C37

MINUTES forming ENCLOSURE to CEN/11/0746

FOR ENQUIRIES REFER

Mr Terry Nelson

Phone: 82269005

CONFIDENTIAL

TO: **CHIEF EXECUTIVE**

THROUGH: **BILL KELSEY, MANAGER INTELLIGENCE AND INVESTIGATIONS UNIT.**

RE: **REVIEW INTO THE DEATH OF PRISONER MARK WILLIAM PAYNE – 'G' DIVISION, YATALA LABOUR PRISON – 2 JUNE 2011.**

BACKGROUND

On Thursday 2 June 2011, prisoner Mark William PAYNE #163253 died at G Division at Yatala Labour Prison (YLP). Mr. D. MULLER, Investigations Officer, Mr Terry NELSON Investigations Officer and Mr W KELSEY, Manager Intelligence and Investigations Unit (IIU) conducted a review of this incident.

The terms of reference of this review are:

1. To describe the processes, which were adopted in relation to the identification of the prisoner's condition and the subsequent handling of the incident.

2. To determine the extent to which there was adherence to established procedures.

3. To determine the appropriateness of the established procedures and to recommend any changes to those procedures.

4. To review the incident in the context of all measures taken to date in response to Royal Commission or Coronial recommendations or any other catalyst.

5. Other circumstances which may have contributed directly to the death.

METHODOLOGY

A chronology of the events was prepared and the following was undertaken:

- documentation was sought from the Yatala Labour Prison and the scene of the death was viewed;
- a review was conducted of the relevant Yatala Labour Prison procedures and of relevant Departmental Operating Procedures;
- discussions occurred with Police Corrections Section of SAPol.
- a review was conducted of other recent deaths in custody, coronial findings and recommendations of the Royal Commission into Aboriginal Deaths in Custody.

PRISONER PROFILE

Mr PAYNE was a 31 year old Caucasian male who was arrested on 21 May 2011. At the instigation of SAPol he was placed in the Lyall McEwen Hospital on a Mental Health Detention Order under Section 21 of the *Mental Health Act 2009*. At the time, Mr PAYNE had been arrested for 'Trespass in a Residence', 'Fail to Comply with a Bail Agreement' and 'Hinder Police'. These offences allegedly centred around domestic issues with his partner. Mr PAYNE was taken to the Lyall McEwen Hospital after he had made threats to the police about self harm.

Mr PAYNE was subsequently discharged from the Lyall McEwen Hospital into the custody of the DCS on 27 May 2011. At this time Mr PAYNE had been remanded in custody to appear before the Elizabeth Magistrates Court on 2 June 2011.

According to departmental records, this was Mr PAYNE'S first time incarcerated in prison. However, on 9 March 2011 Mr PAYNE was placed on a 2 year suspended sentence bond under supervision of Elizabeth Community Corrections (ECC). This bond commenced on 11 March 2010 and had a due end date of 10 March 2013.

On admission to the YLP, Correctional Officer (CO) RAPISARDA gave Mr PAYNE a score of 14 on the stress screening form. At the time it was noted on his Case Notes *"showing some signs of duress"*.

As a consequence of his high stress score and the threats of self harm Mr PAYNE was initially placed on camera observation in cell G4-01 in G Division at Yatala Labour Prison.

SEQUENCE OF EVENTS

The following is a chronological sequence of events relating to the death of Mr PAYNE. The dates and times indicated were obtained from SAPol, DCS case notes, officer reports, journal entries, the incident log that was maintained at the scene and CCTV vision:

2 JUNE 2011

7.28 pm. **Video footage identifies Mr PAYNE lying on bed in cell G1-01 and then getting out of the bed. He looked in the direction of the cell's camera and**

then takes off the canvas smock he is wearing. He places the neck of the smock around the tap and climbs up into the smock and leans his head forward over the collar of the smock and bends his legs.

7.30 pm. Mr PAYNE laid face down with his legs fully outstretched and his head leaning over the collar of the smock. Mr PAYNE's body is swaying slightly.

7.58 pm. Correctional Officer (CO) MAY called CO FIELDHOUSE and asked him to check on the welfare of Mr PAYNE. CO MAY called a code black (medical emergency) via radio after CO FIELDHOUSE attended at Mr PAYNE's cell and leaves passage area.

7.59 pm. CO FIELDHOUSE returns with the emergency key to open the outer door of cell G1-01. He reaches through the bars of the inner door and attempts to unhook MR PAYNE's smock off the tap but is unable to reach the tap. He then leaves the passage area.

8.00 pm. CO FIELDHOUSE returns to cell G1-01 and appears to be talking through the door to Mr PAYNE. CO FIELDHOUSE kicks the door and leaves the passage area.

8.01 pm. CO FIELDHOUSE returns with OIC OTTEY and CO ASKINS. OIC OTTEY opens in the inner door. CO's enter the cell and lift the smock off the tap and place Mr PAYNE on the floor. CO attended with first aid kit.

8.02 pm. Nursing staff: RN JOHNSTONE, RN LOU, RN PIERCE RN VICEBAN and EN JO arrive with medical equipment. Mr PAYNE is carried into the passageway. CO's continue administering resuscitation and cardiac compression. CO's MICHALSKI, HUGHES, HORVAT, LONDON arrive.

8.16 pm. Paramedics arrive and commenced resuscitation of MR PAYNE.

8.26 pm. SAPol members DAWSON and FEARN arrive.

8.40 pm. Paramedics cease providing medical treatment to MR PAYNE.

8.43 pm. Paramedic leaves G Division. General Manager (GM) MANN arrives at G Division.

8.44 pm. CO's LONDON and ASKINS leave G Division.

8.49 pm. RN VICEBAN leaves G Division

8.51 pm. Paramedic leaves G Division. RN REX enters G Division.

8.52 pm. Paramedic enters G Division

8.53 pm. CO ASKINS enters G Division

8.57 pm.	Paramedic leaves G Division
9.00 pm.	SAPol member BUCKINGHAM enters G Division
9.01 pm.	CO BURZYNSKI enters G Division
9.04 pm.	Assistant GM ROBINSON, RN PIERCE and Accommodation Manager Green enter G Division
9.09 pm.	Assistant GM ROBINSON leaves G Division
9.11 pm.	RN PIERCE leaves G Division
9.17 pm.	CO ELLIOTT enters G Division
9.20 pm.	Executive Director BROWN enters G Division
9.28 pm.	CO ASKINS leaves G Division
9.31 pm.	SAPol member and 2 paramedics leave G Division
9.36 pm.	SAPol member enters G Division
9.40 pm.	CO ASKINS and 2 DCS Investigators (KELSEY & MULLER) enters G Division
9.46 pm.	CO HUGHES, CO LONDON and SAPol member enter G Division
9.48 pm.	Assistant GM ROBINSON and staff counselling service enters G Division
9.50 pm.	2 SAPol members enter G Division
9.52 pm.	GM MANN, Manager GREEN and Councillor leave G Division
9.56 pm.	CO ASKINS leaves G Division
9.58 pm.	GM MANN and Accommodation Manager GREEN enter G Division
10.03 pm.	CO ASKINS enters G Division
10.04 pm.	2 Police Correction's members enter G Division
10.18 pm.	CO ASKINS leaves G Division
10.19 pm.	CO HUGHES leaves G Division
1022 pm.	2 SAPol members leave G Division

10.25 pm.	3 SAPol members leave G Division
10.26 pm.	Property Officer enters G Division
10.34 pm.	SAPol member, CO BURZYNSKI and Assistant Manager ROBINSON leave G Division
10.37 pm.	CO BURZYNSKI enters G Division
10.40 pm.	CO MICHALSKI leaves G Division
10.42 pm.	CO AREVALO leaves G Division
1050 pm.	CO ASKINS enters G Division
1054 pm.	CO BURZYNSKI leaves G Division
10.55 pm.	CO HORVAT leaves G Division
11.03 pm.	CO ASKINS leaves G Division
11.05 pm.	CO BURZYNSKI enters G Division
11.08 pm.	2 Pathologists enter G Division
11.12 pm.	Assistant GM ROBINSON enters G Division
11.19 pm.	CO ASKINS enters G Division
11.25 pm.	CO HORVAT enters G Division
11.26 pm.	CO AREVALO enters G Division
11.36 pm.	2 pathologist and CO BURZYNSKI leave G Division
11.37 pm.	CO's MAY, LONDON, HORVAT, AREVALO, FIELDHOUSE, OTTEY and 2 DCS Investigators leave G Division
11.37 pm.	CO BURZYNSKI enters G Division
11.38 pm.	Executive Director BROWN, Assistant GM ROBINSON, Accommodation Manager GREEN and 2 Police Corrections members leave G Division,
11.40 pm.	Property Officer leaves G Division
12.02 am.	Police Corrections Investigator enters G Division

12.09 am. CO WRIGHT enters G Division

12.12 am. Accommodation Manager GREEN enters G Division

12.13 am. CO WRIGHT leaves G Division

12.15 am. CO FIELDHOUSE enters G Division

12.16 am. Assistant GM ROBINSON enters G Division CO FIELDHOUSE leaves G Division

12.19 am. GM MANN enters G Division

12.22 am. Coroners staff member and gurney enters G Division

12.26 am. Coroners staff member, deceased and gurney leave G Division

12.30 am. Incident ceased log off

REVIEW OF THE INCIDENT

1. To describe the processes that were adopted in relation to the identification of the prisoner's condition and the subsequent handling of the incident;

Mr PAYNE was received into DCS custody from the Lyall McEwin Hospital on Friday 27 May 2011, he was admitted to the Holding Cells at 11.50 am. At 2.27 pm that date he was placed in a G Division Camera Observation Cell, Unit 4 Cell 1, due to a score of 14 on the Stress Screening Form.

Ms Karen HARLIN, the Nursing Director, SA Prison Health Services, advises that after admission Mr PAYNE was given NEULACTIL and DULOXETINE on a daily basis for anxiety. She advised the medication may also be used for the treatment of depression.

On Saturday 28 May 2011, Mr PAYNE complained of chest pains during the lunchtime lockdown and was conveyed to the YLP Infirmary at 1.37 pm for examination by Infirmary staff. He was returned to G Division at about 2.10 pm.

Case notes indicate that Mr PAYNE was assessed by Doctor MOSKWA (SA Prison Health Services) on the morning of the 30 May 2011, who recommended that Mr PAYNE be removed from camera observation and progressed accordingly. Subsequently on 31 May 2011 at 9.28 pm Mr PAYNE was transferred into a non camera cell, G Division, Unit 3 Cell 3.

On 1 June 2011, Mr PAYNE was seen by Ms IERACE of the High Risk Assessment Team (HRAT) who reported that Mr PAYNE had threatened suicide on his arrest but had no intention to follow through with these threats. Mr PAYNE provided background surrounding his relationship breakdown with his girlfriend and his methamphetamine use over the last 12 months. He was also scheduled to attended court on 2 June 2011. Ms IERACE advised Mr

PAYNE if he was remanded in custody after his court appearance that she would see him during the following week.

A further case note by Ms IERACI indicates that on 2 June 2011, at 10.30 am a HRAT meeting occurred. Subsequent to that meeting she advised that Mr PAYNE remains on HRAT and is off the yellow sheet.

Investigators Comment:

A 'yellow sheet' is a form that is issued by medical staff that reflects that a prisoner is considered to be at risk of committing self harm. It ensures that the prisoner is monitored daily by medical and also discussed by the High Risk Assessment Committee.

At 1.40 pm that date Mr PAYNE was conveyed from YLP to the Elizabeth Magistrates Court for a 2.15 pm court hearing. DCS Form 134 – Part 1; Prisoner Movement Order/Special Needs Information sheet identified that Mr PAYNE was a 'PRISONER AT RISK – WATCH AT ALL TIMES'. This form was provided to G4S Escort Officers who conducted the escort of Mr PAYNE.

When Mr PAYNE was returned to YLP. Departmental records indicate he was then placed into a camera cell at G Division Unit 1 Cell 1. This placement was made due to threats of self harm by Mr PAYNE whilst at court. Case notes indicate the Officer In Charge of YLP was made aware of the situation. Video footage obtained identified Mr PAYNE punching the wall of the cell on 3 occasions after correctional staff had left the cell.

Video Footage obtained from the YLP closed circuit television system indicates that Mr PAYNE gets out of the bed in the cell at about 7.28 pm and looks in the direction of the camera in the cell. He removes the canvas smock he is wearing and places the neck of the smock around the tap on the hand basin. He then climbs into the smock and leans his head forward over the collar of the smock and bends his legs. At 7.30 pm video footage shows that Mr PAYNE is outstretched facing downwards, the weight of his upper body appears supported by his neck in the collar of the smock and his legs are outstretched, his body is seen to be swaying slightly.

At approximately 7.58 pm. that date CO MAY, who was the Foyer Officer, observed Mr. PAYNE lying adjacent to the basin in his cell. CO MAY alerted CO FIELDHOUSE, the Patrolling officer and asked him to check on the welfare of Mr. PAYNE. CO FIELDHOUSE looked through the trap door and saw that Mr. PAYNE's smock was hooked around the tap in the cell and the collar of the smock was tight around the front of his neck. CO FIELDHOUSE attempted to raise Mr PAYNE's attention but he was not responsive. A 'code black' (medical emergency) was called by CO MAY.

CO FIELDHOUSE obtained the emergency key to open the outer door of unit 1 cell 1 and attempted to reach Mr PAYNE. CO OTTEY who was the Officer in Charge of the watch was in the Control Room of YLP at the time and immediately went to G Division where he met officer FIELDHOUSE with the inner door key. The officers then entered the cell and Mr PAYNE's smock was lifted off the tap and MR PAYNE was placed on the floor. The CO's then commenced resuscitation and cardiac compressions on Mr PAYNE.

At approximately 8.02 pm. Prison Health Staff Registered Nurse's JOHNSTONE, LOU, PIERCE, VICEBAN and Enrolled Nurse JO arrived and assisted with first aid. At this time Mr PAYNE was moved into the passageway where resuscitation continued on Mr PAYNE.

At approximately 8.16 pm. Paramedics arrived and commenced medical treatment on Mr PAYNE. The Paramedics ceased treatment on Mr PAYNE and he was pronounced deceased at 8.50 pm.

SAPol were advised and attended at the institution at about 8.26pm. The Manager Intelligence and Investigations Unit Mr W. KELSEY and Investigations Officer Mr D. MULLER attended at G Division at 9.40 pm. Police Officers from the Police Corrections Section attend at 10.04 pm to commence their investigation.

The pathologist formally pronounced life extinct at about 11.15 pm.

2. To determine the extent to which there was adherence to established procedures.

Admission process

Yatala Labour Prison

At 11.50 am on Friday 27 May 2011, Mr PAYNE was admitted to Yatala Labour Prison and staff completed the standard admissions documentation. Examination of the **'Prison Stress Screening Form'** reveals that Mr PAYNE scored 14. A score higher than 8 indicates that a prisoner is to be regarded as at risk and is to be referred to medical for further assessment. The screening process was conducted by Correctional Officer S. RAPISARDA.

Specifically Mr PAYNE was rated on his answers to the following questions:

INTERVIEW

Q1. Is this your first time in prison? YES
Q2. Are you facing further charges? YES
Q3. Has the offence or your imprisonment caused you a great deal of embarrassment or loss of family or community respect? YES
Q11. Have you ever been assessed or treated in a psychiatric hospital or James Nash House? YES OR NOT SURE.
Q12. Have you ever been diagnosed as having a psychiatric disorder? YES. The notation *'depression/maybe others'* was made alongside this point.
Q13. Has anyone in your family been diagnosed as having a psychiatric disorder? YES.
Q14. Have you used drugs regularly to relax or block out problems in the last month? YES
Q17. Has anyone in your family or a close friend ever committed suicide? YES/PERHAPS. The notation *'his mate when admitted to YLP'* was made alongside this point.
Q19. Note: Check the prisoner's wrists, arms and neck for scars. If present, do they appear to have been caused by suicide or self harm attempts? If prisoner has been in prison before check JIS Health History for previous self harm. NO
If present, note location and description (seriousness, number, age, etc.).
Notation made *'has made threats to police'*.

Q20. Have you thought about committing suicide since you were arrested or imprisoned? YES/MAYBE.
Q23. Do you feel that you have nothing to look forward to? YES
Q24. When answering the last four questions did the prisoner appear evasive or distressed? (if so record details below). YES/MAYBE.
Q25. Do you have any special fears about your imprisonment? (if yes or maybe, record concerns below). YES/MAYBE.

REVIEW OF OBSERVATIONS

Q27. Did the prisoner appear to show marked signs of depression? (e.g. were they tearful or emotionally flat). YES.
Q29. Did the prisoner appear overly anxious, afraid, angry, agitated or confused? YES.

It is stated on the screening form:

CONSIDER AT RISK IF:

1. Score is greater than 8; or
2. Any of the asterisked (**)/shaded items are positive (Yes or Maybe); or
3. Regardless of the score, the interviewing officer feels a further opinion is warranted.

If the answers to any of these comments is *'yes'*, the prisoner is to be referred to medical for further assessment. In this instance Mr. PAYNE scored 14.

The last portion of the Prisoner Stress Screening Form is the section headed 'notes and /or concerns resulting from the interview', the following notations were made in this section:

- *Camera obs - G Division*
- *Possible thoughts of self harm*
- *First time in prison*
- *Has been on detention order*

The document indicated the Admits Nurse had been advised on that date.

A South Australian Prison Health Service "NOTIFICATION: VERY HIGH RISK OF ATTEMPTING SUICIDE – To Case Manager Co-ordinator or Officer in charge of Prison" was issued at 1.00 pm on 27 May 2011 for Mr PAYNE stating that:

> *He was assessed as VERY HIGH RISK and our recommendation is he be placed under constant observations – his name be added to the list of clients on Suicide Risk Assessment Care Plan (yellow sheet) observations AND added to the list of clients to be discussed at the next High Risk Assessment Team meeting.*

This document resulted in Mr PAYNE's placement in G Division. Mr PAYNE's movements within G Division are noted on JIS Records and Journal entries.

A DIRECTION TO KEEP A PRISONER SEPARATE AND APART.
CORRECTIONAL SERVICES ACT 1982, SECTION 36 (2) (b) – SAFETY OR WELFARE OF THE PRISONER in the name of Mark William PAYNE # 163523 was prepared.
The Direction indicated that:

Pursuant to Section 32 (2) (b) of the Correctional Services Act 1982, I hereby direct that you be kept separate and apart from all other prisoners until this direction is revoked.
This direction is made in the interests of the safety and welfare of the prisoner.
The grounds on which this direction is given are as follows:
You have made threats of self harm, you will be placed in G Division.
Pursuant to Section 24 (2) (b) of the Correctional Services Act 1982, I herby inform you that while you are separate and apart from all other prisoners your regime will be changed from:
Admission** to **ICM – 1 (Camera Obs)

The document was prepared at 2.00 pm on 27 May 2011 by Mr ROBINSON the Assistant General Manager of YLP, it was served on Mr PAYNE on 27 May 2011 at 2.45 pm by CO FISHER. The documentation indicates that Mr PAYNE refused to sign it.

The JIS Court Appointment Details show that Mr PAYNE was removed from G Division for conveyance to the Elizabeth Magistrates Court at 1.40 pm on Thursday 2 June 2011. The Prisoner Movement Order/Special Needs Information (DCS Form 134 – Part 1) that refers to Mr PAYNE's movement on that date is stamped in the any other security requirements section '*PRISONER AT RISK WATCH AT ALL TIMES*'. Box 9 – Suicidal Tendencies and Self Harm Tendencies – has this prisoner a history of suicidal tendencies and/or self harm – YES (ticked). Mr PAYNE was returned to G DIVISION at about 5.46 pm on that date.

Correctional Officer HILLIKER was the Supervisor in the Holding Cells on Thursday 2 June 2011, he was on Swing Shift (12 noon – 8.00 pm). He stated he received a phone call that afternoon from a person who said that he was Mr PAYNE's lawyer. This person had advised that Mr PAYNE has made threats to harm himself or take his life in the event that he was returned to prison. CO HILLIKER notified the officer that was in G Division *"doing the watch"*, so that Mr PAYNE would be placed on observation in a camera cell. He also spoke to the Officer In Charge, CO OTTEY who was the person in charge of moving Mr PAYNE from the Holding Cells and returning him to G Division. CO HILLIKER said that he had received the paperwork from G4S on Mr PAYNES return and that there was a yellow post it note attached to the paperwork confirming Mr PAYNE's threats whilst at court. As he was taking action in regard to Mr PAYNE being observed he discarded the note in the bin. CO HILLIKER said that it was normal practice to put a prisoner on an observation regime anytime a prisoner threatens self harm regardless of their placement at the time. In this instance he had done it verbally.

Director's Memorandum No. 29 (issued 29/01/09) states:

Re: Information in relation to concerns for the wellbeing of prisoners.

This Director Memorandum supersedes the Minute from the Director on this subject. Issue date 27/01/06.

> *Where information concerning the wellbeing of prisoners is received from family members, visitors, staff, offenders, or any other person, this information must be clearly and accurately recorded in the Departmental Log Book at that location by the staff person/officer to whom this information was given.*

This information must be immediately brought to the attention of the Duty manager/OIC by the person to who the information was provided.

The Duty Manager /OIC must immediately take the appropriate actions to ensure the wellbeing of the prisoner is not compromised (e.g. Notification to HRAT/Prison Medical).

The Log entry must be sighted and signed by the OIC/Duty Manager noting Actions taken.

General Managers are to ensure:

- *That this directive is posted at all appropriate locations and that all staff are made aware of this directive via musters;*
- *A log book is located at all locations likely to receive information of this nature; and*
- *Where such information is received by phone in a location where a Log Book is not kept, that staff are aware of the requirement to immediately forward the call to the Control Room.*

FINDING:

CO HILLIKER was the Supervisor in the Holding Cells at the time he received the notification by phone regarding the threats to self harm by Mr PAYNE made whilst at court. A Log Book is not kept at the Holding Cells.

CO HILLIKER did not forward the call to the Control Room, but advised the Officer In Charge of the phone call he had received from Mr PAYNE's lawyer regarding the threats of self harm by Mr PAYNE at court.

CO HILLIKER did not advise the OIC that G4S had corroborated the threats of self harm by a yellow post it note attached to paperwork returned with Mr PAYNE as he felt it unnecessary because a process had already been put in place regarding the threats.

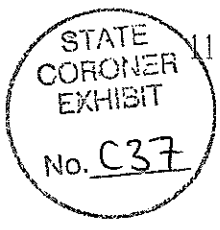
CO OTTEY acknowledged that he spoke to CO HILLIKER and that he escorted prisoner PAYNE to G Division where he was placed on camera observations.

FINDING (Reference Director's Memorandum 29):

CO OTTEY was the OIC and was responsible for the running of the Control Room. An entry was not made in the Control Room Log regarding the threats of self harm by Mr PAYNE.

CO HILLIKER arranged for Mr PAYNE to be placed on camera observations and advised the OIC Mr OTTEY of this.

Examination of the Justice Information System (JIS) revealed that MR PAYNE was placed in Camera Observation Cell G1-01 at 6.13 pm that date.



At about 7.00 pm. Mr PAYNE's mother telephoned the YLP Control Room and spoke to CO ASKINS. She raised the concerns she had that her son may self harm. At the time CO ASKINS was in the control room and advised Mrs PAYNE that he could see her son on the monitor in the control room and that he was fine. No further action was taken in relation to this call.

FINDING (Reference Director's Memorandum 29):

CO ASKINS did not record the information in the Departmental Log Book that he received in the telephone call from Mr PAYNE's mother regarding the possibility of self harm by Mr PAYNE.

Investigators Comment:

G Division staff were not advised of the individual call of concern from Mr PAYNE's mother with regards to Mr PAYNE. However holding cell CO HILLIKER did advise CO MAY of the need for Mr PAYNE to be placed into a Camera Observation Cell because of threats of self harm in accordance with Local Operating Procedure (LOP) 104. A notation regarding Mr PAYNE's movement to a camera cell was made in the G Division Foyer (1st Watch) Log at 6.10 pm.

The G Division Foyer (1st Watch) Log indicates that a patrol was conducted at 7.00 pm that date by CO FIELDHOUSE, the G Division Circle Patrol 1st Watch Officer and all prisoners were sighted with no obvious signs of distress. CO FIELDHOUSE stated that at the time he checked the cell occupied by Mr PAYNE he looked through the *"peep hole"* in the cell door and Mr PAYNE was lying on the bed and had looked back at him.

Investigators Comment:

YLP Duty Statement No 6 refers to the G Division Circle Patrol 1st Watch Officer *duties and states:*

Part 2. DUTIES AND RESPONSIBILITIES

2.13 Observations/sighting of prisoners ensuring that each prisoner is not showing signs of obvious distress: two hourly counts to be conducted and recorded in the log book.

The ***South Australian Department for Correctional Services Log Book*** *has a* ***Key Points for Staff*** *section within the front cover which states:*

> *"Following lockdown and the official count of prisoners where all prisoners must be physically sighted,* ***'Patrol Officers'*** *must carry out a patrol within each two hour period of the shift. All prisoners must be sighted, checking for any obvious signs of distress (direct observations of a prisoner's breathing, and/or skin may not be possible in all circumstances during each patrol). Journal entries must detail the patrol commencement time and any occurrences during the patrol, followed by the time the patrol was completed, and the names of the officers conducting the patrol....."*

Examination of the G Division Foyer Log indicates that CO FIELDHOUSE complied with his responsibilities in regards to the above stipulation.

ENTRY TO CELL

On discovering Mr PAYNE, CO FIELDHOUSE obtained the emergency key which opened the outer door of the cell in which Mr PAYNE was located. He was unable to access the internal cell door and attempted to reach Mr PAYNE through the trap doorway of the inner door without success. CO FIELDHOUSE ran back to the Foyer Officer CO MAY and told him to call a code black (medical emergency). CO FIELDHOUSE returned to the Mr PAYNE's cell but could not enter until the OIC entered with the inner door key.

SOP 44 – relates to KEY, LOCK AND SECURITY EQUIPMENT ISSUE and provides a detailed procedure for the persons who handle, administer and manage keys and equipment. The following are excerpts from that SOP:

PROCEDURE SUMMARY ONLY:
Employees and visitors, who handle, administer and manage DCS keys and security equipment during the course of their duties have a responsibility to ensure that:

- *Security keys and security equipment must be returned to the designated security equipment storage area when no longer required by the individual issued with the keys and/or security equipment.*
- *When security keys and equipment is returned, the receipting officer must sign all items in on the Key and Equipment Issuer Register.*

1. ***Procedure Statement***
   To ensure that a high level of security is maintained through effective management of security keys, locks and security equipment by outlining systems for the recording, storage, issue and receipt, handling and auditing of security keys, locks and equipment within DCS Facilities.

2. ***Rationale***
   To guarantee that a quality approach to the management of security key, lock and security equipment is maintained thereby ensuring a safe and secure environment for prisoners, staff and visitors.

3. ***Procedure***

   3.1 Key and Security Equipment Issue and Return

   3.1.2. The Manager of a correctional facility is responsible for designating security equipment storage areas where security keys/key bunches, key stores and security equipment will be stored in their institution. Security keys and security equipment must be stored in the following manner:

   a) Security keys and security equipment must be stored in a central secure, security equipment storage area/device when not in use.
   d) Access to the area where security keys and security equipment are stored must be restricted to authorised personnel at all times.

3.2 Key and Security Equipment Issue and Return

3.3.1 The Manager of a correctional institution is responsible for the administration and management for the issue and return of all keys and items of security equipment issue.

3.3.2 The following must be followed when managing the issue and return of security keys and security equipment:

e) In Institutions where keys and security equipment are stored in multiple locations, delegated officers must provide a report on key and equipment status to a central delegated officer. The central delegated officer will assume the responsibility for accounting for all issued keys and security equipment within that institution prior to staff standing down for meal breaks or at the completion of shifts.

The following are excerpts from the YATALA LABOUR PRISON – LOCAL OPERATING PROCEDURE NO 16 – ACCESSING MASTER KEYS AND SECURING PRISONERS AFTER HOURS.

*1. **Objective***
To detail the procedure for accessing master keys and securing prisoners after hours.

*2. **Scope***
This procedure applies to all custodial staff.

*3. **Procedure***
*Prior to handing over the divisions to 1st Watch staff, Day staff must ensure **all cells** are placed on master.*

3.7 At the completion of Swing Shift, the OIC is the only person authorised to access and use a Master Key during the 1st and 2nd Watch periods.

Investigators Comment:
The following information has been supplied by Mr Steven MANN, General Manager of the Yatala Labour Prison and relates to inner door access after hours by the Officer In Charge:

- *All cells within YLP are placed onto 'master' when all prisoners are secured for the day and can only be accessed after normal business hours by the OIC.*
- *Wing cells in G Division have both an outer door and inner door unlike all other cells within YLP, this was a specific safety design to support the role and purpose of G Division namely - providing an additional barrier for the safety of staff during normal operations and minimising unauthorised access to cells after hours*

- *G Division staff have emergency access to a master key for the outer door after hours however, they cannot enter a cell until the OIC attends the cell with a key to unlock the inner door, this in essence mirrors after hours access by an OIC to all other cells within YLP afterhours*

- *Emergency master key access to the outer door by G Division staff afterhours is a risk minimisation strategy that allows a face to face exchange between staff and prisoner but limited physical contact until the OIC arrives with the inner door key*

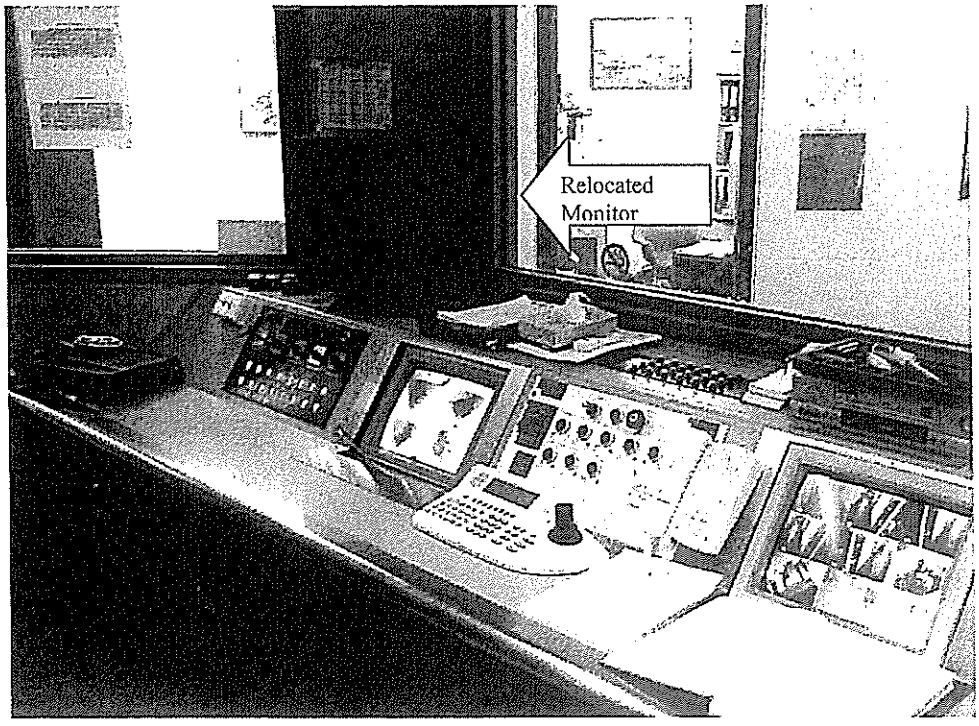
In short, no single staff member can access a cell after hours without the presence of the OIC however limited interaction can take place with G Division prisoners if the outer door is unlocked in an emergency.

PHYSICAL ENVIRONMENT

G DIVISION

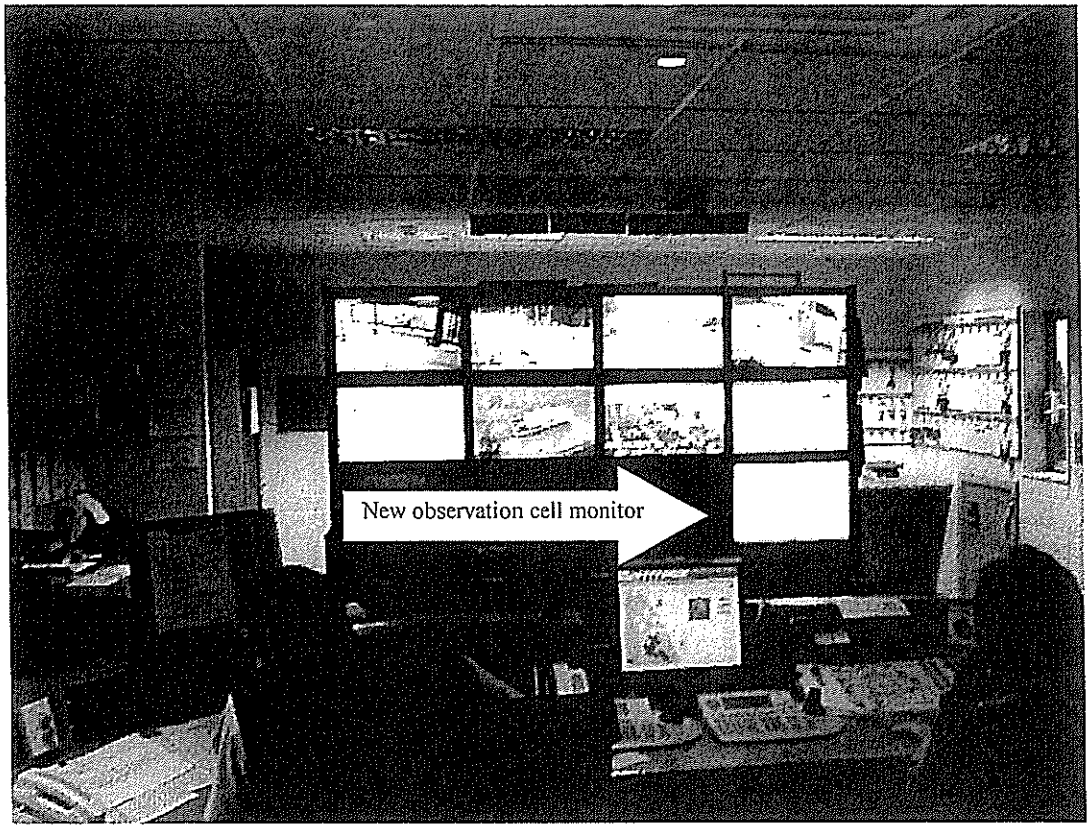
At the time of Mr PAYNE'S death there were two 14 inch monitors in the consol of the G Division Bunker. CO's working in the G Division bunker were able to select what video vision is viewed on the two monitors. Cameras in the Camera Observation Cells are fixed cameras which provide a basic view of the cell. The camera can not be remotely moved or zoomed in to a particular object in the cell.

An additional flat screen monitor was positioned adjacent to the telephone in the bunker. Video vision for this monitor has a dedicated video feed of the 4 Camera Observation Cells in G Division. Since this incident this monitor has now been moved and is now positioned above the consol in the G Division Bunker.



YLP CONTROL ROOM

At the time of Mr PAYNE's death there were 8 flat screen monitors which staff viewed. The monitors were positioned in two rows of 4 monitors. The monitors on the top row respond to video vision when an alarm is activated. The top right monitor (monitor number 4) is programmed to display for 5 minutes every half an hour the Camera Observations Cells in G Division. Monitors on the bottom row can be programmed to display specific video vision. For example the Control Room Officer may have a bottom row monitor display dedicated video vision of the four Camera Observation Cells. On 2 June 2011 Mr PAYNE was the only person in a Camera Observation Cell (cell G1-01). The Control Room Officer can program the bottom row monitor to display only cell G1-01.



CORRECTIONAL OFFICER TRAINING (DUTY OF CARE)

Amanda THOMSON is the Program Manager for the Correctional Officers Training Course for the DCS. Ms THOMSON stated that all CO's employed by the DCS have a six week classroom based training course which is known as the Correctional Officer Training Course. The course is undertaken by Trainee Correctional Officers and covers all aspects of basic training prior to entry into DCS.

The topic of 'duty of care' is discussed in detail in many sessions commencing with the Role of a Correctional Officer. The legal implications are discussed in the context of the role of a CO and providing a service to prisoners in terms of safe, secure and humane containment. Once a prisoner is accepted into custody DCS has a duty of care to ensure their basic human

needs are met as per human rights and the Standard Guidelines for Corrections in Australia (Revised 2004).

The following is a quote from the handouts provided:

> *"Everyone working either directly or indirectly with prisoners is responsible to take reasonable care. While the principle of duty of care clearly extends from Departmental staff to prisoners in their care, it also extends to staff working together. It is important to pass on to other staff any information which it might be reasonable to say affects their safety."*

The importance of duty of care is emphasised throughout the course with class discussion, activities and handouts detailing the legal interpretation of duty of care as it is applied in a prison context.

In the session on Logbooks patrols and counts, regular observation and recording of prisoners is discussed (at least every two hours as per DCS SOPs) when prisoners have been secured in cell.

In the session on Prisoner death or critical injury, regular observation and recording of prisoners is discussed as well as the detailed procedures outlined in the SOP.

During the assessment of trainees on the course and as part of the requirements for attainment of Certificate III in Correctional Practice, duty of care is implicit.

PROCEDURES

YLP LOP 104 provides DCS employees with the procedures for the Observation of Prisoners at Risk of Suicide or Self Harm.

After admission to the YLP on 27 May 2011 Mr PAYNE was referred to the HRAT as a result of the high score he recorded on the Stress Screening Form and the assessment by Prison health Services.

On 30 May 2011 Dr MOSKWA assessed Mr PAYNE and recommended that he be removed from camera observations and progressed through the G Division prisoner regime.

On 1 June 2011 Ms Julianne IERACE of the HRAT met with Mr PAYNE. Mr PAYNE reported that he had threatened suicide on his arrest but had no intention to follow through with these threats.

On 2 June 2011 prior to attending court prisoner PAYNE was taken off the Suicide Risk Assessment Care Plan which is commonly known as a "yellow sheet". This would enable Mr PAYNE to progress through the prisoner regime as recommended by Dr MOSKWA.

On re-admission to the G Division at 6.17 pm. on 2 June 2011 Mr PAYNE'S regime was changed to camera observations in line with Director's Memorandum No 29. Mr PAYNE was placed in a Camera Observation Cell in G Division by the OIC CO OTTEY.

YLP Local Operating Procedure (LOP) 104 states in part:-

- *The control Room Officer is assigned with observing the prisoner/s on camera observations.*
- *The Control Room Officer must undertake an observation of prisoners on camera observation every 30 minutes and note any unusual incident in the Control Room Journal.*
- *Backup observation will be conducted by the G Division Foyer Control Officer via a dedicated split screen monitor.*

CO MAY stated that he worked in the G Division Bunker on the evening of 2 June 2011. He programmed the left side consol screen to display a dedicated split screen of the 4 camera cells while the other monitor displayed video from other cameras in G Division. CO MAY believes that dedicated larger flat screen monitor which continually displays a split screen of the 4 camera cells was turned off. He stated that it was his understanding that it was the "prerogative" of the CO's if they had the flat screen monitor on or off.

Between 7.00 pm. and 7.58 pm. CO MAY believes that he was data entering on the JIS. The JIS monitor is on the opposite side of the bunker. While working on the JIS monitor an officer would not be able to see the consol monitor which displayed the camera observation cells. A JIS audit was conducted on CO MAY'S JIS activity. The JIS audit revealed that CO MAY did not enter any data onto the JIS after 7.00 pm. on the evening of 2 June 2011.

CO DAVIS was the Control Room Officer responsible for the monitoring of the monitors in the Control Room at YLP during the evening of 2 June 2011. CO DAVIS did not change the video vision of the any of the bottom row monitors to enable a dedicated view of the camera cell. The only vision he received in the Control Room was when monitor 4 camera showed the camera cells for 5 minutes during every 30 minutes duration.

CO DAVIS recalled seeing the video vision of the camera cells at 7.06pm. because CO ASKINS was on the telephone talking to Mrs PAYNE when the vision was on the screen. CO DAVIS does not know why he did not see the video vision of the camera cells during the 5 minute duration which commenced at 7.37 pm. He stated that the Control Room Officer apart from monitoring the monitors also is required to answer telephone enquiries, monitor the YLP radio system, operate the automated gates throughout the YLP and operate the alarm system.

FINDING:

The Control Room Officer did not undertake 30 minute camera observations in accordance with LOP 104 when Mr PAYNE was in Camera Observation cell G1-01.

The G Division Bunker Control Officer did not provide backup observation while Mr PAYNE was in Camera Observation cell G1-01.

3. **To determine the appropriateness of the established procedures and to recommend any changes to those procedures.**

Mr PAYNE was placed in a Camera Observation Cell because there were concerns of self harm or suicide. Mr PAYNE commenced to hang himself at 7.29 pm. in Camera Observation Cell 101. CO's did not observe Mr PAYNE until 7.58 pm. when CO MAY saw Mr PAYNE in an unusual position in his cell.

Monitor 4 in the Control room was sequenced to show 5 minutes of video vision of the Camera Observation Cells for 5 minutes every 30 minute duration. If CO DAVIS had observed MR PAYNE when the video sequence had changed to the Camera Observation Cells at 7.37 pm. this would still have been 8 minutes after Mr PAYNE had commenced hanging himself.

CO OTTEY stated that the current system does not have any alarm to alert CO'S when the video vision of the Camera Observation cells is displayed.

To address this issue DCS has installed an additional monitor in the YLP Control Room with dedicated video vision of the 4 Camera Observations cells in G Division to ensure that there is a dedicated monitor to show only the vision from the Camera Observation Cells at all times.

The following:
CUSTODIAL SERVICES – EXECUTIVE DIRECTORS INSTRUCTION 58 -11,
dated 17 June 2011 has been distributed to the General Manager and all Staff Yatala Labour Prison and states:
RE: INSTALLATION AND MONITIORING OF NEW MONITORS IN CONTROL ROOM AND G DIVISION.

> *Following the recent Death of a prisoner in a G Division observation cell a new monitor has been installed in both the control room and G Division foyer. These monitors have been programmed to only view the observation cells in G Division.*
>
> *Staff working in the control room are expected to view this monitor regularly to reduce the risk of harm to a prisoner. This monitor is extra to those already in use and has been installed to ensure that the normal views of the prison are not reduced and that regular checks of prisoners at risk are maintained. For the purposes of this direction regular viewing is considered to be no greater than 3 or 4 minutes. Entries of these observations must be made in the journal every 30 minutes or following any adverse observations.*
>
> *Staff working in G Division are expected to view the monitor regularly when they are situated in the foyer where the monitor is located or have been advised that they have taken over primary responsibility for the monitoring of the prisoners in the observations cells when the supervisor has left the control room.*
>
> *At no stage are the monitors utilised for camera observations permitted to be turned off whilst any prisoner is on a Camera Observation Regime.*

FINDING:

Executive Directors Instruction 58 - 11 will ensure the anomalies of the current LOP 104 (Observation of Prisoners at Risk of Suicide/Self Harm) with regard to the time frames of camera rotation and the responsibilities of staff at the control room and at G Division are clarified.

SOP 90 – MANAGEMENT OF PRISONERS AT RISK OF SUICIDE OR SELF HARM was approved on 30 May 2011, it has been implemented in a number of institutions but has not yet commenced at Yatala Labour Prison. Whilst training of staff has recently started no training in relation to SOP 90 had been put in place prior to Mr PAYNE's death.
The following is an excerpt from SOP 90:

3.9 Special Observations

3.9.3 When notified by the Responsible Officer of a prisoner on observations, the Control Room Officer will maintain surveillance of the prisoner/s on camera, via a dedicated split screen monitor.

FINDING:

The timely implementation of SOP 90 will be beneficial in the management of prisoners at risk of suicide or self harm.

4. To review the incident in the context of all measures taken to date in response to Royal Commission or Coronial recommendations or any other catalyst;

Items Used
Mr PAYNE used the canvas smock that he had been issued and placed the neck area of the smock around a tap on the hand basin in the cell.

The smock is a standard issue for prisoners under observation and who threaten of self harm.

Whilst the smock was used by Mr PAYNE, the review team is of the opinion that the smock is a necessary requirement for prisoners in a similar situation to that of Mr PAYNE at the time.

Hanging Point
Recommendation No. 165 of the Royal Commission into Aboriginal Deaths in Custody, states in part that, *".....steps should be taken to screen hanging points in police and prison cells...."*

Mr PAYNE hanged himself using a smock he had been issued with that he anchored to a tap on a hand basin in his cell.

Cell Design
Attempted Suicide – [redacted] – G Division
At about 10.05 pm on Wednesday 14 April 2004 during a handover count of prisoners, correctional officer's located prisoner [redacted] in Cell 106 in G Division with a jumper wrapped around her neck and attached to the tap handle of the basin in the cell. An officer was able to reach through the inner cell door trap and remove the jumper from prisoner

[redacted]'s neck who slumped to the floor. Prisoner [redacted] was conveyed to the Royal Adelaide Hospital where she was assessed and treated.
The following recommendation was made in relation the suicide attempt by Ms [redacted]:

That the Director Physical and Financial Resources:

- *Reviews the current hand basins, showers and taps in 'G' Division to ensure they do not provide anchor points.....*

Investigators Comment:

This matter was tabled before the Investigations Review Committee. It was taken of the agenda on 10 October 2007.

Attempted Suicide – Self Harm – [redacted] - G Division
At about 3.25 pm on Monday 8 November 2011 prisoner [redacted] was observed in Cell 502 (Camera Cell) tearing up parts of a canvas blanket. She tied a strip of blanket around her neck and was tying a piece around the sink tap when correctional staff intervened. Staff had to struggle with the prisoner to release the material from her neck. She was subsequently removed uninjured to a Safe Cell (observation cell 105) to been seen by medical staff.
The incident report IR/2010/1619 recommended the following action:

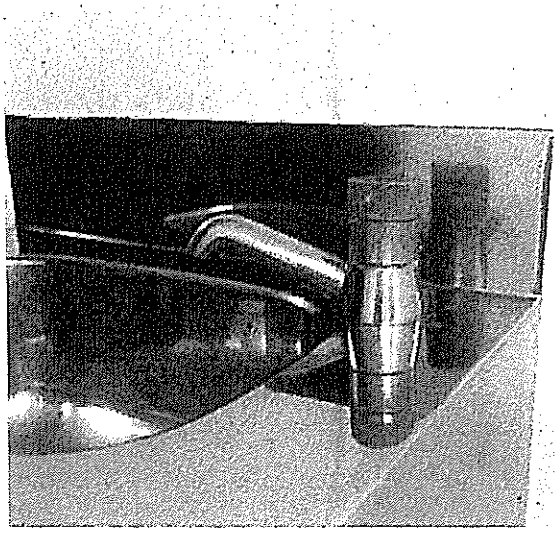
- *That the tap on the sink be replaced with a "safe cell" tap.*

Investigators Comment:

Following this incident the Unit Manager of G Division arranged the attendance of a plumber through the YLP Safety and Psychical Resources Officer and a safe cell tap was installed in cell 502. It was then realised that the other camera observation cells also contained similar taps to the tap used by prisoner [redacted] and previously by prisoner [redacted] as a ligature point. This work was not performed.

FINDING:

That the tap in cell G1-01 was an obvious ligature point which contributed in this instance to Mr PAYNE's death.



On 3 June 2011, a review of potential ligature points within the G Division cells was undertaken by the Accommodation Manager Mr GREEN and the Security Manager Andrew FORD. A number of ligature points were identified and reported to the General Manager of the Yatala Labour Prison. Amongst this were the tap fittings in the observation cells.

Investigators Comment:

Asset services have advised that the four observation cells have all had the old detached toilet and hand basins removed and replacement stainless steel combination pan and basin units have been fitted. The new units do not have any pipe work or tap ware that can be used as a ligature point. This work was signed off and completed on 31 August 2011.

5. Other circumstances which may have contributed to the death

Police Charges

Mr PAYNE was on remand on charges of Trespass in a Residence; Fail to Comply with Bail Agreement and Hinder Police. He had appeared in court on the 2 June 2011 and his next court appearance was due the Elizabeth Court on 8 June 2011.

Note

Mr PAYNE left no note.

Visits

Mr PAYNE had nominated his mother and his de facto wife as visitors. Both had booked visits for the 4 and 5 June 2011, however no visits occurred.

Mail

Mr PAYNE received the following by mail:
31/05/2011 - $30.00 Money Order from Sarah McKAY (listed as his de facto wife).
01/06/2011 - Letter from Centrelink.
03/06/2011 - $100.00 Money Order from Pam PAYNE (mother).
03/06/2011 - Letter from Centrelink.

Telephone

The prison telephone system indicates that Mr PAYNE made one call from YLP at 10.34 am on the 1 June 2011 to his mother Pam PAYNE on number 08 82844006. The duration of this call was 39 seconds. This call appeared to have been picked up by an answering machine. Mr PAYNE can be heard asking if anyone is there and there is no response. The prisoner can then be heard sobbing before a recorded message completes the call.

Other

Case notes indicate that Mr PAYNE had said that his life had *"spiralled out of control"* after he had been involved in an altercation with his fiancée's ex partner in relation to the treatment of his children and he and his fiancée had separated. He had also been using methamphetamine over the past 12 months which did not help the situation. Prior to this he had not been in trouble and had never used drugs. Mr PAYNE had made a number of threats of self harm and had reportedly said that if he was *"locked away"* he would *"neck himself"*.

On attendance at court on the date of his death Mr PAYNE had allegedly said that he would harm himself or take his life if he was returned to prison.

Information was supplied to Police Corrections Section by Mr PAYNE's mother after his death in reference to a 'pact' that Mr PAYNE had with Andrew GILL who died as a result of injuries he sustained at the Adelaide Remand Centre on 1 June 2005. Mr GILL died on the 2 June 2005 at the Royal Adelaide Hospital after jumping head first from the mezzanine floor in an accommodation unit of the remand centre.

CONCLUSION

Mr PAYNE died at the Yatala Labour Prison on 2 June 2011 and the Police have indicated that the probable cause of death was due to hanging.

The review team is of the opinion that there was information available from various sources concerning Mr PAYNE's mental state, which collectively, raised concerns as to the potential for him to harm himself and as such he was placed on camera observations.

The fact that his activity in the cell was not monitored correctly is in the opinion of the review team the major contributing factor in his death.

Terry NELSON
Investigations Officer
Intelligence and Investigations Unit

4 October 2011

William KELSEY
Manager
Intelligence and Investigations Unit

4 October 2011