant to SOP 090, because the supervisor would have been the responsible officer, in my view, from the Department for Correctional Services' perspective, and the nurse during the admission interview would have been the responsible health practitioner who would come together and do that… to do that work.

43. I provide further detail later in this report as to what action should have followed had a Notification of Concern been raised.

Identification of Mr Morrison as an Aboriginal person

44. Apart from the ANA form, none of the other extant paperwork completed before and during the process of Mr Morrison's admission to Yatala identified Mr Morrison as an Aboriginal person. The department has further acknowledged that the ALO was not notified at the time of Mr Morrison's admission to Yatala.

45. Clause 3.9 of SOP 001A relevantly provides:

> 3.9 – Immediate Interventions
>
> 3.9.1 – The operational supervisor must ensure:
>
> ….
>
> (c) Special attention must be given to the risks/needs of Aboriginal or Torres Strait Islander prisoners and referrals should ensure the involvement of relevant Indigenous staff without delay
>
> (d) If a prisoner self-identifies as being Aboriginal or Torres Strait Islander during the admission process, and requests to see an ALO, prison ALO must be notified:
>
> i) by telephone in the first instance (during business hours);
>
> ii) by leaving a voice message if there is no answer (if this service is available);
>
> iii) by providing a copy of the Admission/Discharge Advice for the ALO's perusal the next day (standard for all admissions/discharges);
>
> iv) by sending the ALO an email outlining the prisoner's request; or
>
> v) by recording a case note on JIS (at a minimum for this purpose it must state 'Email sent to ALO').
>
> (e) The intervention process must commence as soon as practicable after referral. In case of a delay…interim measures are to be taken as necessary to ensure the safety of the prisoner, staff, other prisoners and the public at all times. The approving authority must document these decisions.
>
> …

46. The department initially responded to my investigation:

> The general process by which the Department identifies whether a prisoner is Aboriginal or Torres Strait Islander is by prisoner self-identification during the admission process (prisoners are asked if they identify as Aboriginal or Torres Strait Islander). A visual assessment is also made upon admission by the admitting Officer. Details of whether a prisoner identifies as Aboriginal or Torres Strait Islander may be accessible in the Department's Justice Information System (JIS) if the person has been in DCS custody previously and has previously been identified as Aboriginal or Torres Strait Islander. ALO's check the JIS for new admissions every morning and identify any Aboriginal prisoners, a comparison between the Aboriginal Prisoner report and new admissions list is undertaken. Identification may also be made by prisoner family members contacting the prison, or by ALRM contact.

> I am presently advised that the SAPOL paperwork which Mr Morrison was admitted on does not identify Mr Morrison as Aboriginal. It is presumed that Mr Morrison did not self-identify as Aboriginal during the admission process and that his aboriginality[sic] was not recognised at the time of his admission.

47. When asked whether the department has access to any other data by which it could cross check whether a person is Aboriginal or Torres Strait Islander, the department responded:

> ALOs look at the new intake list for any known Aboriginal names and check prisoner photographs to see if they can identify them as Aboriginal.

48. In a subsequent response, the department clarified:

> A report is generated from JIS listing all prisoners who were admitted to YLP on the previous day and their ethnicity. The ALO scans the list each day to identify any prisoners with known Aboriginal surnames. The ALO uses "*White JIS*" to view the prisoner details and photographs, to identify any prisoners who have not self-reported as Aboriginal.
>
> A daily report is then generated from JIS showing all Aboriginal prisoners at YLP. The ALO examines the report to identify any prisoners who are subject to HRAT monitoring and who have not been interviewed by an ALO. Arrangements are then made for an ALO to interview these prisoners.
>
> I advise that the Aboriginal Services Unit [**ASU**] staff are now conducting regular random audits at the Adelaide Remand Centre [**ARC**] and YLP to ensure all Aboriginal prisoners are identified when they are admitted into a DCS institution.
>
> The Department is also reviewing admission and induction processes to ensure additional checks are completed and initial personal demographic information is collected.

49. At the relevant time, [the ALO] was an ALO at Yatala. [The ALO] ceased that role in June 2017. Part of [the ALO]'s role was to visit every new Aboriginal prisoner. A statement from [the ALO] (**[the ALO]'s statement**) was provided to my investigation by the department which included the following:[7]

> Every morning I check the [JIS] for new admissions to the prison and identify any Aboriginal prisoners. Additionally I do an Aboriginal Prisoner report and compare that with the new admissions list to make sure I don't miss anyone. It depends on what division they are in as to what times are available to go and see them, meaning that combined with my workload it can take a few days to get and see them. I would make sure they were a higher priority if there were any concerns about that prisoner.
>
> On the morning of Tuesday the 20th of September I checked JIS as usual for new admissions and saw the name [Mr Morrison]. Although I did not know him because Morrison is a common Aboriginal surname I checked that mornings Aboriginal Prisoners report and saw that his name was not on it so assumed he wasn't Aboriginal.

50. My investigation sought a written response from [the ALO]. In his written response, [the ALO] stated:

> I considered the Department's system for identifying Aboriginal and Torres Strait Islander prisoners was sufficient although it relied upon DCS officers identifying new prisoners as Aboriginal or Torres Strait Islander at the time of admission and uploading that information to the Justice Information System [**JIS**] database in a timely manner so that it was available to me when I reviewed the personal information of newly admitted prisoners each weekday morning. Not all Aboriginal prisoners are willing to disclose that they are Aboriginal when they first come into prison.

---

7 Witness Statement dated 1 November 2016.

> Since Mr Morrison's death DCS has implemented an audit process of prisoner admission documents. I'm not aware of any other changes that have been implemented.
>
> From the perspective of the ALO's role, I think it would be helpful for any personal information concerning a prisoner's culture obtained by SA Police or the Prison Health Service to be made available for uploading to the JIS as well.

51. When asked whether the department considered that any other enquiries should have been made or steps taken to involve ALOs when Mr Morrison was first admitted to Yatala, the department responded:

> A prisoner must self-identify at the admissions interview. Mr Morrison was not identified on the system as Aboriginal; therefore the ALO was not informed of Mr Morrison's admission.
>
> I am presently advised that the SAPOL Detainee Transfer report which accompanied Mr Morrison on admission does not identify Mr Morrison as Aboriginal.

52. The department noted that two of the apprehension reports from SAPOL identified Mr Morrison as Aboriginal, whereas the SAPOL Transfer Report itself and an Intervention Order did not. The department stated:

> It is presumed that Mr Morrison did not self-identify as Aboriginal during the admission process. Also that his Aboriginality was not recognised at the time of his admission to Yatala Labour Prison and if reports were accessed, only the most recent may have been reviewed, hence the obligation to notify the ALO did not arise.

53. Mr Brown elaborated on the department's identification process in his interview:

> A. …[W]hen the admitting officers are interviewing them, the prisoner before them, in reviewing the transfer of custody paperwork provided to them by SAPOL, that they are looking for information that identifies the offender's cultural background, and also specifically asking the person, who they are going through the admission interview with, as to their cultural background.
>
> Q. And is that a checklist question?
>
> A. It's contained on one of the admission check lists or forms that are completed. […] So it's our form 001-002, which is the specific needs assessment and there's a question in that form, question 4 that says: "Are you Aboriginal or Torres Strait Islander or both?" "If yes, referral made to ALO", is the subset of that question, and it's my understanding that the information collected through this form is then transposed onto the Justice Information System, so in all likelihood it will confirm this, that is the source of the Aboriginal persons in custody report that [the ALO] would have been referring to.

54. In responding to my investigation, the department only provided page 3 of Form 001-002. The department did not at any stage draw my investigation's attention to the fact that pages 1 and 2 of Mr Morrison's Form 001-002, which apparently include the relevant question "Are you Aboriginal or Torres Strait Islander or both" cannot be located. This only became apparent to my investigation upon considering the department's own investigation report (**the Muller report**) which relevantly included:

> Also located in Mr MORRISON's dossier was page 3 of form F001/002 DCS Specific Needs Assessment. Form F00/002 is a three page document. CO [redacted] stated he completed pages 1 and 2 and placed these into MR MORRISON's dossier; however the current whereabouts of pages 1 and 2 is unknown.[8]

[8] At page 13.

55. I return to the issue of the missing pages later in this report.

56. When asked whether the department had made any enquiries as to why Mr Morrison was not identified as an Aboriginal person at that stage, Mr Brown responded:

> [T]he investigating officer in our department spoke to the officer concerned, and the officer's account was impacted on by the time from when he was spoken to and when the induction occurred but his response, as I understand it, was "Yes, I would have asked that question". And the records on Justice Information System indicate that the form was completed by the officer.

57. Mr Brown's understanding of Officer [redacted] response was that he could only assume that Mr Morrison answered 'no'.

58. When asked whether department officers may be reluctant to ask a person whether they were Aboriginal or Torres Strait Islander, where they have made a visual assessment, and whether that issue had come up before, Mr Brown responded:

> It's not an issue that has come up before and I think it unlikely that staff would be reluctant to […] ask that question. 23% of the people in our custody are of Aboriginal and Torres Strait Islander descent, staff are working with Aboriginal people every day, so asking someone to confirm their cultural background is a pretty standard question. And, of course, they are not just seeking to identify peoples' Aboriginal heritage and background, but they are also trying to identify other cultural background for other offenders.

59. Mr Brown further noted that once Ms Rule made contact with the social worker at the ARC who subsequently contacted [the ALO], [the ALO] changed Mr Morrison's status to Aboriginal or Torres Strait Islander on the department's system 'relatively immediately'.

60. Mr Morrison's mother, Ms Caroline Andersen, stated the following in relation to Mr Morrison's time in SAPOL custody, and the issue of Mr Morrison not being identified as an Aboriginal person:

> …on the Sunday when I went to see him and I was organising with an Aboriginal Legal Rights service person that was working over the weekend, for anyone that was incarcerated in the cells or whatever over the weekend that was the worker that you got in contact with. So I was in conversations with that guy, I can't remember his name, there will be records of it. We had five, maybe six conversations over that whole period of that day, and the main thing that we were trying to get across was that Wayne needed medical help. He needed a doctor to come in. He has spent all night sick and the police refused to get a doctor in for him, and I wasn't aware of that until Sunday. So they would have had conversations, you know, the police officer that sits at the front desk, that greets visitors as they come in to see people that are being held in the cells, they would have had answered phone calls from this guy. Has a doctor arrived yet? Wayne Morrison has been waiting this amount of time. This is where I'm from, Aboriginal Legal Rights. All of those sorts of conversations, so there's really no corners to hide in to say that he didn't identify as an indigenous person. Well in actual fact he did right from the start…Even the arresting officers knew that he was an indigenous person.

61. In relation to the fact that Yatala's induction documents did not identify Mr Morrison as an Aboriginal person, requiring the ALO to be notified, Ms Andersen responded:

> I have thought of that situation and it could be a number of things. It could be let's look at Wayne, it could be that Wayne personally didn't want to tick that box because he knew what his last name was and he also knew that there were other family members within the prison system and in Yatala and he didn't want to be treated.. it's his first time in. The kid is scared. The kid is sick. He's indigenous. He didn't want to be treated roughly, so maybe he didn't identify because they would have went "Oh, Morrison, you're with such and such, so we'll treat you differently", see.

62. While Ms Andersen acknowledged the possibility that Mr Morrison may not have self-identified as an Aboriginal person, she also stated:

> Wayne was someone that identified. He was an artist, he played the didgeridoo, he played the guitar, you know, was involved with the community. So I don't know if… we can't ask him whether he ticked that box or not.

63. Ms Rule also queried why the system did not identify Mr Morrison as an Aboriginal person, noting that Mr Morrison was a 'strong Aboriginal person who identified'. Both Ms Andersen and Ms Rule confirmed that it is 'more likely than not' that Mr Morrison self-identified as an Aboriginal person.

Concerns raised by Mr Morrison's family during his time at Yatala

64. Ms Rule told my investigation:

> …I was working as a student social work placement at the [Adelaide Day Centre], and I found out through my sister, probably on the Wednesday, about my brother's incarceration. Again we didn't know where he had gone but the Adelaide Day Centre sometimes handles prison requests and stuff like that, so I was able to get through to the Remand Centre to their Aboriginal worker there, and I asked if Wayne had been taken to Yatala and as you will see that is written in my statement that, yeah, she essentially said due to capacity issues. So I said "okay", again like another routine thing, it's shit, but whatever. But then my concern was obviously that he was apparently in this high security part in Yatala. I don't know if that was for his own security or for other security, but that's why I rang the ALO at Yatala who was [the ALO] and I spoke to him. I reckon it was on the Wednesday and the Thursday, and then the Friday was the day that that all happened. I feel like I rang him twice, if not then I don't know.

65. Ms Andersen subsequently clarified that Mr Morrison was in a general wing at Yatala, only to be taken to the high security division after the incident.

66. Ms Rule indicated that she made [the ALO] aware of there being an issue with Mr Morrison's condition and stated:

> So I asked him if he could go and visit Wayne just because I had heard from Mum we were unsure how he was going. Nobody had heard from him or contacted him. So I spoke to [the ALO], [the ALO] assured me that he would visit Wayne and then I guess I didn't hear back anything about that, so the next day I rang him again just to see what the results are, and he said he still hadn't visited him. Then on Friday, obviously [the ALO] was the first person I called when we were told.

67. [The ALO]'s statement records the following in relation to concerns raised by Ms Rule:

> Later that afternoon [i.e. 20 September 2016] I received an email from [the Social Worker], a social worker at the Adelaide Remand Centre, asking me to see MORRISON as she had spoken to his sister, Latoya RULE.
>
> The following day, which was the Wednesday, I received a phone call from Latoya telling me that she had got my name from [redacted]. She asked me to check on him as she thought he got 'banged up' at the time of his arrest, I'm not sure if she meant by the police or by the people at the house. Straight after I got off the phone I got onto the 'White JIS' and amended Morrison's ethnicity to 'Aboriginal' from Caucasian. I know that this must have been the Wednesday because that mornings [sic] report still didn't have him listed as an Aboriginal prisoner whereas the Thursday morning one does.
>
> That week I had to see 15 prisoners for the HRAT [High Risk Assessment Team] meeting Thursday morning so I was extremely busy on the Tuesday and Wednesday and didn't have a chance to catch up with MORRISON. Thursday morning was the HRAT meeting and Thursday afternoon the E Division rotunda where the interviews are done is used for

mainstream prisoner interviews only. He was also transferred to the Holden Hill cells that afternoon.

Friday morning I was involved in a prisoner escort to a funeral and I had intended to go and see MORRISON in the afternoon. Upon returning to Yatala from the funeral the prison was in lockdown. I thought that was a good time to go out to Holden Hill to see him so I rang to make sure to [sic] that it would be okay. That is when I found out that MORRISON was involved in the incident.

From neither the phone call or the email was there anything suggesting that I should see him with any urgency. In the 3 nights he was at the Prison there was nothing from custodial staff, including at admission that raised any concerns.

68. [The Social Worker]'s email to [the ALO] stated:

Hi [the ALO]

I have spoken to Wayne's sister Latoya Rule [[the Social Worker] included Ms Rule's mobile phone number]. She is concerned about him (first time in prison etc) and their mum said he wasn't himself (she had spent the day with him in the police cells). She is hoping you can touch base with him and give her a call. [redacted] has apparently been trying to contact you on your mobile which of course you don't have within YLP.

I have included [redacted] in this in case you are not at work so someone else could see Wayne.[9]

69. According to the department:

On 20 September 2016 an entry was made in Mr Morrison's DCS case notes by a social worker at the Adelaide Remand Centre (ARC) to the effect that Mr Morrison's sister had called the ARC and said that she was worried about Mr Morrison as he had not been in custody before. The note indicates that the social worker spoke to Mr Morrison's sister and that she sent an email to the Department's Aboriginal Liaison Officer requesting a follow up.

The Aboriginal Liaison Officer subsequently spoke to Mr Morrison's sister.

70. [The Social Worker]'s case notes are recorded as follows:

Phone message from [redacted] at the Adelaide Day Centre […] I called back and she explained that Latoya Rule Wayne's sister is doing a SW placement there and is really worried about Wayne as[sic] he has not been in custody before. I spoke to Latoya and advised that Wayne was at YLPand[sic] there didn't appear to be any issues. She asked if someone would be able to visit him for support and said that [redacted] had been trying to contact [the ALO] on his mobile (I explained mobile phones aren't allowed inside the prison and that I would contact [the ALO] for her. She asked if there were chaplains available as well and I confirmed there are but I'm not sure what days they attend YLP.

Contact number for Latoya is […] Email to [the ALO] and CC'ed to MOD requesting follow up.

71. In his written response to my investigation, [the ALO] stated:

At the time Mr Morrison was in custody there were two ALO's employed and based at Yatala namely me and [redacted]. Our line Manager was [redacted] His job description was Manager Offender Development Yatala Labour Prison. When cultural

[9] Email from [the Social Worker] to [the ALO], copied to [redacted], Manager Offender Development, Yatala dated 20 September 2016.

> issues arose in relation to Aboriginal prisoners I could also contact the Director of the Aboriginal Services Unit [the Director].
>
> […]
> I do not know whether any consideration was given to [redacted] visiting Mr Morrison. I did not consider it. I do not know whether [redacted] was available.
>
> [redacted] was my line Manager. He had responsibility for the day to day management of the Aboriginal Liaison Service at Yatala.
>
> I do not know whether consideration was given to anyone else visiting Mr Morrison. I did not consider that possibility. Consistent with my usual practice, my intention was always to see Mr Morrison within 48 hours of his admission to Yatala.
>
> I did not know Mr Morrison and had not met him previously. Morrison is a common Aboriginal name and I believe I know some of his family from Ceduna.
>
> My first contact with Mr Morrison's immediate family was on the afternoon of Wednesday 21 September 2016 when I received a telephone call from Ms Latoya Rule. I had received an email the previous day about Mr Morrison from [the Social Worker] who was a Social Worker at the Adelaide Remand Centre. The email referred to a conversation between [the Social Worker] and Ms Rule that Ms Rule was concerned about Mr Morrison because it was his first time in prison and his mother had said that Mr Morrison wasn't himself.
>
> Ms Rule asked me to check on Mr Morrison and I told her that I would do so the following day.

72. When asked whether concerns raised by Mr Morrison's family were appropriately addressed, the department responded:

> Information available at this time in [the ALO]'s statement notes that there was nothing in the telephone call or email to suggest that he should see Mr Morrison with any urgency. In the three nights he was in prison there were no concerns raised by correctional staff, including at admission.
>
> The Department will make further enquiries as part of its ongoing internal investigation, as to whether appropriate weighting and follow up was given to the concerns raised by Mr Morrison's family. I undertake to update you accordingly.

73. The department's subsequent response indicated that the department did not have anything to add to its previous response on this issue.

The incident preceding Mr Morrison's death

74. The following is an outline of the incident preceding Mr Morrison's death which is based on information provided to my investigation by the department.

75. On 22 September 2016, due to limited bedspace at Yatala, Mr Morrison was transferred to the Holden Hill Police Cells.

76. On 23 September 2016 Mr Morrison had a court appearance via video-link scheduled for 12.00pm. As the Holden Hill Police Cells are not equipped with the necessary equipment to facilitate a video-link, Mr Morrison was transported back to Yatala at around 9am on 23 September 2016. Mr Morrison was placed in Cell 5 within the holding area, which is close to the rooms which are equipped with video-link facilities. At this time, another prisoner was also placed in Cell 5 with Mr Morrison. Cell 5 is not equipped with toilet facilities.

77. At or about 11.20am, the other prisoner in Cell 5 requested to use the toilet. An officer escorted the other prisoner from Cell 5 to Cell 6.

78. The department has advised that an officer determined to also move Mr Morrison to Cell 6, so that he also had access to a toilet if required.

79. As the officer opened the door to Cell 5, the department states that the following events took place:

> Mr Morrison 'growled' and rushed at the door pushing the Correctional Officer against the passage wall. Another Correctional Officer who was in the passageway was then punched in the face by Mr Morrison. A duress alarm (Code Yellow – Officer Requiring Assistance) was activated. A Correctional Officer who responded to the duress alarm was struck in the face by Mr Morrison. A number of other Correctional Officers responded to the duress alarm.

80. Mr Morrison was then restrained by a number of officers. The number of officers involved is unclear, but I note that the department has indicated that five officers suffered facial injuries and were taken to hospital for assessment.[10]

81. At 11.34am, Mr Morrison was carried by a number of officers to an internal prison movement van. It appears at this stage that due to Mr Morrison's behaviour, it had been determined to transfer him to G Division, Yatala's high security division.

82. As the van entered G Division, officers observed that Mr Morrison was unresponsive. A Code Black (Medical Emergency) was called. I understand that the issue of what occurred in the van is subject to a Coronial inquest and a SAPOL investigation, and was also considered as part of the department's internal investigation.

83. Mr Morrison was removed from the van and officers commenced Cardiopulmonary Resuscitation.

84. At 11.39am, in response to the Code Black, SAPHS staff attended and took over the attempts to resuscitate Mr Morrison.

85. At 11.48am, South Australian Ambulance Service (**SAAS**) staff arrived and continued attempts to resuscitate Mr Morrison.

86. At 12.39pm, Mr Morrison was taken by ambulance to the Royal Adelaide Hospital (**RAH**). He was pronounced to be in a coma upon arrival. SAPOL were also advised of the events which had taken place.

The use of a van to transport Mr Morrison to G Division

87. In his interview, Mr Brown was asked to provide an opinion as to why it was necessary for Mr Morrison to be transported to G Division by van. Mr Brown responded:

> A. […] It is a practice at Yatala, where a prisoner has been identified for transfer to G division, especially where that prisoner has been involved in a use of force incident, for that transfer to occur via vehicle by the internal escort vehicle.
>
> Q. Is that regardless of distance?
>
> A. That's my understanding, yes.
>
> Q. Is that in a written [Standard Operating Procedure]?
>
> A. No, it's not.

[10] In his interview, Mr Brown clarified that the officers were not 'hospitalised' (i.e. admitted as in-patients).

Q. And how far is it from G Division to where the incident occurred?

A. That's a relatively short distance, I think it's about 25 metres.

88. My investigation asked Mr Brown whether any of the vans have security cameras in them. Mr Brown explained that the van in question had CCTV in it. Mr Brown further responded:

Q. Was [the CCTV] operating at the time?

A. It was.

Q. Is there footage of that?

A. No, there's not?

Q. Why is that?

A. Because there is no recording capability in the van.

Q. I don't understand that.

A. The original intention of having the CCTV in the van is to assist the passenger in the front of the van to observe the prisoners in the rear of the van. It's not that it was not on, it was…

Q. There's a screen or something?

A. There's a screen…

Q. …in front seat.

A. …in the front of the van, so you can see..

Q. But it doesn't actually record?

A. That's correct.

89. When asked whether the department has considered installing recording capability in vans, Mr Brown stated that on 28 August 2016 [sic], a rollout commenced to retrofit all of the department's escort vans so that CCTV within those vans is recorded. The department subsequently confirmed that the rollout commenced in August 2017.

90. The department subsequently responded:

> It has been standard practice for internal movements to G Division at YLP to be undertaken using an escort van. As such, when the Code Yellow was called the internal escort van was driven to door 7 at the Holding Cells, to transport Mr Morrison to G Division, as was common practice.
>
> I can advise that on 1 May 2018, DCEI 18-012 and DCEI 18-013 (attached) were issued to provide clarification around the restraint of a prisoner following an incident and the transportation of restrained prisoners in vehicles.
>
> At the time of the incident, the CCTV cameras fitted to escort vans did not have the capability to record or store footage (other than those at Mt Gambier Prison). In August 2017, a rollout commenced to retrofit all escort vans with a recording function.
>
> The following DCS escort vehicles have now been fitted with digital video recorders:
> - YLP x3;
> - Adelaide Women's Prison x 2;

- Mobilong Prison x2;
- Port Lincoln Prison x1;and
- Port Augusta Prison x1.

The following vehicles are to be fitted with digital video recorders, with works planned to be completed in the first quarter of 2108-19 financial year:

- Port Augusta Prison x2;
- ARC x2; and
- Cadell Training Centre x1.

91. The reference to 'DCEI' is a reference to Deputy Chief Executive Instructions. I address DCEI 18-012 and DCEI 18-013 later in this report.

92. My investigation also queried whether there are any circumstances in which the department uses bodycams when moving prisoners to which Mr Brown responded:

> A. No, there isn't at this stage. If we are recording the move of a prisoner at this stage we use handheld video recorders.
>
> Q. Does that happen?
>
> A. It does, yes.
>
> Q. Did that happen here?
>
> A. No, I don't believe it did.
>
> Q. What is the policy in relation to using handheld…
>
> A. We can give you some specific information around that but it really comes down to whether the move constituted a planned or unplanned move. So if there's time to go and get the camera, and to assign somebody the responsibility to be the operator of the camera, then that would occur.
>
> Q. But it doesn't happen as a matter of course?
>
> A. No, we don't have people who are carrying cameras around, so ultimately when we arrive at the point where we can roll out body-worn cameras, then that certainly would add an operational capability we don't currently have.
>
> Q. Is that something that the department is considering?
>
> A. It is, yes.

93. The department subsequently clarified:

> Where there is a planned use of force and time permits, hand held cameras are utilised, in accordance with Section 3.8 of Standard Operating Procedure 079 – Use of Force.
>
> The Correctional Services (Miscellaneous) Amendment Bill 2017 was introduced to Parliament in 2017 and contained provisions to amend section 35 [sic][11] of the *Correctional Services Act 1982*, to enable the use of body worn cameras in prisons. The Bill progressed through the House of Assembly, however did not reach debate in the Legislative Council prior to Parliament rising for the session. The new Minister for Correctional Services has indicated his intention to seek Cabinet approval to introduce a new Miscellaneous Amendment Bill to Parliament in 2018. DCS will be proposing that the Bill again include amendments to section 35 [sic] of the *Correctional Services Act 1982*.

[11] I understand this to be a reference to section 35A of the Correctional Services Act.

94. The relevant section of the *Correctional Services (Miscellaneous) Amendment Bill 2017* is as follows:

> **13—Amendment of section 35A—Power to monitor or record prisoner communication**
> (1) Section 35A(2)—delete subsection (2) and substitute:
> (2) The regulations may, in relation to a communication of a kind prescribed by the regulations that may be monitored or recorded, provide that the parties to the communication must, at the commencement of the communication, be informed of that fact.
> (2) Section 35A(3)(f)—delete "inspector" and substitute:
> official inspector
> (3) Section 35A—after subsection (5) insert:
> (5a) Despite any other Act or law (but without limiting subsection (5)), a communication monitored or recorded under this section or evidence 30 or information revealed by such a communication may be provided to, and may be received and used by—
> (a) —
> (i) law enforcement agencies; and
> (ii) prosecution authorities; and
> (iii) any other person or body prescribed by the regulations,
> for the purposes of—
> (iv) any criminal investigation or proceedings; or
> (v) proceedings for the imposition of a penalty; or
> (vi) national security (within the meaning of the *National Security Information (Criminal and Civil Proceedings) Act 2004* of the Commonwealth); and
> (b) the Independent Commissioner Against Corruption and the Office for Public Integrity for the purposes of any investigation or action in relation to suspected corruption, misconduct or maladministration in public administration.
> (5b) Terms and expressions used in subsection (5a) and in the *Independent Commissioner Against Corruption Act 2012* have the same respective meanings in that subsection as they do in that Act.

Mr Brown's dealings with other department staff following the incident

95. Mr Brown explained to my investigation that when an incident occurs in a prison, the person in command, if they are on-site, is the General Manager and that 'in this instance, the General Manager of the prison (in this case, [the Prison Manager]) had overall command of the incident scene'. That said, Mr Brown also confirmed that in his role as Chief Executive, he gave directions regarding the incident.

96. Mr Brown described the circumstances of him being notified of the incident as follows:

> A. And in terms of my whereabouts, I was presenting at a conference here in Adelaide at the Hilton Hotel, which is a positive psychology conference, and I was there at the request of the South Australian Health and Medical Research Institute, and immediately following my participation in that session, I was notified of the critical incident.
>
> Q. And who notified you?
>
> A. […] I can't recall to be honest. Whoever it was in the back of the room pacing and signalling with their body language that I had a critical incident that I need to deal with.
>
> Q. Was it a corrections staff [member]?
>
> A. […] it was a Corrections staff member, yes.
>
> Q. And do you remember what they said to you?

A. That we had a critical incident at Yatala […] involving an assault. Very basic, and to be honest, what they told me and then what Ms Bray told me when I got back to the office, those two pieces of information most probably melded together in my memory but then I got …as soon as I got back…

Q. Can you tell me what you did after you were notified of that critical incident?

A. I returned immediately to my office at 400 King William Street.

Q. And did you speak to anyone on the phone?

A. I may well have spoken to someone on the phone. In all likelihood I could have, but I got a briefing from Ms Bray as soon as I got back to the office.

Q. You met with Ms Bray?

A. That's correct.

Q. In person?

A. Yes.

Q. So what was discussed at that meeting?

A. I would have been briefed on the circumstances surrounding the incident.

Q. Do you remember what she was able to tell you at that stage?

A. That there was a critical incident involving an assault on staff by a prisoner and that as a result of that, the prisoner was being moved from the holding cell area to G division, and a medical emergency ensued and that he had been rushed to hospital.

Q. Did she tell you anything else about it?

A. I can't go into specifics of conversation, except to say that we have standard types of questions and information that is communicated when we have a critical incident at this stage, it's a time, place et cetera.

Q. Is that written down anywhere?

A. There are procedures around responding to emergencies, yes, but in terms of how the executive respond, it's through experience.

Q. Was there anyone else with you when you met with Ms Bray?

A. Not to my recollection, I think it was the two of us.

97. When asked what instruction, guidance or direction he gave to his Deputy Chief Executive, Ms Jackie Bray, in relation to handling the incident, Mr Brown responded:

A, That's a very broad question, and yeah.

Q. What was the plan?

A. With respect to what, please?

Q. The incident. So you discussed the incident, you have got the details of the incident, and presumably decisions were made about what should happen next.

A. I think as I have made mention earlier, the incident is managed by the general manager of the prison, so it's the general manager of the prison's responsibility to take overall command and control of that sort of incident, and it's not something

> that's managed remotely from corporate office. So what I seek to establish in that process is that I have got accurate information available to me, that the general manager has the necessary resources and supports that they require to manage the incident, and if necessary to follow up on the well-being and welfare of the people injured in any incident. But primarily the responsibility for the management of the incident rests with the general manager.
>
> My focus was to ensure that I had factual information, that I could rely on, to ensure that I provided appropriate briefings to the Minister and the other key direction I gave at the time was to have the director of the Aboriginal Services Unit [i.e. [the Director]] attend my office.

98. In relation to his meeting with [the Director], Mr Brown responded:

> A. So I…that was the reason for my requesting [the Director] to come to my office, was to ask her, or to direct her to take responsibility for establishing who Mr Morrison had nominated as his next-of-kin and to communicate to them that he was critically ill and had been transported to the Royal Adelaide Hospital.
>
> …
>
> And also for [the Director] to contact the Aboriginal Legal Rights Movement.

99. Mr Brown's meeting with [the Director] is discussed in further detail later in this report.

100. My investigation asked Mr Brown whether he met with anyone else following his meeting with Ms Bray. Mr Brown responded:

> Not that I can specifically recall, but I would have had ongoing discussions with members of the team in response to the incident.

The Court hearing on 23 September 2016

101. According to a statement provided by Ms Andersen to SAPOL:

> At about 10.45am on Friday 23rd September 2016, Ella, Latoya and I arrived at the Elizabeth Magistrates Court for Wayne's bail hearing. We went straight to the Aboriginal Legal Rights office and then waited at Court 5 as I knew this is where he would be appearing via video. The lawyers came up to me at about 11.30am and told me to come inside as Wayne was about to appear. We all sat down and they said his name. They started to talk about the bail application, that there was an address and a backup address. Someone then came through the court room doors and handed someone a note. This note was then handed to the Judge and all I heard was that there had been an incident and Wayne wouldn't be appearing in court. I got up and walked out.
>
> I was then told by one of the lawyers that Wayne had been taken to hospital. I asked what I could do to try to find out what was going on and I was told all I could do was ring the hospitals. The girls and I spent the next 5 hours phoning the hospitals and Yatala prison trying to find out what was happening.[12]

102. Ms Rule told my investigation:

> So somebody came in. We were sitting in the court. Somebody came in with a note, pretty much as soon as we sat down, because there were not many staff in the room at all. It was just the...I don't know who they are, like the police person and the magistrate, yeah, so they came in with a note, gave it to the judge, sorry the magistrate, and essentially he was just saying that Wayne wouldn't be able to appear today. We would have to go away and ask questions of our Aboriginal Legal Rights lawyers to see where Wayne was.

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12 Statement of Ms Caroline Andersen dated 5 October 2016.

> So then we...I was quite upset at that stage and I asked the magistrate directly "Where is my brother?" He just said that you will have, he literally doesn't know, and I believe that. I don't believe he did know. Because the moment he said it, he made a comment and he was like "Oh that looks very encrypted". I said "What do you mean?" Like you know "Can you show us the letter, the note?" He said "I don't really understand it myself, just says pretty much Wayne can't attend", so then we went out to visit our own lawyers because there is the office at the Elizabeth Magistrates with the Aboriginal Legal Rights, and they didn't know anything. Essentially from there my sister was ringing hospitals.

103. My investigation asked Mr Brown whether the department was responsible for organising the note, referred to by Ms Andersen, which was provided to the Magistrate. Mr Brown did not know who wrote that note, confirmed that he was not involved in that decision and added:

> I would imagine that the officer responsible for the audio-visual link would have communicated to the court that Mr Morrison was not able to attend.

104. When asked whether he considered that it would have been appropriate for Mr Morrison's family to be provided with a point of contact in the department at that point (i.e. at the point when the department knew that Mr Morrison would not be attending court), Mr Brown responded:

> A. No, I don't. People don't turn up to court for a range of reasons, so…
>
> Q. Presumably it was the department who had to inform the court that he wasn't arriving?
>
> A. Well, that's correct.
>
> Q. And do you think it would have been appropriate for the family to have been provided with a point of contact?
>
> A. No. I don't.

105. Ms Rule and Ms Andersen told my investigation that ALRM had not been notified of the incident with Mr Morrison and that ALRM staff suggested that they ring 'anyone and everyone you know'. After that Mr Morrison's family stayed in their car at Elizabeth, ringing hospitals and other people around Adelaide, trying to find out information about Mr Morrison.

106. My investigation asked Mr Brown in his interview whether he considered it reasonable that Mr Morrison's family was put in that position. Mr Brown responded:

> A. Well, that's a matter for ALRM. I didn't put them in that position and nor did I give them that advice and nor did any officer of the department give them that advice.
>
> Q. Is there anything you consider that the department could have or should have done to avoid them being put in that situation of not knowing what was going on and having to ring around hospitals?
>
> A. It was open to the ALRM officer, who gave them that advice, to contact the Department for Correctional Services and they could have done that through the Elizabeth Community Corrections Staff who have a presence in the court. They could have done that through the Aboriginal Services Unit in the department, and they could have done that through the corporate office, and as [the Director] noted, as soon as requested by myself she made contact with the General Manager of the Aboriginal Legal Rights Movement.

107. According to Ms Rule, she rang [the ALO] a number of times throughout the day. Ms Rule stated:

> And all he was saying, literally all he said was "I can't speak now, we are all in a meeting. I'll have to give you a call back". He just wasn't calling back, so I called again. I think I rang about four times.
> ….
> …yeah, the third call, yeah I gave him like an hour. Okay, he could just literally be in a general meeting but every single time it kind of got more suspicious because on the third call he said to me "I can't talk now. We are still in this meeting. We are with David Brown, and he's the head of corrections and they are all here, including the staff and we are all having a meeting". I said "What are you meeting about?" He said "I can't tell you, but what are the relations of Wayne? Who is he related to?" I said "Why do you need to know who he is related to?" He said "We just need to know for security purposes". Then I said "Well I'm going to give you a call back" and I rang one of my cousins who has previously been incarcerated and I rang him and said "Hey, do you know [the ALO]?" And he said "Yes, of course, I know [the ALO], he's a good guy". I said "Why would he be asking for the relations of Wayne when he knows the Morrison family very well? He's an Aboriginal person. He's worked with you for a long time" and I said "Why would he be asking for the name?" He said "I don't know, he knows all of us. He knows who we are. He knows our family. "And I said "Okay" so I rang back [the ALO] and I said "you know our names. You know their names who is in there." And he said "Yeah, but I just want to know if there is anybody else I should be careful of." And I said..I was just getting quite frustrated and then I said "Look, well give us a call back when you know anything. Like where's Wayne." And he just said "I need to go, I need to go" and then he hung up. Yeah, I tried to ring him again and he didn't answer. So then, once we got to the hospital and all of that he came.

108. My investigation asked Mr Brown about [the ALO]'s alleged reference to a meeting:

> Q. According to Ms Rule, she said that she rang [the ALO] at least four times and each time he said he was in a meeting and he would have to give her a call back. During the third call, [the ALO] told her he was in a meeting with you, Mr Brown, and all the staff. Do you recall that meeting?
>
> A. No, I don't.
>
> Q. Do you remember a meeting with a large number of staff or all of the staff?
>
> A. No, I don't.
>
> Q. Do you have any idea why he may have said that?
>
> A. That is a question you would have to put to him.
>
> Q. Did you meet with [the ALO] at all?
>
> A. Not that I recall.
>
> Q. [The ALO] allegedly said that he could not tell Ms Rule what they were meeting about, but that he asked her who Mr Morrison's relatives were. So, do you have any recollection of…
>
> A. As I have just indicated, I don't recall meeting with [the ALO], so no, I don't have any recollection.
>
> Q. Okay. Did [the ALO] discuss any of his phone calls with Ms Rule with you at any stage?
>
> A. Not that I recall.
>
> Q. Are you aware of whether he discussed them with anyone else who informed you about them?
>
> A. Not that I can recall.

109. Mr Brown was further asked about why the department did not inform Mr Morrison's family that Mr Morrison had been taken to the RAH and why the family had to find that information out through their own enquiries:

> Q. In short, [I'm] just seeking a response to the general issue of why weren't Mr Morrison's family…so my understanding is they found out by their own enquiries that Mr Morrison was in the ICU at the RAH, and why weren't they informed by the department of that fact?
>
> A. As you have just indicated, the family members were in the court when Mr Morrison was due to appear, and they were advised by officers of the court, through ALRM, that he had been taken to hospital. So it is unlikely that any officer of the department could have made them aware of that any faster than they had discovered that information, because they were in the court waiting to support him in that appearance.
>
> In terms of the formal contact from the department, as I have indicated, as soon as I was briefed on the incident, I sought the assistance of the director of the Aboriginal Services Unit to make contact with the next of kin, and that process started, according to [the Director]'s email, from about 1.20pm and that she had made contact with the next of kin shortly thereafter at 1.50pm. So from my recollection, the appearance in the court was to occur at approximately 11.30, going back to the timeline.
>
> Q. That's correct.
>
> A. And so within a little over a two hour period, following what was a very significant incident and medical emergency, the department were taking active steps at the most senior levels to ensure the family were advised.
>
> Q. Do you have any idea how the ALRM lawyers would have known Mr Morrison had been taken to hospital?
>
> A. My understanding from your own account was that that was communicated to the court, so that's what I relied upon in assuming that to be the case.
>
> Q. That wasn't my information. It just says that the note was handed to the judge and they heard in the court room was there had been an incident and Wayne wouldn't be appearing.
>
> A, Okay. So if that's the case, I'm not sure how they went from that point to ringing every hospital around the state. It would appear to me that based on the account you have just given me, there must have been some information available to the people in the court that he had been… that there had been a medical emergency.
>
> Q. It's possible that the lawyers had information that wasn't necessarily read out.
>
> A. I'm not sure. I'm speculating as to how they got that information.

The attendance of Mr Morrison's family at the Royal Adelaide Hospital

110. In her submission to the Parliamentary Inquiry into the Administration of South Australia's Prisons (Ms Rule's submission),[13] Ms Rule stated:

> In the late afternoon, we received a call from someone who had wanted to remain anonymous telling us that Wayne was in the Intensive Care Unit on life support. We immediately rushed to the Royal Adelaide Hospital and my mother and sister presented at the triage desk where they asked to see Wayne – it is relevant to note that my mother is Wayne's next of kin. Hospital staff turned my mother away and said that Wayne was not

[13] Submission addressed to the Select Committee on Administration of SA's Prisons dated 14 March 2017.

> present. At this time I stood next to a different liaison desk where staff did not realise I was accompanying my mother and sister. I overheard staff saying they felt sorry for my mother as Wayne's name had been changed and she would not be able to see him. I then called the staff out for lying to us and we were then asked to wait, while being told I should not be "eavesdropping". We decided to wait outside of the hospital after we were met with security for asking respectfully about my brother's condition. I felt that we were treated terribly. I grew further suspicious of the circumstances occurring. If my brother had been hurt, he may have still been at risk from those around him and I felt that we could not have been there with him to protect him.

111. According to Ms Andersen and Ms Rule, they were 'pretty much escorted out' to the car park by hospital security and 'just sat there all night'. Ms Rule stated to my investigation 'It was so embarrassing'.

112. In her SAPOL statement, Ms Andersen stated:

> Ella, Latoya and I went to the Royal Adelaide Hospital. We went into Emergency where I got the run around and they told me he wasn't there. Then a nurse came out and took me to ICU and sat me down. The nurse warned me, that before I saw him:
>
> She said, "You need to be aware of his condition as we do not think he is going to make it through the night. He has been left for 50 minutes."
>
> I said, "What does that mean?"
>
> She said, "That he hadn't been breathing for 50 minutes before they resuscitated him and that he was mostly likely brain dead. The brain dies after it is starved of oxygen for that amount of time. He is in a coma, on life support. He is in a pretty bad way, he is all bruised and it looks like he's been beaten.
>
> I got up and walked into the hallway and just collapsed. I rang Patrick straight away and told him what the nurse had said.

113. Ms Andersen told my investigation:

> I remember we got in the car and we drove straight to the Royal Adelaide, got in there, and went straight to Emergency because that is where [they had been told Mr Morrison was]. But then we got turned away. They said "No, there's no one here of that name."

114. According to Ms Rule:

> ..so my sister when she was ringing around to the hospitals, while we were still in the car park at Elizabeth, she did get through to the Royal Adelaide Hospital and she did get told that like somebody under "Wayne Morrison" may be there, and then she got directed to another number and they were like "No, he's not here at all." So she did get through and that is why we were, like, he might be in hospital.

115. When asked whether she was ever provided with an explanation as to why Mr Morrison was listed under another name at the RAH, Ms Andersen responded:

> So I did ask, I don't know how many days it was, during the time he was in hospital. I did ask why his name was changed. I asked one of the head doctors that was looking after him and they said that it was pretty much policy procedure and it's to… it's the hospital's policy to change [a] patient's name to keep the patient safe. That's what they told me. And I said, in my mind I went 'that makes sense because these guys have beaten him to a pulp, like he's in a coma now. They are keeping him safe from them. I automatically thought they are keeping Wayne safe from these other screws, prison officers. But then it didn't make sense because there were prison officers always outside, like I would say to the head security guy "Who are these guys?" I would say to him in the corridor "[i.e. the security guard], are these guys safe? You're not going to let anyone in that is not going to be not safe with Wayne, are you?" "No, no, no, I'm in charge, I have it all under control".

116. Ms Andersen clarified that her understanding was that the security officer was from the department, rather than the RAH.

117. My investigation asked Mr Brown to explain the department's procedure when a prisoner is taken to hospital. Mr Brown responded:

> Look, I think it would be of benefit for me taking those questions on notice and providing you a more detailed response. In general, when a prisoner is taken to hospital, the communication in an emergency situation occurs between the South Australian Ambulance Service, who are transporting that person, and the hospital, itself. We send escort staff on that transport.
>
> Now, the type of communication that occurs between the prison health service and the hospital, and how that is managed, is something that they would be best placed to communicate. The security arrangements are determined pursuant to the relevant procedures for an unplanned emergency medical escort.

118. Mr Brown explained that the normal procedure would be for [the Prison Manager] (in this case) either himself directing, or through one of his delegates directing, giving instruction to escorting staff. Mr Brown confirmed that the escorting staff would in turn liaise with RAH staff on the ground. Mr Brown stated that he did not know the nature of any instruction which was given in relation to Mr Morrison.

119. Mr Brown also responded that he did not personally have any dealings with the RAH between 23 September and 26 September 2016. Mr Brown explained that either [the Prison Manager], a Security Manager or Officer-in Charge would have determined the number of department staff at the RAH, and that he had no input into that decision. Mr Brown considered that the numbers of department staff would, or should, have been reviewed in line with the department's procedure.

120. The department subsequently clarified the hospital escort and admission process as follows:

> In the event of an unplanned escort of a prisoner to hospital, such as in the case of Mr Morrison, the escort should occur in accordance with *SOP 013 – Prisoners at Hospital* [**SOP 13**], *SOP 031 – Supervised Prisoner Escorts* [**SOP 31**], SOP 032 – *Use of Restraint Equipment* [**SOP 32**] and *SOP 020A – Code Black – Medical Emergency* [**SOP 20A**].
>
> In accordance with SOP 31 the General Manager [GM] is responsible for ensuring that prisoners are escorted in accordance with their security classification or assessment. Mr Morrison had a High 2 security rating and was required to be escorted by a minimum of two officers. In Mr Morrison's case, three officers from the Emergency Response Group [**ERG**] undertook the initial escort, at the GMs request. The GM also determined that restraints were not required.
>
> It is standard practice when the ERG undertakes an escort, for three officers to be used, depending on the level of risk. The first four hospital shifts were undertaken by ERG officers. On 24 September 2016, the escort was handed over to non-ERG officers and the number of officers was reduced to two. This decision was made by the Security Manager in consultation with the GM. On 25 September 2016, G4S Custodial Services Pty Ltd (G4S) was engaged to assume the escort, in consideration for Mr Morrison's family.

121. The department provided my investigation with details of officers on each watch and relevant log book entries.

122. The department further stated:

> Upon arrival at the RAH, Mr Morrison was initially taken into the resuscitation room and was then moved into the Intensive Care Unit [**ICU**]. Two officers remained outside his

room and had a clear view of Mr Morrison, enabling them to make relevant log book entries, as required by *SOP 098 – Log Books and Observations*. [Officer] [redacted] remained at the RAH and was required to provide half hourly updates to YLP management.

Compliance checks were conducted by Compliance Officers, to review security arrangements and prisoner wellbeing, as is required by SOP 13. The checks were undertaken as follows and the relevant forms are attached:

- 9.30pm on 23 September 2016;
- 5.05pm on 24 September 2016; and
- 12.00pm on 25 September 2016.

Although DCS officers undertake the escort, they do not play a key role communicating with SA Health staff. When SA Ambulance Service (SAAS) respond to an emergency, such as in the case of Mr Morrison, SAAS staff assess and triage the medical emergency. I understand that the SAAS staff provide a documented and verbal handover to the receiving hospital based on their assessment. Whilst I understand there is also communication between SAPHS and SA Health hospital staff, I am unsure of the exact nature of this communication.

I can confirm that escort staff have ad hoc contact with hospital staff when they enter and exit the prisoner's room and all such movements and conversations are noted in the log books. Compliance officers also contact hospital staff when undertaking compliance checks, particularly if an injury to a prisoner is identified. In relation to prison sites obtaining the medical status of prisoners in hospital, I can advise that SAPHS acts as a conduit with hospitals in this regard.

In accordance with *SOP 004 – Incident Reporting and Recording,* if a prisoner is admitted to hospital in a critical condition, the General Manager/Duty Manager shall determine if their next of kin is notified. In this case. Mr Morrison's mother, Caroline Anderson [sic], was notified of her son's hospital admission by the Director ASU, at 2.40pm on 23 September 2016.

123. My investigation asked Mr Brown whether, given Ms Andersen was Mr Morrison's next of kin, there was any reason from the department's perspective that she should not have been allowed to see Mr Morrison when she attended the RAH. Mr Brown responded:

> Well, the approval to visit needs to occur for a family member to visit. As we stepped through earlier, [the Director] sought those approvals at the most senior level. She sought them from me, and I gave those approvals and gave instructions for that to occur.

124. Mr Brown speculated that it could have been a hospital issue, and could have resulted from the timing of the approvals being put in place.

125. My investigation asked Mr Brown whether he was aware that anyone from the department at any point instructed RAH staff that Mr Morrison was not to be visited. Mr Brown responded:

> Not that I'm aware of, but it is normal practice that any visit to a prisoner admitted to hospital has to be approved and escort staff advised, so that would not be unreasonable for an officer, who has just taken a prisoner to a hospital, to say "Look, if the mother or the sister need to visit, I'll need to have approvals", and that is what we worked actively on to ensure those access arrangements were put in place.

126. Mr Brown also responded that he did not have any understanding as to why Mr Morrison was kept in the RAH under another name. When asked whether that would have been in accordance with any department policy, Mr Brown responded:

> Not to my knowledge. But that's something I would have to take on notice. There are circumstances where we might seek to have a person held under a different name. I'm

> not clear as to whether any officer in our department saw that as necessary in this instance, but on the face of it, I don't see a reason for why it would be necessary. But it could also have been a decision taken by another agency, so we'd need to confirm who made that decision.

127. The department subsequently clarified:

> Mr Morrison was admitted to the RAH under his own name. By mid-afternoon on the day of admission escorting ERG officer, [redacted] became aware of telephone calls being received by the RAH and ICU staff seeking Mr Morrison's location. The identity of the callers making the enquiries was unknown, which raised concerns about the safety and security surrounding Mr Morrison. As a result, [redacted] contacted the YLP Security Manager, [redacted] who approved Mr Morrison's change of name to Ben Waters.
>
> This is not an unusual practice and is used to ensure prisoner safety and security, as well as to protect prisoner confidentiality.

The department's response to Mr Morrison's family

128. The department provided the following summary of the department's contact with Mr Morrison's family:

> The ambulance conveying Mr Morrison to the Royal Adelaide Hospital departed YLP at 12.39pm on 23 September 2016.
>
> [The Director], telephoned Ms Anderson [sic] at 2.40pm on 23 September 2016 and provided her with contact details for RAH ALO. [The Director] made a further call to Ms Anderson [sic] at 2.45pm to advise her that the RAH ALO should have further information about Mr Morrison's condition in around half an hour.
>
> [The Director] also contacted ALRM, who were supporting Mr Morrison's family.
>
> Deputy Chief Executive, Jackie Bray, [the ALO], also had contact with Mr Morrison's family at the RAH on the evening of 23 September 2016.
>
> Following Mr Morrison's death advice was received that any requests to contact Mr Morrison's family should go through ALRM. It was via ALRM that Mr Morrison's family advised they did not wish to be contacted by [redacted] who was tasked with undertaking an independent review of the incident. [redacted] did not end up undertaking this investigation, which was instead conducted by Mr Rob Zadow. On 30 November 2017, [the Director] again emailed ALRM to see if the family wished to be involved in Mr Zadow's investigation. No response was received in answer to that enquiry.

129. The department provided my investigation with an email from [the Director] to Mr Brown. The email is dated 25 September 2016 and appears to contain [the Director]'s notes of her involvement after the incident, as follows:

> Jackie Bray called me and asked me to come up to her office – 12.50pm. David and Jackie were meeting went back down stairs at 1pm and waited for David's call. Went back upstairs at 1:10pm, met with Jackie and David was briefed about medical episode of Pr Morrison – was instructed to find next of kin, advised David and Jackie if Pr Morrison is not doing well and may not make it, family will need to be contacted and given opportunity to see him as Aboriginal belief is if family are with him they can bring him back from unconsciousness. Also family will be very upset if they had not been given opportunity to say goodbyes
>
> Went back down to my desk at 120pm to find details of next of kin and phone call received from a Latoya Rule stating she and Pr Morrison[sic] mother, Caroline Anderson [sic] were at court waiting for Pr Morrison to attend by AVL, they were told Pr Morrison was not able to appear due to being admitted to hospital. They wanted information about what happened. I told Latoya due to confidentiality that I couldn't provide her any

information but will check who Pr Morrison has named as his next of kin and make contact with them as soon as I know something.

I then called David CE to get advice on contacting next of kin, David advised me to make contact with the ALO at the RAH as a point of contact for the family then contact next of kin to advise.

At approximately 140pm I called the ALO at RAH '[the RAH ALO]' and told her who I was, and we had a prisoner admitted through emergency, she was aware of him, I then contacted Caroline Andersen around 150pm and gave her the ALO's contact details.

I called [t]he ALO back approximately 230 to see if she had received a call from Caroline which she had but couldn't give any details as they can't[sic] get access to prisoner.

I called David CE and asked him to get arrange [sic] access for the ALO and the Aboriginal unit nurse.

I called the ALO at RAH and informed her the access approvals have been arranged.

I called CE of ALRM at approximately 240pm left a message on her mobile to call me

Approximately 245 I called Caroline Anderson[sic] to let her know the ALO at RAH are on their way to see Pr Morrison now so give them about half an hour and call them.

Caroline Anderson[sic] called me back approximately 445 saying she spoke to the Aboriginal unit nurse who informed her they could not give any information over the phone she was heading down.

I called the ALO, the Aboriginal unit nurse answered and said they were not happy with the position, and could not provide info to family, the DCS staff will not allow.

I called David CE straight away and David said he would take care of it

At 510pm CE of ALRM called me and I informed her of a medical incident of Pr Morrison

I received another call from CE ALRM at 6pm asking for family members of the prisoner to be added to have access

I called CE of ALRM at 630 to inform her access has been arranged

This is to my best memory of phone calls and contact with family

130. In relation to the RAH ALO's access to information, I note at this point that the department's investigation found:

During early to mid-afternoon on 23 September 2016, the RAH ALO attended at ICU and sought information in relation to Mr MORRISON's health status. The ALO stated that she was instructed by someone from DCS head office to obtain this information to provide to Mr MORRISON's family. EO [redacted] stated that at the time he was not given approval by YLP management to provide any health updates to anyone except for YLP management. As a consequence, the RAH ALO was not provided with a health update for Mr MORRISON.

EO [redacted] explained that where a prisoner is of high notoriety, where potential security risks have been identified, or is the subject of media attention, it is normal practice for the prisoner to be admitted to hospital under an assumed name.

EO [redacted] stated that he became aware during early to mid-afternoon on 23 September 2016, that RAH and ICU staff were receiving telephone calls requesting Mr MORRISON's location, After EO [redacted] became aware of these telephone enquiries to RAH staff he sought approval from [redacted] Manager Security (MS) to have Mr MORRISON's admission name changed. [redacted] approved EO

[redacted] request. RAH staff changed Mr MORRISON's admission name to 'Ben WATERS' after they received EO [redacted] request.

[…]

At the time MS[sic] [redacted] approved EO [redacted] request to change Mr MORRISON's admission name, he was not aware that [the Director] had contacted the RAH ALO and asked her to assist Ms Caroline ANDERSON [sic], Mr MORRISON's mother by providing her with an update with regards to his health condition.[14]

131. Mr Brown elaborated on his meeting with [the Director] in his interview. When asked about the department's policy in relation to contacting next of kin when a person dies in custody, Mr Brown responded:

A. There's a specific reference in that policy, which is SOP 6A, and where a prisoner has sustained a critical injury that is likely to result…in the prisoner's death, the general manager in consultation with the Deputy Chief Executive, Statewide Operations, and other key agencies, where possible, must ensure that the emergency contact or next-of-kin of the prisoner is contacted.

Q. Is there a definition of next-of-kin?

A. There's a…we specifically collect that information from the person who is in custody and record that on the system, so that's the definition of next of kin. Now in the event that the person has passed away, then responsibility for contacting next of kin goes to SAPOL, so SAPOL then take on that responsibility. But in this instance, given that Mr Morrison was critically ill in hospital, I asked that the director of the Aboriginal Services Unit to initiate that process.

Q. And who was identified as Mr Morrison's next of kin?

A, I understand it was his mother, Caroline Andersen.

Q. And that was the only person as far as you are aware?

A. As far as I'm aware, yes.

132. When asked about the apparent delay in identifying next of kin for Mr Morrison, Mr Brown responded:

A. I don't think there was a delay. In my opinion, steps taken to identify the next of kin and to make those contact arrangements happened in a very timely manner, but to go to the specifics of how [the Director] established who the next of kin was, it was really a question for [the Director], but the timeframes for me do not indicate a delay.

Q. I guess it's not clear to me what time the department positively did identify that Ms Andersen was Mr Morrison's next of kin. [The Director] said she went back to her desk and she was getting a phone call from Ms Rule saying that she and Ms Andersen were at court. At that stage, [the Director] said she needed to check who was named as the next of kin and make contact with them.

A. It would appear to me that between when [the Director] returned to her desk at 1.20pm and when she contacted Caroline Andersen at 1.50pm, that she established somewhere in that time period who the next of kin was. And it's readily available on the Justice Information System.

Q. I guess…

A. I'd also note that the admitting officer, [redacted], had facilitated telephone calls from Mr Morrison to that person. I'm assuming that the details were on the system.

[14] The Muller report at p28.

Q. The question I guess I had was that Ms Rule was with Ms Andersen, and I just query why there was that delay in [the Director] having to check before speaking with Ms Andersen, even though she was there with Ms Rule at the time?

A. The way I read [the Director]'s email is that Ms Rule called her as soon as she got back to her desk. She hadn't even had a chance to establish her approach to the job she had just been given, and Ms Rule had reported she was Ms Rule, indicated that her and her mother were at the court. I don't read this as that her and her mother were together at that point in time. That would be a question for [the Director] to answer.

133. Mr Brown elaborated on the visiting arrangements later in his interview:

A. … So we made arrangements, as I understood it, and to make sure that Ms Andersen could visit. Ms Andersen didn't want to visit on her own and [wanted] one of the other family members to go in and see Mr Morrison with her. My understanding and recollection was that Ms Axelby from the Aboriginal Legal Rights Movement was in attendance at the time and because approval had only been granted for the mother to visit, we didn't have the details of the other family members, I understand Ms Axelby contacted [the Director] as the key contact people, and said "Ms Andersen wants to visit with some of her other family members", and [the Director] asked her for those details, and then came to me and got approval.

Q. Once the approval was granted by you, in terms of further communication, that would have been communicated back to [the Prison Manager]?

A. Either directly or through Ms Bray.

Q. And then [the Prison Manager] would presumably contact whoever is in charge of the escort?

A. That's correct.

Q. And that process, in general, that would be the usual process?

A. Well no, what is unusual about this process was my involvement and [the Director]'s involvement.

Q. So if you hadn't been involved, would it be usual, for example, for the Aboriginal Legal Rights Movement to have a direct line of communication with the General Manager?

A. It could do, yeah. But these are not usual incidents, so they are not the sort of thing that happens on a regular basis. Thankfully, they are very infrequent, so it really depends on the specific circumstances and the time of the day, and what resources are available et cetera.

134. Mr Brown's interview also included the following exchange:

Q. Just to be really clear, I guess the information provided from Mr Morrison's family suggests that they consider that there was some obstruction on the part of the department, in terms of them getting access to information. Do you have any comment on that? Was there anything about this situation that was handled differently or was there any attempt from the department to block their access to Mr Morrison, or to information about him?

A. In terms of visitation rights for the family members, family members cannot attend a hospital and ask to visit a prisoner like they would another patient in a hospital. There is a process that is gone through to get approvals for those visits to occur. We intervened at the most senior level to make sure that those approvals were put in place as quickly as possible, and staff are not going to permit access to a prisoner

without having the right approvals in place for them to do that. So as soon as…someone would consider that blocking and I could well imagine and appreciate why the family would feel that way, but as soon as we got those approvals in place, the family were permitted to visit.

Q. And it's coming back to that comment of the Unit nurse that her understanding was that DCS staff would not allow information…

A. As I said, she wasn't the Unit Nurse, she was an Aboriginal nurse. So, as I understand it, she wasn't involved in the direct care or treatment of the prisoner and information provided to a relative of a patient at a hospital about their medical condition is a matter for the Department for Corrections. Quite often and, in fact, there was a case in this instance as well, the Health Department won't even share information with the Department for Corrections about the condition of the patient. It's medical, confidential information that they would only share with the next of kin.

135. When asked whether there was anything that would prevent [the Director] from telling Ms Rule that Mr Morrison was in hospital, Mr Brown stated:

> Yes. Section 85C of the Correctional Services Act has very strict provisions around the provision of information concerning offenders, and [the Director] was asked by me to contact the next of kin. So until such time as she had established who the next of kin was, it would not be unreasonable for her to be cautious in terms of responding to Ms Rule.

136. Mr Brown responded to my investigation that, to the best of his recollection, the department does not have any policy in terms of offering support when a person dies or is critically injured in custody. In relation to Aboriginal and Torres Strait Islander prisoners, Mr Brown stated:

> We seek to work with the Aboriginal Legal Rights Movement and the Aboriginal Legal Rights Movement would ordinarily put those supports in place. We also use our prison chaplain service to assist in that regard, and it's not uncommon for either a social worker or senior manager to liaise with the next-of-kin of the person who has passed away in custody.

137. Mr Brown confirmed that when a person dies in custody, the news is communicated to their next-of-kin by SAPOL. When asked about the situation where a person is critically injured, Mr Brown responded:

> [Notification] would ordinarily occur through the general manager of the prison or their delegate. In this instance, I asked [the Director] to initiate that contact, given the critical nature of the incident and the other factors that the general manager had to manage on that site.

138. My investigation asked Mr Brown about the discussion referred to by [the Director] in which she advised him that the ALO at the RAH could not get access to Mr Morrison. Mr Brown stated that he recalled the conversation and stated:

A. Look, I think [the Director] summarised it quite effectively. She contacted me and advised me that the ALO at the hospital and the Aboriginal nurse, I believe was the title she used, wanted to have access to the prisoner and we made arrangements for that to occur.

Q. Is there any reason why they wouldn't have had access to Mr Morrison before that?

A. Our custodial staff, who [are] escorting a prisoner in hospital, will not allow general access to that person except where those people are part of the treating team, the clinical team.

139. Mr Brown further responded:

Q. What about access by family members when a prisoner is taken to hospital for any reason?

A. Ordinarily, if a prisoner is taken to hospital, family access to that prisoner is defined in procedure as well, and it's treated as a visit to a prisoner. In this circumstance, given the critical condition Mr Morrison was in, then steps were immediately taken to put those approvals in place for approved family members to visit.

Q. How does the approval system work?

A. Ordinarily…well, the approval process is to the general manager of the prison.

Q. So the family member would apply or how would that…

A. Normally it would be facilitated by the family member applying or being supported by a social worker or an ALO to do that process but as [the Director] had been the person who established the contact, [the Director] liaised with the family, liaised with the hospital staff and myself to get those approvals.

Q. So when [the Director] advised you that the ALO at the RAH couldn't access Mr Morrison, did you take any steps in response to that discussion?

A. Yes, I did.

Q. What steps did you take?

A. From memory I either through Ms Bray, or directly, had contact with the General Manager to make sure that happened.

Q. That's [the Prison Manager]?

A. That's right.

140. In its subsequent response to my investigation, the department provided the following information:

> In accordance with SOP 13, access to prisoners in hospital is determined by the GM and is overseen by the hospital watch officers. The details of the visit requirements are as follows:
>
> ***3.13 Prisoner Visits***
>
> *3.13.1 Hospital Watch officers must not allow prisoners to receive visitors unless the prisoner has been in hospital five (5) days, approved by the GM or where compassionate or extenuating grounds exist.*
>
> *3.13.2 All visitors must be approved persons recorded on the prisoner's nominated visitor list and must be approved by the GM.*
>
> *3.13.3 All visits must take place during normal hospital visiting hours and will be of duration of no longer than forty (40) minutes, unless specific approval is given by the GM for extenuating circumstances.*
>
> *3.13.4 Prior to the visit commencing all visitors must produce photograph identification or identification as prescribed in SOP 022 – Prisoner Visits.*
>
> *3.13.5 Visitors must not give the prisoner any item, including food and drinks, unless approved by the GM. Personal items EG. handbags, mobile telephones, etc. are not to be taken into the visit.*
>
> *3.13.6 The use of mobile phones by visitors during visits is strictly prohibited and will result in immediate termination of the visit.*

3.13.7 Hospital Watch officers must be located in a position to directly observe the prisoner and visitors all times during the visit.

3.13.8 The hospital watch officer/s must record the time and duration of each visit, including the name and address and identification details of the visitor/s in the Hospital Watch Log Book.

Mr Morrison was initially not permitted to have any visitors, however, prior to 5pm, several discussions took place and approvals were given for Mr Morrison's family to visit. Caroline Anderson [sic], Mr Morrison's mother, was subsequently advised that she was permitted to visit her son. Ms Anderson [sic] also provided a list of other family members who wished to visit Mr Morrison. Mr Morrison's family were advised that they could visit two at a time and that personal property must be left outside the room.

The initial decision in relation to the number of visitors permitted in Mr Morrison's room was made by the Deputy Chief Executive [i.e. Ms Bray], who was at the RAH at the time. The GM YLP was responsible for approving all visitors. I also understand that the ICU had a visitor policy that requested a minimal number of visitors at one time, to ensure health staff had easy access to the patient.

141. In his interview, Mr Brown explained that the department's officers who escort a prisoner to hospital report to the General Manager of the relevant prison and that in the case of Mr Morrison, it was [the Prison Manager] who was in charge of what happened at the hospital.

142. In his interview, Mr Brown further responded:

Q. When you spoke to [the Prison Manager], what was discussed?

A. I said I can't recall specifically who I spoke to. I indicated that I would have spoken to Ms Bray to follow that through, or to [the Prison Manager].

Q. Do you have any recollection about those discussions?

A. No, I don't, and I don't recall whether it was a combination of discussion and email, but I was clear that the nominated family members were to be provided access to visit.

Q. Did you personally have any discussions with the hospital staff or corrections staff at the hospital about the issue of access?

A. No, I did not.

Q. And it appears that following the ALO at the RAH being granted access to see Mr Morrison, she was of the understanding she was not authorised to give any information to Mr Morrison's family. Do you have any explanation for why she might…

A. No, I don't. What information hospital staff share with the next of kin of a patient is a matter for hospital staff. So it would be unusual for Department for Correctional Services staff to indicate to a hospital, to a Department of Health employee what information they could or couldn't share with respect to the medical condition of a person.

Q. And are you aware whether there was any communications from Corrections towards hospital staff about information being provided?

A. No, I'm not.

Q. I understand the ALO was granted access. So can you explain what was the purpose of that, if she wasn't able to then give any information to Mr Morrison's family?

A. That's a view that she's reported. I'm not clear how she or he arrived at the position…I think it was a lady…

Q. Yes.

A. …that they weren't permitted to give information to the family. As I said, the sharing of the information with family members of a patient in the hospital, where that patient is a prisoner, is a matter for the health department.

143. My investigation specifically asked Mr Brown about [the Director]'s assertion that she was told by the Aboriginal Unit Nurse that department staff would not allow information to be provided to Mr Morrison's family, and that [the Director] called Mr Brown who said that he would 'take care of it'. Mr Brown responded:

> Well, I don't recall the specific steps that I took after that contact, except to reaffirm that the provision of the information concerning the medical condition of the patient to family is not something that DCS staff would relay to family or approve or not approve to be granted. That is a matter for Health.

144. When asked whether it was possible that department staff were inappropriately interfering in that process, Mr Brown responded that he could not comment on that and that he could not recall whether he followed up on the fact that there appeared to be an allegation that department staff were not allowing information to be provided.

145. Mr Brown in his interview was unable to recall specific details of other meetings throughout the day but commented that 'there would have been rolling discussions and meetings during the course of the afternoon and into the evening'. Mr Brown elaborated:

> The focus would have been in ensuring that I got updates from Ms Bray, in terms of the operational management of the incident. I would have had discussions with the adviser in the Minister's Office to ensure that the Minister was updated in relation to the incident, and I had contacts with [the Director] to assist with the facilitation of the access for the family members, and I would have had discussions with our communications officer because we would have expected, as we did, [to] have media interest in the incident, so making sure I was across the types of questions that would be asked and that the appropriate approvals were in place for the granting of those things. And, I would have liaised with my director of the Ethics and Investigation and Intelligence Unit because that is part of our response, is to ensure that officers from that unit go out to the site to assist SAPOL, but also to assist with our… the commencement of our internal investigation. So they are the types of communications that I would have had.

146. Mr Brown could not specifically recall any discussions or meetings concerning what information should be provided to Mr Morrison's family, but acknowledged that 'there could well have been' such discussions or meetings.

147. Ms Rule described contact with the department to my investigation as follows:

> But then from everything we were hearing, like we were like no, we would get told if he was in hospital. Let's just go wait to see if [the Director] or [the ALO] or somebody, because there were people who seemed to be like "We'll get back to you" like [the Director]. We just had to wait and to be honest like, I don't know, you don't think about like that he is going to be in that condition. So okay. Whatever has happened maybe he is still at the prison or maybe they have had to take him there. I was telling [Ms Andersen] it's okay, like, it's probably just routine where they have to be assessed or there's been some

> altercation at the prison. It has nothing to do with him being in such a state. But when we walked in…sorry…

148. When asked to clarify the extent of her contact with [the Director], Ms Andersen acknowledged that she left a message for [the Director] who returned her call. Ms Andersen told my investigation in relation to that phone call:

> I think the gist of the conversation was pretty much as soon as I know..that's it. As soon as I know something I'll let you know. That is the gist of what the conversation was. She picked up the phone and touched base because she had been bugged by these two, [Ella and Latoya], so much and whoever else. It's just that sort of conversation.

149. Ms Rule did not recall any mention of hospital and reiterated that the first mention of hospital was during the ALRM phone call. Ms Andersen and Ms Rule told my investigation that the family had not heard any information from the department before arriving at the RAH. Ms Rule stated:

> …but as soon as we got there, we were parking the car I checked my phone and I had a missed call from Cheryl Axelby, who is Aboriginal Legal Rights and it was a voicemail and she was like "Oh Latoya, I have just been told". Sorry, this is after we came out because we were sitting in the car park for so long.
>
> …
>
> When we came out to the car park I checked my phone she's like "Latoya, I have been told that Wayne is in hospital", like when we are there, she's like "I have been told that Wayne has been in to the, like, ICU. You need to go down there, I'm on my way", and then pretty much I just called her back and she's like "I'm on my way" and then like Cheryl was the first person to visit us and then it was [redacted], and Cheryl rang, what's her name, [the Director].

150. My investigation sought clarification as to who visited the Morrison family while they waited in the RAH car park. Ms Rule and Ms Andersen confirmed that as well as Ms Axelby and [redacted] an Aboriginal Elder, the 'deputy' (i.e. Ms Jackie Bray), [the ALO] and [redacted], the 'security person' also visited them. When asked to recount details of those conversations, Ms Andersen and Ms Rule responded:

> MS ANDERSEN: Pretty much briefly what happened was they came out, the Deputy [of] Corrections, an Aboriginal guy and [redacted], the head security guy, the corrections officer. They came out, I went straight up to them. No Patrick went up to them first.
>
> MS RULE: Yeah.
>
> Patrick went up to them and then said "Mum", because obviously I was a mess by this time. I had spoken to a nurse who had, you know, relayed the whole situation about Wayne to me and Patrick. Patrick was on the phone. So Patrick approached them as they..when they came out. I don't know what was said. I got called over. She [i.e. Ms Bray] introduced herself and said "And this is the whoever Aboriginal worker and this is Patrick, Corrections", I think she said something along the lines of "I'm really sorry this has happened".
>
> MS RULE: Yeah. She apologised.
>
> MS ANDERSEN: Yeah. I think that was pretty much…she introduced herself and introduced them, and then I think the first thing out of her mouth was that she was apologising. And I can't actually remember. I think I just went, put my hand up to her face and just went "I don't even want to hear this", like I had had enough. You know we had been waiting in the car park for hours and then all of a sudden they send out all these official people, you know. Patrick rushed straight in. Patrick wasn't allowed to go straight up there. I couldn't. He was going to go up with one of the others to go and see Wayne. They were stopped. We get stopped at the counter. We had stopped all during the day.

> And I think…and I just thought I don't want to speak to you from what I have actually heard, so I think Patrick just stepped in again and spoke to her.
>
> MS RULE: I spoke to her. They came out and you and Patrick were there on my left and then I was standing there just pretty angry by this stage, and then I knew that was [the ALO] because he introduced himself.
>
> MS ANDERSEN: Sorry, mind you, there is police rocking up right, left and centre. The media is there.
>
> MS RULE: There is like two police cars.
>
> MS ANDERSEN: It's a fiasco and it's like. And it's like, you know, they were staring at us, like staring us up and down, like ready to pounce and it's really intimidating, you know what I mean. And I'm not talking about one or two police officers just hanging around out I the car park, I'm talking about a small crowd over in Emergency and they are over here and they are across the road and what is going on? This is one kid that you just put in a coma
>
> […]
>
> MS ANDERSEN: Like what did you think is going to happen.
>
> MS RULE: That's right. Yeah. So they came out, the woman and Wayne, the security guard, and [the ALO], they were all together and she just said "I'm sorry for what has happened" and I said "Can you tell us what else? What has happened?" She said "There's just been an altercation." So that word is all we have been told by that stage. We didn't even know what had actually happened. Sheryl was already told there had been an altercation.
>
> MS ANDERSEN: To our knowledge, that is all that she was told.
>
> MS RULE: Like we didn't even get told what had happened. There were two separate incidents like that. The time between when he was breathing, when he wasn't, how he got there. Nobody told us any of that. So, yeah, but then I asked her "What are you apologising for?" She's like "I can't say. I'm just sorry." Then I was like "What are you apologising for? Tell us." She's like "I'm just sorry." I'm like "Why are you just sorry?" And then I turned to [the ALO] and I said "Oh you are [the ALO]." And he said "Yeah." "I'm Latoya, like nice to meet you. I have been calling you. Why didn't you visit him?" And then he's just like "I'm sorry." I'm like "No, tell me why you didn't. Is there a reason why you didn't get to visit him? Did somebody stop you visiting him? Like, you know, why didn't you visit him?" And then he's just like "You have to understand I have got like 100 prisoners or something."

151. My investigation asked Mr Brown about whether he instructed department staff to visit Mr Morrison's family in the car park of the RAH. Mr Brown responded:

> Not to my recollection though I did know that Ms Bray had attended the hospital to see our staff, who were taken to the hospital for treatment, and I understand she went to check on the escort, and I understand she did have a conversation with family members.

152. Mr Brown stated that he 'may have' had some discussion with Ms Bray before the visit occurred but that he could not recall a specific discussion. Mr Brown recalled having a discussion after Ms Bray's visit to the RAH:

> Q. Can you provide any details of that discussion?
>
> A. The only memory I have related to, obviously, the distressed state of the family.
>
> Q. Did you provide any direction or guidance in relation to that?
>
> A. No, not that I can recall.

Q. Did you have any discussion with Ms Bray as to what information could be relayed to Mr Morrison's family?

A. Yes, we did have a discussion to that effect.

Q. What was the basis…what was discussed?

A. From memory it was…from memory it was to allow Ms Bray to make it, advise the family that he had been involved in the incident, but I'm not 100% certain with any recollection there.

Q. Did you have any discussion about whether Ms Bray should offer an apology to Mr Morrison's family?

A. No, and I wouldn't have considered that appropriate at the time anyway, so I think that unlikely.

Q. Did you have any discussion with Ms Bray about whether any support should be offered to Mr Morrison's family?

A. I may have well, but not that I can recall.

Q. You can't recall anything?

A. No.

…

A. But I would add there that we had specifically had contact with the Aboriginal Legal Rights Movement through [the Director] and Cheryl Axelby and from memory, it's my understanding that Ms Axelby did attend the hospital with the family. So that would have been our focus in terms of support for the family through the Aboriginal Legal Rights Movement, and obviously through the hospital's support services that are available to any family members who have critically ill relatives in hospital.

153. In her submission to the Select Committee, Ms Rule stated the following, regarding the actions of the department while the Morrison family was at the RAH:

> When we were finally given approval to visit my brother we were told only two family members could enter the room at one time…Before going into my brother's room two corrections officers sat outside of [Mr Morrison's] room and made sure we were not taking any belongings into the room with us. I thought it was disgusting that two corrections officers were watching my brother's room and us, especially as we had been told by this point that there was an alleged altercation with the guards at the prison by the very prompt statement by David Brown – Chief Executive Corrections…It was also hard to deal with these circumstances as I felt that they should not have been present as we were grieving. For example, at one point I was praying…and I looked up at the officers because they were laughing – they stopped when my sister asked them to stop. It was disrespectful to have them there. With their presence, they let us know that we were visiting a prisoner and that we were being surveilled. I felt unsafe.
>
> When I entered the room I saw [Mr Morrison] and it was traumatising to comprehend what had happened to him – he did not look like himself anymore. We spent less than three days next to [Mr Morrison's] bedside before we had to say goodbye. When it was time to say our goodbyes security attempted to block our family from being in the room together as they reiterated that only two family members could be present at one time. This was the time just before we were to switch off [Mr Morrison's] life support machine. I am still angry and saddened that one security guard lent on my arm as to attempt to push it away from the door frame so they could remove us by force from the room, as they stated they would do if we didn't move.

> Medical staff had to tell the security guards to leave at that moment because they were causing a great deal of emotional pain for my family and I. The way my family and I were treated from the Friday to the Monday morning by the corrections system was traumatising…

154. Ms Andersen and Ms Rule told my investigation that they were not told by the department that Mr Morrison was in a coma and that instead, Ms Andersen was informed by a nurse at the RAH. According to Ms Andersen:

> Yeah, someone came out and got me and said to me, you know…it was a nurse, and she…so she came out and got me and said "Come upstairs, I need to talk to you, Wayne's in the ICU". And I'm like "Okay, what about the others?" And she said "No, just you at the moment." So we went upstairs, followed her upstairs. In the elevator she was saying to me "Look, I was here when Wayne arrived." That's when she started telling me he wasn't breathing, and then she'd stop, and then she'd start to pick up the conversation, a sentence, and then she would stop again. The woman was breaking down in the elevator, you know.
>
> We got around to the ICU and she said to me "Okay" like we are in a room, like this was people were waiting to go in, and she… she was by my side and she came around to face me and she sort of put her hands on my shoulders and said "Caroline, I really need to prepare you for what you are about to see." I just lost it. It was just…she was in tears. I said "I can't do this here." I went into the corridor, I collapsed. I got onto the phone to Patrick and said "I have to bring in my son, I need someone else to hear exactly what you are about to tell me." So I did, I rung Patrick and I said "Patrick" and I put him on loudspeaker and I said "Patrick, there is a nurse here, she's about to tell me Wayne's condition" and he said "Where's Wayne?" And I just said "He's in the ICU" and he said "All right" and I said…so she started saying, you know, how he had been to their knowledge, this is first she was there as soon as he was brought in with the ambulance. She said "They were told he hadn't been breathing for 50 minutes or more", and then she went into the detail. He's badly beaten. He doesn't look like he will, you know, you would see him and you would remember him and you know, he's on a ventilator to help him breathe and we don't think he's going to make it.
>
> Patrick automatically…you could hear him gasping and her trying to be this…I know she's a nurse and she'd done a good bloody job trying to tell me, but she was finding it hard to keep herself together, and he spoke on the phone and said […] "Don't let my mum in there, I'm coming straight in", he said "Mum, don't go in there. You know I have seen things before, I'll be okay, but don't go in there until I come in", and the nurse just said "Yeah, that would be better if you did, Patrick." So we went down, she took me back downstairs and then I told, tried to tell these guys the small amount of what she had told me, but how can you relay that to your kids when I couldn't even stand hearing it from her.

155. According to Ms Andersen, this happened at about 6pm, approximately half an hour before she met with Ms Bray and [the ALO] in the car park.

156. In her submission to the Select Committee, Ms Andersen submitted that, as Mr Morrison was in a coma, it was hard to see the need for the presence of department security officers patrolling the room and the area, and that the family regarded this conduct as insensitive and disrespectful.

157. Ms Andersen and Ms Rule also told my investigation:
- that there were correctional officers present at the time that they visited Mr Morrison in the ICU
- only two people were allowed to visit Mr Morrison at a time
- they were never taken to a visitor's room and had to enter directly from the car park
- nobody showed them where the ICU was
- when Ms Rule and her sister Ella went into the room they had to hand over their belongings (including handbags and phones).

158. Ms Andersen made the point that Mr Morrison's family were treated "as if they were visiting a prisoner". Ms Andersen stated:

> Yeah, I asked the head of Corrections, why that was, why is it like that and he said "Oh this is the procedure, this is what we need to do to contain all of this" and I said "Yeah, but a whole mob is not going to come, we are not that family. A whole mob is not just going to come in and fill the room and ward and go off their heads and everything, you know what I mean." He said "No, no no we have to keep it down to two people at a time", and he started talking about the list and people had to go on the list and authorisation only came from the top. You know, he had a direct line with the top guy and it was done through them, all of this, and no one else was to be involved.

159. Ms Andersen clarified that she thought that the person she spoke to was taking instruction from the Chief Executive of the department (i.e. Mr David Brown). Ms Andersen further described the process for visiting Mr Morrison:

> …as soon as you get into ICU before you even get into the ward, the front counter you have to have your name, your identity shown, so you have to show a face, driver's licence, to say who you are. Then they would buzz you in, security would come down and collect you and take you back up there, and there was always four in the beginning, there was four corrections officers.

160. In his interview, Mr Brown denied that he had any direct conversations with Mr Morrison's family:

> A. Well, I had no discussion with Ms Andersen. So it seems her…that account seems a bit confused because she said she was talking to the head of Corrections and so it might be she was simply talking to the officer in charge of the escort or Ms Bray.
>
> Q. What about him allegedly saying that all the directions were coming from the top guy?
>
> A. Well, the top guy at Yatala was the General Manager of the prison. He was a male, and it was [the Prison Manager]. So that does not surprise me, that he was giving instructions around the escort. In terms of the access for visiting, I gave those directions, as I said.

161. Both Ms Andersen and Ms Rule acknowledged that the number of officers present during visits 'dropped down…quickly' to two.

162. When asked if she was ever allowed to have time on her own with Mr Morrison, Ms Andersen responded:

> No, no. I got angry one day with the group of four. Predominantly because, you know, if you look at this room, the bed is here, Wayne is here, there is an area to walk around, there's a nurses' desk here, there's curtains here, there's a corridor about this wide, and then you have got four corrections officers sitting there right in front of his bed watching continuously, 24/7.

163. Ms Andersen stated that she 'had no privacy with Wayne whatsoever' until the day before he died (i.e. 25 September 2016). Mr Morrison was at the RAH from 23 to 26 September 2016.

164. Ms Andersen and Ms Rule provided a detailed account of their dealings with Corrections Officers at the RAH which included the following:

> MS ANDERSEN: [after hearing that Mr Morrison had made facial expressions and moaned in pain because his stomach was swollen and bruised]…As soon as I heard that, I'm a Christian, I had already previously organised with Latoya's father to give me some, what we call, anointing oil. I had anointed him in front of these officers and because I

knew that he could hear and because I knew that he could feel and he most probably knew that they were sitting there, I got the shits and I just looked at all of them I said “I’m closing these fucking curtains”. I closed the curtains and then I just went around to Wayne and was praying, and I anointed him in oil and everything, you know. I heard one comment, you know “You are not allowed to do that. You have to leave them open”, and I just totally ignored them. I heard snickers, sniggers and giggles and the, like, pathetic remarks and all of that sort of thing when I was doing it but I really didn’t care, because…

MS RULE: They were laughing at me the first day.

MS ANDERSEN: I was doing what I believe was right for my son, you know…

…

MS ANDERSEN: [after opening the curtains, she described an officer as follows] He was pacing like a pit bull back and forwards, back and forwards across the curtains, just pacing with this such an angry face and with an elastic band in his hand flicking it and he was so, like agitated because I had closed these curtains and he couldn’t see what I was doing. You know, I just thought…so when you ask about privacy, we had absolutely no privacy. That was the only strip of privacy that I got…

MS RULE: Until they told us. So at the very end they gave us like the time just before he passed away, but the doctors came in and explained to us, and then took us to the family room and told us that they are going to be turning it off soon and so to say our final good-byes, but during that time you would think they would go away by then, but they were already announced on [unclear], that’s when the Corrections still sent two people at a time and that is when I got angry because they have just said like..

MS ANDERSEN: He’s about to pass away.

MS RULE: … about turning it off, say your final goodbyes and then we were taken out and whoever wanted to be there could go back in to be with him, so at that time that we got to go back in to be with him when it was being turned off, it takes a while, that was private, but the time when the doctor said “Say your final good-byes”, the security stayed there. And now I was quite angry and I told my family to go in and I just put my hands up on both sides of the door.

…

And I was just like “No.” This woman in particular, there were only two officers there, sorry, security.

MS ANDERSEN: He was okay I think.

MS RULE: He was.

MS ANDERSEN: But she was just wanting to rip someone’s head off. Same aggression as this guy that was pacing back and forwards, back and forwards.

MS RULE: She lent on my arm to try to break it down and I said “I’m not…” literally it was very calm but was like passive aggressive to the max because I was holding these doors, I’m like “No, like the doctors say in here, they have just said this is our time to say goodbye, let my mum say goodbye, let us say goodbye together. We haven’t even been together as a family yet, Let us be in there together.”

MS ANDERSEN: And it was embarrassing because I was on the floor, kneeling next to Wayne, crying, yeah I’m saying goodbye to my son and I could hear this commotion going on over here, and I spun around and I had tunnel vision and the only person I seen was Latoya like this, and I just, I told her off…

…

> Wayne's about to take his last breaths and I'm telling my daughter off because I think she's about to have an argument with the security that have been here and smothered us for the last three or four days. We weren't getting any privacy. We weren't going to be left by ourselves. She wanted to see him take his last breath, this woman, and she wouldn't have been satisfied until she seen it and that was the attitude she had.
>
> …
>
> MS RULE: Yeah, but then she told us she was going to remove me by force if I didn't put my hands down and that is why she just like put her body weight on my arm because she was quite short, and then I was just like "No" and then after all of that, we were like in this really awkward position, her trying to push into the room and me being like "No, give my family a chance".

165. According to Ms Rule, it was only when a doctor and nurse intervened that the Corrections officers left the room. Ms Rule also stated that the female Corrections officer threatened to make a report against her.

166. Ms Andersen told my investigation:

> That moment was one of the most disgusting moments in the entire situation. Not only seeing Wayne's condition and going over all of his body and the nurses allowing me to do it in front of security, I didn't care, what she did then was disgusting. How dare you force me to embarrass not only myself, but my daughter and you're the one that is perpetrating this aggression against her. You know, but it was a sacred time, you know. Yeah, I think about it now and I just think how utterly disgusting of you as a human to allow yourself to be that wound up that you feel that you have to physically press against someone, and that someone is just trying to stop you from entering the room where a life is about to leave, and all you're concerned about is making sure that you have a foot into that area and you won't give us…

167. The response provided by the department subsequent to Mr Brown's interview included the following:

> **Officer Conduct at the RAH**
> The officers on duty on the day of admission [redacted] reported during interview that the family members were visibly upset and grief stricken. They advised that they were sympathetic to the family and that they acted professionally at all times.
>
> [redacted] advised that on the evening of 23 September 2016 he and [redacted] engaged in a conversation which was unrelated to Mr Morrison. [redacted] further advised that the conversation resulted in them laughing quietly. The Investigator was told that Mr Patrick Morrison approached [redacted] and [redacted] and accused them of laughing at Mr Morrison and the family. Mr Patrick Morrison was assured that no disrespect was intended towards Mr Morrison or his family.
>
> No action has been taken against the officers in relation to allegations concerning their conduct.
>
> **Family conduct at the RAH**
> I received verbal briefings from relevant senior managers about the conduct of Mr Morrison's family at the RAH. Members of Mr Morrison's family were understandably distressed and grief stricken. There was no behaviour reported to me that required any intervention and no formal documentation has been created.
>
> **Powers of Correctional Officers**
> Correctional Officers do not have power to act against a member of the public who is behaving inappropriately, unless it is to prevent prisoner injury or escape. In all other circumstances, Officers would be expected to call hospital security or the police.
>
> **Complaints received by DCS from Mr Morrison's family**

> Other than the complaint outlined above, the only complaint received by DCS was an email sent from Ms Cheryl Axelby of ALRM, about the conduct of a female officer immediately prior to Mr Morrison dying[.]

168. Ms Axelby's complaint stated:[15]

> I confirm I have spoken with Wayne's family this morning. We shared our sincere condolences and are ensuring they are well supported.
> The family have shared with me a very disturbing incident relating to the attitude and behaviour directed at them by the female member of Corrections security who was present at the hospital at the time family were with Wayne, during his passing. There were 2 prison officers present. A male and a female. The male was outside the room and the female was inside. One of the family members asked the female officer to leave the room, immediately after the time family were advised by the hospital that Wayne was about to pass away. The female officer refused this reasonable request. The family report she was rude and insensitive and advised them that they shouldn't even be there. One of the family members again requested her to leave the room and she again refused. The family members were very upset that the female officer wouldn't leave them to spend their last moments with Wayne. The male officer, then entered them [sic] room, whilst being on the phone and he approached [the] female officer, spoke to her and they both left the room. We wish to bring this to your immediate attention. This is totally insensitive and unacceptable behaviour.

169. The department stated:

> The complaint relates to when four family members attended Mr Morrison's room in the early hours of 26 September 2016, after the decision had been made to turn off his life support. G4S Officer, [the G4S Officer], was standing in the doorway of Mr Morrison's room and was pushed by Latoya Rule to leave the room. [The G4S Officer] indicated to Ms Rule that she understood the situation but that she had to be there. Ms Anderson [sic] intervened and advised that she wanted it to be a peaceful time.
>
> The other officer in attendance, [redacted], was in contact with the G4S control room and was advised to let the four family members remain in the room. I do not believe that the staff acted in a manner that requires disciplinary action.

170. In response to my draft final report, the department forwarded responses by G4S and [the G4S Officer] respectively.

171. G4S' responded:

> In relation to the hospital watch of Mr Morrison, DCS provided G4S a list of approved visitors, of which there were 10, and instructions that visits be conducted on the basis of only 2 visitors to enter the room at one time and all visitor personal belongings to be left outside the room on a table that had been supplied. Otherwise the daily log shows:
>
> - The family were aware of the instructions and the limits on the number of visitors and storing personal items on the table and complied with those requirements with some family members waiting in the designated waiting room.
> - A G4S EO received a handover from DCS officers at 12.45pm on 25 September 2016.
> - A second G4S EO commenced at about 2.15pm and received a handover
> - EOs [the G4S Officer] and [redacted] commenced their shift at about 11pm on 25 September 2016.
> - At about 1.30am on 26 September 2016 Mr Morrison's sister Latoya asked if more than 2 visitors could be in the room. She was advised that G4S needed a fax from DCS to approve that request.
> - All family members were in the room with Mr Morrison at about 3.36am on 26 September 2016.
> - At about 4.02am the life support was removed.

[15] Email from Ms Cheryl Axelby to [the Director], Mr Brown and others dated 26 September 2016.

- [The G4S Officer and [redacted] left site at about 5.25am.

172. According to G4S, on 26 September 2016 G4S received a complaint about the Hospital watch and the manner in which [the G4S Officer] interacted with the family and obtained incident reports from [the G4S Officer] and [redacted]. As G4S has highlighted, those accounts are more contemporaneous than those provided to Mr Muller, discussed later in this report.

173. In her incident report, [the G4S Officer] stated:

> At approx.. 0325 all five family members entered the room of (P) [Mr Morrison], disregarding hospital protocol. At this point I arose and stood in the corner of the entrance of the room to observe while [redacted] called control ([redacted]) to advice [sic] all family members were now inside the room. [redacted] advised us that as long as the nursing staff were okay then we would not ask the family to leave. The (P) [Mr Morrison] sister Latoya Rule moved towards me and extended her hands out to prevent me being in the room and with her back to me stated that "this is Kaurna land you are standing on". The brother Patrick also stated "you don't need to be here". I replied that I "respected their feelings but was just doing my job". At this point the (P) [Mr Morrison] mother walked over and look [sic] Latoya in the face and said "No more. Stop now." She sat back down. Latoya was still extending her arms to prevent any movement or access to the room and nurse [redacted] put his hands on her shoulder & said "You are stopping us from doing our job, your focus should be on him (P) [Mr Morrison], just be sensible". Latoya then sat down behind her mother.

174. [redacted] account of the incident was generally consistent with [the G4S Officer]'s.

175. I address [the G4S Officer]'s personal response to my draft final report later in this report.

176. My investigation asked Mr Brown about the security arrangements at the RAH. Mr Brown responded that he did not have an understanding of what those security arrangements were and further responded to questioning as follows:

> Q. Did you have any input into the decision as to what those arrangements should be?
>
> A. No, I didn't. I may well have asked for a review of those arrangements after he had been admitted because that would be something I quite often make an enquiry into, but, no, the security and escort arrangements are determined by the General Manager or his or her delegate. And in the event even that I sought input into reviewing those, that would be through those delegates.
>
> Q. Do you recall any reports to you on a review or…
>
> A. Not offhand, no.

177. My investigation further sought a response from Mr Brown concerning details of Mr Morrison's family's treatment at the RAH:

> Q. …According to the information provided by Ms Andersen and Ms Rule, there were correctional officers present at the time they visited Mr Morrison in the ICU and only two people were allowed to visit Mr Morrison at a time. They were never taken to a visitor's room, and had to enter directly from the car park. Nobody showed them where the ICU was. When Ms Rule and her sister, Ella, went to the room they had to hand over their belongings including handbags and phones. Do you know whether that information is correct?
>
> A. It sounds reasonable in the sense that the arrangements for showing a family member where a ward is in a hospital, and how to access that ward, and access to visitor rooms, is a matter for the health department and their team. The staff we had present were there to provide escort and custody to Mr Morrison, and not unlike a

visit to a prisoner where you are visiting a prisoner, personal belongings would not be permitted to be taken into that prison.

Q. Is that governed in accordance with the SOP security arrangements?

A. Yes, it would [be], yes.

Q. Are there details in there about two people at a time?

A. Look, I'm not clear from your account of the family's version as to whether limits on the numbers were determined by the department or whether they were determined by the ICU staff.

Q. I'm not very clear on that either.

A. Certainly my recollection, and revisiting the notes, that was initially approval was granted for Ms Andersen to visit, and then she didn't want to visit on her own, and she wanted other family members to be able to visit with her. And the staff, as I understand it, had a very specific instruction about who was authorised to visit that came back to me, through [the Director], and we established who the family members were that were going to join Ms Andersen, which included Ms Rule and a further approval was granted. So my understanding was there was a brother, might have even been two brothers, and Ms Rule and Ms Andersen. Now it could be that the hospital, given the critical nature of the environment of an ICU, placed a limit on how many family members could go in at once. It could well be that the custodial staff exercised a judgement that they only wanted to permit two people at a time, but I'm not clear as to who made that decision.

Q. I guess I was trying to get to the bottom of whether there is a particular policy in relation to that. Obviously there's a discretion of the hospital staff and the Corrections security staff.

A. Yes.

Q. And in terms of handing over the belongings, that would be a Corrections decision?

A. That is correct. Yes.

Q. Because people were visiting a prisoner.

A. Yes. That's correct.

Q. Is there any flexibility in relation to that policy, where someone is critically injured?

A. There would be…every officer has to exercise their judgement and determine whether they have an ability to exercise discretion in certain circumstances. If I'm a Correctional Officer managing a situation such as this, it's [sic] less likely to exercise discretion and that would need to be referred up to a more senior officer to determine.

178. My investigation asked Mr Brown whether there was any direction coming from 'the top' as how this situation should be handled on the ground. Mr Brown responded:

> Well, clearly there were directions, even coming from the very top, in terms of myself, with respect to facilitating access for support staff in the hospital with the ALO and the Aboriginal nurse, and then making the arrangements for the family to be able to visit. What's clear, and [isn't] always appreciated, is that those things don't always happen in the time frame that those people caught in the middle of that are expecting, but I think we took…I think it's…I'm satisfied that we had the family at the centre of our consideration when we were making those interventions, and giving those directions, and hence why [the Director] was reporting directly to me on those things.

…

I think it is unusual for a chief executive to make operational decisions around granting access to family members. But the reason we did that is that I had instructed [the Director] to make the contact and, therefore, it made sense for [the Director] to work back through me in following that through. And then we would have worked with [the Prison Manager] and Ms Bray to get those things put into effect, because you've got to have clear command and control in these circumstances. You can't have a chief executive ringing escort staff on the front line giving them directions, it has to be through their superiors and their managers.

…

There's a difference between having direct involvement in decisions, and how those decisions are directed or communicated. So clearly I have direct involvement in approving the visits of the family, but then my view would have been that I would have given that instruction to Ms Bray and/or [the Prison Manager] to have that occur.

179. Ms Andersen's specific allegations about the lack of privacy at the RAH were put to Mr Brown in detail in his interview:

Q. Do you consider it appropriate and necessary that Mr Morrison's family was not allowed to visit him privately?

A. Firstly, I'm not in a position to respond to Ms Andersen's description of staff conduct and behaviour. That incident, as described, is unacceptable from my perspective but, of course, we need to give those officers an opportunity to give their account of their management of the escort because my expectation, unless they are directed otherwise by a more senior officer, [is] that a prisoner in hospital is under the direct line of sight, observation of a correctional officer at all times and it is my view that that is a requirement of the Correctional Services Act.

Q. And there is no flexibility in relation to the condition of a prisoner?

A. Not for the front-line officer. The flexibility needs to really be directed and determined by a more senior officer.

180. Mr Brown's subsequent written response on behalf of the department included:

Whilst I understand Ms Anderson's concerns about not being permitted to visit Mr Morrison privately, hospital watch officers are required to observe the prisoner and visitors at all times to ensure appropriate custody of the prisoner is maintained. This also ensures the safety of the prisoner and the visitor/s. Near the end of Mr Morrison's life, four visitors were permitted in Mr Morrison's room, however, G4S Officers remained outside the room at all times.

181. Mr Brown's interview also included the following exchange:

Q. Did you provide any guidance as to how to deal with Mr Morrison's family?

A. With empathy and discretion. I would have thought, and to show maximum tolerance.

Q. Do you remember discussing that issue with anyone?

A. In general terms, I remember discussing it, yeah.

Q. Who with?

A. It would have been with Ms Bray.

182. Mr Brown subsequently stated in the department's written response:

I have publicly acknowledged the pain and grief experienced by Mr Morrison's family as a result of his tragic death. I have publicly stated that any death in custody is unacceptable and issued my sincere condolences to Mr Morrison's loved ones.

183. Mr Morrison died early in the morning of 26 September 2016.

The department's internal investigation

184. In his interview, Mr Brown provided the following information about the department's internal investigation:

A. … Part of the approach of our internal investigation, and the role that Mr Rob Zadow plays in that investigation was for Mr Zadow to reach out to the family to see if they would like to speak to him about the incident and the events leading up to Mr Morrison's passing. My…and that approach has primarily been tried to be arranged through the Aboriginal Legal Rights Movement and to date the family have declined the offer.

Q. Has that occurred more recently that the family has been involved?

A. Well, it was originally initiated when [redacted] had taken on that role, and there had been no, as my understanding and advice, they declined the offer at that time. When Mr Zadow took over that responsibility, I understand a further approach was made, and to date the offer has been declined.

Q. As you would be aware, Ms Andersen and Ms Rule made submissions to the Select Committee on Administration of South Australia's prisons.

A. Yes.

Q. Has the department taken any particular steps in relation to the issues that they raised in that committee, or what is happening, I guess, in relation to those issues?

A. The department is investigating the incidents and events surrounding Mr Morrison's death and as the matters raised are relevant to that, they have been incorporated.

Q. […] Has the department had any debrief or review in relation to its dealings with Mr Morrison's [family]?

A. Look, only in the context of the debrief after incidents, so there's an operational debriefing that occurs.

185. The department subsequently provided me with copies of the Muller report and a report prepared by Mr Rob Zadow (**the Zadow report**).[16]

186. I address those reports as necessary throughout this report.

[16] Dated 20 October 2017.

Relevant law/policies

188. The department's SOP 001A 'Custodial –Admission – Case Management' in place at the relevant time included:

> **3.3 Prisoner Case File**
>
> 3.3.1 The operational supervisor must ensure:
>
> […]
>
> (d) All information that is relevant to the Admission Interview and Assessment process is placed in the Admission section of the prisoners Case File.
>
> …
>
> **3.5.1 Admission process**
>
> 3.5.1 Upon admission of a prisoner in to custody, the operational supervisor must ensure:
>
> […]
>
> k) The prisoner, whether newly admitted or transferred in from Community Corrections or another DCS prison is seen by the South Australian Prison Health Service (SAPHS)
>
> […]
>
> 3.5.4 During the admissions process, the Admitting Officer must read and take notice of the following forms:
>
> - SAPOL Custody Transfer Form (PD346)
> - Prisoner Screening Form (PD331).
>
> 3.5.5 The Admitting Officer must review the SAPOL Custody Transfer Form (PD346) and ensure that any box/es ticked in the section as "Prisoner Welfare Information" are taken into consideration when determining an appropriate placement and/or regime for the prisoner.
>
> 3.5.6 The Admitting Officer must review the SAPOL Custody Transfer Form (PD346) and ensure that any forms identified in the tick boxes in the section listed as "Prisoner Risk Assessment and Contact History" are also in the package of paperwork at the time of handover.
>
> **3.7.1 Risk/Needs Assessments**
>
> 3.7.1 The operational supervisor must ensure that an admission interview is conducted with each prisoner regardless of status and having regard to SOP 090 – Management of Prisoners at Risk of Suicide or Self Harm. The following forms are to be completed and placed in the admission section of the Prisoner Case File, with relevant information then entered onto the JIS prior to the prisoner being placed into an accommodation unit/wing:
>
> a) Admission Checklist (F001/001)
> b) Specific Needs Assessment (F001/002)
> c) Prisoner Stress Screening Form (F001/003) (Must be completed for new admissions and also be completed for those prisoners transferring between DCS institutions, the Prisoner Stress Screening Form – On Transfer (F001/003b))
> d) Prisoner Interview Form (F001/004)

e) Compatibility to Share Accommodation (F001/005)
f) Prisoner Health Information Form (F001/006). (Must also be completed for those prisoners transferring in from Community Corrections or another South Australian prison).
g) PTS – Prisoner Declaration Access and Use Conditions (F007/001).

[…]

3.7.3 The operational supervisor must ensure that when a newly admitted prisoner is received into custody, a Prisoner Stress Screening Form (F001/003) is carefully completed with as much detail as can be reasonably obtained from the prisoner in order to appropriately flag any issues that may have the potential to lead the prisoner to self-harm. For prisoners transferring between institutions, the Prisoner Stress Screening Form – On Transfer (F001/003b) version must be used.

3.7.4 The operational supervisor must ensure that the Prisoner Stress Screening Form (F001/003) or Prisoner Stress Screening Form – On Transfer (F001/003b) is completed using any supporting information such as the Prisoner Screening Form (PD 331) that has been provided by SAPOL.

3.7.5 The operational supervisor must ensure that ALL sections of the Prisoner Stress Screening Form (F001/003) or Prisoner Stress Screening Form – On Transfer (F001/003b) are completed, including the sections related to Concerns/Advice, Information from Police/Transporting Staff, Special Accommodation/Observation Requirements and Referral To.

3.7.6 The operational supervisor must ensure that a copy of Prisoner Stress Screening Form (F001/003) or Prisoner Stress Screening Form – On Transfer (F001/003b) and the SAPOL Prisoner Screening Form (PD 331) are handed directly to the SAPHS admitting nurse, with the originals placed into the Prisoner Case File.

[…]

3.8 Initial Health Assessments

3.8.1 Health Assessments are the responsibility of the SAPHS.

3.8.2 The Department for Correctional Services (DCS) and the Department of Health (DoH) have developed Joint Systems Protocols that are collectively aimed at improving the health and wellbeing of prisoners.

3.8.3 The Joint Systems Protocols detail specific responsibilities for DCS and SAPHS relating to the Intake process. These responsibilities are:
a) SAPHS must conduct an initial health assessment and complete a Prisoner Health Information Sheet (F001/006) and make specific placement/management recommendation where necessary for each prisoner that is admitted into a prison.
b) Joint discussion between DCS admissions staff and SAPHS staff must take place in relation to the placement and management of prisoners deemed at high risk, taking into account both agencies [sic] risk assessments.
c) Prisoners should remain in the admissions area until joint discussion/communication has occurred regarding safe placement.
d) SAPHS staff must forward the completed Prisoner Health Information Sheet (F001/006) and any specific placement/management recommendations to DCS admissions staff
e) The operational supervisor must ensure that the Prisoner Health Information Sheet (F001/006) is placed in the prisoners [sic] Case File and a case note recorded on the JIS under the “Medical” heading listing any issues that have been identified.

f) In the event of late admits to rural prisons where health staff have left for the day, the prisoner must be risk assessed by admissions staff and placed in appropriate accommodation overnight pending a health assessment and joint prison placement evaluation the next day.

3.9 Immediate Interventions

3.9.1 The operational supervisor must ensure:

a) A prisoner identified as possessing any of the indicators of suicide or self-harm is managed according to SOP 090 – Management of Prisoner at Risk of Suicide or Self Harm

b) Other immediate individual risks/needs and/or acute medical needs are referred to relevant staff for intervention.

c) Special attention must be given to the risk/needs of Aboriginal or Torres Strait Islander prisoners and referrals should ensure the involvement of relevant indigenous staff without delay.

d) If a prisoner self-identifies as being Aboriginal or Torres Strait Islander during the admission process, and requests to see an Aboriginal Liaison Officer (ALO), the prison ALO must be notified:
   i) by telephone in the first instance (during business hours);
   ii) by leaving a voice message if there is no answer (if this service is available);
   iii) by providing a copy of the Admission/Discharge Advice for the ALO's perusal the next day (standard for all admissions/discharges);
   iv) by sending the ALO an email outlining the prisoner's request; or
   v) by recording a case note on JIS (at a minimum for this purpose it must state 'Email sent to ALO').

e) The intervention process must commence as soon as practicable after referral. In case of a delay, for example weekend admissions, interim measures are to be taken as necessary to ensure the safety of the prisoner, staff, other prisoners and the public at all times. The approving authority must document these decisions.

f) Any immediate intervention action must be documented on JIS as a case note under the most appropriate heading.

g) Accommodation, supervision and other specific prisoner management requirements are to be recorded throughout the admissions process, case noted on JIS and forwarded to the appropriate authority for further action.

h) If a prisoner is required to be placed in Protective Custody in accordance with SOP 005 – Protective Custody or separated under Section 36 of the Correctional Services Act 1982 (CSA), the reasons for this must also be provided.

i) All relevant information in relation to specific prisoner management requirements must be communicated to staff responsible for the supervision of the prisoner without delay. A copy of relevant documentation must be placed in the Prisoner Case File.

j) During the immediate intervention process, intervention personnel must determine any ongoing intervention requirements.

[…]

3.14 JIS Case Noting

3.14.1 Upon completion of the admission process, a case note must be entered on JIS for each prisoner, outlining their admission/transfer Prisoner Stress Screening score, accommodation placement, and that they have been seen by the SAPHS and any issues. This must be done within twenty-four (24) hours.

3.14.2 Case notes must be entered on JIS throughout the admission and induction processes detailing any issues that are identified that could have an impact on the health and welfare of a prisoner.

3.14.3 Issues that may have an impact on a prisoner's health and welfare could include, but are not limited to:
a) Age;
b) Restricted Mobility;
c) Protection Status;
d) Cultural Background;
e) Gang Affiliation;
f) Enemies in the prison system; and
g) Personal health issues.

[…]

189. The department's SOP 006A – 'Prisoner Death or Critical Injury' in place at the relevant time includes:

3.9 Notifying the Emergency Contact/Next of Kin of the Death

3.9.1 SAPOL must advise the emergency contact person of the prisoner's death. Any inquiries subsequent to the death claiming to be from relatives or other interested parties must be referred to SAPOL.

3.9.2 Details of the death of a prisoner must not be given to any person unless expressly authorised by the General Manager.

3.9.3 Where a prisoner has sustained a critical injury that is likely to result in the prisoner's death the General Manager in consultation with the Deputy Chief Executive Statewide Operations and other key agencies where possible, must ensure that the Emergency Contact/Next of Kin of the prisoner is contacted.

190. The department's SOP 013 – 'Prisoners at Hospital' in place at the relevant time includes:

3.3 Prisoner Visits

3.12.1 Hospital Watch officers must not allow prisoners to receive visitors unless the prisoner has been in hospital five (5) days, except where compassionate or extenuating grounds exist.

3.12.2 All visitors must be approved persons recorded on the prisoner's nominated visitor list and must be approved by the General Manager.

3.12.3 All visits to admitted prisoners must take place during normal hospital visiting hours and will be of a duration of no longer than forty (40) minutes, unless specific approval is given by the General Manager for extenuating circumstances.

3.12.4 Prior to the visit commencing all visitors must produce photograph identification or identification as prescribed in SOP 022 – Prisoner Visits.

3.12.5 Visitors must not be allowed to give the prisoner any item, including food and drinks, unless authorised by the General Manager.

3.12.6 The use of mobile phones during visits is strictly prohibited and will result in immediate termination of the visit.

3.12.7 Hospital Watch officers must be located in a position to directly observe the prisoner and visitors all times during the visit.

3.12.8 The hospital watch officer/s must record the time and duration of each visit, including the name and address and identification details of the visitor/s in the Hospital Watch Log Book.

191. The department's SOP 090 – 'Management of Prisoners at Risk of Suicide or Self Harm' in place at the relevant time includes:

3.4 Correctional Officer Responsibilities

3.3.1 A correctional officer who becomes aware of a prisoner at risk or observes the behaviour or presentation of a prisoner as indicating an increase in risk of suicide or self harm must ensure that the Responsible Officer is notified verbally and must complete a Notification of Concern Form – Part 1 (F090/001) immediately.

3.3.2 The staff member completing the Notification of Concern Form – Part 1 (F090/001) must:
a) list all the relevant information that indicates the prisoner at-risk of suicide or self harm;
b) sign and specify the date and time of the notification;
c) forward the Notification of Concern Form – Part 1 (F090/001) to the Responsible Officer as soon as the form is completed;
d) make a JIS case note indicating that a Notification of Concern Form – Part 1 (F090/001) has been completed and;
e) take all reasonable steps to ensure that the prisoner's safety is maintained until appropriate placement of the prisoner has been determined.

3.3.3 A prisoner is to be considered at risk and Notification of Concern Form – Part 1 (F090/001) must be completed if:
a) A prisoner on admission presents with:
- a score of 9 or greater on the Prisoner Stress Screen Form (F001/003); and/or
- has a history of recent (within previous 7 days) deliberate suicidal or self harm behaviour (e.g. through the SAPOL Prisoner Screening Form (PD331),Prisoner Stress ScreeningForm (F001/003); or

b) If a prisoner is presenting at any time with;
- acts of attempted suicide or self harm or;
- threats of attempted suicide or self harm.

3.3.4 Appendix 1 - Information and Characteristics of self harm and suicide (A090/001) provides further guidance to staff in making a determination about a prisoner at-risk.

3.3.5 When a prisoner is placed on an observation regime, correctional officers must ensure that all potentially harmful articles such as, but not limited to, cigarette lighters, pens, belts and shoe laces are removed from the prisoner and the cell is thoroughly inspected for hazardous and/or prohibited items, prior to the prisoner being placed in the cell.

3.3.6 If at any time, correctional officers have concerns regarding the management of a prisoner deemed at-risk, officers are to contact the Responsible Officer in the first instance and then if the matter is not resolved, the appropriate Manager or General Manager.

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

[…]

3.7 Chair of High Risk Assessment Team (HRAT) Responsibilities.

3.7.1 The actioning of follow up assessments and reviews is the responsibility of the Chair of the HRAT.
3.7.2 High Risk Assessment Teams assess, intervene and review placement, discharge plan and follow up evaluation through a case review process.
3.7.3 High Risk Assessment Teams must follow the meeting and documentation process outlined in Appendix 2 - HRAT Meeting Requirements.(A090/002)
3.7.4 The chair of HRAT must ensure that on the next working day of a receipt of a Notification of Concern Form – Part 1 (F090/001), the prisoner is independently assessed for risk of suicide or self harm by a minimum of:
• Psychologist or Social Worker;
• Nurse; or,
• ALO (where applicable).
3.7.5 The chair of HRAT must ensure actions arising through HRAT discussions are noted in both the DCS JIS system and the SAPHS medical record.
3.7.6 The chair of HRAT must ensure prisoners on the HRAT list transferring to other prisons are referred to the HRAT of the receiving prison.
3.7.7 The Initial Response Plan – Part 2 (F090/001) and Follow-up Care Plans (F090/002) for
all prisoners must be monitored and reviewed at each HRAT meeting. All aspects of the plan must be discussed, reported against, and agreed upon. This must be documented in the HRAT meeting minutes.
3.7.8 The Follow-up Care Plans (F090/002) for prisoners no longer requiring an ongoing Care Plan, must be reviewed for a minimum of two (2) subsequent HRAT meetings, prior to removal from HRAT list and this must be documented in the HRAT meeting minutes.
3.7.9 The HRAT committee is responsible for ensuring that all Follow-up Care Plans (F090/002) are completed, implemented, and reviewed.
3.7.10 If the HRAT members deem a prisoner to no longer be at-risk of suicide or self harm and does not require continued management by the HRAT, they can be removed from the HRAT list. This decision making process must be documented in the HRAT minutes.
3.7.11 If a prisoner in custody (sentenced or remanded), who is subject to a Follow-up Care Plans (F090/002) is to be discharged into the community (i.e. Bail Home Detention, Section 38 Bonds, Community Based Orders, Parole or Sentenced Home Detention), the prisoner's 'at-risk' status must be considered for transitional and pre-release planning. Contact should be made by the Custodial Case Management Coordinator with the relevant Community Correctional Centre, Manager of Case Management, to advise them of the prisoner's risk status and to provide a copy of the Follow-up Care Plans (F090/002) The Custodial Case Management Coordinator must ensure that this is documented as a JIS case note.
3.7.12 If a prisoner on the HRAT list is released from court with no Departmental supervision requirements, the HRAT Chair must inform the Assessment and Crisis Intervention Service (ACIS) and SA Police (SAPOL), as soon as they become aware of the prisoners release.

192. Section 85C of the Correctional Services Act provides:

85C—Confidentiality

(1) A person must not disclose information relating to a prisoner, probationer or parolee, or derived from the Victims Register, being information obtained (whether by the person or some other person) in the administration or enforcement of this Act, except—

(a) as required or authorised by this Act or any other Act or law; or

(b) as reasonably required in connection with the administration or enforcement of this Act or any other prescribed Act; or

(ba) if, in the opinion of the CE, it is necessary to disclose the information in order to avert a serious risk to public safety; or

(c) for the purposes of legal proceedings arising out of the administration or enforcement of this Act; or

(d) to a government agency or instrumentality of this State, the Commonwealth or another State or Territory of the Commonwealth for the purposes of the proper performance of its functions; or

(e) with the consent of the prisoner, probationer, parolee or registered victim to whom the information relates; or

(f) in accordance with subsection (2).

Maximum penalty: $10 000.

(2) The Board must, in respect of a prisoner released on parole, notify the Commissioner of Police of–

(a) the place of residence of the parolee; and

(b) the conditions to which the release on parole is subject.

193. Section 13 of the State Records Act 1997 provides:

13–Maintenance of official records

Subject to this Act, every agency must ensure that the official records in its custody are maintained in good order and condition.

194. Section 23(1) of the State Records Act provides:

23–Disposal of official records by agency

(1) An agency must not dispose of official records except in accordance with a determination made by the Manager with the approval of the Council.

Consideration

Whether the department appropriately followed up on issues identified at Mr Morrison's admission to Yatala Labour Prison

Physical health issues identified in the SAPOL Detainee Transfer Report

195. While it appears that Mr Morrison sought medical attention for various issues while in SAPOL custody, I do not consider that the department failed to appropriately follow up on those issues. In that regard I note that the Transfer Report indicated that a medical examination had occurred and Mr Morrison was 'fit for custody'. Regardless, Mr Morrison was assessed by SAPHS as required by the Joint Systems Protocol. SAPHS did not identify any health issues or injury.

196. In those circumstances, I do not consider that the department erred in its handling of Mr Morrison's physical health issues which were identified during his time in SAPOL custody.

Mr Morrison's past attempted suicide and family history of suicide

197. The records provided to my investigation indicate that Mr Morrison had a past suicide attempt and that his father and uncles had committed suicide.

198. On the basis of the department's processes in place at the relevant time, a Notification of Concern should have been raised. That did not occur.

199. The department's requirements were unambiguous. According to the Stress Screening Form completed by Officer [redacted], a Notification of Concern was required to be raised if a prisoner answered 'yes/maybe' to any of the questions at 21 to 23 of the Stress Screening Form. While an officer has a residual discretion to raise a Notification of Concern 'regardless of the score', in Mr Morrison's case, the raising of a Notification of Concern was mandatory on the basis that he answered 'yes/maybe' to the following questions:
    - Question 21: Have you thought about deliberately harming yourself since you were arrested?
    - Question 23: Have you ever tried to intentionally hurt yourself?

200. The Stress Screening Form also specifically records at question 23 that Mr Morrison tried to hang himself 20 years ago. At question 16, 'Has anyone in your family or a close friend ever committed suicide?' It was recorded that Mr Morrison's father and uncles had committed suicide ten years ago. While this answer would not by itself have necessitated the raising of a Notification of Concern, I consider that it would have been relevant to the exercise of the residual discretion.

201. Despite that information being recorded on the Stress Screening Form, Officer [redacted] ticked 'no' to the question 'Is a Notification of Concern required to be raised?' and no Notification of Concern was raised.

202. The department has acknowledged that a Notification of Concern should have been raised.

203. In my view, the department has not offered any adequate explanation for the failure to raise a Notification of Concern. The department's investigator was satisfied that some discussion took place between Officer [redacted] and a SAPHS nurse. While I am willing to accept that evidence, I also agree with the department's submission that:

Whilst conferring with SAPHS is always appropriate including when a DCS Officer has a discretion to raise a NOC, it is not a substitute for complying with SOP 090 when a NOC is mandatory as it was in Mr Morrison's case.

204. Had a Notification of Concern been raised, the requirements of SOP 090 as in place at the relevant time should have been met. Those requirements included:
    - prioritisation of assessment and/or observations of Mr Morrison[17]
    - at a minimum, making of daily JIS case note entries detailing Mr Morrison's demeanour[18]
    - taking all reasonable steps to ensure that Mr Morrison's safety was maintained until appropriate placement was determined[19]
    - removal of all potentially harmful articles from any cell prior to placement (in the event that it had been determined to place Mr Morrison on an observation regime)[20]
    - completion of an Initial Response Plan[21]
    - the High Risk Assessment Team (**HRAT**) assessing, intervening and reviewing Mr Morrison's placement, discharge plan and follow up evaluation through a case review process.[22]

205. Had HRAT been notified, the requirements of SOP 090 as in place at the relevant time should have been met. Those requirements included:
    - on the next working day, Mr Morrison should have been independently assessed for risk of suicide or self-harm by a minimum of :
        - Psychologist or Social Worker
        - Nurse or
        - ALO[23]
    - Mr Morrison's ongoing care would be monitored and reviewed.[24]

206. As a Notification of Concern was not raised, none of the above occurred. In my view, this is a particularly serious error. The fact that a SAPHS nurse interviewed Mr Morrison about his family history of suicide and also decided that a Notification of Concern was not required to be raised does not in any way change my view.

207. As a result of no Notification of Concern being raised, Mr Morrison was denied the level of assessment, monitoring and review required by SOP 090. This is especially concerning, given that Mr Morrison was an Aboriginal prisoner. The particular risks and needs of Aboriginal prisoners are well known and have been set out at length in the Royal Commission into Aboriginal Deaths in Custody report (**the RCIADIC Report**). I discuss the findings of that report in more detail later in this report.

208. In my view, the department's process requiring the raising of mandatory Notifications of Concern is crucial. That process goes some way to addressing the issues identified in the RCIADIC Report. It is difficult for me to comprehend why that requirement was not met in Mr Morrison's case. Ultimately, Mr Morrison was a vulnerable prisoner whose risks and needs were not appropriately met by his custodian, the department.

209. In response to my provisional report, the department noted:
    - the raising of a Notification of Concern is intended to trigger additional assessment and consideration of a prisoner's circumstances

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17 SOP 090 at 3.2.7.
18 SOP 090 at 3.2.8.
19 SOP 090 at 3.3.2.
20 SOP 090 at 3.3.5.
21 SOP 090 at 3.5.7.
22 SOP 090 at 3.7.2
23 SOP 090 at 3.7.4.
24 SOP 090 at 3.7.7 to 3.7.9.

- following the raising of a Notification of Concern, an Initial Response Plan (**IRP**) is completed which provides option for officers to consider in relation to a prisoner's placement suitability, observation requirements and other needs.

210. The department submitted:

> The IRP is based on individual prisoner circumstances and as such, does not guarantee that any particular measures will be considered necessary or implemented. At the time of Mr Morrison's admission, two independent assessments both concluded that additional measures were not required and that Mr Morrison was not at increased risk of suicide and self-harm. Should a NOC have been raised correctly, the subsequent IRP would have defined Mr Morrison's ongoing management. Based on SAPOL transfer documents, the South Australia Prison Health Services (SAPHS) assessment and the Department's own assessment; as well as liaison between SAPHS and the Admissions Officer, it is unlikely that increased monitoring or measures would have been considered necessary or implemented.

211. I accept that in the event that a Notification of Concern had been raised, it is possible that, in the circumstances, it would have been determined that no further monitoring or measures would have been considered necessary. From this vantage point, it is only possible to speculate what difference such an assessment would have made. That does not, however, change my view that, as acknowledged by the department, a Notification of Concern should have been raised.

212. The department has provided me with its revised Stress Screening Form (**the Revised Stress Screening Form**) and SOP 090 (**the Revised SOP 090**).

The Revised Stress Screening Form

213. Questions 21, 22 and 23 on the Stress Screening Form in place at the time of Mr Morrison's induction were:

> 21. Have you thought about deliberately harming yourself since you were arrested?
> 22. Do you feel like that now?
> 23. Have you ever tried to intentionally hurt yourself?
> (if yes, record details below)
> Note: Check the prisoner's wrists, arms and neck for scars.

214. The equivalent of those questions in the Revised Stress Screening Form are (the department's emphasis):

> 19. In the past **five years** have you ever tried to end your own life?
> 20. In the past **five years** have you intentionally harmed yourself?
> 21. Have you thought about harming yourself or ending your life since you were arrested?

215. It is clear that if the Revised Stress Screening Form had been in place at the time of Mr Morrison's induction, a Notification of Concern would only have been required to be raised on the basis that Mr Morrison had thoughts of self-harm since his arrest. His previous suicide attempt would not in itself have required a Notification of Concern to be raised.

216. In my provisional report I expressed concern at the department's changes to the Stress Screening Form, noting that the department had not offered any explanation for the inclusion of the five year limit.

217. In response to my provisional report, the department provided the following explanation for the changes:

> In 2014 Dr Henry Pharo prepared a discussion paper on the use of the Prisoner Stress Screening Form within the Department for Correctional Services.[25] This comprehensive review of the PSSF recommended changes to ensure Departmental practice aligned with best-practice as identified in academic literature. The academic literature (Konrad et al[26], Humbera et al[27], Mills and Kroner[28]) identified that recent episodes of self-harm were especially relevant in assessing current risk, The World Health Organisation (WHO)[29] also noted that a risk assessment should place specific emphasis on incidences of suicidal behavior within the previous one or two years. To ensure a conservative approach, the Department determined that a focus on incidences over the previous five years should be introduced in the PSSF. The Department endorsed this paper for further consultation on 25 July 2014.
>
> As a result of this work the PSSF now assesses:
>
> - Any historical self-harm or suicidal intent (long term history) through questions 16, 17 and 18.
> - More recent self-harm or suicidal intent (in the past five years) through questions 19, 20 and 21.
>
> A statistical analysis was also undertaken by qualified psychologists to determine the most appropriate cut-off score for the revised PSSF. The analysis demonstrated that the revised form is significantly better at both correctly identifying prisoners at risk of self-harm and differentiating between prisoners who are and are not at risk. It is the Department's view that, should all prisoners who have ever self-harmed or attempted suicide be subject to the same level of monitoring as those who are assessed as having a high current risk, there would be an increased risk of self-harm and suicide incidents in prison. The Department manages its current resources to ensure that clinicians are able to prioritise prisoners demonstrating genuine and current risk of self-harm.

218. The department has also noted that, regardless of the Prisoner Stress Screening Form cut-off score and questions in relation to self-harm and suicide, a Notification of Concern may be raised at any time when the interviewing officer feels the prisoner requires further assessment or monitoring.

219. Regardless, I consider that the changes are inappropriate.

220. It is not clear to me how increased monitoring of prisoners would in itself increase the risk of self-harm and suicide.

221. Regardless, as indicated earlier, the requirement to raise a mandatory Notification of Concern goes some way to addressing the department's obligations to properly manage the unfortunately high risk of suicide to Aboriginal prisoners as identified in the RCIADIC Report. The RCIADIC report makes no distinction between recent and less recent suicide history and generally highlighted the importance of identifying any previous attempts or threats to commit self-injury:

> …The evidence before the Commission clearly established that any person who makes an attempt to commit an act of self-harm or who threatens to do so should be presumed to be at risk.[30]

222. In light of the department's important obligations to Aboriginal prisoners (and the department's obligations to protect all prisoners), it remains unclear to me why a history of suicide attempts beyond five years would not necessitate a mandatory Notification of

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25 Prisoner Stress Screening Form used within the Department for Correctional Services SA – A Discussion Paper July 2014.
26 Konrad, N., M.S,, Daniel, A.E., Dear, G.E., Frottier, PI, Hayes, L.M., Kerkhof, AI, Liebling, A., & Sarchiapone, M. (2007).Preventing suicide in Prisons, Part 1.[the department's reference]
27 Humbera, N., Hayesa, A., Seniora, J., Fahyb, T., & Shaw, J. (2011). Identifying, monitoring and managing prisoners at risk of self-harm/suicide.[the department's reference]
28 Mills.J.F., & Kroner D.G (2005). Screening for suicide risk factors in prison inmates [the department's reference]
29 World Health Organization. Mental and Behavioural Disorders Team . (2000). Preventing suicide: a resource for prison officers.Geneva: World Health Organization. [the department's reference]
30 At 24.3.96.

Concern. It is unclear to me why a person who has attempted suicide in the last six years, say, is any less at risk than a person who has attempted suicide in the last five years. I note that while the World Health Organisation (WHO) emphasised that a history of suicide attempts in the last one to two years places prisoners at particularly high risk, I do not understand the WHO to be suggesting that a particular time limit for screening is necessary or appropriate.[31] The distinction appears arbitrary. In my view, the department has watered down its obligations in relation to high risk prisoners (including its particular obligations to Aboriginal prisoners).

223. In light of my views, I consider it necessary to make a recommendation that the department remove the five year limit from the Stress Screening Form.

The Revised SOP 090

224. SOP 090 has been extensively revised to address a number of matters. For the purpose of this report, I have focussed on those matters most relevant to this investigation.

225. In particular, I note that the Revised SOP 090 now specifically addresses the induction process as follows:

> **3.2 CORRECTIONAL OFFICER RESPONSIBILITIES – ADMISSIONS**
>
> 3.2.1 When a person is admitted to prison, the Admissions Officer will review all documentation available at that time, including SAPOL reports, that may identify any suicide or self-harm risk factors.
> 3.2.2 All SAPOL and DCS warnings should be used in conjunction with other available sources of information to make an informed decision about the prisoner's level of risk and other appropriate actions to be implemented.
> 3.2.3 When reviewing the SAPOL Detainee Transfer Report (DTR), the Admissions Officer will pay particular attention to the 'Welfare Information' and 'Risk Assessment' sections. This should be considered by the Officer to assess for potential risk factors.
> 3.2.4 The Admissions Officer is to complete the Prisoner Stress Screening Form F001/003 or the Prisoner Stress Screening Form – On Transfer (F001/003b) in accordance with SOP 001A Custodial – Admission – Case Management.
> 3.2.5 The Admissions Officer will use information gained from the admission process (in accordance with SOP 001A Custodial – Admission) to identify any concerns about the prisoner being 'at risk', and will verbally notify the Responsible Officer and complete a NOC if necessary.
> 3.2.6 If a current HRAT prisoner is transferred to another prison, a NOC must be raised by the receiving prison to ensure an updated IRP is completed and implemented.
> 3.2.7 When a prisoner is admitted or transferred to prison with prior JIS Warning Flags for suicide, self-harm or HRAT, an electronic automated message is sent to the HRAT DL at the admitting institution. This automatic email does not constitute an automatic NOV and does not automatically require the prisoner to be placed on a NOC, although it should be taken into consideration. The Prisoner Stress Screening Form(F001/003) or Prisoner Stress Screening Form – On Transfer (F001/003b), and assessment process will determine whether a NOC is to be raised.
> 3.2.8 Appendix 1 – Information and Characteristics of Self-Harm and Suicide (A090/001) provides further guidance to staff in making a determination about a prisoner's 'at risk' status.

226. Appendix 1 to Revised SOP 090 states:

> While it is not possible to determine an accurate profile of a prisoner who will, or will not, attempt suicide or self-harm, the following risk factors have been identified as indicating

[31] At page 5.

an increased risk of suicide or self-harm. Any presentation causing DCS, SAPHS staff or any other third party (e.g. family, Courts, SAPOL, G4S), concern about the prisoner's wellbeing should be addressed as soon as possible.

227. Appendix 1 lists a number of potential risk factors which relevantly include:

- First time and first week of imprisonment
- Isolation and dislocation from family. Aboriginal and Torres Strait Islander prisoners often experience greater dislocation from family.
- Previous attempts of self-harm or suicide; both within and outside prison

…

- Family history of suicide; particularly by a close relative, partner or child.

228. Revised SOP 090 also includes the following in relation to admission:

> A prisoner is to be considered 'at risk' and a NOC must be completed if:
> a) A prisoner on admission:
> - returns a score on the Prisoner Stress Screening Form (F001/003) that requires a NOC to be raised; or
> - answers 'yes' to any critical items on the Prisoner Stress Screening Form (F001/003)
> - was identified by SAPOL as being at recent (within the last 7 days) risk of suicide or self-harm (e.g. through the SAPOL DTR)…

229. While I address proposed minor amendments to the wording below, I commend the department on its amendments to SOP 090 concerning the admissions process, particularly the requirements in clauses 3.2.1 to 3.2.3.

230. That said, I consider that it would be useful if the Revised Stress Screening Form and Revised SOP 090 provided additional guidance as to the exercise of the residual discretion. In that regard, I consider that there should be specific reference to the potential risk factors identified in Appendix 1. My concern is to ensure that officers generally turn their mind to their discretion in every situation, rather than just applying a 'tick box' approach to determining whether a Notification of Concern should be raised.

231. For example, on the current procedure, a young Aboriginal prisoner with a family history of suicide (but no attempted suicide history of their own), who is in custody for the first time, would not, without more, be the subject of a mandatory Notification of Concern. In my view, it is highly possible that such a prisoner should appropriately be assessed as being at risk and managed accordingly. While I appreciate that such a decision may appropriately be the subject of an officer's discretion, it is essential that such a discretion is, in fact, exercised appropriately based on all of the relevant circumstances.

232. That said, for the reasons set out earlier in this report, my view is that if that same prisoner had their own history of attempted suicide, whether within five years or not, they should be the subject of a mandatory Notification of Concern.

Discretionary Notifications of Concern

233. In my provisional report, I foreshadowed a recommendation that clause 3.3.3 of Revised SOP 090 be amended to include the option of a discretionary Notification of Concern to be completed including suitable guidance as to the exercise of that discretion.

234. In response to my provisional report, the department responded that it would not be appropriate to include the option for a discretionary Notification of Concern in clause 3.3.3 of SOP 090, given the mandatory minimum requirement in clause 3.3.1 to raise a

Notification of Concern where a correctional officer becomes aware of a prisoner 'at risk' or observes the behaviour or presentation of a prisoner as indicating an increase in risk of suicide or self-harm.

235. The department has pointed out that discretionary Notifications of Concern are provided for at question 4 of the Prisoner Stress Screening Form:

> 4. Regardless of the score, the interviewing officer feels the prisoner requires further assessment or monitoring by the High Risk Assessment Team.

236. In my view, question 4 allows for a broader discretion than clause 3.3.1 of SOP 090. In those circumstances, it would be useful to have the wording of question 4 reflected in SOP 090 to ensure that SOP 090 is not read as an exhaustive list of the circumstances in which a Notification of Concern must or can be raised.

Ms Andersen's suggested recommendations

237. In response to my provisional report, Ms Andersen asked that I make the following additional recommendations:
    1. that at each reception assessment for all prisoners (whether entering into custody on remand or for sentence) a full mental health review be conducted by a Mental Health Nurse, immediately after the intake assessment or within one hour of entering custody. In the case of an Aboriginal prisoner and Aboriginal Mental Health nurse shall undertake the review
    2. that a warning system be developed whereby the custodial history of actual (and threatened) self-harm and suicide attempts are automatically and always electronically visible to officers and health workers within the prison and youth detention systems
    3. that, subject to appropriate privacy measures, a procedure be developed for sharing information about a prisoner's significant mental and medical health risks (e.g. coronary issues and asthma but not personal matters) across services, particularly between Community Health Services and prisons
    4. that prison staff receive training and regular refresher courses to ensure they are able to identify all 'at risk' factors and that the department develops an organizational culture to keep 'at risk' prisoners safe.

238. In my view, the department should carefully consider all of the recommendations proposed by Ms Andersen.

239. That said, I consider that any formal recommendations I make should have a reasonable nexus to the relevant administrative error I have identified and be capable of clear and quantifiable implementation.

240. I consider that Ms Andersen's proposed recommendation 1. and 3. are beyond the scope of the error and I do not propose to make recommendations in that regard.

241. I have adopted Ms Andersen's recommendation 2 and 4 (in amended form).

Opinion

In light of the above, my view is that by failing to follow up on issues identified at Mr Morrison's admission to Yatala, in particular by failing to raise a Notification of Concern or otherwise treat Mr Morrison as an 'at risk' prisoner, the department acted in a manner that was wrong for the purposes of section 25(1)(g) of the Ombudsman Act.

To remedy this error, I recommend under section 25(2) of the Ombudsman Act that the department:

Recommendation 1

Apologise to Mr Morrison's family for failing to appropriately identify Mr Morrison as an 'at risk' prisoner and to monitor and review his welfare accordingly

Recommendation 2

Amend the Revised Stress Screening Form to:

- Delete the words 'in the past five years' from questions 19 and 20
- Provide suitable guidance as to the exercise of the discretion to raise a Notification of Concern in circumstances including but not limited to specific reference to the potential suicide risk factors identified in Appendix 1 of Revised SOP 090

Recommendation 3

Amend clause 3.3.3 of Revised SOP 090 to include the option of a discretionary Notification of Concern to be completed including suitable guidance as to the exercise of that discretion as set out in Recommendation 2

Recommendation 4

Amend clause 3.2.5 of Revised SOP 090 to replace the words 'if necessary' to 'as required'.

Recommendation 5

Develop a warning system whereby a prisoner's history of actual (and threatened) self-harm and suicide attempts is electronically flagged at all times

Recommendation 6

Organise a program of training and regular refresher courses to ensure prison staff are able to identify 'at risk' factors for prisoners

The department has provided detailed submissions on each of my foreshadowed recommendations.

I am pleased to note that the department has indicated that it accepts all of my recommendations relating to an apology to Ms Andersen (which includes Recommendation 1).

In relation to Recommendation 2, the department stated:

> The Department will initiate a further independent clinical and evidence-base review of the Stress Screening Form to inform the predictive validity of the changes you have recommended. This review will also consider the cultural impact of the screening tool. This will ensure we are incorporating both clinical evidence and a cultural lens over the decision to initiate the change.

The department has accepted Recommendations 3 and 4, and Recommendation 4 has been complied with.[32]

In relation to Recommendation 5, the department has explained that it currently has two warning flags on JIS, one for prisoners who are, or have been previously, subject to management through SOP 90 and the HRAT. The department provided details of that process. The department has explained that the suicide/self-harm warning flag is not automatically raised where a prisoner has a history of suicide and/or self-harm in the community, though this option is available to the HRAT Chair. The department stated:

> In considering this recommendation and to inform this response I have sought expert clinical advice from senior directors and clinicians within the Department. I have considered the advice provided and the extensive clinical evidence within the paper prepared by Dr Henry Pharo, of which you have a copy. I note your recommendation, I am of the view that the proposed change could be over-inclusive and therefore reduce the clinical and risk management utility of the warning system. I am considering including the current warning system in the terms of reference for the independent review that the Department will commission (referenced in response to recommendation 2).
>
> I can advise that if there is best practice and clinical evidence that supports a change to how the current warning system works, it will be further considered.

Subject to provision of further detail, I have no issue with the department's proposed approach. I note the department's concern about over-inclusivity potentially reducing utility. That said, this investigation has highlighted a potential gap where notifications of concern are not raised and matters not brought to HRAT's attention.

In relation to Recommendation 6, the department concurred that training and regular refresher courses are important. The department provided a detailed outline of its current processes (including recent changes) which include:

- mandatory suicide and self-harm training, and SOP 090 training, and refreshers
- delivery of the internationally recognised Connecting with People training, a suicide and self-harm mitigation and prevention course for both clinical and non-clinical staff
- delivery of Aboriginal Mental Health training to relevant staff.

While I still consider it appropriate to include Recommendation 6, I acknowledge that it appears that the department has already taken significant steps towards compliance.

[32] The department also considers that Recommendation 3 has been complied with and I will discuss that issue further with the department in monitoring implementation of all recommendations.

Whether the department had appropriate processes in place to identify a prisoner as being Aboriginal or Torres Strait Islander to ensure compliance with Standard Operating Procedure 001A

242. The department has acknowledged that during the induction process, Mr Morrison was not identified as an Aboriginal person. Consequently, the department did not apply clause 3.9 of SOP 001A to Mr Morrison during the admission process.

243. In my view, it is particularly important that a prisoner's Aboriginal identity is established as soon as possible upon admission to prison. In response to my provisional report, the department accepted that view. According to the RCIADIC Report, the greatest specific risk for Aboriginal people in custody is self-harmful behaviour.[33] The RCIADIC Report highlights a number of factors which may be precipitative of suicidal behaviour:

> In summary, there are a complexity of factors which may be precipitative of suicidal behaviour. The cases investigated have highlighted a number of factors which appear to be significant but which have not been reflected in the past in either custodial officers training or in police and prison practices and procedures [..]. These are:
>
> - Intoxication, including alcohol withdrawal
>
> - Anger, aggression and emotional distress
>
> - Mental disorder
>
> - Previous attempts or threats to commit self-harm
>
> - Age and gender (younger adult males appear to be the most vulnerable).
>
> - Time. The Research Unit found that the majority of suicides occurred within the first three hours of admission to custody. Method of self-harm. The most common method is hanging. Other situational factors, for instance loss of job, family disagreements and isolation in custody.
>
> - There may not necessarily be any outward signs of depression.
>
> While not discussed in this chapter, the literature identifies first-time prisoners, those prisoners whose offences involve violent crime, for example domestic murders and prisoners who face long sentences. Sexual offenders may possibly also be included in this category.
>
> Another area of great risk for Aboriginal people in custody relates to the failure, by health care workers and custodial authorities, to recognise or anticipate treatable life-threatening conditions. [original footnotes deleted].

244. The RCIADIC Report also highlights the importance of Aboriginal prisoners having access to the types of service provided by ALOs:

> 25.5.1 It is apparent that the circumstances of imprisonment, most particularly the trauma associated with trial, sentence and incarceration, results in the need for extensive welfare support and assistance amongst Aboriginal prisoners in particular. The evidence presented to the Commission indicates that those welfare needs are best met by Aboriginal people themselves. In his report of the inquiry into the death of Kingsley Dixon, Commissioner Muirhead noted support from the South Australian Government for such a proposition, while recognising the claim of the Executive

[33] At 23.5.7.

> Director of the State's Department of Corrective Services, that the department has encountered difficulties in recruiting Aboriginal people to work in the department. In its submission to the Commission, the QCSC referred to the success of having Aboriginal elders at Townsville Prison provide counselling to distressed Aboriginal inmates. The submission refers to the opinion of prison managers in that State that elders 'have undoubtedly contributed to the prevention of some suicides of Aboriginal inmates'. The submission of the National Aboriginal and Islander Legal Services Secretariat (NAILSS) containing the results of a survey of Aboriginal prisoners in Western Australia has argued that, on the basis of the survey, `it is quite clear that prisoners overwhelmingly desire that the person they deal with [for welfare and parole matters] be an Aboriginal person'. The submission also indicates a considerable degree of dissatisfaction amongst Aboriginal prisoners with prison welfare services in that State, and reports that almost 50% of those surveyed would see the services of stress counsellors as being helpful or very helpful. The majority of prisoners who expressed a view on the matter desired that such counsellors be Aboriginal.
>
> 25.5.2 The value of Aboriginal people providing welfare services to Aboriginal prisoners is associated with their (perceived) sensitivity toward Aboriginal prisoners and their ability to identify with Aboriginal problems. Moreover, it appears that Aboriginal people are more able, or are perceived by prisoners to be more likely, to facilitate communication with friends, family, institutions and agencies outside of prison. The New South Wales AIU has reported that Aboriginal prisoners in country prisons in that State regard Aboriginal welfare officers as one of their major links to the outside world. It was in this context that the Sansbury Association submitted to the Minister in South Australia that an Aboriginal liaison officer, employed by the then Department of Aboriginal Affairs, should work at each correctional institution in order to assist Aboriginal prisoner communication with those outside the prison. While the Minister conceded that the proposal had 'merit' he argued that 'it would be seen as an inefficient use of scarce government resources'
>
> 25.5.3 The abolition of Aboriginal welfare officers in Western Australia has apparently exacerbated the problem of meeting the welfare needs of Aboriginal prisoners in that State. While the abolition of that service was the result of the introduction of a Unit Management regime whereby mainstream correctional officers have greater welfare service responsibilities, the existence of specialist Aboriginal welfare officers is not incompatible with Unit Management. Commissioner Dodson and Commissioner O'Dea are strongly of the view that Aboriginal welfare officers should be re-established in Western Australian prisons. Commissioner Wootten is strongly supportive of Aboriginal welfare officers in New South Wales.[original footnotes deleted]

245. While Ms Rule specifically requested that an ALO visit Mr Morrison, unfortunately, this never occurred. While I accept [the ALO]'s explanation as to why he did not personally visit Mr Morrison during his time in custody, it does not appear that any consideration was given to another ALO contacting him. I do not intend to attribute any particular fault to [the ALO] as an individual. It is clear that the ALO resources are limited, an issue which I discuss later in this report. Instead, my view is that the department's system failed Mr Morrison in that it failed to give any special attention to the risks or needs of Mr Morrison as an Aboriginal person during the admission process.

246. In my view, Mr Morrison's Aboriginal identity should have been established when Mr Morrison was first inducted into Yatala.

247. The Specific Needs Assessment form includes question 4:

> Are you Aboriginal or Torres Strait Islander or both? Yes □No□
> If Yes, referral made to ALO? Yes□ No□

In my view, it is essential that that question is asked and the answer recorded. Relying on a visual assessment alone is clearly inappropriate.

248. In that regard, I note that Officer [redacted] told the department's investigation that he 'would have' asked Mr Morrison whether he was an Aboriginal person (accepting also that Officer [redacted] recollection would have been significantly impacted by the passage of time). As pages 1 and 2 of the Specific Needs Assessment form have not been retained,[34] it is impossible to know whether Officer [redacted] evidence is correct.

249. In response to my provisional report, the department stated:

> The fact that [the ALO] changed the JIS entry to read Aboriginal corroborates the fact that the admitting Correctional Officer [redacted] did not record Mr Morrison's cultural group as Aboriginal at the time of his admission, however it does not advance an understanding as to whether [redacted] asked Mr Morrison whether he was Aboriginal or not.
>
> The Deputy State Coroner received evidence that the process of selecting the appropriate response to a question concerning a new admittee's ethnicity involves navigating a drop down menu that lists several nationalities as well as Aboriginal and Torres Strait Islander. The Deputy State Coroner was informed that operator error when making a selection from the drop down list is not uncommon. Therefore, the possibility that [redacted] posed the question to Mr Morrison and that he responded by disclosing his Aboriginal heritage did in fact occur, and that [redacted] inadvertently "clicked" on the wrong item in the drop down menu. [redacted] evidence before the State Coroner remains part heard.

250. I also note the comments from Ms Andersen and Ms Rule as to the likelihood of Mr Morrison self-identifying as an Aboriginal person. Both Ms Andersen and Ms Rule made the point that Mr Morrison's Aboriginal identity was important to him. That said, Ms Andersen also acknowledged that Mr Morrison may have had concerns about his treatment in prison if he had been identified as an Aboriginal person.

251. While I consider it a possibility that Officer [redacted] neglected to ask Mr Morrison whether he was Aboriginal, ultimately, I am unable to conclude with any certainty whether Mr Morrison was specifically asked that question, and, if so, what Mr Morrison's response to that question was. I accept the possibility that the question was asked by Officer [redacted] and the possibility of user error. Unfortunately, there is no way of determining that issue on the basis of the records provided to my investigation. That in itself is a cause for serious concern which I comment on further at the end of this report.

252. I further note that SAPHS identified Mr Morrison as an Aboriginal person, however, no change to JIS was recorded at that stage to reflect that fact. This is despite the fact that the Joint Systems Protocol provides that the department must ensure that SAPHS's Prisoner Health Information Sheet is placed into a prisoner's Case Management file and a case note recorded on JIS regarding any potential issues. It appears from the department's investigation[35] that this process has never been implemented after concerns were raised by nursing staff. A further proposed two tier system for sharing information was not implemented after concerns were raised by correctional officers.

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[34] In response to my provisional report, the department provided the following explanation for the failure to retain pages 1 and 2 of Form F001/002:

> The effect of the evidence presented to the Deputy State Coroner is that the information recorded on pages 1 and 2 of Form F001/002 Specific Needs Assessment, including the enquiry as to the cultural group of a new admittee, has been reproduced in electronic form on the JIS database since approximately 2013. The prospect of an electronic version of the Specific Needs Assessment was alluded to in the Department's investigating officers report (refer page 13 of the investigation report).
>
> It would seem that an electronic version of substantially the same questions contained on the first two pages of Form F001/002 explains the inability of the DCS investigator to produce a hard copy of the two pages from Form F001/002.

[35] The Muller Report at p. 33

253. If the Prisoner Health Information Sheet had been properly considered by the department's officer, the fact that Mr Morrison was Aboriginal should have been detected at that stage, JIS amended and implementation of clause 3.9 of SOP 001A commenced. I note that [the ALO] told my investigation that:

> From the perspective of the ALO's role, I think it would be helpful for any personal information concerning a prisoner's culture obtained by SA Police or the Prison Health Service to be made available for uploading to the JIS as well.

254. While SAPHS is not the subject of this investigation, I note with concern that SAPHS had an obligation to 'liaise with, or refer….Aboriginal prisoners to ALOs and Indigenous specific special care services'. That did not occur in this instance. I intend to raise this issue separately with SAPHS.

255. While I appreciate that [the ALO] and other ALOs make genuine efforts to cross check the information recorded on JIS, it is clear that that system is an inexact one and not as reliable as it could be. In that regard, I note that while [the ALO] observed that Morrison was a common Aboriginal surname, he assumed that Mr Morrison was not an Aboriginal prisoner as he had not been recorded as such. This calls into question the efficacy of checking the new admissions list if it is assumed that a person with a common Aboriginal surname is not Aboriginal on the basis that they have not been recorded as such.

256. I consider that the failure to identify Mr Morrison as an Aboriginal person was a particularly serious error. It had significant consequences, in that no special attention was given to his needs as an Aboriginal prisoner. It was Mr Morrison's first time in custody, and his family had serious concerns about his welfare. It is likely that Mr Morrison would have benefited from contact with an ALO. I can only speculate the extent to which the incident preceding Mr Morrison's death could have been avoided if he had received appropriate support. It is a matter of great concern that his needs as an Aboriginal prisoner were never addressed.

257. I note that the department has advised that regular random audits are occurring to ensure that all Aboriginal prisoners are identified upon admission and that:

> The Department is also reviewing admission and induction processes to ensure additional checks are completed and initial personal demographic information is collected.

258. While I commend those steps, I have considered the amendments which the department has made to various forms since the incident but do not consider that those amendments have addressed this issue.

259. I accept that a prisoner may have reservations about disclosing their Aboriginal identity when first admitted to prison for the reasons identified by Mr Morrison's family. That said, it is important that information concerning that issue, provided by other agencies such as SAPOL and SAPHS, is properly captured by the department to ensure that clause 3.9 of SOP 001A is applied and access to ALOs made available.

260. In response to my provisional report, the department stated:

> The Department is presently planning a comprehensive review of the SOP 001 suite of procedures. This review, which is scheduled to commence in 2019, will take into consideration your views and recommendations in relation to the identification of Aboriginal and Torres Strait Islander prisoners. An interim evaluation of SOP 001A Custodial Admission Case Management and audit of the admissions process has identified some omissions in data recording. As a process improvement, amendments will be incorporated into the Operational Compliance Framework and the SOP to ensure ongoing compliance and cross checking of information.

261. Ms Andersen proposed the following further recommendation in response to my provisional report:

> [T]hat the department must implement policies and procedures to ensure there is a comprehensive health handover between South Australian Police Force and South Australian Corrective Services. This includes but is not limited to all records and observations pertaining to the prisoner's ethnicity and health matters. It should include a standardised handover form from police or escort services to the prison service.

262. To the extent that the issues raised by Ms Andersen are not yet covered by the Joint Systems Protocol, I expect that the department will consider them as part of the review identified at Recommendation 7.

263. Ms Andersen subsequently proposed the following in response to my draft final report:

> There is about 20% of the male prison [population in South Australia] who are Aboriginal and having only one liaison officer is insufficient to deal with all their problems at Yatala. Further, it is disappointing to the family of Mr Morrison that the identifying of Aboriginal prisoners is done solely on the intake – at the very least notices should go up at the prisons or should be distributed to every prisoner which includes information about contacting the ALO if a person slips through the intake form procedure.

264. I sought the views of the department in relation to that proposed recommendation and have addressed it in Recommendation 9 below.

Opinion

In light of the above, my view is that by failing to have proper processes in place to identify Mr Morrison as an Aboriginal person, the department acted in a manner that was wrong for the purposes of section 25(1)(g) of the Ombudsman Act.

To remedy this error, I recommend under section 25(2) of the Ombudsman Act that the department:

Recommendation 7

Review its processes to ensure that information concerning Aboriginal identity in SAPOL Transfer Reports (including apprehension reports), SAPHS documents, and documents from any other relevant agencies are cross-checked against information recorded on induction concerning a prisoner's Aboriginal or Torres Strait Islander identity.

Recommendation 8

Report to me on any further improvements made to the department's processes to ensure that Aboriginal prisoners are identified as early as possible in the induction process and access to ALOs provided.

Recommendation 9

Take steps to ensure that the ALO service is publicised in all prisons by way of posters and information provided to prisoners upon induction.

The department provided a detailed response to my proposed Recommendations 7 and 8 which acknowledged the importance of establishing whether a prisoner is Aboriginal as soon as possible upon admission, expressed support for my recommendations.

The department's response noted that:

- the department is undertaking a comprehensive review of case management procedures which will have regard to my views
- the department has been funded to implement a new offender management system, to support integrated end to end case management
- a key objective of the new offender management system will be to improve access to information to support safer decision making and improve data and information sharing across agencies.

In relation to Recommendation 8, the department stated:

> DCS provide ALOs for the assistance, advocacy and support of Aboriginal prisoners to ensure that their individual needs are being met whilst in custody. The Director, Aboriginal Service Unit (ASU) has confirmed that correctional officers are making referrals to ALOs when Aboriginal prisoners are being admitted, especially if prisoners are deemed high risk. Dependant on need and complexity either an ALO or ASU member of staff responds to the referral, To provide further assurance ASU remains committed to undertaking audits as referred to in paragraph 48 of your report. These audits require site visits and access to unit accommodation to physically sight prisoners. Due to COVID-19 restrictions audits have not been completed for a period but will recommence as soon as possible.
>
> DCS works collaboratively with Aboriginal Legal Rights Movement (ALRM). This partnership has been formalised with the signing of a MoU. DCS values its partnership and the services ALRM provide to Aboriginal prisoners and offenders.
>
> The Aboriginal Visitors Scheme (AVS) was in operation at the Adelaide Remand Centre (ARC) through a DCS funded granted during 2019. AVS assists by providing welfare checks to newly admitted Aboriginal prisoners, follow up with bail addresses and families to alleviate any stressors about their loved ones being incarcerated, and the AVS also provides opportunity for prisoners to link with legal services. The contract with SERCO, who now manage the ARC, requires the AVS program to operate, and I can advise that SERCO will continue this program.
>
> Since late 2019 the ARC has become the primary reception prison for all new admission in the metropolitan area, this service is an important initiative in the provision of support to those newly admitted. The ARC has an Induction Handbook which is provided to prisoners and for Aboriginal prisoners the following services are referenced as available [:] ALOs, ALRM, AVS and the Aboriginal Elders Visitor Program (AEVP).
>
> Through DCS grant funding, the AVS is to be piloted at the Adelaide Women's Prison (AWP) to also offer this support for that cohort of prisoners.

The department also expressed support for Recommendation 9, and is already exploring ways to implement it.

Whether the department took appropriate steps to respond to concerns raised by Mr Morrison's family before the incident preceding his death

265. While it clearly would have been beneficial if [the ALO] (or another ALO) had been able to visit Mr Morrison as soon as Ms Rule raised her concerns about Mr Morrison's welfare, I note that at the relevant time there were only two ALO's based at Yatala. I also note that there was a relatively short time frame between [the ALO] being notified and Mr Morrison being transferred to the Holden Hill police cells.

266. I have no reason to doubt [the ALO]'s evidence that:
    - he intended to visit Mr Morrison within 48 hours of being notified by Ms Rule but that he had a high workload dealing with 15 prisoners for the HRAT team meeting on the Thursday morning
    - Mr Morrison was transferred to the Holden Hill cells on the Thursday afternoon.

267. It concerns me that [the ALO] also stated:

> Thursday afternoon the E Division rotunda where the interviews are done is used for mainstream prisoner interviews only.

I simply comment that this in itself is not in my view an appropriate reason for a prisoner not being provided access to an ALO, and where circumstances so require, alternative arrangements should be made.

268. [The ALO] responded frankly to my investigation that he did not give consideration to the other ALO, [redacted] visiting Mr Morrison. In my view, [the ALO]'s approach was understandable in the circumstances and I do not criticise him for that response.

269. That said, for future reference, and with the benefit of hindsight, it is concerning that so much seems to have been dependent on an individual (i.e. [the ALO]'s) somewhat limited availability. I query whether further consideration could have been given to another ALO visiting Mr Morrison (whether from within Yatala or elsewhere within the department) particularly given that the family were expressing concerns. In that regard, I note that [the Social Worker]'s email was copied to [redacted]

270. Further, the possibility of an ALO visiting Mr Morrison at the Holden Hill Police Cells could have also been considered.

271. I am also conscious of the fact that Ms Andersen and Ms Rule did not seek to attribute blame to [the ALO] for his failure to visit Mr Morrison before the incident.

272. Ms Andersen did query whether [the ALO] had considered the impact on Mr Morrison of being sent to a single cell at Holden Hill.

273. In all of the circumstances, I do not consider that there is sufficient evidence to conclude that the department's response to Ms Rule's concerns amounted to an administrative error for the purposes of the Ombudsman Act. That said, this issue highlights the importance of prisoners as being appropriately identified as Aboriginal and assessed as high risk, as discussed above. Had Mr Morrison been assessed as high risk, it is likely that visiting Mr Morrison would have assumed greater priority for [the ALO].

274. Ms Andersen's response to my provisional report included:

> Ms Andersen understands that one reason for the failure of the department to have an ALO visit Mr Morrison was their failure to identify Mr Morrison as Aboriginal however they[sic] do not accept the finding that the department did not act in a way that was

> unlawful, unreasonable or wrong in responding to concerns raised by Mr Morrison's family before the incident. In particular, Ms Andersen contends that an opportunity to intervene and identify Mr Morrison's agitated condition was lost when the department failed to respond to the calls and emails of Ms Rule who made two calls to the Aboriginal Liaison Officer and believes that she may have followed up with an email to ask the ALO to check on Mr Morrison's welfare. Ms Andersen makes no personal criticism of any individual, but she believes that if the department had adequately funded the ALO service that prompt action might have ensured that Mr Morrison received appropriate mental health services.

275. In light of those submissions, Ms Andersen sought that I make the following recommendations:
    1. increase culturally appropriate support (Aboriginal Liaison Officers, chaplains, counsellors, social workers) for prisoners who are deemed 'at risk' or who are notified by family members or other prisoners that they might be at risk
    2. increase support (Aboriginal Liaison Officers, chaplains, counsellors, social workers) for all first-time prisoners
    3. institute processes to ensure that all first-time Aboriginal prisoners are seen by a culturally appropriate Aboriginal Liaison Officer, chaplain, counsellor or social worker within 6 hours of being incarcerated
    4. escalate visits by Aboriginal Liaison Officers, chaplains, counsellors, social workers to prisoners […] where family members, other prisoners or guards express concern about a prisoner's welfare.

276. While I have carefully considered those submissions, my view remains that the department did not make an administrative error in relation to this issue and on that basis, I do not intend to make any recommendations.

277. Further, I am pleased to note that the department has informed me in response to my provisional report:

> The department has completed an initial recruitment process to provide additional casual ALOs following identification of the limited access Mr Morrison's family had to the ALO's at the time. Two applicants have been identified as suitable and are expected to commence in early 2019.

Opinion

In light of the above, my view is that the department did not act in a way that was unlawful, unreasonable or wrong in responding to concerns raised by Mr Morrison's family before the incident.

Whether the department's decision to transport Mr Morrison to G Division by van was unreasonable or wrong

278. Mr Brown told my investigation on oath that there is an informal practice at Yatala, where a prisoner has been identified for transfer to G Division following a use of force incident, to use a van. This was reiterated in the department's subsequent written response. This practice was followed despite the fact that the distance in Mr Morrison's case was about 25 metres.

279. The department did not initially offer my investigation any explanation for why a van is necessary for such a transfer after a use of force incident, especially where the distance is short. In response to my provisional report, however, the department stated:

> Mr Morrison was restrained following a violent altercation between him and several Correctional Officers. He was non-compliant throughout the restraint. His legs were restrained. In such circumstances the van was deployed to ensure Mr Morrison's security and the safety of the Department's officers. The distance between the holding cells and G Division is not the determining factor. The time it takes to drive from the holding cells to G Division is just over two minutes. G Division is outside the main secure walls of the prison. If a prisoner was walked to G Division there exists the risk that if a further incident occurred, and the prisoner broke away from the escort party, the prisoner then has access to the perimeter fence, to vehicles in the area delivering to the site and to the Gatehouse.

280. I am willing to accept that transport by van in such circumstances is a standard practice, and there could be reasons linked to the good order and security of the prison for doing so. While I queried in my provisional report the necessity of a van in this situation given the relatively short distance, I accept as a general proposition that there may be good reason to use a van regardless of distance. I consider, however, noting the absence of a formal procedure or guidelines, that each situation needs to be assessed on a case by case basis.

281. That said, I consider that it is particularly important that a prisoner's transport after a use of force incident (whether by van or otherwise) is properly recorded to ensure that a prisoner is not subject to unnecessary or unreasonable force. In this particular instance, the department's decision to transport Mr Morrison by van has resulted in Mr Morrison essentially being sequestered during a crucial period following the incident. It was during the van transfer that Mr Morrison was first observed to be unresponsive. Having viewed the video footage of the incident, it is also my understanding that Mr Morrison was subdued by the time of the transport to G Division. If, for whatever reason, he was unable to walk, he should have received immediate medical attention.

282. The fact that the van had no capacity for recording vision is addressed below as a separate issue (noting that the department has taken steps to address the issue of recording vision in vans). In the circumstances, I have carefully weighed whether or not the decision to transfer Mr Morrison by van in itself amounts to an error. On balance, I consider that it does.

283. While I consider that in certain circumstances, transport by van following a use of force incident may be reasonably open to the department, in the circumstances of the present case:
    - where the relevant van had no recording capacity
    - where there was no particular reason why transport by van was necessary, given that Mr Morrison was subdued by the time of transport

    I consider that the decision to transport Mr Morrison by van was unreasonable.

284. Ms Andersen's response to my provisional report included the following proposed recommendations:
    - that the department develop guidelines on the way a prisoner should be restrained within a van and the number of guards travelling with any prisoner […][36]
    - that the department installs 2x CCTV cameras with sound recording capacity in all prison vans: 1 in the driver's cabin and the other in the rear transport cabin. Such CCTV cameras are to be monitored, maintained and reviewed by an external authority
    - that the department report to the Ombudsman on the guidelines and any further improvements made to the department's processes in relation to the transportation of prisoners and the progress of the installation and monitoring of the CCTV and other cameras.

285. While I suggest that the department have regard to all of the issues raised by Ms Andersen, I do not intend to make any formal recommendations in that regard noting that:
    - they arguably are beyond the scope of the error
    - as discussed later in this report, the department has taken steps to improve video recording in vans
    - I am separately recommending the implementation of body-worn cameras.

286. I note at this point that I will request the department to report back to me on implementation of all of my recommendations.

Opinion

In light of the above, my view is that by transporting Mr Morrison to G Division in a van without recording capacity, the department acted in a manner that was unreasonable for the purposes of section 25(1)(a) of the Ombudsman Act.

To remedy this error, I recommend under section 25(2) of the Ombudsman Act that the department:

Recommendation 10

Amend its procedures to:

- clarify the circumstances in which transport of a prisoner by van following a use of force incident is necessary and appropriate, having regard to factors such as:
    - the prisoner's physical and psychological welfare
    - the distance to be travelled
    - the good order and security of the prison
- clearly provide that where a van with recording capacity is not available, the transport must be recorded by hand held camera or alternative means of transport must be arranged, and that transport be appropriately recorded at all times.

The department expressed support for this recommendation, noting that:

[36] I have not included the second proposed recommendation as I consider that it relates to matters outside the scope of this investigation.

- the internal escort van at Yatala is fitted with a CCTV management system and the Local Operating Procedures for Yatala state that where a van with recording capacity is not available, the transport must be recorded by hand-held camera
- there is a schedule in place to ensure that recording capability of all vans is updated.

The department also noted that recording of incidents where use of force is utilised is addressed in SOP 079 'Use of Force' and the requirement for transport vehicle recording is addressed in SOP 031 'Supervised Prisoner Escorts'.

Whether the department's failure to take further steps to ensure that there was video footage vision of Mr Morrison's and correctional officers' actions was unreasonable or wrong

CCTV footage of the incident

287. While I am not investigating the incident itself, I have viewed the CCTV footage that was taken of Mr Morrison's restraint before being placed in the van. Mr Morrison is off camera for some of the duration of that footage. In my view, it is impossible to ascertain with any certainty whether the officers were using reasonable force in restraining Mr Morrison. As stated above, my understanding is that Mr Morrison was subdued by the time he was being transported by van.

288. On the evidence before me, I am unable to draw any inference from the fact that some of the incident occurs off camera. This situation highlights, however, the limitations of CCTV footage and in my view also highlights the need for greater use of bodycams in recording incidents.

289. The department has told my investigation that where there is planned use of force and time permits, hand held cameras are utilised in accordance section 3.8 of the department's SOP 079 – *Use of Force.* I accept that the incident itself was not a planned use of force and in those circumstances it does not appear unreasonable that no hand held cameras were used at that point.

290. That said, the department has noted that once Mr Morrison was under control, the incident became a planned use of force and acknowledged that, at that point, steps should have been taken to record the incident.

291. In response to my provisional report, the department also noted that:
    - the Admissions Area of Yatala was built in 1986 and has been modified and extended over time
    - the Admissions Area is a difficult built environment to manage and it is also problematic to obtain good CCTV coverage in the area
    - the department has to prioritise CCTV resourcing across the state in accordance with risk, need and available budget
    - in the 2018/19 budget, the government approved the construction of a new Admissions area, as well as the conversion of all electronic security infrastructure to a digital platform.

292. In response to my draft final report, Ms Andersen stated:

> The failure to use a hand held camera both in the cell area and in the van are important omissions by the dept as there was a planned use of force and is noteworthy.

293. It is clear from the department's responses to my investigation it supports the implementation of body-worn cameras in principle. Further, the department has undertaken a project to assess the use of body-worn cameras and a request for funding for body-worn cameras was included within the 2017-2018 Budget bid process. According to the department, that bid was not supported by the government at the time. In my view, this is a significant issue that should be pursued and supported by the government as a matter of priority.

Lack of security footage from the van

294. It appears uncontroversial that at some time during the transport of Mr Morrison to G Division, he was observed to be unresponsive.

295. According to the department, no video footage from the van was recorded. Mr Brown explained in his interview that while there was CCTV operating in the van at the time, there was no recording capability. The CCTV was to assist the front seat passenger to observe prisoners in the rear of the van.

296. Since the incident, Ms Bray has issued two Deputy Chief Executive Instructions (**DCEI**), DCEI 18-012 - 'Management of prisoners following a restraint' and DCEI 18-013 – 'Internal/external transporting of restrained prisoners in vehicles'.

297. In my view, DCEI 18-012 is of most relevance to the incident itself, which is not the subject of this investigation. In those circumstances I have limited my consideration to DCEO 18-013.

298. DCEI 18-013 relevantly provides:

> **Prior to vehicle use:**
> Prior to any escort taking place whether an internal or external escort, the vehicle must be checked by the driver to ensure that it is fit for purpose, is roadworthy and that the video recording system is operational and is recording. The pre-drive checklist must be completed at the time the inspection is done.
>
> **Movement to and from an escort vehicle:**
> The prisoner is to be walked to the escort vehicle using approved escort techniques, the prisoner must not be carried.
>
> **Placement in vehicle:**
> When a vehicle is being used to transport a restrained prisoner the prisoner must be seated in the upright position and not be placed in the prone (laying down) position at any time during the transport/escort.
>
> The prisoner is to be seated in the escort vehicle facing outward from the seat. Where installed the seatbelt is to be placed around the prisoner and secured.
>
> If available the prisoner should be secured in a separate cell/section of the escort vehicle away from staff.
>
> If this is not possible then an officer is to be seated either side of the prisoner. Leg restraints may be utilised with the approval of the manager to prevent kicking out.
>
> Tactical communication to be utilised to maintain compliance and monitor prisoner's wellbeing.
>
> **Compliance checks:**
> Vehicle driver:
> Vehicle checks must be undertaken by the driver prior to driving a vehicle utilising the pre-drive checklist for escort vehicles.
>
> **Site management:**
> Management compliance checks of vehicle systems must be undertaken once daily to unsure that the vehicle is operational and all systems including the video recording system are fully operational.
>
> Vehicle video footage must be downloaded and checked weekly to ensure compliance with these directions.

299. The department provided further information in response to my provisional report:
    - in August 2017 a process commenced to trial Digital Video Recorders in all departmental escort vehicles

- in April 2018 a security specialist was engaged to assist in the development of a Functional Brief which included an enhanced security of the system, self-diagnosis of errors or failures; automatic downloading of recorded video
- during May 2018 the Functional Brief was submitted for endorsement and market research identified potential providers to meet the department's specifications
- the department has now completed the trial phase, and, as at December 2018, all prisoner transport vans at Yatala are fitted with the new CCTV management system.

300. The department also advised that Yatala staff have received training in the use of escort vehicles including:
    - current vehicle uses
    - the reasons for implementation of camera recording
    - a step through of the new processes
    - an explanation of the layout of the vehicle and seating arrangements.

301. The transfer to G Division occurred immediately after a serious use of force incident. It is essential that the department's processes in transporting such a prisoner (particularly noting that Mr Morrison had not yet been medically assessed) are properly monitored and that officers are accountable for ensuring that no unreasonable force is used. While I do not draw any such conclusions in the present matter, I consider it reasonable to surmise that a prisoner who is transported in a van without recording capacity is vulnerable to abuse.

302. Further, I query why consideration was not given to using a hand held camera to record Mr Morrison's transport by van, consistent with the department's SOP 079 which provides for recording of a planned use of force.

303. In my view, the failure to record any video footage of Mr Morrison's transport to G Division was a particularly serious error by the department.

304. That said, I commend the department on the steps it has taken to address these issues and the improvements made.

305. In response to my provisional report, Ms Andersen proposed that I recommend that the department implement procedures which enforce a:
    - mandatory requirement that one Corrective Service officer is required to film every stage of a cell extraction, a critical incident or the transport of prisoners with a hand-held video camera with sound recording capability. Corrective services officers must be instructed that the prisoner should be the focus of the recording and efforts made to record the whole of the prisoner's body (especially their face) at all times
    - mandatory procedure that Corrective Service videos are checked fortnightly to ensure any batteries (if any) are charged and there are no technical problems with the cameras or their position
    - requirement that every video and CCTV camera in South Australian prisons is fitted with a time recorder and time stamp, to assist in the chronology of events
    - an independent inspector of South Australian prisons should be employed to keep, control and maintain all video cameras and video footage obtained within South Australian prisons.

306. While I do not consider it necessary to make recommendations in the prescriptive terms suggested by Ms Andersen, noting that the proposed recommendations are partly beyond the scope of the relevant error, I would urge the department to carefully consider Ms Andersen's suggestions.

Opinion

In light of the above my view is that by failing to record meaningful footage of Mr Morrison's restraint by Correctional Officers and transport by van, the department acted in a manner that was wrong for the purpose of section 25(1)(g) of the Ombudsman Act.

While I note the department's submissions in relation to budgetary restraints, to remedy this error, I consider it necessary to include a recommendation under section 25(2) of the Ombudsman Act that the department:

Recommendation 11

Take steps to implement body-worn cameras within all of its prisons

I also recommend that the State Government:

Recommendation 12

Consider allocation of funds to enable implementation of body-worn cameras in all of the State's prisons

The department has acknowledged the utility of body-worn cameras, and noted that they are being piloted at Mt Gambier prison and the ARC. The department also stated that a working group has been established to further scope additional deployment of body-worn cameras across the correctional system.

The department also stated:

> The Department is supportive of utilising technology to increase safety and security. The government's Better Prisons program has committed $159M to further expand YLP, including the construction of a new admissions area, a new master control room and an across site upgrade of security systems. This capital program is scheduled for completion in 2022. Security system upgrades will see all CCTV upgraded to new high-quality IP cameras, with minimum 30 days recording. The new Admissions area will include in the order of 50 cameras providing 100% coverage to all areas, excluding those specifically requiring privacy i.e. showers/toilets/medical rooms. All holding cells and interview rooms will have camera coverage. There is a mix of high-resolution pan-tilt-zoom and fixed cameras in the new upgrade. The new MCR will adopt the latest in video wall technology to display the new cameras, giving more flexibility to the operators. The Digital Electronic Security System being implemented is a significant enhancement of the current system, which will improve the Department's capability to review critical incidents.
>
> Of further relevance to these recommendations is the policy work the department is undertaking with respect to the operation of Master Control Rooms. Policy 55 – Audio and Visual Recording of Control Rooms has been drafted to outline the requirement to record (audio and visual) control room communications. The Department has recently commenced consultation on this policy. This action formed part of the agencies Reducing Risk of Prisoner Self Harm Action Plan that the Department's Incident Review Committee (IRC) oversees.

Whether the department took appropriate steps to communicate with Mr Morrison's family and provided support after the incident preceding his death

The Court hearing

307. Mr Morrison's family was first alerted to the fact that something that had occurred with Mr Morrison when they attended court. At that stage, they were provided with no information other than that Mr Morrison would be unable to appear. It appears from Ms Rule's evidence that the Magistrate was not informed as to the reason for Mr Morrison's absence and was understandably only able to provide limited assistance in that regard.

308. The circumstances of Mr Morrison's non-attendance must have been alarming and distressing for Mr Morrison's family, particularly given that they had previously expressed concerns about Mr Morrison's welfare and were not provided with any information as to the reason for Mr Morrison's absence. Nor were they given any point of contact within the department to find out further information at that stage. While Mr Morrison's family contacted ALRM, at that point ALRM had not been informed as to the reasons for Mr Morrison's non-appearance.

309. As a consequence of all this, Mr Morrison's family were left in the unfortunate position, apparently on advice of ALRM, of having to ring around hospitals in an attempt to find out information. This must have been a particularly frustrating and anxious task, particularly knowing that something was wrong, but without any detail as to the nature of what had occurred or its seriousness, or simply knowing where to start to find out meaningful information.

310. When asked by my investigation whether he considered it reasonable that Mr Morrison's family be put in that position, Mr Brown responded:

> Well, that's a matter for ALRM. I didn't put them in that position and nor did I give them that advice and nor did any officer of the department give them that advice.

311. Mr Brown went on to explain that it was open to the ALRM officer who gave that advice to contact the department through the Elizabeth Community Corrections Staff who had a presence in court. In my view, that is beside the point. The advice provided by ALRM is not in issue. I fail to see why, if ALRM could have sought information from Elizabeth Community Corrections staff, Mr Morrison's family could not have been directed to those staff as a first point of contact by the department. If nothing else, it would have provided Mr Morrison's family reassurance that they would be provided updates from the department in due course, rather than being forced to make their own enquiries.

312. Mr Brown told my investigation that he did not think it would have been appropriate for the family to have been provided with a point of contact at court, noting that 'people don't turn up to court for a range of reasons, so…'.

313. According to the timeline provided by the department, Mr Morrison was due to appear in court at 12.00pm. Sometime between 11.34am and 11.39am Mr Morrison was found to be unresponsive. It should have been clear that, at the time the court was notified of Mr Morrison's non-attendance (according to Ms Andersen this occurred some time after 11.30am) the reason for that non-attendance was due to his serious medical condition.

314. While I agree that it would not be necessary for families of prisoners to be provided with a point of contact at court as a matter of course, in my view, in this situation, the reason for Mr Morrison's non-appearance was that he was in a serious, if not critical, medical condition. It was not a routine procedural matter. The nature of Mr Morrison's physical

condition meant that there was urgency in the family being notified. Families of a critically injured prisoner should be informed of that fact as soon as practicable and given every reasonable opportunity to visit that prisoner as a matter of priority. Clearly, from Mr Morrison's family's perspective, time was of the essence.

315. I also note [the Director]'s comments highlight the significance of family of an Aboriginal prisoner being notified as soon as possible, that there is a belief that being with family can bring a person back from unconsciousness, and the importance of saying goodbyes.

316. In all of the circumstances, I consider that the department erred by failing to provide Mr Morrison's family with a point of contact at Court.

Whether and when the department notified Mr Morrison's family that he had been taken to the RAH

317. There is some divergence in the parties' accounts as to what happened during the afternoon of 23 September 2016. I note the passing of time since the incident and that witnesses are recounting facts arising from a very emotive situation.

318. According to Ms Rule, the only way that Mr Morrison's family found out that he was in intensive care and on life support at the RAH was due to a phone call from someone who wished to remain anonymous.

319. Ms Rule stated that she rang [the ALO] up to four times and that he kept saying that he could not speak, referred to being in a meeting 'with David Brown, and he's the head of Corrections and they are all here, including the staff and we are all having a meeting'. Ms Rule stated that [the ALO] asked who Mr Morrison was related to 'for security purposes'.

320. [The ALO] told my investigation that when he spoke to Ms Rule at approximately 12.30pm on 23 September 2016 she asked him if he could tell her what had happened to Mr Morrison. [The ALO] stated that he did not know but that he hoped someone would get back to her soon. According to [the ALO], Ms Rule told him that Mr Morrison was going to hospital. [The ALO] also stated:

> In relation to Ms Rule's statement to your investigation, my recollection is that I spoke to her on the phone on two occasions on Friday, 23 September 2016. I do not know whether she rang at other times during the day. I have no recollection of speaking to her more than twice.
>
> I did not tell Ms Rule that I was in a meeting with Mr Brown and I did not say that I needed to know who Mr Morrison was related to for security reasons.
>
> I did not attend any internal meetings about Mr Morrison on Friday 23 September 2016. I attended on a prisoner escort to a funeral on the morning of the 23rd. When I returned to Yatala, the prison was in lockdown following the incident involving Mr Morrison. When I first spoke to Ms Rule at approximately 12.30pm all I knew was that there had been an incident involving Mr Morrison. I had no other details.
>
> By the time Ms Rule rang back on Friday afternoon I had been advised by my line Manager [redacted] that no information was to be given to any-one who rang up inquiring about Mr Morrison. [redacted] told me that if anyone rang I should say that I was going into a meeting and that I would call back.

321. Mr Brown told my investigation that he did not recall a meeting with [the ALO] or with a large number of staff.

322. In terms of formally authorised contact with Mr Morrison's family, the department's response to my investigation included [the Director]'s recollection of her involvement after the incident as set out in an email to Mr Brown dated 25 September 2016 (i.e. the following day). According to that information:
    - she was asked to attend Ms Bray's office at 12.50pm, and returned at 1.10pm because Mr Brown and Ms Bray were meeting when she first attended
    - at the 1.10pm meeting, [the Director] was briefed about Mr Morrison's 'medical episode' and was instructed to find Mr Morrison's next of kin
    - [The Director] emphasized the importance of contacting Mr Morrison's family
    - at 1.20pm [the Director] returned to her desk in order to find details of Mr Morrison's next of kin and received a phone call from Ms Rule
    - [The Director] told Ms Rule that due to confidentiality she could not tell her any information but would check who had been named as Mr Morrison's next of kin and make contact with them as soon as she knew something
    - [The Director] then rang Mr Brown to get advice on contacting next of kin and was advised to make contact with the ALO at the RAH as a point of contact and then advise the next of kin accordingly
    - at approximately 1.40pm [the Director] called [the RAH ALO] who confirmed that she was aware of Mr Morrison
    - at approximately 1.50pm [the Director] contacted Ms Andersen to give her [the RAH ALO]'s contact details
    - at approximately 2.30pm [the Director] called [the RAH ALO] to see if she had received a call from Ms Andersen; [the RAH ALO] confirmed that she had, but was not able to provide any details due to a lack of access to Mr Morrison
    - [The Director] then called Mr Brown who arranged access to Mr Morrison for [the RAH ALO] and the Aboriginal Unit Nurse at the RAH
    - at approximately 2.40pm [the Director] left a message for Ms Axelby
    - at approximately 2.45pm [the Director] called Ms Andersen to let her know that the ALO at the RAH was on her way to see Mr Morrison and that Ms Andersen should give them about half an hour before calling
    - [The Director] called [the RAH ALO], and the Aboriginal Unit Nurse answered and said 'they were not happy with the position, and could not provide info to family, the DCS staff will not allow'
    - [The Director] called Mr Brown 'straight away' and Mr Brown stated that he 'would take care of it'
    - At 5.10pm Ms Axelby called [the Director] who informed her of the medical incident involving Mr Morrison
    - At 6pm Ms Axelby rang again seeking that family members of Mr Morrison be added to the list for access
    - At 6.30pm [the Director] called Ms Axelby to inform her that that access had been arranged.

323. Ms Andersen acknowledged that she spoke to [the Director] who said something along the lines of 'as soon I know something I'll let you know'. Ms Andersen's recollection was that [the Director] phoned because she had been 'bugged' by members of Mr Morrison's family.

324. Ms Rule did not recall any mention of hospital by [the Director] and reiterated that the first mention of hospital was during 'the ALRM phone call'. Both Ms Rule and Ms Andersen told my investigation that the family had not received any information from the department before arriving at the RAH.

325. That said, as a relatively contemporaneous document, I have no reason to doubt the reliability of [the Director]'s account.

326. While being mindful of the discrepancies in the parties' accounts, on the assumption that [the Director]'s recollection as set out in her email to Mr Brown is correct, it appears that Mr Morrison's family were provided with [the RAH ALO]'s details at approximately 1.50pm. It is not clear that there was any discussion about hospital at that point, although I accept that there may have been. At the least, presumably the fact that Mr Morrison was in hospital should have been made clear by [the Director] in her phone call to Ms Andersen at approximately 2.45pm.

327. According to the department's records, Mr Morrison was taken to the RAH by ambulance at 12.39pm. It appears that contact was made by [the Director] concerning Mr Morrison's presence in hospital over an hour later. I accept that Mr Morrison's family appear to have already been informed by a third party that Mr Morrison was in hospital by that time. It does not appear, however, that that third party was able to tell them which hospital Mr Morrison was taken to. Further, Ms Andersen and Ms Rule do not specifically recall being notified by the department that Mr Morrison was at the RAH.

328. On the basis of [the Director]'s account, it appears that the family was notified that Mr Morrison was in hospital over an hour after he was taken there. On the other hand, Ms Andersen told SAPOL that the family spent 'the next 5 hours phoning the hospitals and Yatala prison trying to find out what was happening'.

329. It is difficult for me to ascertain the level of detail provided to Mr Morrison's family as to Mr Morrison being taken to the RAH and when that occurred (I address the issue of information provided about more general access to information about Mr Morrison later in this report). I have no reason to doubt that Mr Morrison's family first found out that he was in hospital via a third party, which is most unfortunate. I accept, however, that [the Director] contacted Ms Andersen at 1.50pm and provided the details of the ALO at the RAH. It does not appear, however, that at any stage the department advised Mr Morrison's family that he was in the intensive care unit.

330. With some reservation (having particular regard to the family's distress), in all of the circumstances, I am unable to conclude that the department's delay in informing Mr Morrison's family that he was in hospital at the RAH was unreasonable or wrong. I address the issue of access to information about Mr Morrison's critical condition later in this report.

Support offered to Mr Morrison's family

331. In terms of its dealings with Mr Morrison's family after the incident, the department took the following steps:
    - [the Director] was instructed by Mr Brown to:
        - ascertain Mr Morrison's next of kin apparently for the purposes of informing them that Mr Morrison was critically ill and taken to the RAH (although according to Ms Rule, Mr Morrison's family had to make their own enquiries to establish that Mr Morrison was at the RAH)
        - contact ALRM
        - contact the ALO at the RAH as a point of contact for the family (although the ALO was not initially able to get access to Mr Morrison)
    - Mr Brown organised access for Mr Morrison's family at around 6pm after being requested by ALRM
    - Ms Bray, [the ALO] and another Corrections officer visited Mr Morrison's family in the car park at the RAH at which time Ms Bray expressed that 'she was sorry this has happened' and acknowledged that Mr Morrison was involved in an incident.

332. In my view, the department did not appear to have any structured process in place for offering support to Mr Morrison's family. In the circumstances, I consider it particularly shameful that:

- Mr Morrison's family were directed to the ALO at the RAH without that ALO being able to access information about Mr Morrison's health status – there is no reason why department staff could not have obtained that information and directly relayed it to Mr Morrison's family. Mr Morrison's family must have felt as if they were being given 'the run around', which would only exacerbate an already distressing situation
- it took between five to six hours after the incident before there were approvals in place for Mr Morrison's family to visit him
- no support was offered to Mr Morrison's family in terms of counselling or emotional support. There was a brief conversation in a car park, after Mr Morrison's family had been anxiously searching for information about Mr Morrison for some six hours, knowing that he was critically injured. There does not appear to have been any attempt to organise the use of a private room to meet the family.

333. These issues were compounded by the difficulties faced by Mr Morrison's family in accessing Mr Morrison at the RAH which are discussed later in this report.

334. My overall impression is that the department did not clearly and directly take responsibility for informing Mr Morrison's family of events that occurred while Mr Morrison was in the department's custody, or his whereabouts and health status, relying instead on third parties such as ALRM or RAH staff. That said, I accept that responsibility for providing detailed health information lay with the RAH. My point is that the department could have done more to facilitate access to information and provide support.

335. Of particular concern to me throughout this investigation is that the department appeared to have underestimated its duty to Mr Morrison's family. There does not appear to have been a cohesive strategy for meeting their needs. It was clearly not a priority of [the Prison Manager] and Yatala management, who developed a plan with two main objectives:

> 1. To appropriately manage the significant incident involving Mr Morrison and
> 2. To appropriately manage YLP operations.
>
> In his management of these objectives, [the Prison Manager] took the following factors into account:-
> 1. Raised anxiety among staff
> 2. Loss of staff
> 3. Risks around prisoner management
> 4. Media attention
> 5. Loss (or restriction) of operational areas due to the incident (i.e. Holding Cells).[37]

336. There appears to have been no consideration of Mr Morrison's family in developing that plan. I consider that appropriately and sensitively dealing with Mr Morrison's family should have been another main objective to be considered as part of any plan.

337. Responsibility for communicating with Mr Morrison's family was left to [the Director], with assistance from ALRM. In my view, while noting that Ms Bray offered an apology in the RAH car park, there should have been more formal contact from the department at the highest level, oversight, and follow up on the department's dealing with the family. It appears that the department was not sufficiently prepared for this situation. I accept also that Mr Morrison's family understandably interpreted the department's poor communication with suspicion.

[37] The Muller Report at p.83.

338. The department does not have a policy that addresses how to deal with a prisoner's family when the prisoner dies or is critically injured while in custody. Mr Brown told my investigation that in relation to Aboriginal and Torres Strait Islander prisoners:

> We seek to work with the Aboriginal Legal Rights Movement and the Aboriginal Legal Rights Movement would ordinarily put those supports in place. We also use our prison chaplain service to assist in that regard, and it's not uncommon for either a social worker or senior manager to liaise with the next-of-kin of the person who has passed away in custody.

339. While I note that [the Director] attempted to contact Ms Axelby of ALRM approximately two hours after the incident, I consider that the department should have had a clear point of contact for Mr Morrison's family within the department to provide information and offer support. Further, it does not appear that any thought was given to offering the support of a social worker or chaplain.

340. I consider that the department's failings in this regard were a serious error. Mr Morrison's family should never have been put in the situation that they were put in. I am appalled at their treatment.

341. In forming my view, I have had regard to the RCIADIC Report, in particular, the following passage:

> 4.6.1 Major problems observed in police investigations and inquests into deaths in custody concern the lack of sensitivity with which relatives of the deceased and Aboriginal communities were treated. The historical background of Aboriginal-police relations has resulted in custodial deaths being regarded with a high degree of suspicion by Aboriginal people, even in cases which are ultimately found to be straightforward deaths by natural causes. This is indicative of the suspicion with which Aboriginal people often regard police and prison officers. It demonstrates the need for openness and frankness when dealing with the family of the deceased at all stages of the coronial inquiry.
>
> 4.6.2 The experience of the Commission has shown that the anguish of relatives and their fears and suspicions have not been appreciated by persons involved in post-death investigations, and the family of the deceased have often been dealt with in a way which heightens their worst suspicions. It is natural for friends, relatives and community members to be apprehensive as to the circumstances of death when a person enters custody apparently alive and well and leaves dead. In many instances, custodial authorities have been secretive and defensive about a death in custody, rather than recognising the fact that relatives and the public have a right to know what happened. The family of the deceased are often regarded as trouble makers who do not deserve to be dealt with frankly. In many instances there has been little recognition that the family and the public have the right to expect a full, open and impartial inquiry with the greatest possible access to all relevant information.
>
> 4.6.3 Commissioner Wootten, in his paper delivered at the Institute of Criminology Seminar on Coronial Inquiries in 1990, noted that there has been a particularly undesirable practice of police and prison officers using the coroner and pending coronial inquiry as a shield behind which to hide. He stated that:
>
> > *the body cannot be seen because it is in the charge of the Coroner; the site cannot be visited because it is the subject of coronial investigation; information cannot be given out because the matter is in the hands of the Coroner; nothing can be said until the coronial investigation is completed and the inquest over. Much of this use of the Coroner's name has taken place without any reference to the Coroner, who may well have been quite unaware of the frustration being suffered by relatives and their representatives.*
>
> 4.6.4 There is a need for openness, frankness and sensitivity to the feelings of the relatives and friends of the deceased from the point of notification of death throughout the

> various stages of investigation. It should include the family of the deceased's full involvement in the inquest, if this is what the family wishes.

342. I expressed concern in my provisional report that the department had not appeared to have taken any heed of these comments. In my view, Mr Morrison's family were not treated with the openness, frankness and sensitivity that they deserved. It is not at all surprising that Mr Morrison's family appear to have regarded the department's actions with suspicion. The department's actions did not instil confidence or trust in its dealing with Aboriginal prisoners in custody.

343. The department's response to my provisional report did not agree with my view that the department did not promptly facilitate contact and, among other matters, suggested that my report:

> did not have adequate regard to the prevailing circumstances on the day of the incident or the complexities of the legislative and ethical framework that touch on the issue of privacy and the provision of information within the Corrections system.

344. I have earlier acknowledged in this report that it is easy to be critical in hindsight but it is essential that I continue to hold the department to a high standard. Having carefully considered all of the department's submissions, my view remains that the department failed to provide Mr Morrison's family with sufficient information and support.

345. In response to my provisional report, Ms Andersen proposed the following additional recommendations:
    - That the department implement time-sensitive procedures for dealing with next-of-kin of prisoners who are critically injured. Recommendation 10 [now 11] should include a requirement that 'next of kin are advised and provided clearance to visit the prisoner as soon as possible after the prisoner is evaluated as having a life-threatening condition or is unconscious'
    - That the department understand and acknowledge cultural protocols when dealing with next-of-kin prisoners who are critically injured and incorporate them into their practices and policies. In this regard, the family would like to draw the Ombudsman's attention to the fact that elders were turned away from visiting Mr Morrison. It is unlikely that a priest administering last rites would be turned away in similar circumstances. It is also important for the department's policies to address the fact that in most traditional Aboriginal and Torres Strait Islander communities, the definition for next-of-kin is broader than the non-indigenous definition. This should be made clear in departmental policies and trainings
    - That the department prepare and implement procedures which make a single Corrective Services officer the point of contact for next-of-kin prisoners who are critically injured. This Corrective Services officer should be required to proactively contact the next of kin of the prisoner and ensure that all appropriate service providers are promptly notified that the prisoner's family, elders and next of kin are cleared to visit the prisoner. Any requirements such as ID etc must be communicated to the prisoner's family at the earliest opportunity
    - That the department report to the Ombudsman on the guidelines and procedures and any further improvements made to the department's processes in relation to the matters above.

346. I would expect that in implementing my recommendations, the department will have regard to all of the matters raised by Ms Andersen. I have also made some amendments to my provisional recommendations in light of Ms Andersen's submissions.

Opinion

In light of the above, my view is that the department's failure to facilitate the provision of appropriate information and support to Mr Morrison's family was wrong for the purposes of section 25(1)(g) of the Ombudsman Act.

To remedy this error, I recommend under section 25(2) of the Ombudsman Act that the department:

Recommendation 13

Formally apologise to Mr Morrison's family for its failure to facilitate the provision of appropriate information and support.

Recommendation 14

Develop a procedure for dealings with next-of-kin prisoner who are critically injured or die in custody including:

- Identification of single point of contact and chain of command for enquiries and information
- Requirement that all relevant clearances are provided as soon as possible after a prisoner is evaluated as having a life-threatening condition or is unconscious and that next of kin are advised of all requirements for access to the prisoner
- Provision of counsellors, social workers, chaplains and other support as appropriate
- Emphasising the need for frankness, clarity, sensitivity and efficiency in communicating with a prisoner's family
- Identification of special needs of Aboriginal and Torres Strait Islander prisoners, including consideration of definition of next of kin

The department has indicated that it is generally supportive of my recommendations.

The department stated:

> The Department will work with representatives from the Department of Health and Wellbeing and the relevant Local Health Networks to develop a policy and procedure for the provision of support and information to the next of kin and family of a prisoner who is critically ill and or who passes away. This policy and procedure will consider issues such as:
>
> - Next of kin
> - Points of contact and escalation paths
> - Visiting procedures
> - Welfare and pastoral support
> - Health and custody information sharing protocols
> - Cultural and linguistic supports
>
> I acknowledge that you found the Department failed to provide enough information and support to Mr Morrison's mother (Ms Andersen) and his family. Whilst I maintain the view that, as this information and clinical knowledge was the remit of Health staff, the Department was not in a position to provide all the information that the family were seeking, I do accept that a clear set of policies and procedures will assist both agencies to better support the loved ones of a prisoner who is critically ill.

> As such, I will communicate these !earnings and the commitment to develop a policy and procedure to Ms Andersen and will also apologise for the inadequacy of the information sharing and personalised support provided to them at the time Mr Morrison was admitted to the Royal Adelaide Hospital (RAH).
>
> Further, I will indicate to Ms Andersen that the recommendations she has made (repeated in your report at paragraph 334) are practical, helpful and will be given active consideration as we develop the new policy and procedure in response to recommendation 13.

I consider it is to the department's credit that it although it does not fully agree with my views, it has reflected on the issues raised and intends to take the steps outlined above.

Whether the department obstructed access to information about Mr Morrison

347. It appears uncontroversial that while the details of the ALO at the RAH were provided to Mr Morrison's family as a point of contact by the department, the ALO was not provided with access to any information about Mr Morrison's condition. In his interview, Mr Brown's explanation for that was that the sharing of information with the family members of a patient in hospital was a matter for SA Health.

348. That said, the department's own investigation found that the reason for the ALO not being provided with a health update was that the relevant Corrections Officer [redacted] was not given approval by Yatala management to provide any health updates to anyone except Yatala management.

349. Further, the department has acknowledged that while Mr Morrison was admitted to the RAH under his own name, that name was subsequently changed to 'Ben Waters' on the basis that RAH and ICU staff had received calls seeking Mr Morrison's location. According to the department, this raised concerns about safety and security surrounding Mr Morrison and 'this is not an unusual practice and is used to ensure prisoner safety and security, as well as to protect prisoner confidentiality.'

350. I accept that there may be genuine privacy and security reasons for the department limiting the information provided about a prisoner's health and taking precautions to that end. In that regard, I do not consider that providing an assumed name for Mr Morrison was in itself an error. In circumstances where Mr Morrison's family were not provided with any other updates or point of contact who could provide those updates, however, the fact of the assumed name understandably heightened the family's mistrust and aggravated their distress.

351. In response to my provisional report, the department stated:

> The Department has acknowledged that Mr Morrison's identity, and subsequent admission to RAH under an alternative name, caused confusion. Despite this the Department maintains a strict policy in relation to the confidentiality of prisoner information and the need for safety and security when prisoners are outside the secure perimeter. As advised […] repeated calls from unidentified people raised Departmental concerns. In hindsight, the Department concedes that this was problematic. Aside from this, I strongly believe that the Department provided appropriate information to Mr Morrison's family in relation to this location and situation as soon as possible. I also maintain however that the Department was not in a position to provide medical information to the family.
>
> The Department maintains strict confidentiality of prisoner information in accordance with the *Correctional Services Act 1982*. Likewise it is also constrained by SA Health and SAPHS confidentiality provisions. In both cases, the default position is that a person's identity must be confirmed before any information can be provided, and then information may only be revealed in accordance with legislative provisions. The Joint Protocol For The Exchange of Information between SA Health and *The Department For Correctional Services For the Treatment, Care or Rehabilitation of A Prisoner* was developed in 2015 to provide a framework to allow for the lawful exchange of information from SAPHS to DCS. This protocol states, in relation to health information:
>
> > CONFIDENTIALITY
> > The confidentiality of patient or consumer information is protected by health confidentiality provisions – section 93 of the *Health Care Act 2008* and section 106 of the *Mental Health Act 2009*. However, in each case, there are exceptions which permit disclosure. Both Acts permit disclosure of a patient or consumer's information without their consent, including when:
> > - Disclosing information as required by law, or

- Authorised or required to disclose that information by the Chief Executive
- If the disclosure 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.

At the time of the incident, Mr Morrison's situation did not fit with the SAPHS and SA Health exceptions which permitted disclosure. I maintain the Department's position that it was not privy to any medical information in relation to Mr Morrison's condition, and therefore was not able to provide any medical information to Mr Morrison's family. It is for this reason that the Department made early contact with the RAH ALO, to ensure that the family had a point of contact for medical information. Further, given the lack of qualifications and training, it would not be appropriate for Departmental staff to provide or explain medical information.

352. To clarify, I do not suggest that department officers should have been providing Mr Morrison's family with any medical information. Instead, my concern is that the department did not take further steps to facilitate access to that information or explain the processes. My view remains that Mr Morrison's family should not have been left to their own devices to piece together what had occurred.

353. It is unfortunate that the department did not provide Mr Morrison's family with any point of contact (whether within the department or by liaising with RAH staff) that could provide them with any meaningful information about Mr Morrison's condition or appear to explain how information could be accessed. The fact that the ALO was unable to access information must have been particularly frustrating for Mr Morrison's family and the ALO. I have carefully considered Mr Brown's assertion that this was simply a matter for SA Health, especially in light of the department's own investigation. My view remains that the department could have taken steps to facilitate the process through liaison with SA Health. Mr Morrison was critically injured and time was of the essence. As Mr Morrison was critically injured while in custody of the department, in my view the department had a duty to ensure that his family was as fully informed as possible.

354. While I do not have evidence that there was a deliberate attempt to obstruct access to information about Mr Morrison, I can understand why Mr Morrison's family might draw that conclusion, given their overall treatment by the department.

355. At the very least, there appears to have been a concerning breakdown of communication between Mr Brown and Yatala management on the issue.

356. In concluding that the department erred, I have noted with particular concern that Mr Morrison's family:
    - were given details of the RAH ALO without organising access for that person to provide them with any information about Mr Morrison's condition
    - Mr Morrison's family were effectively turned away when they first arrived at the hospital and made to wait in a car park
    - Mr Morrison's family were not given access to Mr Morrison until approximately 6.30pm.

357. The department's focus appeared to have been concern for security rather than any concern for Mr Morrison's family. This is exemplified by Officer [redacted] not being given approval to provide **anyone** with health updates other than Yatala Management. At that point, [the Prison Manager] and other Yatala Management staff should have at least turned their mind to the needs of the family.

358. In all of the circumstances, I consider that the department's failure to facilitate access to information about Mr Morrison's condition was a serious error.

359. In response to my provisional report, Ms Andersen proposed the following additional recommendation:

That Correctional Services implement culturally appropriate and time sensitive for allowing next-of-kin to be updated regularly with timely and meaningful information during critical medical incidents involving a prisoner and to ensure that the next of kin of the prisoner have access to treating clinicians.

360. In my view, Ms Andersen's suggestions should be considered by the department in implementing Recommendation 11. On that basis, I have not made a separate recommendation in that regard.

Opinion

In light of the above, my view is that the department's failure to facilitate the provision of sufficient access to information about Mr Morrison's condition was wrong for the purposes of section 25(1)(g) of the Ombudsman Act.

To remedy this error, I recommend under section 25(2) of the Ombudsman Act that the department:

Recommendation 15

Formally apologise to Mr Morrison's family for its failure to provide appropriate information and support

Given that communication will be dealt with in the procedure envisaged by proposed recommendation 12, I do not propose to make a separate recommendation in that regard.

The department has indicated that it supports this recommendation.

Whether the department provided Mr Morrison's family with appropriate access to Mr Morrison

361. I accept that in organising Mr Morrison's family to visit him in hospital, the department was acting in accordance with SOP 013. In particular, I note that:
    - approvals were given for Ms Andersen initially, and subsequently other family members to visit (3.12.1)
    - Mr Morrison's family were required to leave personal property outside Mr Morrison's room (3.12.5).

362. SOP 013 is silent as to the number of visitors allowed access to a prisoner in hospital at any time. The department has stated that Ms Bray made the decision to limit the number to two, noting that ICU policy requests a 'minimal' number of visitors. I note that subsequently four visitors at a time were allowed.

363. I consider that SOP 013 reasonably allows the department to exercise its discretion in extenuating circumstances. In my view, these were extenuating circumstances and particular sensitivity was required.

364. I accept that having to comply with the department's procedures must have been frustrating and to some extent humiliating for Mr Morrison's family, particularly given the distressing circumstances of Mr Morrison's injuries and coming after the wait in the RAH car park, the general lack of information provided and confusion of the day's events. That said, I do not consider that the department's actions were unreasonable, in light of its policy.

365. I also accept that the department had to maintain supervision of Mr Morrison and that it was appropriate for department officers to be able to see Mr Morrison while he was visited. That said, I query whether it was necessary or appropriate for there to be four officers present, noting that it was ultimately decided that two officers were sufficient. The presence of four officers appears to have been viewed by Mr Morrison's family as particularly intrusive.

366. I also query the extent to which officers had to be present in the room at all times. Mr Morrison was in a coma and clearly presented no security risk. There was clearly discretion to treat his family with greater humanity and empathy in the circumstances. In my view, the situation demanded the regular presence of a more senior department officer on site, for example Mr Brown as Chief Executive, Ms Bray as Deputy Chief Executive or [the Prison Manager] as manager of Yatala. Their presence would have demonstrated that the department was taking responsibility for managing the situation seriously. Conversely, their absence suggested that the situation required no more consideration and supervision than a routine hospital stay by a prisoner.

367. Officers with the necessary authority could have guided the visiting process and made the necessary decisions as to the extent to which extenuating circumstances necessitated departure from strict compliance with the department's procedures. Those decisions could have included:
    - the number of officers present at any given time, and their location (i.e. whether in Mr Morrison's room or not)
    - whether it was necessary for Mr Morrison's family to leave personal property outside Mr Morrison's room on every occasion
    - the number of visitors allowed at any time.

368. Also of concern to me are the allegations that Mr Morrison's family were treated disrespectfully by the department's officers and that they were not afforded sufficient

privacy with Mr Morrison, especially during his final hours. I address the department's handling of those allegations below.

General allegations of disrespect and inappropriate laughter

369. In regard to general allegations of disrespect and inappropriate laughter, I note the following:
    - according to Ms Andersen, when she closed the curtains so that she could be alone with Mr Morrison to anoint him with oil and pray:

        > …I heard one comment, you know "You are not allowed to do that. You have to leave them open", and I just totally ignored them. I heard snickers, sniggers and giggles and, the like, pathetic remarks and all of that sort of thing when I was doing it…

    - according to Ms Andersen, after that incident, one of the Corrections officers was:

        > pacing like a pit bull back and forwards, back and forwards across the curtains, just pacing with this such an angry face and with an elastic band in his hand flicking it and he was so, like, agitated because I had closed these curtains and he couldn't see what I was doing. You know, I just thought…so when you ask about privacy, we had absolutely no privacy. That was the only strip of privacy that I got…

    - according to the department, its officers 'were sympathetic to the family and [..] they acted professionally at all times'
    - according to the department, there was an incident where two officers were laughing quietly at a conversation unrelated to Mr Morrison when they were approached by Mr Patrick Morrison and accused of laughing at Mr Morrison's family; the officers assured Mr Patrick Morrison that no disrespect was intended
    - the department has not taken action against any of the officers who were present at the RAH.

370. I accept that in an emotionally heightened atmosphere surrounding a critically ill patient, there could be scope for misunderstandings as to the Corrections officers' conduct. That said, I have no reason to doubt the detailed accounts of Ms Andersen and Ms Rule. Ultimately, I am faced with two differing accounts and I am unable to determine with any certainty what occurred.

371. That said, I consider it completely insensitive and inappropriate that Corrections officers should have been laughing within earshot of Mr Morrison's family for any reason.

372. I also consider that greater consideration should have been given to the privacy needs of Mr Morrison's family. I accept that the officers' actions were consistent with the department's policy which provides at 3.13.7 'Hospital Watch officers must be located in a position to directly observe the prisoner and visitors at all times during the visit'. In those circumstances, it is understandable that the officers objected to the curtains being closed. That said, it is clear that such a situation should be handled by officers with sensitivity rather than with anger.

The incident between [the G4S Officer] and Ms Rule

373. The incident between [the G4S Officer] and Ms Rule allegedly occurred after doctors had informed Mr Morrison's family that they were taking him off life support.

374. According to Ms Rule and Ms Andersen's response to my investigation:
    - Ms Rule became angry at the fact that officers remained in the room after the family had been told to say their goodbyes to Mr Morrison
    - Ms Rule told the family to go in and put her hands up on both sides of the door

- [The G4S Officer] was aggressive and 'wanting to rip someone's head off'
- [The G4S Officer] lent on Ms Rule's arm to 'try to break it down'
- Ms Rule explained that it was the family's time to say goodbye together, that they had not been in the room together as a family, and asked that the family be allowed in the room together
- [The G4S Officer] told Ms Rule that she would remove her by force
- [The G4S Officer] threatened to make a report against her.

375. The contemporaneous complaint lodged on the family's behalf by ALRM is generally consistent with this version of events and also includes an allegation that [the G4S Officer] was 'rude and insensitive and advised them that they shouldn't even be there'.

376. According to the department:
    - [The G4S Officer] was 'pushed' by Ms Rule to leave the room
    - [The G4S Officer] indicated that she understood the situation but had to be there
    - Ms Andersen intervened and said that she wanted it to be a peaceful time
    - the other officer, [redacted] contacted the G4S control room and was advised to let the four family members remain in the room
    - Mr Brown does not believe that the officers acted in a manner that requires disciplinary action.

377. I consider that Officer [redacted] acted appropriately in the situation, and Ms Andersen and Ms Rule have acknowledged as much.

378. Both G4S and [the G4S Officer] provided a detailed response to my investigation after being provided with my draft final report. While I have not included either G4S or [the G4S Officer]'s response in full in this report, I have carefully considered all of their submissions.

379. According to [the G4S Officer]:
    - she never had any intention or desire to enter Mr Morrison's room and remained seated with her chair turned to the side to be as discreet as possible
    - when the family members entered the room as a group, and not in pairs as per the direction from G4S, she stood to observe at the corner entrance of the room but did not enter
    - she did not:
        - behave as someone 'who wanted to rip someone's head off'
        - state that she would remove Ms Rule by force or write a report against her
        - want to add to the family's pain
        - instigate or exacerbate any physical contact
        - handle the situation in anger
    - Ms Rule extended her arms out and backed into [the G4S Officer]
    - [The G4S Officer]'s comment about the family being allowed in the room was not to suggest that they shouldn't be there, but that they <u>all</u> shouldn't be there.

380. [The G4S Officer] stated:

> I completely understand that any verbal communication between me and the family would not be ideal in their grief; however I had not yet been told that permission had been given by our Supervisor for more than two family members at one time. Once I was aware, and the family entered on the second occasion, I had no problem allowing the family in the room together, with the curtain closed, and no further observations were made by me.

381. [The G4S Officer] also stated:

> I am so very sorry that Ms Andersen feels I had taken any personal pleasure in the death of her son. She states that I 'wanted to see him take his last breath' and that I 'wouldn't have been satisfied until I'd seen it'. This statement is quite devastating to me as I would have preferred not to have been present for their grief and suffering. I most definitely was 'moved' by what I was witness to. I happened to be on duty that night and tried very hard to be discreet, professional and have as little contact with the family as possible. Once I knew G4S had given permission for the entire family to be in the room with Mr Morrison, I had no further contact with them.

382. It is clear that my investigation has received contrasting versions of the incident.

383. I consider Ms Andersen and Ms Rule's account of [the G4S Officer]'s conduct was detailed and persuasive. Both Ms Rule and Ms Andersen appropriately acknowledged Ms Rule's role in the incident. I do not consider that they have any motive to be anything other than frank with my investigation and they were both compelling witnesses.

384. [The G4S Officer] has also provided a detailed account, and I have no reason to consider that she has not responded truthfully. It is also clear that [the G4S Officer] has reflected on the incident.

385. I comment at this point that it is understandable that Ms Rule was angry and that she took steps to ensure the family's privacy.

386. Clearly, it would not have been at all appropriate for [the G4S Officer] or any other officer to instigate any physical altercation with Ms Rule. In that regard, I note the department's response that Corrections officers do not have power to act against a member of the public who is behaving inappropriately (and I do not accept that Ms Rule's actions were necessarily inappropriate in these circumstances) unless it is to prevent prisoner injury or escape.

387. That said, I am not satisfied on the information before me that [the G4S Officer] instigated the incident or what her role in it was. Ultimately, given the contrasting accounts, I cannot be satisfied with any certainty as to what actually occurred.

388. I accept that it could be challenging for the officers dealing with the emotions of an angry, grieving family. I repeat that this situation should have been handled with sensitivity, not anger, by the officers concerned. In my view it is the department's responsibility to ensure that its officers are appropriately trained and equipped to deal with such situations.

389. I accept that [the G4S Officer] may have considered her actions were necessary to comply with SOP 13. That said, the department clearly had discretion as to how it handled the situation, as was evidenced by [redacted] actions.

390. I also note with concern that the department has not provided any evidence that it initially carried out any detailed investigation of Ms Axelby's complaint at the time it was made. I agree with Ms Axelby's characterisation of the allegations as 'totally insensitive and unacceptable behaviour', that is, allegations which clearly warranted investigation by the department.

391. In response to my provisional report, the department:
    - noted concerns that neither [redacted] nor [the G4S Officer] had been provided with a chance to provide an account to my investigation, thus denying them natural justice
    - noted that both officers were employed by G4S and they would expect G4S to consider any allegations and evidence to determine if misconduct had occurred, and, if so, what sanctions are appropriate

- had enquired with G4S if any investigations had been completed and if any disciplinary action was considered and was awaiting a response.

392. I acknowledge the department's comments. I also acknowledge that, ultimately, the department did consider [the G4S Officer]'s conduct, seek her version of events and provide it to my investigation. As I have not investigated [the G4S Officer] as an individual, I did not consider it necessary to interview her for the purposes of this report. That said, having considered the department's views, I considered it appropriate to provide [the G4S Officer] with a copy of this report for comment, and I have had regard to her response in forming my final view). I also expected that the department would seek information from [the G4S Officer] as necessary for the purposes of responding to my investigation.

393. As a general proposition, I do not consider it to be at all appropriate conduct for an officer performing services for the department to get into any kind of disagreement, let alone a physical altercation, with a member of the public in the process of farewelling their dying family member.[38]

394. I consider that Ms Andersen's comments on the incident bear repeating here:

> And it was embarrassing because I was on the floor, kneeling next to Wayne, crying, yeah I'm saying goodbye to my son and I could hear this commotion going on over here, and I spun around and I had tunnel vision and the only person I seen was Latoya like this, and I just, I told her off…
>
> …
>
> Wayne's about to take his last breaths and I'm telling my daughter off because I think she's about to have an argument with the security that have been here and smothered us for the last three or four days. We weren't getting any privacy. We weren't going to be left by ourselves. She wanted to see him take his last breath, this woman, and she wouldn't have been satisfied until she seen it and that was the attitude she had.
>
> …
> That was one of the most disgusting moments in the entire situation. Not only seeing Wayne's condition and going over all of his body and the nurses allowing me to do it in front of security, I didn't care, what she did then was disgusting. How dare you force me to embarrass not only myself, but my daughter and you're the one that is perpetrating this aggression against her. You know, but it was a sacred time, you know. Yeah, I think about it now and I just think how utterly disgusting of you as a human to allow yourself to be that wound up that you feel that you have to physically press against someone, and that someone is just trying to stop you from entering the room where a life is about to leave, and all you're concerned about is making sure that you have a foot into that area and you won't give us…

395. It is difficult to imagine how anyone could remain unmoved by such a statement. It is utterly disgraceful that any family or any individual should be placed in that situation at such a time of great sorrow.

396. That said, I have not been able to satisfy myself with any certainty as to what happened during the incident. Instead, the focus of my investigation of this issue has been on the department's response to the allegations concerning [the G4S Officer].

397. In response to my provisional report, Ms Andersen proposed the following additional recommendations:

---

[38] As it is arguable that section 18(5) of the Ombudsman Act does not apply to [the G4S Officer] given her capacity as a contractor, I do not intend to formally report her actions as misconduct to Mr Brown.

- That the department implement culturally appropriate protocols for family members of prisoners who are critically injured and where death is imminent. For example, to implement flexible protocols and procedures to encourage Correctional Services officers to:
  - wait outside of a prisoner's medical ward or room
  - reduce staff to two officers
  - allow family members to bring their belongings inside the ward or the prisoner's room
- That the department implement a policy that allows family members to be alone with the dying or unconscious prisoner whenever it is safe to do so.

398. Again, I expect that the department would have regard to the suggestions made by Ms Andersen when complying with Recommendation 14.

399. I also consider that this situation highlights the importance of a detailed plan and clear communication with all officers involved, including extra sensitivity at crucial times. In my view, a situation should not have arisen where [the G4S Officer] was still under the impression that only two family members be allowed in the room at one time, at the time of Mr Morrison's death, or of ensuring that protocol was followed was a priority at that particular time.

400. In closing, I remain highly critical of the department's treatment of the family.

Opinion

In light of the above, my view is that the department acted unreasonably for the purposes of section 25(1)(b) of the Ombudsman Act and wrongly for the purposes of section 25(1)(g) of the Ombudsman Act in failing to provide Mr Morrison's family appropriate access at the time of his death.

To remedy this error, I recommend under section 25(2) of the Ombudsman Act that the department:

Recommendation 16

Formally apologise to Mr Morrison's family for its failure to provide appropriate access at the time of Mr Morrison's death

Recommendation 17

Remind staff of their obligations to treat family members of critically ill or deceased prisoners with dignity, respect and sensitivity at all times (including incorporating those principles into relevant department procedures)

The department has indicated that it supports both recommendations.

Whether the department's failure to maintain records in accordance with the State Records Act 1997 was contrary to law

401. It is of great concern to me that the department has failed to maintain appropriate records. The fact that pages 1 and 2 of the Specific Needs Assessment form are missing, as acknowledged in the department's own investigation report (i.e. the Muller report) is completely unacceptable.

402. I cannot help but draw an adverse inference from the fact that the department never explicitly drew my investigation's attention to the missing pages in its initial responses to my enquiries. It indicates a lack of transparency. In response to my provisional report, the department asserted it was contradictory of me to assert that the agency never explicitly drew my attention to the missing pages while that fact was included in the investigation report. I disagree. I consider that the department should have explicitly drawn my attention to the missing pages when providing the document.

403. I have expressed the view in other reports that the department's failure to maintain records in a number of other matters is contrary to law. I intend to raise this with the Manager of State Records and urge him to address this systemic issue with the department as a matter of priority.

404. The department responded to my provisional report:
- noting that it has acted upon my recommendations concerning records management made in other matters
- stating that the department has undertaken an assessment of its record management policy, procedure and practice against the State Records Adequate Records Management Standard audit criteria and that a briefing and action plan is being considered
- the department has revised its Information Management Policy and Standard Operating Procedure and published those on its intranet
- a new records management awareness training is being rolled out to a test group prior to implementation and records management training will be incorporated into the department's training calendar for staff.

405. I commend the department on the steps it has taken to improve its records management.

406. In response to my provisional report, Ms Andersen proposed two further recommendations:
- That the department implement a procedure which includes electronically scanning all relevant documents pertaining to a prisoner in a chronological order to ensure documents can be located at all times and to understand when they were created.
- The department should develop a culture of consistently and thoroughly recording all incidents.

407. While I consider that Ms Andersen's suggestions are useful, and I would expect the department to have regard to them, I do not consider it necessary or appropriate for me to make such a prescriptive recommendation.

408. I also note the evaluation of the department undertaken by the Independent Commissioner Against Corruption which I understand will consider information management more generally. In light of that evaluation, I intend to provide the Commissioner a copy of my report.

Opinion

In light of the above, my view is that the department, in failing to retain official records, acted in a manner that was contrary to law within the meaning of section 25(1)(a) of the Ombudsman Act.

I understand that the department is reviewing its record management processes more generally. In light of that, I recommend under section 25(2) of the Ombudsman Act that the department:

Recommendation 18

Provide me with a detailed update of processes implemented to review and improve records management systems

The department has indicated that it supports this recommendation, and, in addition to information already provided to my Office, has committed to provide a detailed update of processes implemented to improve and review record management systems.

General comments

409. Before summarising my views, I consider it appropriate and necessary to make the following comments.

410. I have noted both the Muller Report and the Zadow Report. I have referred to certain sections of the Muller Report in this report.

411. The Zadow Report is a six page document and briefly documents a review of:
    - processes, procedures and practices
    - systems
    - critical issues
    - enablers.

412. I do not consider that the Zadow report engages with the concerns raised by Mr Morrison's family in any depth. That said, I consider that it contains some useful observations and I particularly support the following recommendations:

> The correct use of forms particularly where there are critical questions that would engage mechanisms and support need to be monitored. The process of identifying Aboriginal people and [that] appropriate components of the forms are completed as required cannot be understated.
>
> Regular scheduled audits need to be undertaken of documentation and completion and the results analysed. Observers or Supervisors undertaking regular snap audits or observing documentation being completed at the site is one method to highlight the important part of the process.
>
> The ALO work force and resources for those roles are increased as a matter of urgency. The significant rise in Aboriginal people in custody should also translate to an increase in the numbers of ALO's. The role should also have appropriate resources or access to resources including a vehicle or access to vehicle.
>
> Aboriginal Prisoner should not be placed at Holden Hill Police Cells unless as a last resort and after a significant risk analysis of the Prisoner has been undertaken together with full and appropriate completion of their documentation.
>
> Communication to family and with ALRM needs to be a priority. The joint work with ALRM needs to be an organisational priority not just within the ASU.

413. Finally, I have noted that Mr Brown has 'publicly acknowledged the pain and grief experienced by Mr Morrison's family as a result of his tragic death' and offered condolences. In my view, an actual apology for the department's actions is warranted.

Summary and recommendations

In summary, my view is that:

Issue one:

By failing to follow up on issues identified at Mr Morrison's admission to Yatala, in particular by failing to raise a Notification of Concern or otherwise treat Mr Morrison as an 'at risk' prisoner, the department acted in a manner that was wrong for the purposes of section 25(1)(g) of the Ombudsman Act.

To remedy this error, I recommend under section 25(2) of the Ombudsman Act that the department:

Recommendation 1

Apologise to Mr Morrison's family for failing to appropriately identify Mr Morrison as an 'at risk' prisoner and to monitor and review his welfare accordingly

Recommendation 2

Amend the Revised Stress Screening Form to:

- Delete the words 'in the past five years' from questions 19 and 20
- Provide suitable guidance as to the exercise of the discretion to raise a Notification of Concern in circumstances including but not limited to specific reference to the potential suicide risk factors identified in Appendix 1 of Revised SOP 090

Recommendation 3

Amend clause 3.3.3 of Revised SOP 090 to include the option of a discretionary Notification of Concern to be completed including suitable guidance as to the exercise of that discretion as set out in recommendation 2

Recommendation 4

Amend clause 3.2.5 of Revised SOP 090 to replace the words 'if necessary' to 'as required'.

Recommendation 5

Develop a warning system whereby a prisoner's history of actual (and threatened) self harm and suicide attempts is electronically flagged at all times

Recommendation 6

Organise a program of training and regular refresher courses to ensure prison staff are able to identify 'at risk' factors for prisoners

Issue two:

By failing to have proper processes in place to identify Mr Morrison as an Aboriginal person, the department acted in a manner that was wrong for the purposes of section 25(1)(g) of the Ombudsman Act.

To remedy this error, I recommend under section 25(2) of the Ombudsman Act that the department:

Recommendation 7

Review its processes to ensure that information concerning Aboriginal identity in SAPOL Transfer Reports (including apprehension reports), SAPHS documents, and documents from any other relevant agencies are cross-checked against information recorded on induction concerning a prisoner's Aboriginal or Torres Strait Islander identity

Recommendation 8

Report to me on any further improvements made to the department's processes to ensure that Aboriginal prisoners are identified as early as possible in the induction process and access to ALOs provided

Recommendation 9

Take steps to ensure that the ALO service is publicised in all prisons by way of posters and information provided to prisoners upon induction.

Issue three:

The department did not act in a way that was unlawful, unreasonable or wrong in responding to concerns raised by Mr Morrison's family before the incident.

Issue four:

By transporting Mr Morrison to G Division in a van without recording capacity, the department acted in a manner that was unreasonable for the purposes of section 25(1)(a) of the Ombudsman Act.

To remedy this error, I recommend under section 25(2) of the Ombudsman Act that the department:

Recommendation 10

Amend its procedures to:

- clarify the circumstances in which transport of a prisoner by van following a use of force incident is necessary and appropriate, having regard to factors such as:
    - the prisoner's physical and psychological welfare
    - the distance to be travelled
    - the good order and security of the prison
- clearly provide that where a van with recording capacity is not available, the transport must be recorded by hand held camera or alternative means of transport must be arranged, and that transport be appropriately recorded at all times.

Issue five:

By failing to record meaningful footage of Mr Morrison's restraint by Correctional Officers and transport by van, the department acted in a manner that was wrong for the purpose of section 25(1)(g) of the Ombudsman Act.

While I note the department's submissions in relation to budgetary restraints, to remedy this error, I consider it necessary to include a recommendation under section 25(2) of the Ombudsman Act that the department:

Recommendation 11

Take steps to implement body-worn cameras within all of its prisons

I also recommend that the State Government:

Recommendation 12

Consider allocation of funds to enable implementation of body-worn cameras in all of the State's prisons

Issue six:

The department's failure to provide Mr Morrison's family with sufficient information and support was wrong for the purposes of section 25(1)(g) of the Ombudsman Act.

To remedy this error, I recommend under section 25(2) of the Ombudsman Act that the department:

Recommendation 13

Formally apologise to Mr Morrison's family for its failure to facilitate the provision of appropriate information and support.

Recommendation 14

Develop a procedure for dealings with next-of-kin prisoner who are critically injured or die in custody including:

- Identification of single point of contact and chain of command for enquiries and information
- Requirement that all relevant clearances are provided as soon as possible after a prisoner is evaluated as having a life-threatening condition or is unconscious and that next of kin are advised of all requirements for access to the prisoner
- Provision of counsellors, social workers, chaplains and other support as appropriate
- Emphasising the need for frankness, clarity, sensitivity and efficiency in communicating with a prisoner's family
- Identification of special needs of Aboriginal and Torres Strait Islander prisoners, including consideration of definition of next of kin

Issue seven:

The department's failure to facilitate the provision of sufficient access to information about Mr Morrison's condition was wrong for the purposes of section 25(1)(g) of the Ombudsman Act.

To remedy this error, I recommend under section 25(2) of the Ombudsman Act that the department:

Recommendation 15

Formally apologise to Mr Morrison's family for its failure to provide appropriate information and support

Issue eight:

The department acted unreasonably for the purposes of section 25(1)(b) of the Ombudsman Act and wrongly for the purposes of section 25(1)(g) of the Ombudsman Act in failing to provide Mr Morrison's family appropriate access at the time of his death.

To remedy this error, I recommend under section 25(2) of the Ombudsman Act that the department:

Recommendation 16

Remind staff of their obligations to treat family members of critically ill or deceased prisoners with dignity, respect and sensitivity at all times (including incorporating those principles into relevant department procedures

Issue nine:

The department, in failing to retain official records, acted in a manner that was contrary to law within the meaning of section 25(1)(a) of the Ombudsman Act.

I understand that the department is reviewing its record management processes more generally. In light of that, I recommend under section 25(2) of the Ombudsman Act that the department:

Recommendation 17

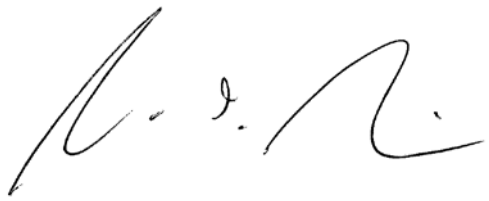
Provide me with a detailed update of processes implemented to review and improve records management systems

In accordance with section 25(4) of the Ombudsman Act the department should report to the Ombudsman by 30 November 2020 on what steps have been taken to give effect to the recommendations above; including:

- details of the actions that have been commenced or completed
- relevant dates of the actions taken to implement the recommendation.

In the event that no action has been taken, reason(s) for the inaction should be provided to the Ombudsman.

I have also sent a copy of my report to the Minister for Correctional Services as required by section 25(3) of the *Ombudsman Act 1972*.



Wayne Lines
SA OMBUDSMAN

19 August 2020