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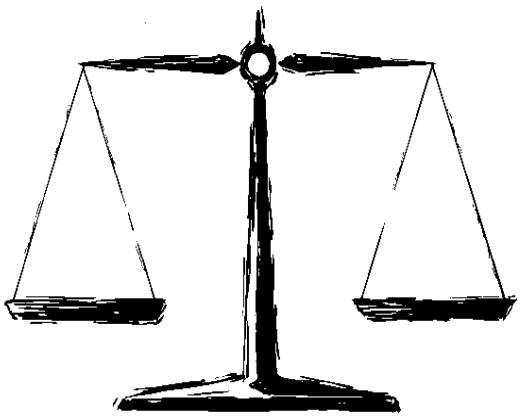

MAGISTRATES COURT

TASMANIA

FINDINGS
DEATHS IN CUSTODY
INQUEST

Chris William DOUGLAS
Thomas Patrick HOLMES
Jack NEWMAN
Laurence Colin SANTOS
Fabian Guy LONG

Coroner S Tennent
26 March 2001

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OPENING SUMMARY

This document relates to an inquest held in the deaths of 5 people **CHRIS WILLIAM DOUGLAS, THOMAS PATRICK HOLMES, JACK NEWMAN, LAURENCE COLIN SANTOS** and **FABIAN GUY LONG** all of which occurred within the Risdon Prison complex at Risdonvale. Their deaths occurred between the 4/8/99 and the 10/1/00.

On the 22/2/00 the Chief Magistrate directed pursuant to Section 50 of the Coroners Act 1995 ("the Act") that inquests into the above deaths be held together. The investigations in relation to each death had been ongoing since they occurred. From my knowledge of those investigations it was my view that there were many issues common to the deaths which needed to be explored and it was appropriate to deal with them together. The formal hearings at which evidence was taken and submissions from interested parties were heard commenced on the 20/3/00 and concluded on the 16/8/00. On the opening morning of the hearings, I visited the prison complex together with Counsel Assisting and Counsel appearing for parties granted leave to appear. This proved invaluable during the taking of evidence from custodial officers, prison staff and prison inmates in that it allowed for a much easier understanding of the evidence where it involved references to places within the complex. It also provided some assistance when submissions were made.

A coroner has specific functions in relation to any death. His or her role is expanded where that death occurs in custody. Section 28 of the Act sets out a coroner's duties and it provides as follows:

28. (1) *A coroner investigating a death must find, if possible -*

(a) *the identity of the deceased; and*

(b) *how death occurred; and*

(c) *the cause of death; and*

(d) *when and where death occurred; and*

(e) *the particulars needed to register the death under the Registration of Births and Deaths Act 1895; and*

(f) *the identity of any person who contributed to the cause of death.*

(2) *A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.*

(3) *A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.*

(4) *A coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence.*

(5) *If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that person was escaping or attempting to escape from prison, a detention centre or police custody or from an institution, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care.*

The Registration of Births and Deaths Act 1895 provides for there to be findings as to the date and place of birth and the sex of the deceased.

The role of a Coroner is essentially to make findings of fact.[1] The Coroner must if possible identify any person who contributed to a death but it is unwise to attempt to define contribution and a common sense approach is to be preferred.[2]

In considering the evidence before a Coroner and determining findings to be made based on that evidence, the standard of proof is that of balance of probabilities. However it is appropriate when dealing with findings under section 28(1)(f) to adopt the test postulated in *Briginshaw v Briginshaw* [1938] 60 CLR 336.[3] Dixon J. said at pages 362-3

> *"reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. 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 to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect references… When, in a civil proceeding, a question arises whether a crime has been committed, the standard of persuasion is, according to better opinion, the same as upon other civil issues…. But, consistently with this opinion, weight is given to the presumption of innocence and exactness of proof is expected."*

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[1] See Keown v Khan [1999] 1 VR 69 at page 75
[2] See Commissioner of Police v Hallenstein 2 VR 1 at page 18
[3] See also Anderson v Blashki [1993] 2VR 89 at page 95-96 and Hallenstein (supra) at page 19

The statutory obligations of those in authority and the statutory rights of those detained by them are also worth noting. The Corrections Act 1997 which came into effect on the 1st August 1998 contains a number of relevant provisions. That act was enacted *"to provide for the establishment, management and security of prisons and the welfare of prisoners and detainees, ……and to provide for related matters"* [4]

Section 3 contains a number of definitions:

"detainee" - means a person, other than a prisoner, who is subject to an order of a court by which he or she is remanded or otherwise committed to prison
"hospital" - means a place approved as a hospital under section 35
"prison" - includes a place of detention irrespective of the title by which it is known, and includes the whole area, whether or not walled or fenced, established as a prison
"prisoner" - means a person who is subject to an order of a court by which he or she is sentenced to a term of imprisonment

Section 6(1) provides in relation to the Director of Corrective Services:

"The Director is responsible to the Secretary

(a) for the care and direction of all prisons, prisoners and detainees and the control of all prisons; and

(b) for the order and control of all prisoners and detainees."

Section 29 (1)(f), (g) provide:

"Every prisoner and detainee has the following rights

(f) the right to have access to reasonable medical care and treatment necessary for the preservation and health;

(g) if intellectually disabled or mentally ill, the right to have reasonable access within the prison or, with the Director's approval, outside the prison to such special care and treatment as a medical officer considers necessary or desirable in the circumstances."

A number of coronial findings have been handed down over the 10 years prior to the first of the deaths the subject of this inquest which related to deaths of persons in the Risdon Prison Complex, ie in either the prison proper or the prison hospital. Findings were handed down in 1992 (Kelly), 1994 (Crowder), 1995 (Crowden), 1996 (name restricted) and 1999 (Hayes). All of these inmates died

[4] See preamble to the act

as a consequence of hanging. There have been other findings. It was a significant feature of this inquest that it heard evidence about a number of issues about which evidence had been heard and findings made in previous inquests.

Quite clearly, having assessed the evidence that I heard in this inquest, many of the findings and recommendations made by earlier coroners have been completely ignored by those authorities who have responsibility for the care of persons at the prison complex.

ORDERS RESTRICTING PUBLICATION

Orders have been made restricting the publication of various parts of the evidence. Unless otherwise specified there is an absolute restriction pursuant to Section 57 of the Coroners Act 1995 against the publication of the following material:

1. Exhibit 2 being a plan of the layout of Risdon Prison. [5]

2. Any evidence relating to the bruising on the buttocks of Chris Douglas found at post mortem and any other evidence relating to the possible cause of that bruising.[6] (The order restricting publication of this information was vacated on 26 March 2001)

3. The telephone and direct contact arrangements in relation to Dr. Jager.[7]

4. Any part of the material comprised in the tape recording which is exhibit 40 and in the transcript which is exhibit 41 appearing after the words "No, I won't, I'll get on to them." (on page 8 of the transcript)[8]

5. The name of a witness "X" (a counsellor) who appeared at the Inquest on the afternoon of 24 March 2000.[9]

6. The words on page 4 of the original affidavit of Mark Thomas Armstrong [10] starting 7 lines from the bottom with the words *"Fabian was known as the…"* and ending with the words *"head job"* on the next page.

7. The paragraph on page 8 of the original affidavit of Steven Roy Edwards commencing on the third line of that page *"I have also heard he had…".*[11]

8. The sentence commencing on page 5 at the end of the fourth line of the original affidavit of Michael James Smith [12] with the words *"I had also heard rumours that…"* and to the end of that paragraph.

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[5] See transcript page 79 line 1534
[6] See transcript page 2386 line 7881
[7] See transcript page 280 line 3719
[8] See transcript page 511 line 803
[9] See transcript page 607
[10] See exhibit 148 and transcript at page 1478
[11] See exhibit 155 and transcript pages 1547 and 1548
[12] See exhibit 160 and transcript page 1629

9. Four paragraphs commencing on the third page of the original affidavit of Kenneth Ross Bain sworn the 2/2/00 with the words *"In February 1998 I received a report from one of my officers….* and ending with the words *"opportunity to bring this back up"* on the fourth page.[13]

[13] See exhibit 202 and transcript page 1752

WITNESSES

(in order of appearance and with occupation at time of incident in respect of which evidence given)

1.	Stephen Charles Lawler	Custodial Officer
2.	John David King	Custodial Officer
3.	Hugh Goodwin	Custodial Officer
4.	Dale Ernest Fawkner	Custodial Officer
5.	Malcolm Scott Harris	Custodial Officer
6.	Alexander Cowley	Custodial Officer
7.	Brian John Thomas	Custodial Officer
8.	Michael Keith Wildbore	Custodial Officer
9.	Donald Craig Lehner	Custodial Officer
10.	Arnold Dick Van Leeuwen	Custodial Officer
11.	Blair Francis Saville	Custodial Officer
12.	Shane Andrew Lawrence	Custodial Officer
13.	Darryl John Streets	Inmate
14.	Dean Richard Fitzpatrick	Inmate
15.	Daniel Luke Bennett	Inmate
16.	Mark Rodney Jones	Inmate
17.	Robin James Clark	Inmate
18.	Mark Anthony Riley	Inmate
19.	Vicki Lee Douglas	Mother (Chris Douglas)
20.	Neville Winston Howell-Smith	Nurse
21.	Sharon Ann O'Halloran	Custodial Officer
22.	Christopher Ronald Welch	Inmate
23.	Timothy James McKenna	Inmate
24.	Witness X (Name suppressed)	Counsellor
25.	Winston Fairbrother	Inmate (Hospital)
26.	Karl Woisetschlager	Custodial Officer
27.	Peter John Hughes	Custodial Officer
28.	Stephen Frank Davidson	Nurse
29.	Victoria Georgina Norris	Nurse
30.	Christine Geraldine Webster	Nurse
31.	Rosaleen Macaulay	Former Partner (Thomas Holmes)
32.	Peter Michael Holmes	Brother (Thomas Holmes)

33.	Brett St. Clair Berry	Police Officer
34.	Craig Douglas Mackie	Solicitor (Thomas Holmes)
35.	Gary John Williams	Police Officer
36.	Kriss Ellison Lawler	Police Officer
37.	Sharon Fae Carnes	Custodial Officer
38.	Ian Gregory Smith	Custodial Officer
39.	John Mark Radcliffe	Custodial Officer
40.	Jo-anne Thompson	Nurse
41.	Scott Darrell Shaw	Nurse
42.	Ian Rex Balmer	Clinical Nurse Consultant, Programs Psychiatric
43.	Russell Ashby Pargiter	Consultant Psychiatrist
44.	James Graham Galloway	Pharmacist
45.	Steven Roy Edwards	Nurse
46.	John Frederick Cassidy	Nurse
47.	Gaye Elizabeth Brown	Forensic Services secretary
48.	Kim Maree Woodberry	Records Clerk, Prison
49.	John Philip Schofield	Police Officer
50.	Richard Gordon Dickenson	Inmate
51.	Glenn Reginald Jackson	Custodial Officer
52.	Alan Smith	Custodial Officer
53.	Judith Anne Santos	Mother (Lawrence Santos)
54.	Kim Anthony Barker	Custodial Officer
55.	Kenneth Maxwell Collins	Inmate
56.	Mark Thomas Armstrong	Inmate
57.	Kevin Richard Bell	Inmate
58.	Jason Steven Halliday	Inmate
59.	Stephen Grant Randell	Inmate
60.	Melissa Jean Bailie	Inmate
61.	John Beadle	Prison Medical Officer
62.	Basil John Fraser	Senior Custodial Officer
63.	Steven Mark Gridley	Senior Custodial Officer
64.	John Anthony Gilbert	Police Officer
65.	Ian Michael Sale	Consultant Psychiatrist
66.	Denise Erica Mullan	Mother (Fabian Long)
67.	Leanne Mary Millhouse	Family Friend (Fabian Long)

68.	Elida Assenheimer	Psychologist (Forensic team)
69.	Colin Baldwin	Probation Officer
70.	Georgia Anne Hickman	Probation Officer
71.	Kenneth Ross Bain	Unit Manager, Risdon Prison Hospital
72.	Craig Anthony Hughes	Custodial Officer
73.	Alan Burton	Unit Manager, Security, Prison
74.	Norman John Dodd	Director of Prisons
75.	Ivor Jones	Emeritus Professor, Psychiatry
76.	Kenneth Kirkby	Professor of Psychiatry, University of Tasmania
77.	Timothy John Lyons	Forensic Pathologist
78.	Denbeigh Richards	Deputy Secretary, Department of Justice and Industrial Relations
79.	Jacob George	Consultant Psychiatrist
80.	Kevin Douglas Salter	Accommodation Manager, Prison
81.	Kathryn Claire Campbell	Government Analyst
82.	Graeme Harris	General Manager, Prison
83.	Wilfred Prazeres Lopes	Consultant Psychiatrist (formerly Clinical Director Forensic Mental Health Service)
84.	Paul DeBomford	Director of Nursing, Prison Hospital
85.	Stuart Ramsay McLean	Associate Professor, Pharmacy Department, University of Tasmania
86.	Colin Wayne Harris	Mental Health Social worker (Forensic team)
87.	Rosemary Vivian Schneider	Consultant Psychiatrist
88.	Estelle McCarthy (Dr. McCarthy)	Psychologist (Forensic team)
89.	Gregory John Jones	Operations Manager (Prison)
90.	Wendy Joy Quinn	State Manager, Mental Health Services
91.	Sandra Kathleen Barwick	Nurse (Forensic team)
92.	George Robert Henry Kelsall	Forensic Pathologist
93.	Melanie Allen	Southern Manager, Mental Health
94.	Alan Deighton Jager	Clinical Director, Forensic Services

CHAPTER 1 RISDON PRISON COMPLEX

For the purpose of these findings the complex will be viewed as consisting of the main prison and the prison hospital. The complex is operated by two government departments. The main part of the prison is operated and staffed by the Department of Justice and Industrial Relations ("DJIR") through it's Corrective Services Division. The hospital is operated by the same department which employs both custodial and nursing staff. However there are also staff employed by the Department of Health and Human Services ("DHHS") who comprise the Forensic Mental Health Service ("FMHS") team which staff work within the hospital as well.

There is a separate management structure responsible for the employment and management of each of these two groups.

Further the hospital is, within the meaning of section 6A of the Mental Health Act 1963, a special institution. It was made so by virtue of the Mental Health (Special Institution) Order 1979. By virtue of this, the hospital is not only a hospital in the ordinary sense but is also an institution in which persons found not guilty of crimes by reason of their mental state may be securely housed.

The deaths under investigation are said to have occurred in E Division of the main prison and in the inpatient area of the prison hospital. The people who died were not all persons convicted of crimes at the date of their death. Chris Douglas was on remand awaiting trial on serious charges, Thomas Holmes was also on remand, Jack Newman and Laurence Santos were the subject of orders under mental health legislation while only Fabian Long was serving a sentence.

Exhibit 2 tendered to the inquest was a plan of the prison complex. While a restriction order has been made in relation to that plan, it is useful to know the general layout of the areas where the deaths occurred.

E Division consists of a yard across the front of which is a wire mesh fence. Around both sides and the rear of the yard there are cells. On the ground floor as you face into the yard there are 12 cells along the left hand side of the yard and 6 along the back. Not all of these are currently used as cells, the E division office being at the front with a laundry and toilet behind. On the first floor level, accessed by means of stairs at the front left of the yard are cells running round 3 sides of the yard. There is a walkway in front of the cells.

To the right front of the yard on ground level there is the combined E and F Division office. Behind that on the right hand side of the yard at ground level underneath a row of cells is an open area where inmates can be outside but under shelter. In that area there is a phone which can be accessed by the inmates. It is that phone which is part of the Arunta recording system to which I will refer later. Access to the yard is from a walkway which runs along the front of a number of yards. That is also enclosed by wire mesh. Beyond that walkway is an open area around which the main body of the prison is built.

Chris Douglas occupied Cell 20 which is upstairs on the left as you face in to the yard, almost above the E yard office. Fabian Long occupied Cell 42 which is also upstairs but on the right hand side. As to each of those cells, photographs were tendered to the inquest. Those which are exhibit 3 relate to Chris Douglas and his cell. Those which are exhibit 7 relate to Fabian Long and his cell. Both cells are essentially the same. They are rectangular. The door has no window. To the left of the door is a window which consists of a number of panes. Most are glass while some are wire mesh. There are vertical bars behind this panel of glass panes and mesh. The floor is concrete and as you enter the cell to the left there is a toilet and basin.

After the toilet and basin, the left wall is recessed back about two feet. Attached to that wall of each of the cells, there is an old heater which consists of metal piping snaking up the wall and comprising 8 horizontal rungs. The lowest rung of the heater where it exits the wall of the cell into the cell is only a few feet off the floor while the top rung where the pipe re-enters the wall is several feet off the floor.

As to the hospital complex, the cells in which Jack Newman, Laurence Santos and Thomas Holmes died were in the southern and eastern wings of that set of buildings comprising the hospital. Those wings run off a central square area at right angles to each other. In that central area there is what is known as "the roundhouse" which is the central observation area for staff. Staff in the roundhouse are able to look down the corridors of each wing. The roundhouse itself is able to be secured and each of the wings can also be locked. On the other side of the roundhouse from the south and east wings there are observation cells which face directly into the square occupied by the roundhouse. These cells are used to house on a short term basis inmates who are considered to be at varying levels of risk of suicide.

These areas are secure and are what may be described as the inpatients section of the hospital. They may be accessed from basically two directions. One is on the western side of the hospital where people may enter from the main part of the prison through a garden area. The other access is through what is known as the outpatients section of the hospital which is situated at the opposite

end of the building from the inpatients south wing. That consists of a number of offices and other rooms.

The prison hospital is a discrete set of buildings set apart from the main part of the prison. While it sits within the overall perimeter fence of the prison and may be accessed through the main prison, it is not necessary to do so. It may be accessed by, once entering within the perimeter fence, driving round to it and entering from it's own parking area.

The rooms occupied by Newman, Santos and Holmes in the hospital are to all intents and purposes cells. They are brighter and airier than cells in the main prison, they having the advantage of large external windows. The doors accessing them have a window through which an occupant may be observed.

CHAPTER 2 - CHRIS WILLIAM DOUGLAS

A. Formal Findings

I find that Chris William Douglas ("Chris") died in Cell 20, E Division, Her Majesty's Prison, Risdon on the 4/8/99. [14]

I find that he was a male person born at Hobart on the 14/3/81. He was aged 18 at the date of his death. [15] He was at that time an inmate at the prison, being held on remand on charges relating to the death of an elderly person.[16]

I find that he died as a consequence of neck compression due to hanging.[17] I find that he utilised a piece of cord, one end of which he tied to the disused heater attached to the wall of his cell with the other end being tied around his neck. He then suspended himself from the heater with the intention of taking his life.

I find that the following contributed to the cause of death:

(a) Chris himself in that he took the actions which ended his life

(b) the DJIR in that it failed to provide a physical environment which would minimise the risk of self harm and a system of care which would recognise a vulnerability to suicide and actively provide for steps to prevent it.

B. Discussion of Evidence Relating to Death

For the sake of convenience and with no disrespect I propose to refer to Chris William Douglas in these findings as Chris, this being largely the manner in which he was referred to during the course of the inquest.

In relation to Chris's death, evidence was presented in the form of files, prison documents and affidavits and oral evidence from a number of custodial officers, prison inmates and professionals. The evidence given at the inquest covered a number of areas. These were Chris's history as far as the prison was concerned, the events leading up to the evening of his death, the events of the night

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[14] See Affidavit of Stephen Charles Lawler sworn 5/8/99 and Simon Butterley sworn 19/11/99
[15] See affidavit of Vickie Lee Douglas sworn 18/8/99
[16] See copy Prison file (exhibit 58)
[17] See affidavit of Timothy John Lyons sworn 23/12/99 (exhibit 226)

of the 4/8/99 and prison practices and procedure in so far as they potentially affected Chris's death. I propose to deal with the evidence under those headings.

History

Chris was sentenced on the 12/6/98 to an effective period of 5 months imprisonment on charges of aggravated burglary and stealing. He was then only 17 years old but was already well known to the authorities. He had been diagnosed with Attention Deficit Disorder when he was 15 years old and had been medicated periodically for that. He had been in trouble with the police and involved in drug use for some time when he came into custody in June 1998. He escaped from custody on the 12/7/98 and was recaptured on the 15/7/98. He completed his sentence and was released from prison on the 4/10/98. Approximately 3 weeks later, Chris was arrested and charged with motor vehicle stealing, aggravated burglary and wounding with intent to do grievous bodily harm. He was remanded in custody on those charges on the 27/10/98. He was placed at Risdon prison, the remand centre at the time being built in the city not yet being open. The elderly lady, the victim of the alleged offences, then died and Chris was charged with murder. At the time of Chris's death he remained on remand on that charge and was next due to appear before the Supreme Court on the 30/8/99. [18]

When Chris re-entered the prison on the 27/10/98, he was initially housed in N Division for his own protection because of his age despite his wanting to move to E Division. His prison file showed that on the 29/10/98 he was in the prison hospital but it does not show when he was placed there, why he was placed there or when he left. The only note appeared on the back of a report form of an incident involving Chris in cell 4 in the west wing of the prison hospital . It reads

> *"To Gen. Mgr, Inmate Douglas C had been placed in the Prison Hospital by nursing staff on Suicide Category B prior to this disturbance. Dr. W. Lopes had assessed the inmate after the incident and the behaviour is <u>not</u> related to mental illness."*

The file disclosed Chris was in N Division on the 19/11/98 because there is a note of his asking to go to E Division. This request was refused. There is a note of, it appears Mr. Greg Jones the operations manager of the prison, to the effect that Chris was considered to be at serious risk because of the nature of his offences and would therefore remain on N Division. The file showed Chris was in N Division on the 17/12/98 and on that day was placed in E Division at his request and despite an apparent warning from staff that he may be bashed. This decision was made only 4 weeks after the previous request and there is no explanation as to why the authorities felt Chris' situation had

[18] See copy Prison file (exhibit 58)

changed sufficiently to warrant the different approach to his request. At that point Chris was still only 17 years old.

On the 28/12/98 Chris was reported for causing damage to his cell in E Division. As a consequence he was "sentenced" to spend 28 days in N Division Eastside. On the 30/12/98 the file disclosed Chris, while in N Division, stated to Custodial Officer (CO) Blair Saville he was going to "neck up". As a consequence Chris was taken to the prison hospital and placed on "Cat A". That is the highest suicide category rating and means that an inmate would be placed in an observation cell, have all his clothes removed and basically have nothing in the cell that he might harm himself with. The observation cells are commonly described as "fishtanks". [19]

On the 4/2/99, Chris was the subject of a classification committee discussion. By that date it appears he was actually serving a term of imprisonment for escape (that which occurred in July 1998) and, on that charge, had a release date of the 23/2/99. He was then classified as maximum security. It appears he had asked to move from E Division and to work in the tailor shop. A decision appears to have been taken that he would go to F Division and work in the bakery from the 23/2/99 but would remain maximum security. This decision seems to have been taken against a background of Chris, after the 23/2/99, returning to the status of a remand prisoner. It is not possible to be more precise about the nature and reasons for Chris's movements within the prison complex because of the inadequate records.

The prison file disclosed that on the 20/6/99 Chris mutilated himself by cutting his arms. He told CO Lehner this and as a consequence was again taken to the prison hospital.

Chris's FMHS file was also produced in evidence.[20] It showed that on the 27/10/98 (the date he was taken into custody in respect of the alleged bashing of an elderly woman) Chris was referred for advice and treatment to the prison hospital. The referral advised

> *"1.extremely tearful 2.voiced self harm intent 3. Suicidal ideations 4. 17 yrs old 5. Agitated (punching and kicking cell walls)."*

Chris was seen by Dr. Lopes on the 30/10/98, who said he was

> *"……tearful….rather truculent, not suicidal, bit unstable, observe further, could be a risk from other inmates".*

[19] See transcript page 530
[20] See original Forensic Mental Health file (exhibit 56)

This file also showed a referral to the hospital for advice and treatment on the 20/6/99 as a consequence of Chris having cut his arm after having problems with his girlfriend. He was seen then by Dr. McCarthy who determined he had no suicidal ideation or intent of self harm. She reported he denied any intent to suicide. There is also a note to the effect Dr. McCarthy saw Chris on the 4/1/99 following threats of self harm. Her note said there was no suicidal ideation nor intent of self harm and she took Chris off all categories. There was no referral on the file relating to that attendance nor any indication of what if any suicide category Chris may have been on.

On this file there was also a community corrections court report dated the 3/6/98 attached to which was a report of Mr. Michael Marriot, a psychologist. That was a detailed report in which Mr. Marriot deemed Chris to have a borderline intellectual disability. That community corrections report could no doubt have provided very useful material as to Chris's background and situation for the FMHS. Unfortunately it is unlikely to have achieved that result because 3 of its 7 pages were missing.

The only indication of when Chris was returned to the yards after the June 1999 visit to the hospital was the ward round notes of Dr. Lopes and Dr. Benjamin which indicate

> *"no mental illness, not suicidal ,take off all categories, observe further 24 hours in hospital, then to yards - security decision as to disposal".*

The other prison record placed in evidence in relation to Chris was his prison medical file.[21] This file consisted of a number of loose pages. It contained the originals of the referrals on the forensic file and also contained nursing progress notes and the category forms. It showed Chris was on category A (that is maximum suicide precaution) on the 30/12/98 and the 20/6/99 and on a lesser category (B) on the 21/12/98 and 27/10/98.

A reading of the 3 files I have referred to shows

- there is no one clear record of Chris's movements around the prison complex and the reasons for them available to all staff in the complex
- the prison file, apparently kept in a loose leaf form, is unreliable as a source of information given the capacity to add and remove documents in any place and for documents to fall out when the file is used.

[21] See exhibit 57

Notwithstanding those comments, it is very clear from these files that prison and hospital authorities knew or ought to have known when they were dealing with Chris Douglas that they were dealing with a boy

- who was young, not very tall, slight in build and with a borderline intellectual disability [22]
- who had been charged with but remained on remand for serious offences, including murder, involving an elderly lady
- recognised to be at risk from other inmates in the yards[23]
- who had on 4 occasions between 27/10/98 and 20/6/99 been placed on suicide categories in the prison hospital
- who had self mutilated and threatened suicide.

As indicated there is nothing in these records to tell me when Chris was placed in E Division prior to his death. The evidence suggests he had been there for several months. There is evidence from more than one custodial officer that E Division was a "protection" yard and was used to house inmates considered in need of protection by reason of the nature of their crimes, their age or because they had a problem with an inmate in another division. The evidence was also that the division was one used to house those charged with or convicted as sex offenders, including rapists and paedophiles.

Events Leading up to the Evening of the 4/8/99

Chris was not allocated regular work nor it appears did he necessarily want it in the days leading up to his death. He spent most of his time in E yard either in the yard itself or locked in his cell. As to the day of Chris's death , I heard evidence from 6 inmates who were housed in E yard at the time and from custodial officers on duty. There was also other evidence about events prior to that day.

Dealing with the day itself, CO Lehner gave evidence that on the morning of his death Chris had asked to be locked in his cell. He said that Chris often did this. He said he locked Chris in about 9 a.m. A little after 10.30 a.m. Chris asked to be let out of his cell. He was and went downstairs into the yard. Between 15 minutes and an half an hour later Chris came up to the officer alone and asked to see the psychiatrist or "psych". The officer said he asked Chris if he was all right. Chris responded by saying his head was a bit funny. CO Lehner said he rang the prison hospital and spoke to CO Sharon O'Halloran. He thinks that he asked if Chris could come down and see the psychiatrist and that he was told he was in Hamburg and Chris might have to see Dr. McCarthy. CO O'Halloran told CO Lehner that Chris would still have to fill out a request form and give it to the nurse at the

[22] See report of M. Marriot on file being exhibit 56
[23] See prison file - exhibit 56

lunchtime medication parade. CO Lehner said he told Chris that. CO O'Halloran confirmed she received that phone call. She believed it to have been about 10.30 a.m. to 11 a.m. CO Lehner did not feel he had any obligation to have any continuing role in ensuring Chris put in a request. He said he knew Chris could read and write and he seemed quite happy.

All the inmates from E yard who gave evidence said they got on well with Chris and that he seemed to fit in. More than one described him as an attention seeker. More than one said he felt Chris was "down" because of uncertainty over how long he might be in prison. There was an indication he was upset at times in the days before his death, two reasons being given being that his grandmother was ill and a visit with his mother.

I heard differing versions of what happened during the day on the 4/8/99 from the inmates who had direct dealings with Chris. Some of that evidence is not consistent with that of CO Lehner. It is relevant because it impacts on the state of the knowledge of CO Lehner that day about Chris.

Inmate Streets asserted [24] he and Inmate Bennett were under the landing on the other side of the yard from Chris' cell watching television when Chris came downstairs after being let out of his cell mid morning. Inmate Streets said Chris told them *"Look Benno I just tried to neck myself"* and then showed them a piece of black TV antennae cord about a metre and a half long. Inmate Streets said they told Chris to see the officer. Inmate Streets then said he went to the entrance of E yard just near the E yard office to get the tea bucket. He said another inmate - Broderick- came over with Chris Douglas and Chris spoke to *"the officer"* saying *"Can you get me down to see the psychiatrist."* Inmate Streets says the officer told Chris that he had to put in a request. He said he saw Chris show the officer the cord and heard him tell the officer *"I just tried to neck myself"*. He said he also saw Chris give the officer the cord.

Inmate Streets then says he saw the officer make a phone call and come back to Chris and say there was no psychiatrist available. Inmate Streets asserts Chris said to the officer then

> *"If you don't get me down there I'll do it again tonight"*.

He said the officer then said to Chris it was not his fault there was no psychiatrist at the hospital.

Inmate Fitzpatrick said he came back into the yard about 9.30 a.m. He said Chris was in his cell with one window open and was yelling out to him and Inmate Bennett. He said Chris was yelling how he'd just tried to hang himself and the cord broke and he woke up on the floor. Inmate Fitzpatrick said

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[24] See affidavit of Darryl John Streets sworn 10/8/99

Chris held the cord out the window and that *"the officer"* was directly under Chris's cell when this happened. Inmate Fitzpatrick further said he heard Inmates Bennett and Stephens talk to the officer just after that explaining Chris was stressed and to get someone at the hospital to see him.

Inmate Fitzpatrick said he heard Chris say later in the afternoon in the officers presence *"I'm losing it boss. I'm going mad"* and at the same time gesturing as if he was pulling his hair out. He said the officer repeated Chris had to put in a request. Inmate Fitzpatrick asserted that just before tea he tried to talk Chris out of doing anything stupid.

Inmate Fitzpatrick also raised the issue of Chris' drug use in prison. He said Chris got depressed during the week because most of the drugs were gone on the weekend. This was every week. He said at this time he would hear him suggest suicide or harming himself. He claimed Chris was also taking prescription drugs.

Chris' medical file does not show that he was being prescribed any drugs at the time of his death. However the toxicology report of Annette Marrington [25] shows that greater than therapeutic levels of an active ingredient in the drug Efexor were found in Chris's blood as were sub-therapeutic levels of an active ingredient in drugs Tegretol and Teril. The report also indicated the presence of cannabis.

I should comment here about the witness Fitzpatrick. I observed him as he gave evidence. He was jumpy, vague and appeared somewhat divorced from what was going on. His evidence was at times confusing and his descriptions of events appeared not well founded in time or place. Having looked at the evidence of other inmates I am of the view this witness's evidence cannot be accepted as a reliable version of events unless substantially corroborated by other witnesses.

Inmate Bennett appears to have been the closest to Chris in terms of being his friend. They were close in age. He said that before lunch while Chris was in his cell, Chris yelled out to him through a window he could push out. He (Chris) said *"Danny look at this"* and he then saw him drop a piece of black cord out of the window. Shortly after that an officer let Chris out of his cell. In his affidavit [26] Inmate Bennett did not say definitely that the officer had either heard what Chris called out or seen the cord he was holding and dropped. He however said in his oral evidence [27]

> *"He was in that office, and I don't know how he didn't hear it- his ears must be painted on if - yeah."*

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[25] See affidavit of Annette Gayle Marrington sworn 14/10/99 - exhibit 53
[26] See affidavit of Daniel Luke Bennett sworn 10/8/99
[27] See transcript page 403

Inmate Bennett said Chris then came out of his cell, picked up the cord, came downstairs and joined him under the landing. Chris then told Inmate Bennett he'd just tried to hang himself. Inmate Bennett said that he told Chris he was going to tell the screw and Chris' response was he'd be a rat if he did that. Inmate Bennett spoke to Mr. Salter on the night of Chris' death and repeated this. Inmate Bennett said that after he spoke to Chris, Chris walked over to the screw but Inmate Bennett did not hear what he said - except he thought it was something about his head. Inmate Bennett spoke of seeing a note Chris had written. Even though it was acknowledged by him that Inmate Bennett had difficulty reading and writing I am satisfied this was the note later found in Chris's cell.

Inmate Clark gave evidence that Chris had asked him that day for help in how to fill out a request form. He did not know if Chris had actually filled one out.

There is no doubt having heard the evidence of the witnesses and read all relevant documents that the officer referred to as the one being in E yard on the morning of the 4th August was CO Lehner.

As to whether Chris called out from his cell while still locked in it, Inmate Streets does not say that he did. Inmates Bennett and Fitzpatrick both talk about Chris calling out from a window in his cell and waving a piece of black cord. When this happens, Inmate Fitzpatrick places Inmate Bennett under the landing outside Chris's cell almost immediately outside the E yard office. Inmate Bennett clearly places himself across the other side of the yard. Both agree an officer was in the E yard office.

CO Lehner was not questioned specifically about this incident and so I do not know if he heard Chris calling out or not. I accept that Chris did call out and that he called out what Inmate Bennett asserts namely "*Danny look at this*". I do not accept Inmate Fitzpatrick's version of what Chris is supposed to have said when he called out. I also accept it is likely Chris pushed open a window in his cell and dangled a piece of black cord out of it. However even accepting that Chris did both of these things CO Lehner could not have seen the cord from where he was underneath the cell and is unlikely to have been alerted to any problem by the words Chris said.

Inmate Bennett conceded in his oral evidence that when CO Lehner went to unlock Chris' cell he, that is Inmate Bennett, could not be sure exactly where the cord he'd seen was. He also conceded that, after CO Lehner unlocked Chris' cell, CO Lehner had gone on to unlock other inmates and would have had his back to Chris and could not then have seen Chris bend down and pick up the cord. Inmate Bennett also could not say that CO Lehner saw the cord in Chris' hand when he went downstairs, walked over to where Bennett and others were and then stayed talking to them. There is no suggestion from any of the inmates that CO Lehner heard the conversation which then took place under the landing.

There is a conflict between Inmate Streets and Inmate Bennett as to where the cord went after the conversation under the landing. Inmate Streets says Chris gave it to CO Lehner. Inmate Bennett said that Chris did not have it when he went across to speak to CO Lehner. CO Lehner was not asked about it. I cannot make any positive finding that Chris did in fact have the cord with him when he went to speak to CO Lehner.

The next phase of the events was when Chris walked over to CO Lehner. On all the evidence given this clearly occurred. Inmate Streets said he saw Chris show CO Lehner the cord and heard him tell CO Lehner he had just tried to hang himself. Another inmate said to be present could not be found and did not give evidence. Inmate Bennett said he was on the other side of the yard still and could not hear what was said. He did say that he saw Chris crying and *"pulling his hair out"*. [28] CO Lehner denies that Chris told him he had tried to suicide or that he showed him a cord.

The only other material relating to this sequence of events is the conversation Chris Douglas had with his mother on the 4th August which was taped as part of the Arunta recording system. [29] The conversation began at 10.27 a.m. and lasted for nearly 6 minutes. This call appears to have been made shortly after Chris was let out of his cell by CO Lehner. Chris said quite early in the conversation

> *"They're about to send me down to the psych. I've lost it….Just tried to hang meself…..I dunno the cord broke, I woke up on me floor shaking all round the floor"*.

Chris' mother Mrs. Vicki Douglas then told Chris that was stupid and asked him why he did it. He said

> *"I dunno I'm losing it, or something's gone wrong, I've been goin' since yesterday I've been crying me eyes out and I've started carrying on again today…. It's something gone wrong in me head."*

Chris then said

> *"…I just went up to the screw and I said don't let me back in that cell. So if he lets me back in there something's gunna happen, I had to get out of there."*

Chris told his mother he was told he'd be sent to the hospital at lunchtime. Chris' mother tried to encourage him to tell the people at the hospital what was wrong. Chris said

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[28] See transcript page 412
[29] See tapes and transcript - exhibits 40 and 41

> *"Oh I tell the psych's. I'll say to 'em today when I go down, I'll started tell 'em everything, as long as they don't put me in the fishtank I'll tell 'em everything what's goin' on. If they're gunna put me in the fish tank I can't tell 'em."*

Chris said further in to the conversation

> *"I just think if I end it now I don't know what time I'll be gettin', all the pain will be gone."*

Chris did not tell his mother he told CO Lehner he had already tried to kill himself. He did not tell her he showed CO Lehner the cord he had used. The words Chris said he used to CO Lehner however are remarkably similar to those Inmate Streets said he heard Chris use to him. I accept in the circumstances that when Chris spoke to CO Lehner and asked to see a psych he was distressed and gave a clear indication he may attempt to harm himself.

Was CO Lehner's response sufficient or appropriate?

There seems no doubt CO Lehner made a call to the prison hospital about Chris seeing a "psych" and that he told Chris to fill out a request form. I am however satisfied on the evidence that when Chris spoke to CO Lehner after being let out of his cell he did not tell him he had already tried to commit suicide nor did he show him the cord he had tried it with. CO Lehner himself said he was not aware of the attempt by Chris to hang himself on the morning of the 4/8/99 until sometime after Chris' death. There is evidence that on the 20/6/99, a matter of weeks before this, CO Lehner had been concerned enough about Chris's state of mind to refer him to the hospital for assessment. On that occasion Chris had been placed on Category A which meant he was placed in an observation cell. There is evidence from Inmate Bennett[30] confirmed indeed by Chris's own statements to his mother in his talk with her on the morning of his death [31]that Chris most certainly did not like the "fishtank" and he would have known from recent experience that that was where he was likely to be put if he said he had attempted suicide.

I accept therefore that it is unlikely that Chris told CO Lehner in the first place of the attempt at suicide. He did however evidence clear distress. The problem CO Lehner faced was he was told there was no one at the hospital to see Chris. In that situation I have to accept that there was probably no more he thought he could do.

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[30] See transcript page 424 and 425

[31] See tapes and transcript -exhibits 40 and 41

Moving on in the day, clearly Chris did not go to see a "psych" at lunchtime or indeed at any other time that day. CO Lehner recalled speaking to Chris again after lunch and then talking to him when he bought a new pair of sandshoes in the afternoon. He said Chris seemed fine and "*pretty happy*". At about 2.15 p.m. the officer spoke to his superior Senior Custodial Officer (SCO) Van Leeuwen reporting that Douglas and another inmate wanted to see the psychiatrist. He believed that officer was going to sort that out. CO Lehner was at lunch when the nurse came for medication parade and did not know if Chris put in a request form.

SCO Van Leeuwen confirmed he spoke to CO Lehner and said he also spoke to Chris. Chris had said he had not put in a request to see the psych. SCO Van Leeuwen told him he would try to get him down to see the psych but he didn't know when. SCO Van Leeuwen said that he rang the hospital at about 1 p.m. Given that he says he spoke to CO Lehner when that officer was escorting inmates back from the canteen and that his call to the hospital was after that, it seems the timing of SCO Van Leeuwen's call to the hospital was probably a bit later than 1 p.m. However there is no doubt he made the call. He says he asked for Estelle McCarthy and told CO O'Halloran it was about her seeing another inmate and Chris, indicating he felt the other inmate should be seen first. He was not aware of any particular problems with Chris. SCO Van Leeuwen said he rang the hospital again just before he finished at 3 p.m. to see if Dr. McCarthy was back but she was not.

CO Lehner said when he last saw Chris during the afternoon of the 4/8/99, Chris was kicking a football with a friend and seemed quite happy.

Since Chris' death CO Lehner said he had spoken to inmates Bennett and Broderick. They told him that Chris had tried to hang himself but they had been sworn to secrecy. They also told him that he (Chris) had said it (that is the hanging attempt) was the biggest rush he had ever had.

Chris was locked down in his cell as were all the E yard prisoners at around 4.45 p.m. There is no suggestion he spoke to any other inmate or officer about any problems he was having or objected to being locked down.

There was evidence given about two other matters which may have had an impact on Chris in the period leading up to his death. They are relevant from the point of view that they may have contributed to the state of mind which caused him to take his life.
The pathologist, Dr. Timothy Lyons, said in his affidavit relating to Chris's death [32] that

[32] See affidavit sworn 23/12/99 - exhibit 226

> *"There are a number of ill-defined yellow bruises on the buttock areas. These are consistent with the buttocks having been forced apart. Subcutaneous tissues of the arms and legs were examined and have revealed further bruising, particularly on the inner aspect of the right thigh confirmed histologically. Rectum examined - bleeding was noted in the deep muscles of the rectum."*

Dr. Lyons gave more detailed oral evidence [33] about his findings. He said [34]

> *"this was a finding that would be consistent with some form of anal intercourse, or something being placed in the rectum, and that there are definite bruises that look like fingertip marks on the buttocks and there is bruising on the inner aspect of the thigh. One mechanism which you could purport is that the legs had been forced apart, say by a knee, which would lead to this type of bruising."*

Dr. Lyons was able to indicate that the bruising was between 24 and 48 hours old. [35] There was a suggestion put to Dr. Lyons that drugs may have been inserted in the rectum but he discounted that.

The evidence seems unequivocal that Chris suffered some form of sexual attack in the period leading up to his death. There is no evidence as to when or how this occurred or who was the perpetrator. Examination of samples taken from Chris did not show the existence of body fluids from a third party. Chris denied to his mother in his conversation with her on the 4th August that anything had happened to him in the showers. None of the inmates from E yard who gave evidence acknowledged knowing about any sexual activity involving Chris. What we do know from Dr. Lyons evidence is that it occurred and I believe I can be satisfied from the evidence of Dr. Lyons that it was unlikely to have been consensual.

CO Thomas gave evidence that if somebody planned it, it would be easy for a prolonged attack of some description to take place on a prisoner. He gave two examples of where this might occur. The first was the area under the landing in E yard because he said there were corners and poles which made it difficult to see. He also said there was a high level of opportunity for an attack in the shops because there was only one officer supervising all shops from a gallery above them and the civilian supervisors could be distracted. CO Cowley gave evidence that there was no way at any time of the day or night that a prisoner could get in to another prisoner's cell. There was also evidence to indicate that perhaps supervision in the showers was not so close that an attack would be noticed.

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[33] See transcript pages 2383, 2384 and 2385
[34] See transcript page 2385 line 7844
[35] See transcript page 2401

Clearly from the evidence there was the opportunity for a sexual attack on Chris both in and out of the E yard.

The other matter was an allegation that two custodial officers, CO Blair Saville and CO Shane Lawrence made comments to Chris Douglas which may have distressed him. Chris told his mother on the 2/8/99 [36] that

> *"One of the screws called me a money bags the other day…….Oh just this screw in here, he's comin' outa me cell, he goes get out, come on money bags."*

He then went on in the same conversation to talk about another custodial officer. He said

> *"Ah he's a wanker…He's the worst one I hate in here….Stuff he says….Someone scored onto him saying it to me and it blew right out…Someone heard him saying it to me and blew right, Danny who heard him saying it. He started sayin' charge him for that…..Yeah it was real bad, the stuff he was sayin'."*

Inmate Bennett said [37]

> *"There was one screw that did give Dougie a hard time. That was Shane Lawrence. About three and a half weeks ago Lawrence asked Dougie how old he was and Dougie said eighteen. Lawrence said 'Well you won't be out until you're fifty four' Dougie was cut up about that. There was another screw there when he said it and it happened in E yard."*

Inmate Bennett went on his oral evidence [38]

> *"I said to Dougie, 'Why don't you charge that' I said-to be-I'm not being rude. I said 'Why don't you charge that cunt…..he said 'Oh just - oh I hate that cunt, I hate that cunt' and was just shook up about it, yeah."*

Inmate Bennett also said[39]

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[36] See transcript of telephone conversation - exhibit 41
[37] See affidavit of Daniel Luke Bennett sworn 10/8/99
[38] See transcript page 414
[39] See transcript page 415

"Dougie told me again that what's his name Saville. Saville kept on calling him a 'granny basher'. He used to call him a 'granny basher'."

Chris's mother also reported that Chris spoke to her in a visit on the 27/7/99 about comments being made to him by CO Lawrence. She said Chris became upset about the comments.

Both of the custodial officers referred to gave evidence. Neither of these officers was cooperative with the court, Mr. Lawrence being less so than CO Saville. CO Saville denied he verbally harassed Chris. However his evidence in respect of a number of the matters he was questioned about was unconvincing. He changed his evidence during the course of it when matters were put to him. He denied he was ever on duty when Mr. Lawrence worked in E yard which subsequently appeared not to be the case.

As to Mr. Lawrence, he resigned from the prison service a few days before he gave evidence. As indicated he was uncooperative in court and at times rude to those who directed questions to him. This behaviour was reinforced by the tone of the letter he wrote to the prison in response to the formal complaints which were made against him.[40] If his attitude demonstrated in court and by his letter was a reflection of his attitude to inmates while he worked, then it is perhaps a benefit to the prison service that he left it.

He initially refused to even concede that he had worked in E yard in the six months before Chris died, doing so only after some probing questions by counsel. His evidence changed as he gave it and his explanation for querying Chris' age was to say the least entirely unconvincing and I do not accept it.

Inmate Bennett's description of the conversation which passed between he and Chris after the alleged comments by Mr. Lawrence is almost identical to that by Chris to his mother on the 2/8/99 when he described the incident to her. Inmate Bennett could not have known precisely what Chris said to his mother. I accept that shortly before Chris died former CO Lawrence used the words to Chris as alleged by Inmate Bennett and that this caused Chris distress. That it would have distressed him is clear because in his conversations with his mother he spoke of not being able to accept the prospect of a long time in jail. Inmate Jones [41] spoke of the same issue namely that it played on Chris' mind not knowing how long he would be in jail.

Events on the Night of the 4/8/99

[40] See letter - exhibit 28
[41] See affidavit sworn Mark Rodney Jones 10/8/99 - exhibit 33

As earlier indicated it appears Chris and the other prisoners in E Yard were locked in their cells for the night at about 4.45 p.m. on the 4/8/99. CO Thomas did a check of E yard prisoners at 7 p.m. He said he approached Chris's cell to ask him to turn down his CD player. His evidence was that the CD player was turned down as he got to the cell and he saw Chris standing near his CD player and then move across to his bed and lie down. [42] Acting Senior Custodial Officer (SCO) Fawkner was the "Op Senior" on the night of Chris's death. That is he was the officer in effective control of the prison, assuming operational control about 5 p.m. He and CO Cowley conducted the routine cell muster, between 7 p.m. and 8.45 p.m. The cell muster in E and F yards was completed about 8.55 p.m. SCO Fawkner acknowledged that an inmate may not be physically checked between then and when they are let out of their cells the next morning unless they seek contact with an officer. [43]

CO Cowley said about the muster that he just checked the locks and SCO Fawkner followed him with a torch. He said SCO Fawkner "…*was checking the cells properly.*" and that there was nothing out of the ordinary. CO Cowley said that SCO Fawkner was always looking in the cells, that he saw him physically check 90% of the cells although he recalled him speaking to only one or two inmates. CO Cowley was not able to say if SCO Fawkner actually saw Chris moving around. SCO Fawkner said he did not communicate with Chris during the muster but he saw him near the heater in his cell facing the wall not long before 8.45 p.m.

The next check of the cells in E Yard was the peg clock check which CO Lawler said he did with CO Wildbore. It appears there was no form of check on the cells or the prisoners between the cell muster and the peg clock check. As to the peg clock check, CO Lawler said he and CO Wildbore did F Division first and then he did upstairs in E Division. The peg clock in E Division was two doors down from Cell 20, Chris's cell.

In his affidavit of the 5/8/99 CO Lawler said that when he got to Chris's cell

> *"his light was on so I looked into the cell. I saw him lying in an arched position. He was stomach down with feet on the floor near his bed and his head being held up in the air by a piece of white 4-5mm thick cord. One end of which was tied to his room heater on the wall opposite his bed, the other end tied right up under his jaw line - round his neck. At that moment his face was obscured from my sight by the basin and toilet in his room."*

He said he called Chris' name and got no response. As he had no cell keys he went back downstairs to the E Division office and tried to phone SCO Fawkner. He could not raise him and so rang the

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[42] See affidavit of Brian John Thomas sworn 11/11/99 - exhibit 19
[43] See transcript page 96

main gate asking for keys. He then rang the prison hospital. His evidence was that 2 other officers then arrived with the keys and it seems all 3 were at the cell.

One of these was CO Malcolm Harris. When he arrived at E division he said he looked into Chris' cell. He said the fluorescent light was painted out but he could see Chris in a slumped position. He said that his view of Chris's chest and torso was obscured by the internal dimensions of the service duct. The other officer, CO John King, entered the cell and told CO Lawler to get the cut down knife. CO Lawler then said that by the time he got back up to the cell with the knife Douglas was already down. He then went back downstairs to let the nurse in to the yard. He went with the nurse to the cell where he was instructed to get the ambulance crew from the main gate, which he did.

CO Harris said that when Chris was found he was facing the wall and his back was arched. He was suspended from a rung of a disused steam heater on the left wall of the cell as you enter. He said the rung of the heater from which Chris was suspended was possibly five feet from the ground and the cord attached to the rung and Chris's neck was about ten inches to a foot long.

CO Lawler said in his affidavit "*At no time was I aware that Chris was unstable or depressed or contemplating suicide. He appeared to be quite normal.*"

CO King in fact came from Main Gate 3 where he was on duty.[44] He collected the cell keys from Main gate 1 and went to E yard. He estimated it took him about 20 seconds even allowing for having to go through 2 locked gates. This is at odds with CO Lawler's evidence that it took 3 to 4 minutes. [45] The difference was not reconciled. CO Lawler also said that it took him a minute or two even before this to make contact with someone because he could not reach SCO Fawkner in his office by phone. [46] The likelihood is that it took far more than 20 seconds for CO King to get from his post to E yard and that the estimate of CO Lawler is the more accurate.

CO King gave evidence that had a personal alarm been activated on the night it would have brought an officer to the cell with emergency keys to allow the cell to be opened without there having to be phone calls. This evidence was given however against the background of a somewhat inaccurate knowledge of the situation with personal alarms. The situation was that alarms activated for the division they were allocated to and not the position of the officer activating them. Therefore even had CO Lawler been carrying the alarm available to him it would have activated for F division not E division.

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[44] See affidavit sworn 5/8/99 - exhibit 12
[45] See transcript page 20 line 578
[46] See transcript page 29

CO King opened Chris' cell. He said there was a piece of white cord made up of smaller pieces of cord knotted together tied from Chris's neck and tied to the heater rail. The position in which he was found indicates that he was able to stand after being tied to the rail and that he either dropped towards the ground or lowered himself to such a position that there would be pressure on his neck.

CO King assisted with cutting Chris down using a pair of nail clippers he found in the cell even though he had asked another officer to get the cut down knife. He said in his affidavit there were 3 officers (himself included) in the cell and 3 outside. The hospital nurse then arrived. After the nurse had checked Chris, CO King cleared the cell and relocked it. He subsequently allowed the ambulance officers in. After they left he relocked the cell. He then unlocked it and allowed the accommodation manager Mr. Kevin Salter in to the cell. They looked for a suicide note and found one. Mr. Salter picked it up without wearing any gloves, read it, replaced it and then left the cell with CO King again relocking it.

At this point in time which was prior to any representative from any external agency arriving, there had been no less than 7 people moving around in Chris Douglas' cell.

General Manager Harris amongst others arrived at the scene. He said he ensured counselling services were available to the staff but conceded that there was no formal procedure for counselling to be made available for inmates saying that was a matter to be dealt with on an as needed basis by the yard officers. This attitude discloses a clear disregard for the well being of the inmates who were a small community in which one of their own had just committed suicide.

The light in Chris' cell had been painted red thus dulling the overall light in the cell. By reason of the recessing of the left wall of the cell, had Chris stood against the heater to tie himself to it and then just dropped himself, he may have been difficult to see from outside the cell in the dim light and with a cursory look in the door. In fact it may have even looked initially as if he were standing against the wall.

It is clear from the evidence of all the custodial officers, hospital nurse and ambulance officers who saw and described the Chris' condition in his cell shortly after 10 p.m. this night that Chris had been dead for quite a period of time when he was found. His body was described as being variously stiff and cold. We know that he was certainly alive and well at 7 p.m. The evidence from the officers who carried out the cell muster and were outside Chris' cell at about 8.50 p.m. is such that I cannot be certain that Chris was alive at that time. The description from the officer who did the cell muster is consistent in fact with Chris already hanging from the heater.

Dr. Lyons estimated Chris died anywhere between 6.30 p.m. and when he was found.[47] He said further[48] that a person who dies as Chris did is likely to do so within 3 to 5 minutes of the compression on their neck beginning.

As a consequence of all the evidence I am satisfied that Chris Douglas died in his cell at a time unknown but somewhere between 7 p.m. and just after 10 p.m. on the 4/8/99 and that being able to access his cell immediately he was sighted would not have meant he would have lived. The situation may however have been different if his hanging had occurred just before he was sighted at about 10 p.m. given that from the time he was first sighted by CO Lawler to the time entry to the cell was gained appears to have been a number of minutes. Such a delay would have been fatal.

A post mortem examination revealed Chris Douglas died from neck compression due to hanging. The examination does not show any other injuries consistent with any violence towards Chris on the night of his death which may have indicated he did not cause his own death. There is also no evidence from any inmate of E Yard or custodial officer to suggest other than that Chris took his own life and I accept that he did.

This is supported clearly by evidence of Chris' attempt at hanging on the morning of the 4/8/99, the statements made by Chris to his mother in the recorded phone call on the morning of the 4/8/99 and the note written by Chris and found in his cell on the night of his death. That was clearly written by Chris and is what can be described as a suicide note.

The source of the pieces of cord with which Chris hanged himself is not known. It resembles the type of cord you might find as a drawstring in track pants.

Issues Arising

A number of issues arose during the course of the evidence that I heard relating to procedures within the prison complex, facilities, staffing and availability and use of equipment. The evidence about these matters needs to be canvassed to see what if any impact they had on the death of Chris Douglas and, if they did have an impact on the death, can any recommendations be made for change which might in the long term prevent the death of another inmate.

Suspension Points

[47] See transcript page 2381
[48] See transcript page 2383

In Cell 20 in E Division there were numerous points from which an inmate could hang himself. [49] The heater actually used by Chris consisted of 8 metal rungs against but not flush with the wall. The heater was not operational and in fact had not been for years. While there was evidence from Mr. Kevin Salter, the accommodation manager, that some of these old heaters had been either removed or covered, it is clear the one in Cell 20 was neither removed nor covered and there was no evidence as to why this one remained exposed as it did. General Manager Harris assumed the reason for the non-removal was budgetary although clearly, as later evidence will show, no application was ever made for funds to cover the removal.

Other obvious points in the cell were the metal frame bed, the window frame at the entrance to the cell which while it was supposed to have fixed panes in it clearly did not, the bars across that window and the frame of the table and chair. There are several others. It is sufficient to report that for an inmate so minded, there were as at the 4/8/99 numerous points in Cell 20 from which an inmate could suspend himself and thus take his own life.

Cell Checks - Frequency and Purpose

CO Lawler in his affidavits [50] said he started work at about 2.30 p.m. in medium security. He said lockdown was completed about 7.15 p.m., he then did some paperwork and later met up with CO Wildbore in the E and F Division office. He said that at 8.30 p.m. SCO Fawkner and CO Cowley began the routine cell muster which they completed about 8.55 p.m. He said that in his experience this meant

> *"the off-sider checks the Jackson lock on the cell doors and the - he counts the ones that are facing in the 'out' position and the Ops. Senior ensures that there is no [*sic *a] person in the cell."* [51]

SCO Fawkner's understanding of a cell muster was that it

> *"..is a check to make sure the cells are secure, the locks are secure and an inmate is in - one inmate per cell, and the headcount is to go with the muster of that yard, the total for that yard, and the inmate appears to be of no problem."*[52]

CO Lawler said in his affidavit of the 5/11/99 that he understood in relation to checking of inmates that

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[49] See photographs - exhibit 3
[50] See exhibit 8 and 9
[51] Transcript page 12 line 313
[52] See transcript page 84

"we walk around the yards hourly to check what is going on in the yards. I listen out for calls from inmates if they require anything. If an inmate is flagged as being under duress or stress we check that person more regularly. We do not log times but the checks are done on a regular basis. I would like to point out that between about 7.30pm and 10.30 p.m. there is only two officers controlling Medium, C, D, E, and F yards. That means we are responsible for about 170 and 180 inmates. Prior to 10pm there is no recording of times that inmates are checked. After 10pm the peg clock checks are done hourly. I am of the belief checks of inmates are to be done hourly. I believe I have seen Directors Standing Orders no. CO18 changed from 30 minute checks to hourly checks in line with the peg."

CO Lawler said in relation to peg clock checks

"we've got a series of peg clocks around the gaol which have to be - put a key in them and have them turned so that it is registered at the front gate that an the officers have been there and the ten o'clock one, you go past the cells that have lights on and ask those inmates if they would like their light turned off at that stage, if not they have their lights turned off at eleven, and that's basically what we do then." [53]

SCO Fawkner saw the peg clock as just indicating an officer had been around at least once each hour, a presence in the yard he described it as. He did not believe as at the 4/8/99 that there was any obligation on a custodial officer to check an inmate physically after the cell muster. He was asked why inmates were not checked physically and he said

"Well it's - they've gone to sleep, I suppose, they've put their covers up over the windows a bit and I don't know, there's no reason as far as I know to go and - I mean how are you going to check, shine a torch in every half an hour, and that's going to upset them they're going to go - they'd be crazy on that…"

Directors Standing Order CO18 [54], that is the order as it stood as at the date Chris died provided, inter alia, that

"2.The purpose of night supervision is to ensure that the prison is secure and that any inmate in distress has an opportunity to communicate with staff.
3.At the initial cell muster after inmates are locked in cell it is essential that the senior officer on duty ensures that each inmate is present in his/her cell, and the cell is secure.

[53] Transcript page 12 line 326
[54] See exhibit 10

4.Thereafter the on duty officer shall walk past each cell door in his/her area of responsibility, at intervals of not less than in the Maximum Security Prison…30 minutes.

5. *The officer shall be alert to security matters and to the possibility that the inmate may need assistance."*

CO Lawler said in his oral evidence he thought cell checks were to be hourly. He was shown exhibit 10 which was Directors Standing Order CO18 and said that he had seen that somewhere with the 30 minutes crossed out and one hour put in. In fact he said when he attended training school the CO18 he saw had the 30 minutes crossed out. He was sure he had seen it like that since then and he remembered seeing one like it on the 7/8/99. He then however said about copies of CO18 in various places that since the 4/8/99

"…yard offices and since the incident, we have checked through all those and none of those have that correction."

CO Lawler said that there was no confusion as far as he was concerned about the frequency of checks before Chris Douglas's death. They were hourly. He and another officer did ask the training officer about 3 weeks after the death because by then he was confused. He then said that since about December 1999 the system had changed and checks were then half hourly.

CO Goodwin was another officer on duty on the night of the 4/8/99. He gave evidence that there could be a mix of maximum and medium security inmates in the one yard. He said that unless it was stipulated that a person needed to be checked more frequently, they would all be checked with the same frequency as maximum security which he understood was hourly. From his evidence it also appeared that after the inmates were locked away early in the evening, there was a cell muster to confirm what prisoners were in the yard. There was then a further check at about 7 p.m. He said in relation to that

"..we generally check to make sure the locks are secure and you probably glimpse across the cells as you're going along" [55]

He said the next check was the "senior's" check at about 8.30 p.m. and the one after that was the 10 o'clock peg check.

[55] See transcript page 72 line 1324

CO Goodwin gave evidence about the period between lockdown and about 10 p.m. now being considered a "critical " time, now meaning after the 4/8/99. He was asked if there was any directive about what officers should do in this time. He said it wasn't clear. He said

> *"It's just says there's 30 minute checks have to be done and I think - I can't quote it verbatim but it's basically that the welfare of the inmate - you're satisfied that the welfare of the inmate is good……Well that (a) he doesn't need assistance and (b) that he's not doing any harm to himself""* [56]

He was then asked if that meant a visual check by the officer and he said

> *"Well as I said it's not really clear, it's a little bit vague that one."* [57]

Another aspect of this issue arose from CO Lehner's evidence of his locking Chris in his cell at his request on the morning of his death. CO Lehner was referred to a prison rule which provided that an inmate is not permitted to return to his cell "*other than in exceptional circumstances*". He acknowledged there were no exceptional circumstances in relation to Chris that day. He was also asked if he was aware that if an inmate was locked in, the rules required that the unit officer visit that inmate periodically. He said he was aware of this rule but it was clear from his evidence that he had not done that nor had he in any way checked to see if Chris was all right while he was locked in his cell on the morning of the 4/8/99.

It was apparent from the evidence of the custodial officers that there was a lack of familiarity by them with the precise requirements of standing orders. It also appeared that while officers were aware of some requirements they were casual about adhering to them. Further there was confusion about the effect of Directors Standing Order CO 18 in that officers were still saying at the time of the inquest that at the time of Chris Douglas' death they had seen amended orders referring to hourly checks of inmates. None like that have been found.

Mr. Harris gave evidence there was no authorised amendment to CO 18 changing the time of cell checks from half hourly to hourly despite some staff claiming that one existed.

Another aspect of the cell checks came from the evidence of CO Harris. He had given evidence about Chris' cell light having been painted out which he said made it difficult but not impossible to see into the cell.

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[56] See transcript page 73
[57] See transcript page 73

He said the only fixed light in a cell was the fluorescent tube and they were frequently painted over, covered with newspaper, pulled out altogether or turned in their socket sufficiently to break the connection. He said that an attempt had been made to replace all the lights at one time but these things just happened again. This officer was asked how he checked an inmate if their light was affected by one of these methods and the inmate had no television going and he said he would try to take a torch. He then said in the next breath that torches were not always available.

Mr. Dodd gave evidence that he directed an internal review following Chris's death. That involved collecting information from the persons involved, a consideration of the relevant standing orders and procedures to see if anything could be learned and an assessment of the performance of the individuals involved. Only one recommendation came out of that review and that was to clarify an ambiguity in standing orders as to the timing of cell checks.

It appears that Mr. Jones, the operations manager, was not involved in that review process but that independently he issued a memo to custodial staff to the effect that at final muster cell checks required an officer to ensure they saw an inmate move or had verbal communication with them.

In January 2000 a revised standing order was issued as a result of the internal review process described by Mr. Dodd. It made clear that cell checks after lockdown were to be at intervals of no more than 30 minutes and that officers were to satisfy themselves *"of the wellbeing of each prisoner/detainee.."*

Communication

This issue has a number of subcategories. There is communication between staff at shift handovers, there is communication between staff in different sections of the prison complex about an inmate and there is communication between the prison and people outside such as family, friends, counsellors or any professionals.

◊ Shift Handovers

CO Lehner who was on duty during the day Chris died was asked how he would find out as an E yard officer when he came on duty in the morning of any problems or concerns with inmates in E yard.
He said

"When you went to the main gates the operations person may say there's a message - something's happened in E yard or something like that, when you are given the keys to go to your yard.".

He was asked about a diary or log being kept in the E and F Division office which might record matters. He knew nothing about any such document or anything in which concerns about inmates could be recorded. On the other hand SCO Fawkner referred to a "yard diary" which he described as a daily occurrence book. He said that if there were concerns about an inmate for example which justified more frequent checks of that inmate it would be noted there.

CO Lehner described the E and F yard office as the "night shift" office. He said there were white boards in there, one for E yard and one for F yard. On occasions notes were written there about things relating to inmates. He however said that concerns about inmates should be in the book in the yard office in this case the E yard office. He said *"That's where you work from."* CO Lehner acknowledged there was a log book mainly for movement of prisoners kept in the E yard office. He said he did not note any concerns about inmates in it on the 4/8/99.

CO Lehner said he was relieved by CO Thomas in the afternoon and he had no recollection of telling him anything in relation to Chris's situation. CO Thomas said when he came on duty at 11.30 a.m. he received no information from CO Lehner about Chris. He was not aware of any concern about his mental state, he was not aware of any request by him to see a "psych" and there was nothing in the E and F yard diary about Chris.

CO Wildbore said he did not get any information about anything unusual in E yard when he took over there about 7.30 p.m. on the 4/8/99. There was nothing on the whiteboards in the office. CO Wildbore suggested in fact there were a number of methods of communication between officers about matters. There was the verbal communication at handover. There were the whiteboards and there was a yard diary and movement log. His evidence was that the movement log was an official document in which just the movements of inmates were recorded. The diary apparently was not. He had no recollection of ever having written in the diary.

Clearly there was confusion as between the officers themselves as to what if any information should be passed between shifts about inmates and how it could be or was.

CO Lawler said he was given no information about Chris Douglas the day he died. He was not told Chris had sought a referral to a psychiatrist or psychologist. [58] He was asked if generally officers are given any information about the state of inmates and he said

> *"If we have an inmate that's had a death in he family or going through a crisis of some sort it's passed from the shift that's off going to yourself. There's a book up in the office for severe cases where it's written in, 'Keep an eye on inmate such and such, what yard and what cell number'"* [59]

CO Lawler said he didn't think there was any actual order requiring entries in the book he referred to nor any criteria for making entries. He thought matters such as getting a lengthy court sentence or family problems might warrant an entry. He agreed a previous suicide attempt or self harm might warrant an entry. CO Lawler was then asked if there was any process to review those sorts of things to see if an inmate is experiencing any of them and he said

> *"As far as I'm aware the efforts, attempted suicide, self harm, that sort of stuff, once they've been cleared by the medical personnel and cleared to come back to the yards they're basically a clean sheet again."*

He was aware of no review process apart from that.

◊ Between Staff Generally Within the Prison

CO Lawler gave evidence he was not told anything about the state of health of any of the inmates under his care on the night of the 4/8/99. CO Thomas said he was unaware of anything about Chris Douglas' background. He did not know Chris was the youngest inmate at the time, why he was in a protection yard or what he had been charged with save from what appeared in the newspapers. He had not been told that Chris had attempted suicide late in 1998 and he knew only from "*mess room talk*" that Chris had been on Category A suicide precautions at the prison hospital then. He did not know that he was also on Category A in June 1999. He also said that custodial officers got very little information about inmates when they returned to the yard from the hospital. Custodial officers were not told what was wrong with an inmate, what treatment if any they were having or anything about any medication.

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[58] See transcript page 11
[59] Transcript page 11 line276

Custodial officers agreed that had they had information about Chris they might have acted differently. CO Wildbore said that he might have done extra checks on the night of the 4/8/99. He said [60] when Chris Douglas' history was put to him

> *"..if I had known everything we would have kept a stricter eye on him but in those circumstances, I don't believe he would have been left in the yard."*

◊ Between the prison and family, friends, counsellors or professionals

Mr. Harris agreed there was no formal conduit or liaison between the prison and family and friends of inmates and that this may have helped Chris Douglas had it existed.

Availability of Drugs in Prison

The toxicology results from testing of Chris post mortem show the presence of prescription drugs in his system. [61] Chris's prison files show he was not being prescribed any such drugs at the time of his death. There was evidence however that other prisoners in E Division were being prescribed the drugs found. None admitted to providing those drugs to Chris nor was there any evidence of any trading of such drugs. Clearly however either that is happening or in some way such drugs are coming into the prison from outside.

In either case prison (and I include in this the hospital in the event that is the source of such drugs) practices need to be reviewed as to the supply of medication to inmates including the circumstances in which they take it and possible circumstances in which such drugs could be passed in from the outside.

The same post mortem results show the presence of cannabis in Chris' system at the time of his death. There was also evidence from more than one E yard inmate that cannabis was freely available in the yard, that Chris smoked it regularly and that his mood was affected by it. Again clearly practices need to be reviewed to reduce and if possible remove the supply of this drug to the yard while it remains illegal to possess, use or supply it.

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[60] See transcript page 171
[61] See affidavit of Annette Marrington sworn 14/10/99 - exhibit 53

Obtaining Medical/Psychiatric Assistance for an Inmate

(including training of custodial officers to recognise the need for it)

From the evidence given by both inmates and custodial officers in respect of Chris's death, it appeared that there were a number of ways by which it could be arranged for an inmate to see a professional at the hospital. These were

* filling in a request form and either handing it to a nurse at the medication parade held 3 times daily or placing it in a box outside the E unit office [62]
* direct request to a custodial officer who contacts the hospital direct
* referral by custodial officer from own initiative

It appeared to be agreed that if it were an emergency situation no written form was required although that depended on the custodial officer recognising the emergency. While that may be obvious in the case of a physical problem the recognition of a need for psychological or psychiatric assistance was another thing altogether. SCO Fawkner was asked if he had had any formal training as to what might constitute appropriate questioning to elicit from an inmate he needed help and he said no, just life skills.

CO Lehner acknowledged he knew unofficially that Chris was the youngest inmate in E Division, that he was charged with serious crimes and that he had cut himself before. He also thought Chris was in E Division because of his age. However he was still not alerted to the possibility Chris was suffering any mental disturbance when he asked to see a "psych". His evidence suggested his training to recognise the possibility of mental disturbance in an inmate was minimal. He also clearly had no background information to let him know Chris had been placed on suicide categories in the past.

CO Lehner's evidence was given on the 21/3/00. Clearly he felt that no formal procedures had altered between Chris Douglas' death and then as far as getting an inmate to see a psychiatrist or psychologist. He did not see he could do much more in the same circumstances than report a request as he had. He was referred to a Directors Standing Order G3 which it was said read

> *"Where any inmate is behaving in a fashion giving rise to a suspicion that he might injure himself or that -attempting to inflict self injury - then that inmate should be considered to be a suicidal risk."*

[62] As to this last option see evidence of Inmate Robin Clark

His view was he was not dealing with a situation such as that covered by this standing order. He saw as an example of the use of such order the actual finding of an inmate trying to hang themselves. Notwithstanding that, he acknowledged that, when Chris Douglas said he wanted to see a "psych", he rang the hospital rather than just tell him to put in a request because "*he had slashed up once before, so I thought it was probably better that I ring.*"

SCO Van Leeuwen gave evidence that the practice of handing of hospital requests by inmates direct to nurses at medication parades came into existence because of suggestions that requests given to custodial officers were not being passed on. He said that this practice was one suggested after discussion by custodial officers and it came into effect about eighteen months before.

There was a diversity of views from inmates and custodial officers about the time they perceived it would take for a referral to the hospital to be acted on.

Activities by Prisoners

The evidence from SCO Van Leeuwen was that for a total inmate population of approximately 280 there were jobs for perhaps 120 and that the inmates without jobs do more or less nothing. The only other option he said was education which program ran on Monday and Wednesday mornings. He said there were possibly 22 jobs for inmates in E division who numbered about 40 when Chris died.

Deployment of Staff/Carrying of Keys by Officers

It appeared from the evidence of the custodial officers on duty on the night of the 4/8/99 that the staff in the whole prison after about 7 p.m. consisted of 2 officers in the accommodation areas (ie in D, E and F yards), an N Division officer, a C Division officer, the operations senior, main gate 1 officer, main gate reception officer, a custodial officer in the hospital and a nurse there. Save for the cell muster carried out by SCO Fawkner and CO Cowley it appears that officers moved around alone. At the time Chris died these officers were responsible for something like 280 inmates.

It appeared also that standing orders/prison rules provided that there must always be two officers present when an inmate's cell was entered. Officers questioned about this recognised that this was not only a security measure but also ensured one officer did not do anything in a cell they should not.

CO Lawler was asked about officers carrying keys at the prison. He confirmed that he had no cell keys and that on the night of the 4/8/99 the only keys were at the main gate which was about 150

metres from E yard. There were however 2 locked gates in between. He said that the officers who brought the keys would have taken 3 or 4 minutes. He was asked why he carried no keys and he replied that was policy. He was questioned further about the possibility of officers carrying keys if there were 2 officers together so that a cell could be accessed quickly and he agreed there was no reason why they could not. He did suggest this might mean carrying 5 sets of keys but agreed that was not a major difficulty.

CO Lawler was not able to give any other reason as to why cell keys were not carried. A number of officers questioned about the same issue agreed there was really no reason they could see why, if 2 officers were patrolling together, they could not have cell keys. They recognised that 2 officers together would overcome both the aspects of security and protection of prisoners.

Carrying of Equipment by Officers Within the Prison Complex

* Personal Alarms

CO Lawler said he did not carry one. He said there was one alarm for the units and the F Yard alarm was left in the office. It was left there because there were two officers who might use it and anyway it was probably quicker to use the phone. It was apparent from the evidence given by officers that the telephones around the complex were the only effective means of communication which existed. He said he believed that system had not changed since August 1999.

CO King said that there are a number of panels around the jail. When a personal alarm was activated officers will respond to the area shown on the panel as being activated. They would normally collect the emergency keys which give access to the cells. He agreed that had a personal alarm been activated on the 4/8/99 someone would have come immediately with a key to open Chris' cell. CO King believed there was a standing order about the carrying of these alarms but he didn't know what was in it. CO King also acknowledged that when a personal alarm was activated, it showed up on the panel as being a particular alarm and not necessarily where it was being carried.

SCO Fawkner gave evidence that in all there were about 12 or 13 personal alarms throughout the prison complex but at night after about 9 p.m. the only one apart from at Main Gate 1 in use was the F division alarm which is kept in the yard office. He agreed that that alarm was not much use for example in C yard. Evidence was given of a new alarm system being implemented. However as at the date he gave his evidence, the 21st March 2000, it was not working. [63] SCO Fawkner's response as a senior officer was that that was just how it had always been done.

[63] See transcript page 91

* Radios

CO Lawler said there were some radios but they were only issued to managers, security and the operations senior. He did not have one.

SCO Fawkner had a radio but the only place he could communicate with at night with it was the main gate. All those issued to management level simply went off air when the persons carrying them finished their day and went home. He could think of no reason why radios, which were clearly available at the prison, could not be made available for use by custodial staff on duty in the prison complex at night.

* Cut Down Knives

CO Lawler said the closest cut down knife to Chris Douglas' cell was in the first aid box in the yard office which was basically directly below cell 20. He said he knew what a cut down knife looked like and agreed such knives were kept in their own individual pouch designed to be worn on a belt. He said it was jail policy not to carry them.

SCO Fawkner said about them that he had not actually even seen one for a couple of years. He agreed it would be better for officers to carry them but that it was a management decision that they not and that is how it had always been done. He said cut down knives were locked in the emergency cabinet and you have to break glass to take them out. It was put to him that on the night of Chris Douglas' death he had sent someone to get the knife and he responded

> *"I think Johnny said he wanted to get a knife, but by that time, the time he would have had to go down into the office downstairs, and it's taking time, so we just had to get the cord…so we used - I used nail clippers, yes….An urgent situation at the time.."* [64]

* Torches

CO Lawler said he did not carry a torch but there was one in the E and F unit office. When

questioned about why he had no torch CO Lawler said it just wasn't done because inmates got fired up if you shone a torch on them at night.

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[64] See transcript page 93

It appeared from evidence from the other officers at the prison on the night of the 4/8/99 that none carried torches. This is notwithstanding the evidence about difficulties seeing in cells.

Availability of Support for Inmates

This arises out of the evidence of Witness X who applied for, and was granted, an order restricting publication of her identifying details. This lady was an employee of a community organisation. She said [65]

> *"The program within which I am employed is JPET (Job Placement Employment and Training), a federally funded program which targets young people in the 15 - 21 year old age bracket, deemed to be at risk, in some way. Eligibility criteria for registration with JPET includes homeless or at risk of homelessness, offenders and ex offenders, refugees, wards of the state.*
>
> *As a case manager with JPET, my role is to assist my clients to address barriers impeding their capacity to move forward, with a focus on re-engaging them in education, opening up employment opportunities, and/or involving them in appropriate training. Typically the young people who register require a high degree of support and my work with them accordingly involves a significant component of personal counselling."*

Witness X became involved with Chris Douglas when he registered with JPET on the 9/10/98. She says she agreed to continue to support him after his incarceration because

> *"…it became clear that no other support was being made available to him. This was following his discharge from the prison hospital to which he had been admitted early in his period of remand as a result of an assessment that he was at risk of suicide……..On the 6/11/98 I spoke to Vicki Douglas on the phone and she expressed considerable concern for her son's state of mind, describing him as 'suicidal' and 'a mess'.*

She said that after Chris went into prison she rang there, explained her connection with Chris and requested a visit for the purpose of counselling/support. She began seeing Chris on the 13/11/98 and saw him on 7 occasions. However early in May 1999 her request for a gate pass to see Chris was denied. She was told she was no longer an 'approved' visitor. She was shortly to commence a period of extended leave and wished to see Chris before she left. After some negotiations with prison management and the provision of some information requested to it, she was permitted to see Chris once before she left. However in relation to any future visits she was told that she must submit

[65] See affidavit of Witness X sworn 7/12/99 - exhibit 46

detailed information on her organisation and an explanation of the capacity in which she was involved with Chris. On receipt of that Mr. Jones advised he would consider the appropriateness of continued visits. She said the implication was that perhaps she should not have been allowed to visit Chris in the first place. She did not ever see him again.

In talking to Mr. Jones prior to her leave, Witness X said that she stressed Chris was young and very much at risk and that he was receiving no professional support from within the prison. She said that Mr. Jones was unable to give any undertaking that Chris would get that support if she were denied access to him and made it clear that was not his area of concern.

Mr. Jones said that he did not ever tell Witness X she was no longer an approved visitor. He said he required more information from her because the person in charge of programs had said they were concerned about the type of counselling being provided and they did not know much about the organisation Witness X was from. The last query raises an issue of competence of the person who made it given that the organisation of which Witness X is a member has been well known in the welfare field for some time and the prison was providing no alternative.

In her evidence Witness X agreed she had no formal qualifications as a counsellor. She had originally trained as a teacher but had held numerous positions over many years which involved her in a counselling and support role. She had for example worked as a probation officer and crisis worker for the Department of Health and Human Services. She said that over time she communicated to Mr. Kevin Salter, Mr Graeme Harris and officers in programs that she felt Chris was in a high risk category. She conceded she could not recall if she specifically mentioned suicide.

There is nothing in any of Chris Douglas' prison files to indicate he received any form of ongoing counselling support of the nature offered by Witness X nor is there anything in any evidence before the court to indicate that in some way Witness X's visits breached any prison protocols or caused any problems for prison authorities in their management of inmates generally or Chris in particular. One is left to ask the question why in relation to an 18 year old prisoner on remand for serious offences and with suggestions of suicide and self harm in his background, prison authorities would seek to cut him off from support not being offered by the prison but being made available at no cost to it.

Arunta Recording System

Evidence was provided to the court of the existence of a system which allowed inmates to use specific telephones to call predetermined telephone numbers. Each inmate who wished to use this

system was registered to do so and had an access code. He had also to supply to the authorities a list of numbers that he might wish to call and these were to be approved before use.

Calls made on this system were always recorded. The extent to which those recordings were monitored was the subject of some debate. In relation to Chris clearly he used the system and he rang his mother and stepfather on more than one occasion in the few days before his death.

The tragedy is that while Chris' calls were recorded and resulted in there being available at the inquest tapes of such calls made on the 2nd and 4th August 1999, nobody listened to them at the time they occurred and heard Chris tell his mother he had tried to hang himself and might try to again.

Chris' mother was left to answer the question why she did not tell the prison of the content of the calls. She not surprisingly did not think she had to because she believed the calls were being monitored and she thought from what Chris told her that arrangements were already in place for Chris to go to the hospital.

Conclusions

I am satisfied Chris Douglas died in a cell where suspension points were abundant and where no ingenuity was required for an inmate to make use of them. I am also satisfied that the DJIR who had responsibility for Chris' care and wellbeing failed to exercise that care. It had been warned repeatedly over a period of at least a decade by coronial recommendations about the availability of suspension points in cells, its representatives were aware of the existence of such points and no steps at all were taken to remove them.

I am also satisfied that on the morning of his death Chris attempted suicide during a period he was locked in his cell and that custodial officers in locking him in his cell at that time had no regard for standing orders/prison rules which provided this should only happen in exceptional circumstances. I am also satisfied custodial officers ignored such rules in that they failed to visit Chris periodically as was required while he was locked in.

I am satisfied that in the 24 to 48 hour period leading up to his death Chris was the victim of a sexual attack and that supervision of inmates was inadequate to the degree that such could occur apparently without detection. Such inadequacy was compounded by the placement of Chris in a yard known to be where sexual offenders were placed.

I am satisfied that there were inadequate systems in place to provide care for a young and vulnerable inmate in that an 18 year old the subject of serious charges and with a history of self harm and attempts to suicide

* was unable to access help when required. Not only was Chris unable to access that help but also it appears that custodial staff were ill-trained to recognise the urgency of the need for it.
* was able to access both recreational and prescription drugs in prison when neither should have been available to him.

CHAPTER 3 THOMAS PATRICK HOLMES

A. Formal Findings

I find that Thomas Patrick Holmes died in Cell 3, South Wing, Prison Hospital, Risdon Prison on the 17//9/99.

I find that he was a male person born at Brisbane in the State of Queensland on the 2/5/70. He was aged 29 at the date of his death. He was a single person and an inmate of the prison hospital at the Risdon Prison. He had been remanded in custody by a court on charges involving setting fire to premises.

I find that Thomas died as a consequence of neck compression due to hanging. I find that he utilised a shoe lace and tied one end round his neck and the other to a bar of the grill across the window in his cell. He then suspended himself with the intention of taking his life.

I find that the following contributed to the death:

a) Thomas himself in that he took the actions which ended his life,
b) the DJIR in that it failed to ensure a system of care which recognised a vulnerability to suicide and put safeguards in place in an attempt to prevent it.

B. Discussion of Evidence Relating to Death

History (Prior to entering prison hospital)

Thomas Holmes ("Thomas") was born in Brisbane in Queensland. He was one of 10 children having 5 brothers and 4 sisters. In or about 1991 he met and formed a relationship with one Rosaleen Macaulay.[66] They began to live together and had a daughter who is now aged about 8. They separated in or about 1997 but remained friends and from time to time Thomas stayed with Ms. Macaulay.

In about July 1998 Thomas was living in a flat at Battery Point. He complained to police that a person tried to break into his flat. Ms. Macaulay reported that Thomas was depressed before that but that this break in appeared to trigger something and he became in her view mentally ill. There is

[66] See affidavit of Rosaleen Macaulay sworn 4/10/99 - exhibit 67

no suggestion Ms. Macaulay has any training sufficient to enable her to actually diagnose such illness. However her conclusion was an obvious one from Thomas' behaviour.

Two police officers, both of whom gave evidence,[67] spoke to Thomas about this incident in September 1998 they being unable to make contact with him until then. Both officers had concerns about the reliability of the complaint and found Thomas' behaviour odd. They had no background on Thomas, the police computer system not recording his involvement with police and ambulance in the same month when he had attempted suicide. The complaint Thomas made was ultimately not followed up because he disappeared.

Ms. Macaulay said she tried to get help for Thomas and in fact took him to the Royal Hobart Hospital in the middle of 1998. There was no psychiatrist available and so she made an appointment for him to see someone at Campbell House some weeks later. He never kept that appointment. Ms. Macaulay reported that Thomas attempted to drown himself in the Derwent river near her home on the 8/9/98. However he came back to say goodbye to her and his daughter and an ambulance and police were waiting for him. He voluntarily went in the ambulance to the Royal Hobart Hospital but left after some hours without any formal treatment. Later in the same month he went on a hunger strike not eating and taking laxatives.

Peter Holmes, an elder brother of Thomas', gave evidence that two of his and Thomas' siblings had been diagnosed as having schizophrenia.[68] An elder brother Ivan had been diagnosed since about 1988 and had been on medication. In September 1998 Ivan attempted suicide by hanging in Queensland. It was an unsuccessful attempt but Ivan was left severely brain damaged and it was thought he might die.

Peter Holmes came to Tasmania and collected Thomas early in October 1998 and took him to Queensland to see his brother. Peter Holmes reported Thomas as hardly eating or sleeping at that time. Thomas then made his way back to Tasmania. On the 7/2/99 [69] Thomas was admitted to the Royal Hobart Hospital as an involuntary patient. He was initially uncooperative but once medicated began to cooperate. He however remained delusional, insightless and denying auditory hallucinations. He absconded from the ward on the 22/2/99 and the police were notified.

In May 1999 Thomas was charged with offences relating to some damage done to the premises of Irish Murphy's Hotel. He was bailed and went to stay with Ms. Macaulay. He then just disappeared for

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[67] See affidavits of Brett St. Clair Berry sworn 10/11/99 (exhibit 69) and affidavit of Kriss Ellison Lawler sworn 8/11/99 (exhibit 82)
[68] See transcript page
[69] See letter from Dept. of Psychological Medicine to Dr. J. Hutchinson in exhibit 64

some weeks and failed to appear in court when he should have. When he came back to her she believed he was very ill and paid for his fare to go to Melbourne to see his brother. It seems he stayed with his brother for some 5 to 6 weeks but returned to Tasmania on the 3/9/99 in the knowledge there was a warrant out for his arrest.

Peter Holmes reported that during this period, Thomas fantasised about committing suicide and that in fact he, Peter, found a noose. When questioned about it Thomas responded that he couldn't get the rope the right length to complete the act and laughed about it.

The day after he arrived in Tasmania Thomas went to Irish Murphy's. He was arrested on the outstanding warrant but bailed. He went to stay with Ms. Macaulay. He went out taking her car and did not come home. Early the next morning she heard of the arson attack on the Irish Murphy's Hotel. She believed that Thomas was responsible and reported that to the police. Thomas was taken into custody on the 10/9/99, arrested and interviewed over the alleged arson. It became apparent to the interviewing police officers that Thomas was mentally unwell. The video recorded interview makes it clear just how irrational he then was. [70] An officer involved said [71] that he was not aware of Thomas' suicide attempt in 1998 and there was no method for flagging on the police computer system a person who had come to police notice because of mental illness.

Thomas was remanded in custody. On the 11/9/99 he was in the remand centre in the city. As part of normal practice for all persons detained there he was assessed by the on duty nurse. That was Nurse Victoria Norris. She said [72] she went through a health assessment form with Thomas. He disclosed he had recently seen a psychiatrist and had medication for schizophrenia. She rang the Royal Hobart Hospital about him and was sent a copy of a letter with some background. She said he was saying quite bizarre things but gave no indication of self harm or suicide. She made the decision to admit him to the prison hospital for observation and assessment and he was transported there that day. He went with the health form, her notes, the fax from the hospital and a referral that he be seen by a psychiatrist. She was familiar with prison suicide categories but did not place Thomas on one.

Miss Norris was a trained psychiatric nurse. She said that the factors she used to determine if a person needed to be on a suicide category were whether the person said they might commit suicide or spoke of it, the general content of their conversation and how they looked. She said the fact they might be suffering from schizophrenia did not necessarily affect her consideration. She did not know the incidence of suicide in people suffering from schizophrenia but imagined it might be quite high

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[70] See video tape of interview - exhibit 71
[71] See affidavit of Gary Williams sworn the 20/10/99 - exhibit 81 and oral evidence
[72] See affidavit of Victoria Georgina Norris sworn 5/10/99 - exhibit 63

for those people in jail. Had she known of the suicide attempt in 1998, she said that coupled with the schizophrenia would have meant she probably would have put Thomas on suicide category A.

Period Between 11/9/99 and 16/9/99 inclusive

General Manager Harris said that the prison was not advised by either the Court of Petty Sessions or Thomas' solicitor of any exceptional circumstances relating to Thomas. Nurse Webster [73] was on duty at the prison hospital when Thomas arrived at about 10.30 a.m. She was a generally trained as opposed to psychiatrically trained nurse although she had done a 12 week psychiatric addition course in 1998. She worked casually at the prison hospital between July and September 1999. She had never worked in a psychiatric institution or a jail before. She was asked about any training for her position and her knowledge of the various prison hospital categories on which inmates could be placed. She said she had a couple of days induction which involved just being shown around and being told things by the nurses who took her around. She therefore had no formal training at all and virtually no informal training about categories used in the prison hospital.

She completed the pre-admission assessment of Thomas. She said he was hearing voices and she believed he may be suffering alcohol withdrawal symptoms. She placed Thomas on Category S but noted on the form [74]that he was to have suicide blankets and be assessed by the forensic team. She then checked Thomas half hourly through to the end of her shift.

Nurses Webster was questioned about why she wrote suicide blankets on the category form given category S was a segregation not suicide category. She said [75] she was not concerned about suicide risk but did it

> *"because the only other option was ordinary blankets and I hadn't instituted one of these categories before so I thought better play safe."*

She was then asked why she placed Thomas on category S at all. She said [76]

> *"Because he was sent over to the hospital from the Remand Centre. The nurse at the Remand Centre was concerned about him. When he came to the prison hospital he appeared to be responding to auditory hallucinations. The nurse who sent him over had filled out a referral for the psychiatric team to see him and when he got to me he certainly*

[73] See affidavit of Christine Geraldine Webster sworn 6/10/99 - exhibit 65
[74] See purple category S form in file - -exhibit 64
[75] See transcript page 706
[76] See transcript page 708

seemed to be listening to other voices and I just thought that the safest thing to do was to put him on a category S until he was seen. Not being a psychiatric nurse I didn't want to risk just sending him up to the yards. I wanted him to be safe until he was seen."

It was apparent from Nurse Webster's evidence that as far as working in the prison hospital was concerned, she was inexperienced and not appropriately trained. Nurse Webster knew that the incidence of suicide amongst people suffering from schizophrenia was high and probably higher for those in jail. She did not believe her knowing about the suicide attempt in 1998 would have changed what she did with Thomas.

Nurse Norris, who was clearly a more experienced psychiatric nurse and more familiar with the prison system said she would have found the categorisation of S with suicide blankets confusing.

Nurse Webster was asked about changes in categories. She said the fact that someone was taken off a category should be recorded in at least two places, the nurses notes and the nurses daily report. This was confirmed by the Director of Nursing. She then added it should probably be on the category form itself. CO Peter Hughes was on duty at the prison hospital on the 11/9/99 when Thomas was admitted. He said [77] Thomas was admitted on category S and taken off it a couple of days later. He was told about that but he could not recall how.

There were two files tendered into evidence from the prison relating to Thomas. They were exhibits 64 and 80. It is difficult to categorise them accurately since neither is actually clearly identified on its face. Exhibit 64 appears to be a loose leaf file begun by Nurse Norris at the Remand Centre and has the description "health record" on it's cover. The other file simply has Thomas' name on it but appears to be a forensic unit file.

These files disclose that Thomas was seen by Dr. Jager, the psychiatrist at the hospital, on the 13/9/99. The diagnosis was paranoid schizophrenia and Dr. Jager prescribed Modecate (Fluphenazine). He also prescribed a second drug Benztropine (Cogentin) "prn" (meaning as required). He noted that Thomas was to appear in court on the 15/9/99.

The drug chart on the files showed the first drug having been given but not the second at all. Given the second drug was to be given as required that is not surprising in itself. The nurses progress notes show the first drug having been given on the 13/9/99 but there were no other entries at all until that about Thomas's death on the 17/9/99. On the same file which contained the drug chart and nurses progress notes there was also the category S purple form completed by Nurse Webster. It was

[77] See affidavit of Peter John Hughes sworn 17/9/99 - exhibit 61

dated the 11/9/99 and the completion of it was noted in the progress notes. There was no indication of any change of category at any time between the 11/9/99 and the 17/9/99 in that file and none on the category form itself.

The forensic unit file (exhibit 80) showed that Thomas was seen again by Dr. Jager on the 14/9/99. His notes indicated little change in Thomas and but said Thomas complained of feeling tired. He noted "no adverse side effects" and that the plan was to continue as before. There was no other entry by Dr. Jager until that about the death. There was no entry about any change of category from category S. That same file contained a request form completed by Thomas on the 16/9/99. It was marked apparently by him as routine and in it he asked to see Dr. Jager about "medication for the side effects of injection".

Thomas appeared in court on Wednesday the 15/9/99. Mr. Craig Mackie, a solicitor with the Legal Aid Commission of Tasmania, appeared for Thomas that day at the request of a friend. [78] He had not seen him before that day nor did he have any detailed knowledge of him or the matters he was appearing in court on. Mr. Mackie obtained details of the charges from the police prosecutor and was advised bail would be opposed. Before going to the cells to see Thomas, Mr. Mackie spoke to Ms. Macaulay and other friends of Thomas' about possible bail. They told him they wanted Thomas to stay in custody to get medical help and that he had schizophrenia.

Thomas' friends would not provide a home for him nor act as surety. Mr. Mackie made the decision after talking to Thomas not to apply for bail and he said that while Thomas appeared to be confused about that in court, afterwards when he spoke to him he was quite calm and Mr. Mackie arranged to see him at the jail the next week. In Mr. Mackie's view Thomas was clearly mentally ill. Thomas had told Mr. Mackie that some people believed he had schizophrenia but that he (Thomas) did not believe he was unwell. Mr. Mackie did not recall Thomas' mental state being one of the reasons given to him for bail opposition by the police. However the interviewing officer who gave evidence said that he opposed bail being granted to Thomas because he believed he needed help which he thought he would get in custody. Mr. Mackie said that he rang the prison hospital to speak to Dr. Jager about Thomas on the 17/9/99 but Dr. Jager was not available.

As a separate exhibit and being documents which had not been supplied as part of Thomas's medical or forensic files, copies of nurses daily reports from the prison hospital for the period 11/9/99 to 18/9/99 were tendered. [79] According to these documents, Thomas was given Cogentin on the

[78] See affidavit of Craig Douglas Mackie sworn 28/10/00 - -exhibit 70
[79] See exhibit 73

13/9/99 and the 15/9/99. The Director of Nursing conceded that there appeared to have been an oversight on the 2 occasions when Thomas was given Cogentin in that the nurse giving it neglected to record the medication on the drug chart.

Ms. Macaulay saw Thomas at the hospital on the 16/9/99. She said he complained of adverse effects from medical treatment, that he had to call twice for treatment and that he said he had an appointment to see Dr. Jager and was hoping to get some Cogentin. She said he did not tell her of any planned suicide.

17/9/99 (Date of Death)

CO Hughes began work at 2.30 p.m. this day. He said that on that shift there was only one custodial officer and one nurse at the hospital. On the earlier day shift there are two custodial officers. When he started that day he was not made aware of anything out of the ordinary concerning Thomas and this is perhaps reflected in the nurses daily report - there was no mention of Thomas for that day. He spoke to Thomas at about 3 p.m. CO Hughes said Thomas appeared to be in the best spirits he had seen him that week. All inmates in the hospital were returned to their cells for the night at about 4.30 p.m. He said there were 24 inmates in the hospital that night and he did half hourly checks which he understood was what was required.

He also gave evidence that he had been at the hospital when inmate Hayes had hung himself in 1998 and that he thought then the checks were hourly changing to half hourly after that. He also worked at the hospital although he was not on duty when another inmate hanged himself early in 1996. He said the checks were hourly then.

At 7.30 p.m. Nurse Davidson came on duty.[80] He was a general as opposed to psychiatrically trained nurse. When he came on duty he was not made aware of any particular problems with any inmate. He was told Thomas was a patient with a psychiatric problem but there was no mention of suicidal ideation. He said about Thomas that he knew Dr. Jager had already seen him and there were no instructions to put him in any risk category. He had his boots in his cell with laces because he was not considered at risk. He prepared the medications in preparation for going round with the operations senior to distribute them.

At about 8 p.m. CO Hughes began another round of checks. He reached Thomas's cell at about 8.10 p.m. The light was out and he shone his torch into the cell and saw Thomas standing near the window looking out smoking. Thomas did not turn and he moved on.

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[80] See affidavit of Stephen Frank Davidson sworn 18/9/99 - exhibit 62

SCO Woisetschlager, the operations senior for the prison that night, arrived at the hospital some time later. He began going round the cells with Nurse Davidson and CO Hughes checking inmates and so that they could be given their medication. When medications had been completed he went on to finish the cell check. Nurse Davidson, having given out his last pills to the inmate in cell 2 in south wing, walked back to the roundhouse. SCO Woisetschlager reached cell 3 in the south wing at about 8.45 p.m. He shone his torch into Thomas' cell and saw him hanging. He had no keys to the cell and called out to CO Hughes who was perhaps 10 to 15 feet away. He came and opened the cell. SCO Woisetschlager ran to the roundhouse to turn the cell lights on and came back with the nurse. SCO Woisetschlager used scissors he had found in the roundhouse to cut the brown shoe lace which Thomas had tied round his neck and to the top bar of the grill across his window. This was despite there being a cut down knife for this purpose in a glass fronted case in the roundhouse.

CO Hughes and Nurse Davidson then lifted Thomas down and laid him on the bed. Nurse Davidson removed the shoelace from Thomas's neck, commenced resuscitation and kept that up for approximately 15 minutes until he was unable to keep going. SCO Woisetschlager called the ambulance and police. The ambulance arrived shortly after Nurse Davidson had stopped CPR. CO Hughes observed Thomas's lips to be purple and his face to be drawn and pale when he was found. Nurse Davidson said he checked vital signs and found none and he noted Thomas's arms and hands were a purply mottled colour and his eyes were open.

A subsequent post mortem examination was conducted by Dr. Robert Kelsall. In his report [81] Dr. Kelsall concluded that death was as a consequence of neck compression due to hanging. He attended the scene and examined the brown shoe lace removed from Thomas's neck and the piece still attached to the bar in the cell. He measured them and found the pieces to be consistent with the report of the finding of Thomas's body. There was nothing else found on post mortem which could have contributed to Thomas's death.

CO Hughes had no specific explanation for why there appeared to be 40 minutes between the last two checks on Thomas's cell on the night he died, saying only that he would have been busy.

[81] See affidavit of George Robert Henry Kelsall sworn 6/11/99 - exhibit 305

Communication between staff of information relating to inmates

In relation to the hospital, SCO Woisetschlager said he would have identified the level of risk for a prisoner by the stickers outside their cell. He was asked if there was any documentation he could have access to in the hospital to allow him to check an inmate's status. He said he was sure the hospital had a file, he guessed he could have access to it but he had never done it.

CO Hughes was asked how he would find out about a prisoner's status if he had been off duty for a period. He identified a number of methods. He referred to

- verbal briefing from the officer handing over to him
- day book - he said if a person is on a category, it goes in here
- board -this sits in the roundhouse and has the inmates names and cell numbers on it. There would be a coloured sticker for a particular category beside an inmate's name on that board
- sticker on a cell door
- also sometimes things might be written on the chalk board above the inmate's cell door where their name goes

Nurse Davidson gave evidence about how he would ascertain the situation on the ward when he came on duty. He said there would be the verbal briefing from the nurse handing over to him and there would be the folder with the category forms. He said that while an inmate was on a category the nursing progress notes would be in the category folder although once an inmate came off category the notes would go back to the medical file.

He said there was also the nurses daily report. That was a book with carbon in it. For each shift there were entries. At the end of that shift the original sheets were pulled out and went to the Clinical Nurse Consultant (CNC) while the copies remained in the book. You could check in those back copies for information about inmates. That book was usually in the roundhouse.

In the context of communication the issue of a change in an inmate's category was raised. As to Thomas, while he was clearly placed on category S when he came into the hospital, and Nurse Davidson says he came off it a couple of days later, there was no evidence any where of any record of that change or who did it. Nurse Davidson said that if a psychiatrist changed a category then that change may be noted in the medical file or on the back of the category form. Otherwise the change

was only likely to appear in the nurses progress notes in the category folder. It seems in relation to Thomas the system broke down.

Nurse Davidson said specifically in relation to Thomas that his coming off category S should have been recorded in the nurses daily report and progress notes. Further the sticker noting the category would come off the board and the cell and the category form and progress notes would come off the category file and go to the medical file. He could think of no reason why this all would not have happened in Thomas' case. There was no evidence as to precisely where the category form or progress notes relating to Thomas were at the time of his death.

However the change of category from S to none and the failure to record it cannot be said to have contributed in any way to Thomas's death.

Communication Between Persons Outside the Prison Hospital and Staff about Inmates

The records in the hospital relating to Thomas produced at the inquest show no communication from the hospital to any family or friends in an effort to obtain background on Thomas. The only background sought was from the Royal Hobart Hospital where Thomas had been a patient early in 1999. The information thus obtained was not extensive.

Ms. Macauley in her evidence details that she visited Thomas twice at the hospital but on neither of these occasions did she try to volunteer to either medical or custodial staff any background information about Thomas. Her explanation for that was that she thought they would contact her. She was shown on the hospital admission records as the person to be contacted in case of emergency as was her relationship to Thomas.

Clearly no contact was initiated to her. Had such contact been initiated medical staff would have discovered that Thomas had attempted suicide before.

Category System and Training of Staff With It

It appears that there are 6 categories in which an inmate can be placed at the prison hospital. These are categories A, B, C, R, S and I. All except R are what might be described as medical categories. Category R or restricted is one for use by custodial officers.

Categories A, B, and C are suicide categories. A is the highest and will result in an inmate being stripped naked and placed in an observation cell off the roundhouse. Categories B and C, while still suicide categories, leave the inmate in his own cell but with various restrictions. That is he may only be allowed finger food and will have belts or laces removed and be issued with suicide blankets. These inmates may also be subject to more frequent checks.

Category S is a segregation category and is allocated, for example, to protect a prisoner from others or from him, because of his own situation, causing trouble for himself with others. I is an isolation category for medical reasons. That is the inmate has something which may be contagious.

SCO Woisetschlager did not know what categories S or R were although he knew generally about suicide categories. CO Hughes appeared to have a much clearer knowledge of the categories and said that he always liked to make sure he had copies of the category forms in "our folder". Just what folder that was I am not sure.

It was clear from the evidence of Nurse Webster that she had inadequate training in just what the various categories were to be used for and did not seem to know who to ask or where to look to get the information. In either event the system which placed her in the position she was in was not operating properly.

Both Nurse Davidson and Nurse Norris saw category S plus suicide blankets to be unusual and confusing. Nurse Davidson said that you might have S with a suicide category. As to suicide categories, nurses could place an inmate on such a category but once on it was not the function of a nurse to remove an inmate without an assessment from a psychiatrist or psychologist. Nurse Davidson did acknowledge however that he has done it "informally" when on review of a patient the next day he felt the decision to place him on category was not the correct one.

Nurse Davidson said that as a general trained nurse he would not feel able to drop someone off a category S without referring it to the "psych. CNC"

An additional issue arises from Thomas's death. We have a situation where of the three nurses who gave evidence who dealt with Thomas only one had any significant psychiatric nursing training. Another who had some was working casually and was unfamiliar with the system while the third was a general nurse only. All however at different times could be expected to deal with potentially seriously disturbed patients. This issue needs to be addressed.

Information Keeping

The evidence before the court suggested that within the prison hospital there were several different places in which information about inmates was kept which did not ever necessarily come together.

These were the "file" opened in relation to Thomas at the Remand Centre by Nurse Norris, the forensic unit file, the category folder, the nurses daily report, the progress notes, a book Nurse Davidson described as the "suicide book" and "our folder" referred to by CO Hughes. At any given time one could look at one or even more of these documents and only ever get part of the picture. While there was insufficient evidence to suggest this specifically contributed to Thomas' death the system created a potential for confusion and necessary people having inadequate information to deal with an inmate.

Keys to Cells/Cell Muster

The evidence of SCO Woisetschlager and CO Hughes showed that while SCO Woisetschlager did not have keys that would allow him to access cells in the prison hospital (he had master keys which would have allowed him to open cells in the prison), CO Hughes did. These keys however would be taken from the custodial officer after the cell muster and returned to main gate. CO Hughes said notwithstanding he had the ability to access cells until then he knew he was not supposed to access cells alone.

Further SCO Woisetschalager's description of a cell muster was

> *"I check each occupied cell, I make sure the locks are properly applied - the Jackson, which is in the old side. And, if the light is not on I use a torch and look inside the cell and make sure the prisoner is present. If the prisoner is asleep in bed but I can see his face I will not disturb him. If a prisoner is lying in bed and I can only see their hair or none of his body, I would usually use my keys against a door until a prisoner moves. That gives me the assurance, it is occupied and is alive. And that's what I do cell by cell really. I count them and add it all up and make sure no one has escaped and everyone is well."*

Conclusions

I am satisfied that Thomas died by his own hand. Again he was housed in an environment which provided an abundance of suspension points, a failing again for which the DJIR is responsible.

There can be criticisms of the custodial and nursing staff who dealt with Thomas in that

- the recording of information relating to administration of prescribed medication to Thomas was flawed,
- the checks on the cells on the night of Thomas' death were not done with the frequency intended by Directors Standing Orders.

However it is not likely that either of these errors contributed to Thomas' death. At best it can be said that "the system" let Thomas down in that had information been provided to the hospital staff from different sources which may have highlighted a tendency to suicide Thomas may have been placed on a suicide category, observed more closely and not provided with shoe laces.

Thomas was in the prison complex for a week. He was reviewed twice by a psychiatrist and appropriately medicated for the condition from which he was suffering. While inquiries were made of the hospital which had last treated Thomas, no apparent attempt was made to contact family to obtain background. The information lacking in relation to Thomas may have prevented his death.

CHAPTER 4 JACK NEWMAN

A. Formal Findings

I find that Jack Newman (formerly Rory Jack Thompson) died in Cell 9, East Wing, Special; Institution (Prison Hospital) Her Majesty's Prison, Risdon on the 18/9/99.

I find that he was male person born in Seattle, Washington in the United States of America on the 10th May 1942. He was aged 57 at the date of his death. At the time of his death he was a detainee pursuant to the Mental Health Act 1993.

I find that he died as a consequence of neck compression due to hanging. I find that he utilised a shoe lace, tying one end of it around his neck and the other end through an air vent in the wall of his cell suspending himself with the intention of taking his own life.

I find that the following contributed to the cause of death:

a) Mr. Newman himself in that he took the actions which ended his life
b) the DJIR in that it failed to provide a physical environment to minimise the risk of self harm by an inmate or an adequate system of care which could recognise the potential risks of such self harm and take steps to reduce them.
c) DHHS/Dr. A. Jager in that they failed to ensure that mechanisms were in place so that all relevant information relating to a mental health detainee was communicated as soon as it was available to the person treating him and failed to respond adequately to matters which were within their knowledge.

   In particular there were a number of pieces of information in the hands of various people, namely the Arunta telephone recordings, the finding of a will in Mr. Newman's cell shortly before his death, his sending large amounts of money to family in the same period, the diagnosis by Dr. Pargiter on the 18/8/99 of a major depressive disorder which Dr. Jager disagreed with 3 days later without allowing for any period of observation by him, numerous comments by nursing and custodial staff as to Mr. Newman being depressed and "down" more so than any had seen before and the contents of the request by Mr. Newman dated the 15/9/99 which Dr. Jager read and left on his desk before leaving the state on the 16/9/99.

B. Discussion of Evidence Relating to Death

History (Up to the 5/7/99)

Rory Jack Thompson was arrested for and charged with the murder of his wife in 1983. At the time he and his wife had two small children, a girl, Melody, and a boy, Rafi. Mr. Thompson appeared in court and was remanded in custody. He was admitted to the prison hospital at Risdon Prison on the 21/9/83. Mr. Thompson was found not guilty of his wife's murder by reason of insanity on the 29/2/84 and was formally ordered to be detained in a special institution (in this case the hospital attached to Her Majesty's Prison, Risdon). He remained the subject of that order until he died.

Mr. Thompson's children were taken in by his wife's sister in America and were brought up there having no contact with their father.

Over the years of his incarceration, Mr. Thompson made a number of applications for release to the Mental Health Review Tribunal. On more than one occasion that tribunal recommended to the government of the day that he be released. None of those recommendations was accepted. Mr. Thompson was said to hold the view he was a political prisoner. There had been a change in legislation governing the process by which a person such as Mr. Thompson might seek release but there is evidence to suggest he thought that legislation was in effect more restrictive on his chances of release.

By a deed poll dated the 18/8/94 and registered in the Registrar General's Office Tasmania on the 25/8/94, Rory Jack Thompson legally changed his name to Jack Newman and remained known by that name for all purposes until he died.

Mr. Newman suffered from depression occasionally as a reaction to disappointments he suffered. He was from time to time placed on suicide categories by nursing staff although there was no evidence of any actual attempt at suicide or overt threats of it. Such a situation occurred in April 1999 following another rejection by the government of a recommendation that Mr. Newman be released.

Mr. Newman, in the earlier years of his incarceration, was examined by a number of psychiatrists. The general view appeared to be that he suffered from a significant personality disorder but was otherwise not mentally ill. He however was unable to relate on a social level to people and was often described as arrogant. He was known to be very intelligent and had little in common with the people with whom he dealt on a daily basis. He had no family in Australia, his children and brother living overseas. In or about 1998, there was a resumption of limited contact with his son Rafi,

although until the day he died Mr. Newman's daughter Melody refused contact with him. There was another older daughter by an earlier relationship although there appears to have been no contact between her and her father either.

Mr. Newman had a long-standing interest in gardening. He had by and large been a well behaved inmate and had been granted the privilege of being allowed to work unsupervised in gardens outside the perimeter of the jail. He was known to take great pride in his garden work and spent long periods there. It was acknowledged by witnesses that the work in the garden was very important to him.

Mr. Newman was principally under the care of Dr. Lopes but also had contact with Dr. Pargiter. Dr. Jager took over management of his care in February 1999 on Dr. Lopes' retirement. Mr. Newman objected to being under the care of Dr. Jager. On the 2/5/99 he wrote to Mr. Paul DeBomford, the Director of Nursing, outlining his reasons for this. He began that letter by indicating that Dr. Jager had persisted in calling him 'Rory' , despite his not having been known by that name either legally or habitually for some years and despite Dr. Lopes having introduced Mr. Newman to Dr. Jager by the name 'Jack Newman'. Dr. Jager told the inquest that was an unintentional error on his part. Mr. DeBomford's reply to Mr. Newman's complaint was to tell Mr. Newman to try to work out his problems with the "service provider" or discuss it with his lawyer, the Ombudsman or the Health Complaints Commission.

Mr. Newman also claimed he had been forced to return to Dr. Jager's office on one occasion when he did not wish to go. CO Hughes told the inquest that on a Sunday late in April 1999 he was in his office in the outpatients section of the hospital when Mr. Newman walked past his office alone. CO Hughes went to Dr. Jager's office about this. He said that on several occasions he had already had cause to raise with Dr. Jager his practice of letting inmates out of his office after an interview without telling custodial staff. He said Dr. Jager told him that Mr. Newman had simply terminated the interview and walked out. CO Hughes asked Dr. Jager if he wanted Mr. Newman back and he said yes. CO Hughes then went out to where Mr. Newman remained waiting and told him he was required to go back. He said Mr. Newman did not want to but when he was told he was required he went. CO Hughes said there was no suggestion at all that he dragged Mr. Newman back.

Given the acknowledged intelligence of Mr. Newman and his character, both of which would have been well known to Mr. DeBomford, it was unlikely against the background of the incidents complained of by Mr. Newman that he would discuss with Dr. Jager his objection to his treating him. There is no evidence to suggest Mr. Newman took up any of the other options suggested by Mr. DeBomford.

Events Between 5/7/99 and 17/9/99

On the 5/7/99, Mr. Newman, having obtained a credit card while in the prison hospital, walked away from the prison surrounds while out working in its gardens. He then made his way to the airport where he was able to purchase an air ticket. He was apprehended boarding a flight out of the state. He was brought back to the hospital the same day.

Mr. Dodd, the Director of Prisons, who had after discussion with the Director of Nursing and other staff, initially approved Mr. Newman's working in the gardens, directed his confinement to the hospital on his return. Some 3 weeks later it appears Mr. Dodd approved limited access by Mr. Newman to secure prison gardens. Mr. Dodd commented in his evidence that Mr. Newman's legal status changed on his return to prison after the escape in that he became a prisoner remanded in custody and as such classified maximum security. That is an issue which may have been subject to some debate. Suffice to say that is evidently the view the prison took of Mr. Newman's status until he died. It apparently did not occur to anyone on the custodial side of the prison hierarchy to consult forensic staff about Mr. Newman's classification after his escape, the view being the same rules applied to everyone be they prisoner or detainee.

Nurse Thompson noted in the nursing notes the day of Mr. Newman's return to the prison hospital

> *"Depressed mood evident on return to prison after unsuccessful escape attempt. Placed on Cat B. Referral to psychiatrist completed."*

She said the referral was with respect to his *"suicide status post escape"*. She said he denied suicidal ideation but appeared depressed stating he had no hope for the future and had given up any hopes. She described him as "*greatly distressed*". Dr. Jager telephoned the hospital to check on Mr. Newman on the 6/7/99 and then saw him on the 7/7/99 and noted

> *"Seen - no longer suicidal → Cat C. I will review on w/e"*

Less than a fortnight later on the 15/7/99, Nurse Cassidy placed Mr. Newman on suicide category C and [82] referred him to Dr. Jager. The referral said

[82] See category form in exhibit 88

"Inmate expressing feelings of worthlessness, questioning whether one would be better off dead than here, 'wish I had just run off into the bush' - tearful for brief periods. Denies he will take his own life as son is visiting soon."

On the 17/7/99, Nurse Thompson noted about Mr. Newman

"Expressing feelings of hopelessness and persecution though denies any suicidal tendency. Concerns about social interaction with others, worried about not being able to develop meaningful relationships with other people in the future, feels he is deficient in this area. Mood much improved by afternoon, smiling and expressing more positive ideas about future. Has the need to continue talking about current situation."

Dr. Jager saw Mr. Newman on the 18/7/99 and noted

"Has had transient suicidal ideation but no longer suicidal. I will continue to monitor his mental state"

The nursing notes referring to Mr. Newman over the next days were positive. They showed him interacting with others and exercising. They also noted a desire to return to the gardens and on the 24/7/99 some resentment at not being allowed to.

On the 28/7/99 Mr. Newman went before the classification board. He indicated he wanted to go back into the gardens. The chairman of the board, Mr. Salter, told Mr. Newman he would have to obtain a report from Dr. Jager before this could be considered. He said Mr. Newman was very dejected by that. The board was to discuss Mr. Newman again on the 13/10/99.

Mr. Newman was seen by Dr. Jager on the 2/8/99. Nursing staff noted that day his mood /affect appeared flat. On the 10/8/99 nursing notes record Mr. Newman "*appears depressed. Not seen by Dr. Pargiter despite requests to do so."* On the 13/8/99 the notes record *"Request to forensic team today, tearful at times and states he is feeling very anxious"*. He was reported two days later as being a bit down.

Dr. Pargiter acted as locum for Dr. Jager for a period in August 1999 and in that capacity he saw Mr. Newman on the 18/8/99.[83]. Dr. Pargiter is a senior consultant psychiatrist with many years experience. He had extensive knowledge of Mr. Newman having been involved in giving numerous reports in respect of him since 1984. Dr. Pargiter had in fact resigned as a member of the Mental Health Review Tribunal in 1991 after the government of the day rejected a recommendation made

[83] See affidavit of Russell Ashley Pargiter sworn the 26/11/99 - exhibit 94

by that body for the release of Mr. Newman saying it had information suggesting that Mr. Newman was a danger to the public. Dr. Pargiter was of the view that if the government had such information it should have been available to the Tribunal.

When he saw Mr. Newman on the 18/8/99, Dr. Pargiter diagnosed him as having a major depressive episode with an alternative diagnosis of adjustment disorder with depression, that being a reaction to the failed escape and it's consequences. He was not overly concerned about suicide but placed Mr. Newman on suicide category, prescribed an antidepressant Ventafaxine (Efexor) and noted Mr. Newman should be reviewed in a fortnight. He indicated it was not uncommon from his knowledge of Mr. Newman for him to suffer depression.

On the 19/8/99, a handwritten will was found in Mr. Newman's cell during a routine cell search. This was brought to Nurse Edwards attention. He noted it in the nursing notes and also noted

> *"Improved affect also noted-smiling, talking, greater animation in movement. During discussion later in morning expressed feelings of hopelessness questioning purpose of living, particularly after access to gardens had been removed. Discussed with Mr. Balmer decision to give Jack escorted access to East Wing garden for 10-30mins. Daily when and if staff are available. Same attended this afternoon with very good effect."*

The next day the notes recorded escorted visits to the garden in the morning and afternoon and that Mr. Newman was very thankful for them and disappointed that his foolish escape had deprived him of his gardening pursuits. While these visits were not what Mr. Newman had enjoyed prior to his escape in July they were his first visits of any description to a garden environment since then.

Dr. Jager was back at the prison on the 21/8/99 and reviewed Mr. Newman. He took him off suicide category and the drug prescribed by Dr. Pargiter noting

> *"Described fluctuating mood. Enjoyed time in garden-feels tense on Ventafaxine. Diagnosis =Adjustment Disorder"*

When he gave evidence, Dr. Pargiter described an adjustment disorder with depression as being a reaction to an adverse event in a person's life which lasts longer and is more intense than is warranted. He described a major depressive episode as more serious and not necessarily linked to a causal factor. He said that drugs were more effective for the latter type of illness than for the former and that in relation to the former, if the cause is removed usually there is a rapid recovery without medication. He said that an adjustment disorder can deteriorate into a major depressive episode. If it gets to the stage where there is a slowing of physical and mental activity, sometimes

agitation, waking early, a tendency to feel better as the day goes on, poor appetite, loss of weight, self reproach and delusions of guilt, then it is a major depressive disorder.

Dr. Pargiter agreed there was no clinical utility in being on Efexor for 3 days. He said that any improvement in that time would be more likely ascribed to another mechanism. He agreed that Mr. Newman could have changed in three days such as to warrant being taken off the antidepressant drug. He agreed the visits, even just to the hospital gardens, could have accounted for Mr. Newman's improvement. He also agreed that the decision of Dr. Jager to revise his (Dr. Pargiter's) diagnosis and take Mr. Newman off antidepressants was a reasonable clinical judgment. [84]

Having said that Dr. Pargiter also agreed that had he been aware of the several factors put to him, namely Mr. Newman disposing of money, the will, the contents of the phone calls to family, the contents of mail and the referral of the 15/9/99, he would have investigated further. However he said he was also aware of Mr. Newman's tendency for self dramatisation and theatricality.

According to the nursing progress notes, Dr. Jager reviewed Mr. Newman on the 31/8/99 and then the 6/9/99. On each occasion the notes made reference to the fact of improved sleeping patterns and a possible move to the main prison. For some reason which was not explained in evidence there are no nursing progress notes on the medical files for the period after the 6/9/99. However according to Volume III of the Forensic file [85] Dr. Jager saw Mr. Newman on the 30/8/99 and he was then considered in ward rounds only on the 6/9/99 and the 13/9/99.

On the 4/9/99, 5/9/99, 12/9/99, 13/9/99, 14/9/99 and the 17/9/99 Mr. Newman made telephone calls to his son and brother. These calls were made through the Arunta system and were recorded. However they were not monitored and their contents were not known by Dr. Jager until after Mr. Newman died. In those calls Mr. Newman clearly sounds "down". He talks of suicide, disposing of money to his children and changing his will. On the 17/9/99, he tells his brother's wife he has heard his daughter Melody does not want contact with him and says at the end *"Alright my greetings to Rogan, say goodbye"*. [86]

On Saturday 11/9/99, Mr. Newman completed a request to the "Unit Manager + Mr. Salter".[87] It said

[84] See page 1028 Transcript
[85] See exhibit 318
[86] See transcript of tapes - exhibit 111
[87] See exhibit 318

> *"Please note this trial apparently relevant. After further thought I will plead "guilty". If asked for mitigation, I will point out just walked off, no-one hurt nor threatened, nothing stolen. -That will be all ……work until 13Oct: bakery, lawn, laundry whatever work"*

Mr. Bain, the unit manager has signed the form and noted on it *"refer to Dr. Jager"* There is no reference in the ward round notes of the 13/9/99, the nearest date after this request, of the request itself having been made or considered.

On Wednesday the 15/9/99 Mr. Newman completed a request to see Dr. Jager. That request said

> *"To see Dr. Jager please, You were right that I was wrong. Now excessive awareness of life-long horrible moral failures and social incompetence hurts. Mercy on undeserving - please allow (garden?) work to distract from all-consuming useless regrets which cannot change the past, and give hope of being valuable to someone"*

Dr. Jager told the inquest he saw that request on the morning of the 16/9/99 just before he left to go interstate for a few days. He read it, put it back in his in tray but took no action.

A number of the custodial officers and nurses who gave evidence had had dealings with Mr. Newman at various levels. All believed Mr. Newman to be depressed after his escape and affected by his inability to go back to the level of freedom he had had in the gardens but none believed, on the varying levels of information they had, that he was actively suicidal. The custodial officers did not have the training to make any real sort of assessment. However a number of the nurses were psychiatrically trained and would have been in a position to make some assessment.

SCO Hughes said he had almost daily contact with Mr. Newman before his escape. After the escape he had much less contact because his office was in the outpatients area and Mr. Newman was no longer going through there to get to the gardens. He noted a stark change in personality and demeanour. He said he wasn't as arrogant after the escape and he thought he was depressed. He said Mr. Newman was apologetic for what he had done which was totally out of character and he thought he might have been a candidate for suicide. Mr. Bain also described Mr. Newman as apologetic and remorseful and thought he was depressed.

SCO Hughes spoke to Mr. Balmer and Mr. Bain when he noted Mr. Newman sending letters about transferring money to his family. He then went and spoke to Dr. Jager direct asking if there was any concern. SCO Hughes said Dr. Jager's response was that it was his money and he could do with it what he liked. Because he thought Dr. Jager was making it clear he should stick with his custodial role he left the subject alone. He said he spoke to Dr. Jager again a little later saying he thought Mr.

Newman was depressed. The clear impression he had from Dr. Jager was that he was not qualified to make any such assumption.

SCO Hughes placed this situation in contrast to his relationship with Dr. Lopes. He said Dr. Lopes was always happy to discuss patients and often came to SCO Hughes' office to tell him who he wanted to see and to ask how they were. SCO Hughes agreed he had no psychiatric qualifications but felt that Dr. Lopes would have listened to his concerns about Mr. Newman whereas he felt fobbed off by Dr. Jager.

General Manager Harris said that he was approached some weeks after Mr. Newman's escape about permission for him to return to the gardens. He refused that but left the matter open for the future. It was not suggested to him that Mr. Newman was suicidal. He subsequently saw letters which came to him for approval dealing with Mr. Newman's sending money to family. He mentioned this to Mr. DeBomford suggesting he might need to be more closely supervised although he did not mention concerns about suicide. He made no note of this conversation because he said Mr. DeBomford said he would raise the matter with forensic and in those circumstances he did not see he needed to follow it up. Mr. Bain also said he thought he mentioned the letters to one of the hospital nurses because he had some concerns about Mr. Newman.

Mr. Burton, who was the manager of the security unit at the time Mr. Newman died, said he listened to some calls of Mr. Newman's at random on the Arunta telephone system early in the week of his death. He said he thought Mr. Newman sounded depressed and thought he was up to something. He said he had a gut feeling and so listened to some earlier calls. He became concerned for Mr. Newman's wellbeing and about another possible escape and so he spoke to Mr. Harris. He made no formal report about it. Mr. Harris said he had no recollection of discussing this with Mr. Burton but he did not rule out entirely it did not happen. Mr. Bain said he had no knowledge of the calls at all and had he done so would have reported them to Dr. Jager.

Mr. Burton had no doubt he raised these calls with Mr. Harris and Mr. Harris's evidence about the issue did not help. I am satisfied that Mr. Burton did raise these calls with Mr. Harris and that nothing was then done to pass that information to relevant authorities.

Mr. Balmer, the Clinical Nurse Consultant, Program and Psychiatric Services, told the inquest he had known Mr. Newman for many years and had almost daily contact with him. When he went on leave on the 5/9/99 he said there had been nothing reported to him that would indicate Mr. Newman was suicidal.

Night of the 17th/18th September 1999

The cell in which Mr. Newman was housed presented its occupant with numerous opportunities to hang himself. The cell had a ventilation grill set into the concrete wall to the left and above the level of the door, Mr. Newman had sturdy shoe laces, the cell had exposed bars across it's window, an exposed pipe at the sink and a bed with bars. [88] Mr. Newman also had available to him several electrical type cords connected to a Walkman, an electric typewriter, a desk light and television.

CO Radcliffe came on duty at 10.30 p.m. on the 17/9/99 to begin an 11 p.m. to 7 a.m. shift. He said in his affidavit [89] that as a result of the death of Thomas Holmes earlier that night surveillance on the other inmates was increased to every half hour. He said these checks involved shining a torch through the observation window in the cell and visibly checking the position of each prisoner. He said he checked Mr. Newman at 6 a.m. on the 18/9/99 and he was lying on his bed on his stomach under the covers. He saw him stir and start to turn over and so he moved on. He said there was enough daylight so that he did not need his torch to see this. He had no knowledge of any suicidal tendencies but knew Mr. Newman was disappointed that he was not allowed to resume his duties in the prison gardens.

When CO Radcliffe gave his oral evidence, he said he had seen Mr. Salter, Mr. Graeme Harris, Mr. Dodd and Mr DeBomford all there at the prison hospital when he arrived that night. He said he was told (he believed by Mr. Harris) he was to maintain half hourly checks, to make sure he actually sighted people and to generally be more alert as to what had happened. Director of Nursing DeBomford said that on the night of Thomas Holmes death he discussed with Nurse Davidson the potential for a copycat suicide. He said he discussed the need to reassess all inmates and take whatever measures he deemed appropriate to minimise the risk. He did not recall any specific instructions about extra checks. However he was also firmly of the view that custodial officer checks were required to be done half hourly.

General Manager Harris confirms he did speak to custodial staff on the night of Thomas Holmes death and instructed them to make "extra" checks. He did not believe he specified a time. Since however he was firmly of the view that standing orders required half hourly checks as a starting point one has to assume he intended there be checks more often than half hourly.

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[88] See photographs -exhibit 5

[89] See affidavit of John Mark Radcliffe sworn 21/9/99 - exhibit 85

CO Radcliffe gave evidence about cell checks that night and generally. He said that peg clocks were introduced about 1994 or 1995 and initially throughout the prison these checks were half hourly. About eighteen months later these checks were changed to hourly by an internal memo. He was then shown Directors Standing Order CO18, read it and said it was inconsistent with the memo he had seen. He said that inconsistency caused some confusion but he made no effort to sort that out. He just stuck to hourly checks.

CO Radcliffe then went on to say that actually he had checked inmates every fifteen minutes on the night of the 17/9/99 and morning of the 18/9/99. He had actually prepared a document in the form of a prison report which was put to him.[90] That document purported to have been prepared at 10.30 p.m. on the 18/9/99 and was dated the 19/9/99. It listed fifteen minute intervals between 10.30 p.m. and 6.30 a.m. and purported to be a record of "*15 minute cell checks maintained during night*". There was some confusion as to what night it related to. CO Radcliffe when he was questioned said the document actually related to the night of the 17th/18th. He then admitted when questioned further he had only ever checked the cells half hourly and last checked Mr. Newman at 6 a.m. His shift was not due to finish until 7 a.m. He should have checked Mr. Newman at 6.30 a.m. but admitted that he had not.

He was asked why he did not do that 6.30 a.m. check. His response was that CO Carnes arrived, they did the handover and he left. He said he expected her to do the check. He agreed he ignored instructions in not checking the cell at 6.30 a.m. He said there was no blanket over Mr. Newman's cell window when he looked in at 6 a.m. CO Radcliffe had no interaction with Mr. Newman on this night. He also said he was not given any specific instructions to be careful of Mr. Newman, he did not know he had been on suicide categories earlier in the year and he was not told of any signs of depression.

Inmate Collins occupied cell 4 in the same wing as Mr. Newman. His cell was not directly opposite but just off to one side. He said he woke up at 6.15 a.m. on the 18/9/99 and looked across at Mr. Newman's cell. He said he saw Mr. Newman wave to him and he waved back. He said it was daylight then.

Nurse Davidson started work at 7.30 p.m. on the 17/9/99. Shortly after that he became involved in the finding of Thomas Holmes. He said that he was directed by Director of Nursing DeBomford to make extra checks in the form of fifteen minute checks on inmates after Holmes death but Davidson

[90] See exhibit 86

concentrated on the south wing where the death had occurred rather than east wing which he said had the longer term inmates. He said when asked if he had in fact done cell checks on this night [91]

> *"It is quite possible, but also because of the-after having dealt with Mr. Holmes I was more or less running on adrenaline and endorphin anyway. I wanted to make sure that nothing else happened within that shift and I was checking every time I heard anybody roll over in bed basically. If I heard a squeak or a rattle I was going up and having a look at who and where it had come from."*

He acknowledged that apart from responding to specific noises he was unlikely to have checked inmates in east wing at fifteen minute intervals because that was not what he considered the high risk area. The nurses daily report completed by Nurse Davidson for that shift [92] showed a note made by him as follows

> *"NB a closer watch was kept on potentially affected inmates over night."*

It was not until the nurses daily report of Nurse Norris on the 18/9/99 after Mr. Newman's death that an entry appeared

> *"Due to the events of the last 24 hrs <u>all</u> inmates are to be observed every 15 minutes. This will be reviewed on Monday 21/9/99 as per Mr. A. Muskett's instructions."*

As to cell checks generally, Nurse Davidson said that cell checks were not done by nursing staff except where there was a health reason to do so. Sometimes however nurses would do the hourly peg clock checks for custodial officers when they were on their rounds just as a matter of convenience.

As to knowledge by inmates of the hospital of Mr. Holmes death on the night of the 17th/18th September, Nurse Davidson said that it was highly probable that south wing prisoners may have known but unlikely that others did. Mr. Newman was of course east wing.

CO Carnes was to work a 7 a.m. to 7 p.m. shift in the hospital on the 18/9/99 [93] and she arrived for handover at 6.30 a.m. She let the mess staff (ie. those inmates to assist with breakfast) out of their cells at 6.45 a.m., made herself a cup of coffee and talked to Nurse Davidson. At 7.05 a.m. she and CO Ian Smith, who had also just begun his shift, went round unlocking the Jackson locks on the cells.

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[91] See transcript at page 881
[92] See exhibit 73
[93] See affidavit of Sharon Fae Carnes sworn the 18/9/99 - exhibit 83

The keys they used were those they collected from the main gate at the start of their shift, there being no cell keys held by custodial officers in the hospital after the final cell muster at night.

CO Carnes unlocked the east wing and CO Smith did the other wings. She described these locks as slides and noisy and that they would wake the inmates. She unlocked the lock on cell 9, Mr. Newman's cell. She says she looked in the window of the cell door and saw Mr. Newman standing with his back to the door near his desk and his left shoulder touching the wall. She says she noticed nothing unusual and said nothing to him. She said he appeared to be just standing there. CO Carnes went back to the roundhouse and had another cup of coffee. Then at 7.35 a.m. she began the unlock of the second locks on the cells.

Lights in the cells are activated from the roundhouse and they are turned on just prior to the Jackson lock opening. When she went to Mr. Newman's cell, CO Carnes had no torch and could not remember if the lights were on or off. She said however there was certainly light in the corridor.

When CO Carnes unlocked Mr. Newman's cell at 7.35 a.m. she said *"he appeared to be just standing there near his desk, still with his back towards me"*. She said she asked if he was alright, he did not answer and so she said his name. She then noticed the bandage round his neck and the black twine going up to the air vent. She touched him on the shoulder, felt he was limp, said his name and then locked the cell and went to get help. CO Carnes made no attempt at this point to see if Mr. Newman was still alive and if so to render him immediate assistance. Because there were other inmates out of their cells she relocked Mr. Newman's cell and went to the roundhouse where she spoke to CO Smith. They then both returned to the cell and re-opened it.

CO Carnes was questioned at some length about her observations of Mr. Newman at 7.05 a.m. and 7.35 a.m. She acknowledged that at 7.05 a.m. she could only see his head and shoulders through the observation window. She was asked why she looked in the cell then and she said

> *"To make sure that he was there and to ascertain that he was alive."*

She was then asked if she was in fact able to determine if he was alive and she responded *"I must have"*. She was asked if she observed any movement and she said

> *"I must have because I don't move to the next cell until I get some response from the inmate."*

Her evidence in this respect was unconvincing. She recorded nothing about any movement when she swore the affidavit she did on the day of death and she agreed that "possibly" Mr. Newman was in

the exact same position at 7.35 a.m. that he was in at 7.05 a.m. She admitted that at 7.35 a.m. before she relocked Mr. Newman's cell, she did not check his pulse and could not recall if she checked his breathing. She admitted that "possibly" he may have still been alive when she locked him back in his cell at 7.35 a.m.

When CO Smith got to the cell and opened it, he said Mr. Newman's name and got no response. He said Mr. Newman was blue in the face and cold to the touch and he checked to see if Mr. Newman was dead. By that it appears that he did not check Mr. Newman's pulse but assumed because of the dark colour of his lips that he had been hanging for some time. He did not check his breathing. He then again relocked the door of the cell and called for the nurse. He agreed he had no way of knowing if Mr. Newman was still alive at this point. Certainly he made no attempt to render immediate assistance.

As to cell checks generally, CO Smith said that at night for normal inmates not on any category cell checks were done hourly and that for those on categories it could be half hourly or every fifteen minutes depending on the category. He was asked where that instruction came from and he said that it was just normal practice. He agreed when he was shown Directors Standing Order CO18 that there was nothing in that which suggested cell checks at night should be done any less frequently than during the day but was firm that hourly checks were usual at night.

On the other hand CO Carnes said about cell checks that she understood they were to be half hourly unless there was a direction for more frequent checks. She however understood checks were hourly in the main prison.

CO Carnes could not recall being told at handover that more frequent cell checks were required because of the death of Holmes nor whether she had been told of any special instructions for managing inmates following the death. CO Smith said he was aware that Mr. Newman was angry or frustrated about having his privileges withdrawn but that, in the week before Mr. Newman died, he did not notice anything untoward about his behaviour.

Nurse Norris arrived at Mr. Newman's cell in response to the call from CO Smith and was let in to the cell. She said she had no difficulty seeing the shoe lace by which Mr. Newman was hanging through the observation window in the cell. She said when she saw Mr. Newman, his feet were just touching the floor. She called out Mr. Newman's name a few times, felt him and checked his pulse (he was cold and there was no pulse) and then lifted him by the waist so that CO Carnes could try to loosen the bandage around his neck. She could not and so went back to the roundhouse to get Nurse Davidson and to get him to bring a cut down knife. She had no idea why, when she initially went to get CO Smith, she did not then get the cut down knife. Nurse Davidson broke in to the glass box

where the cut down knife was and took it to the cell. When he arrived Mr. Newman was still hanging and he noted Mr. Newman's head was bowed, his tongue was out and his lips were purple. Nurse Davidson also believed Mr. Newman's feet were just touching the floor. CO Carnes with Nurse Norris got Mr. Newman's feet on to a stool standing nearby and Nurse Davidson cut him down. Mr. Newman was laid on the floor.

There appears to be some confusion amongst the witnesses as to what resuscitation equipment was at the cell and when and who in fact left the cell to get it. When it was available, resuscitation began and was continued until the ambulance arrived. Other nurses and custodial officers became involved, there being more than the usual number available because the events occurred at the change of shift.

CO Carnes estimated that between the time she locked the door on Mr. Newman the first time until CPR was commenced only a maximum of five minutes had elapsed. On the evidence available to me it is likely the time elapsed was more than five minutes. Having regard to the evidence already given by a pathologist in this inquest about the time it would take a person to die by hanging, it is more than likely that, had Mr. Newman still been alive when CO Carnes saw him at 7.35 a.m., he would have been beyond help by the time resuscitation was finally begun.

Dr. Lyons conducted the post mortem in respect of Mr. Newman and prepared a report. [94] He concluded that Mr. Newman died as a result of neck compression due to hanging. There was nothing else found on examination which could have contributed to Mr. Newman's death. As to the time at which Mr. Newman may have died, Dr. Lyon's evidence was that it was likely to have occurred at some time between 3 a.m. and 7 a.m. on the 18/9/99. [95]

When Mr. Newman's cell was inspected after his death there was a blanket draped over the window. There was evidence that Mr. Newman did that to shut out the outside lights. CO Radcliffe said it was not there at 6 a.m. and CO Carnes was not asked if she saw it at 7.05 a.m. or 7.35 a.m.

Dealing with the evidence I have canvassed, it appears quite clear that CO Radcliffe attempted to mislead both his superiors and to some extent the court in the preparation and production of the prison report which became exhibit 86. He clearly tried to represent that he did inmate checks on the quarter hour over the night of the 17th/18th September when he did not. It appears Mr. Newman was checked at 6 a.m. and not in fact checked again until 7.05 a.m. CO Radcliffe says Mr. Newman was still in bed and alive at 6 a.m. Inmate Collins said he was alive at 6.15 a.m. and I accept that he was.

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[94] See affidavit of Timothy John Lyons sworn 1/11/99 - exhibit 228

In the context of the death of Thomas Holmes on the night of the 17/9/99, the instructions apparently given to staff after that death and Mr. Newman's history, the gap in checks between 6 a.m. and 7.05 a.m. was unacceptable. The question however arises, if Mr. Newman was alive at 6.15 a.m., was he hanging at 7.05 a.m. when CO Carnes first saw him ? CO Carnes' evidence of the cell check she did at that time particularly about detecting any movement was not convincing. Her height, about which she was questioned, was such that she would not have been able to see a great deal of what Mr. Newman was doing given the position he was in. She acknowledged that he was possibly in the same position at 7.05 a.m. as when later found. The cell check is more likely than not to have been a cursory one without any real attempt being made to check the inmate was actually alive.

When regard is had to the estimated time of death, the fact that Mr. Newman's body was cold at 7.35 a.m. and all other evidence, I believe I can be satisfied that Mr. Newman was hanging already at 7.05 a.m. I am unable to determine for how long he might have been or if, had CO Carnes discovered Mr. Newman was actually hanging at 7.05 a.m. and taken immediate action or a cell check had been done at 6.30 a.m., Mr. Newman could have been saved.

The evidence however is sufficient to satisfy me that the response of custodial officers to the finding of Mr. Newman at 7.35 a.m. was unacceptable. Two custodial officers at different times opened Mr. Newman's cell and then relocked it without making any attempt to check if he was still alive. CO Carnes gave evidence she was carrying a personal alarm but did not activate it. There appears no viable explanation for why she did not activate her personal alarm, why she did not attempt to find out if Mr. Newman was alive and why she made no attempt to get a cutdown knife when she did go to get help. There was no satisfactory explanation from CO Smith as to why he did not check to see if Mr. Newman might still have had a pulse or be breathing. If Mr. Newman had still been alive when he was seen by CO Carnes at 7.35 a.m., the delay occasioned by the actions of CO Carnes and Smith may very well have resulted in Mr. Newman's death.

Issues Arising

Possible Interference with Records

A possibly serious matter arose from Ms. Woodberry's evidence. In her position as records clerk she dealt with incoming correspondence about inmates and files. As to correspondence she said that her usual practice was to open letters, read them quickly in case anyone rang with a query, get the file

[95] See transcript page 2388

out that it related to and then give the file and the letter to Mr. Salter, the Accommodation Manager to be dealt with. She said that Mr. Salter had a stamp with the words "Accommodation Manager" on it and she thought provision for a date. When he had dealt with correspondence he stamped it and signed it before it came back to her.

Her evidence was that "*up to 2 weeks*" before Mr. Newman's death a large envelope was received from Dr. Jager's office which contained a number of letters and reports relating to various inmates. In this envelope was a letter from Dr. Jager to Mr. Salter about Mr. Newman. She read it and was about to take the file in to Mr. Salter when he came out to her desk. She showed him the letter. She said in relation to the letter

> *"I clearly remember the letter relating to Jack Newman due to the fact the other letters were in support of transfers requested by inmates whereas the letter about Jack did not recommend him going back into the gardens. I remember this letter so well because I thought Jack is going to be devastated."*

Her evidence was that Mr. Salter was also surprised by the contents of the letter. On the other hand Mr. Salter said the letter now produced and dated the 3/8/99 was that which he believed he saw originally. Ms. Woodberry said that on Thursday 16/9/99 Mr. Newman's prison file was requested by someone at the prison hospital and then collected by someone from there. She never saw the file again. When the file went to the hospital she noted the letter she had seen was at the front of it. When she heard that Mr. Newman had died she was concerned that he had seen the letter. She made inquiries to try to find out if indeed Mr. Newman had seen his file between when it went to the hospital on the 16/9/99 and when he died.

Ms. Woodberry could not recall who from the prison hospital had collected Mr. Newman's file and there was no note on her whiteboard as to who had it. Director of Nursing DeBomford however subsequently gave evidence that he collected it although he could not recall for what purpose and that he passed the file on to either the General Manager of the Prison, Mr. Harris or Mr. Muskett the Clinical Nurse Consultant, Medical on the day of Mr. Newman's death, that is Saturday the 18/9/99. On the 22/11/99 Ms. Woodberry raised what she believed to be a discrepancy with the letters with Mr. Salter and he rang Dr. Jager's office and requested a copy of the letter. On that day a copy of a letter dated the 31/8/99 was received by fax from Dr. Jager's office. She said neither she nor Mr. Salter had seen that letter before and Mr. Salter confirmed this. She was adamant when questioned by Counsel for Dr. Jager that she had not before that day seen the letter dated the 31/8/99 and it was not the one she had seen come into her office prior to Mr. Newman's death.

On the 1/12/99 Mr. Salter looked at Mr. Newman's prison file and the letter of the 31/8/99 was on it. On the 7/12/99 Ms. Woodberry was shown two documents by a police officer which she was told had been retrieved from Mr. Newman's prison file. They were two letters from Dr. Jager to Mr. Salter relating to Mr. Newman and were dated the 3/8/99 and the 31/8/99. She said the one dated the 31/8/99 was that faxed through from Dr. Jager's office on the 22/11/99 which she had not seen before that date. As to the letter dated the 3/8/99 she said she recognised the first paragraph but not the second. She said the letter she saw mentioned the escape and nothing about behaviour being settled. She was quite sure the letter she saw also mentioned gardens because that is what Dr. Jager had been asked to comment about.

Ms. Woodberry also said that usually Mr. Salter would sign all letters that came in and neither of the letters shown to her had his signature on them. Ms. Woodberry was questioned at length by Counsel for Dr. Jager. She was an impressive witness despite Counsel for Dr. Jager's attempts to unsettle her. She remained unmoved from her evidence and said she was aware of the seriousness of the implications arising from her evidence.

Evidence was given by a Constable Schofield [96] that on the 15/12/99 he had inspected the computer of the secretary to Dr. Jager at his office at 2 Terry Street, Glenorchy. He had found two files containing letters from Dr. Jager to Mr. Kevin Salter dated the 3/8/99 and the 31/8/99. The computer showed that the file containing the letter dated the 3/8/99 had been modified at 11.52 a.m. on the 20/9/99, that being the Monday after Mr. Newman's death. He said that a document would not show as having been modified if it were simply opened, looked at and closed. It could be shown as having been modified however if the document were opened, looked at and modified as little as by putting a space in and then closed. He said that there would have to be a change of some description for the computer to show a modification.

Dr. Jager's secretary Ms. Browne gave evidence. She confirmed [97] her computer was searched by police on the 15/12/99 and copies of 2 letters were found. They were letters from Dr. Jager to Mr. Salter in relation to Mr. Newman. She said she had typed both and that she believed they were in the same form as when she typed them. Her evidence was that while her computer was passworded a number of members of the Forensic team knew the password. She believed she was at work on Monday the 20/9/99. She said that she could not recall opening the files on her computer relating to the letters but she might have.

She said in her affidavit

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[96] See affidavit of John Phillip Schofield sworn 4/1/00 - exhibit 106
[97] See affidavit of Gaye Elizabeth Browne sworn the 5/1/00 - exhibit 101

" I am now aware that modifications on files are recorded as being modified if you save them even without making alterations."

In her oral evidence she said Dr. Jager had his own computer and could not access material on her computer from his. He usually dictated letters for her on to a dictaphone, she typed them and gave them back to him to check. If there were to be alterations he noted those on the copy she gave him and gave it back to her to retype. There were occasions when she would sign letters for him. She said Dr. Jager was not at work at the Terry Street office on Monday the 20/9/99 and she presumed he was at the prison. She said in fact that there were no staff there because of the death in custody. [98] She later said he might have been there in the afternoon but she really couldn't recall. When specifically questioned by Counsel for Mr. Newman's family about whether it was possible that Dr. Jager was at Glenorchy around about noon on the 20/9/99 she said she could not recall and in fact couldn't recall who if anyone was there.

Ms. Browne was questioned by Counsel for Dr. Jager immediately after giving those answers. In response to his questions, she said firmly that Dr. Jager was not in the Terry Street office that Monday morning. She said there was no departure from his normal routine of not leaving the prison until at least 12.30 p.m. She agreed it followed that the only person who could have gone into the document at 11.52 a.m. that day was herself. She said definitely that she did not alter it. She also agreed that she would remember if someone came in to her computer and altered a letter that day and that it did not happen. She agreed it was possible she opened the file *"just to see what was happening, or what you know."*. Counsel for Dr. Jager then asked her if it was more than just possible, that it was likely she had a look at the file. Her response was *"Well I don't recall but I could have I mean it is possible that I would have done."* [99] She then agreed with Counsel that the letter simply was not changed.

Some points should be made about Ms. Browne's evidence. Her responses to two different Counsel about the same issues in the space of 10 minutes were completely inconsistent. She also stated quite baldly to Dr. Jager's Counsel that Dr. Jager did not depart from his normal routine on the 20/9/99 having already acknowledged that things were far from normal because of the death in custody. She then basically agreed with any proposition put to her by Dr. Jager's Counsel notwithstanding that her answers to questions from other Counsel were at odds with her answers to him. Further, to some degree her explanation for somehow producing a modification to the relevant letter was implausible. She also vacillated from absolute certainty with some of her answers to being unable to recall anything because she was upset on the 20/9/99.

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[98] See transcript page 1097
[99] See transcript page 1104

At its kindest I was left with the very clear impression that Ms. Browne was saying what she thought was required without any real idea of what happened on the 20/9/99 or indeed to the two letters. Her evidence was not in my view reliable. It is sufficient to say that at 11.52 a.m. on Monday 20/9/99, the first working day after Mr. Newman died, a person within the Forensic team (they being the only ones I am told had the password to the computer) accessed Ms. Browne's computer and opened the file containing the letter dated the 3/8/99 from Dr. Jager to Mr. Salter. I accept the evidence of Constable Schofield over that of Ms. Browne as to what was required to produce the indication in the system that a modification had been made.

The evidence of Ms. Woodberry appears to be that there was only one letter and that was one similar to that dated the 3/8/99. She says that the letter now produced and dated the 3/8/99 is not the one she saw come into her office and implies that the letter now on the prison file is false and that someone has taken the original and replaced it with the false one. It is relevant to this issue that

⇒ Mr. Salter does not have a recollection of the events outlined by Ms. Woodberry and believes the letter of the 3/8/99 to be the same as he saw in his office

⇒ the letter written by the Classification Board to Dr. Jager following its July meeting says that Mr. Newman has asked to get back to doing some gardening and asks *"is he ready to be trusted or does he require some time to rebuild that trust"* [100]

⇒ the letter dated the 3/8/99 produced to the court responds *"In terms of the Classification Panel's question of whether he ready to be trusted, it has been my experience that allowing incremental increases in liberty and regularly reviewing such decisions provides the best way of examining trust."*

⇒ the classification board letter does not say, can he go back to the gardens, and the response answers the question asked in the same terms it was put which seems appropriate.

⇒ there was no evidence, apart from Ms. Woodberry's and Mr. Salter's that they had not seen the letter before, to suggest the letter dated the 31/8/99 was other than a letter written on the 31/8/99 in the normal course of events. As that letter mentions Mr. Newman did indeed write to Dr. Jager. The letter is on the forensic file.

[100] See exhibit 318

⇒ while there is evidence the prison file was taken to the hospital on the 16/9/99, the evidence is it was taken by Mr. DeBomford and that on the day Mr. Newman died he passed it to someone else. It was then made available to senior management for production to coronial staff. There is nothing to suggest Dr. Jager had access to it at or around 11.52 a.m. on the 20/9/99 such as to enable him to, as implied, either substitute a letter or cause someone else to do so. In fact the evidence suggests there is no way he could have had access to it.

⇒ Dr. Jager denies interfering in any way with the correspondence

While the access to and modification of the letter in Ms. Browne's computer on the morning of the 20/9/99 seems on the face of it sinister when taken in conjunction with the other evidence I simply cannot be satisfied that the letter which is exhibit 104 is other than the original letter written by Dr. Jager on the 3/8/99. Ms. Woodberry was clearly mistaken.

Cell Checks

The evidence of various witnesses already canvassed again makes it clear that there was no consistent understanding amongst staff as to how often cell checks were to be done.

Role of Nurses in Prison Hospital

This issue arose out of questioning about knowledge different staff members had of events in Mr. Newman's recent history. The degree of knowledge varied between staff members and the perception of it's use also varied.

Nurse Norris said part of her duties was to keep an eye out for potentially suicidal inmates and if she thought there was a risk report it. She agreed that as part of her training she received instruction in relation to the signs to look for in relation to suicide risk. She said [101]

> *"depressed, they isolate themselves, they don't necessarily talk about harming themselves - their general demeanour - they walk round with head down…looking at changes in behaviour."*

She was aware that Mr. Newman was on category B after his escape, she was aware of Dr. Pargiter's diagnosis in August, she recalled administering the antidepressant medication prescribed and she

[101] See page 898 transcript

was aware that Dr. Jager reduced Mr. Newman to category C and stopped the medication. She said she was surprised the medication was stopped because she thought Mr. Newman was still depressed although she did not think he was suicidal. She did not take any steps about the removal of medication.

She said Mr. Newman appeared quite distressed after the escape. He was not allowed in the gardens and had to spend his time indoors. He read most of the time. She did not know of the will found in Mr. Newman's cell, his sending money out to family members or the contents of the telephone calls with his family. She said that had she known of the transfers of money, the contents of the telephone conversations with family and the will, her view would have been he was potentially suicidal.

Nurse Davidson agreed it was part of his function to note any signs of self harm or suicidal ideation and pass them on to a superior if he interpreted them as relevant. He described Mr. Newman as being less buoyant at this time. As to his role, Nurse Davidson did not know until after Mr. Newman died about the will found in his cell on the 19/8/99. He did not know of the content of the telephone calls between Mr. Newman and his family. He agreed both of these pieces of information would have been useful for him to have and the latter would have prompted a discussion with the psychologist or psychiatrist about Mr. Newman.

Nurse Thompson, who had placed Mr. Newman on a suicide category on the 5/7/99, was asked a number of questions about Mr. Newman's situation around the time he died. She agreed his circumstances had altered since the escape and he did not like that, she knew he had no family support in the state, she was not aware of the will made, the transfer of monies to family or the contents of telephone calls to family. She said that had she known of all of these things she would have formed the view Mr. Newman was a significant suicide risk.

Her background was as a disability nurse as opposed to a psychiatric nurse although she had some knowledge of suicide observation. She agreed that a denial of suicidal intention was only one of the factors but a lot of emphasis was put on it. Other factors were the circumstances of the inmate and the support available. Nurse Thompson also made some comments [102] about Mr. Newman being a psychiatric patient in a hospital contained in a prison and said

> *"There's a very fine line between treatment and punishment, it's a-it's difficult, it's very difficult to combine the two."*

[102] See transcript pages 918 and 919

She expressed the view that the removal of Mr. Newman's gardening privileges was a punishment rather than treatment. It is interesting that these views reflect to some degree views expressed by Dr. Lopes when he wrote to the Secretary of the Law Department about Mr. Newman in August 1984[103]. Nurse Thompson, notwithstanding her expressed concerns, did not raise them with the forensic team.

Nurse Shaw, also on duty the morning Mr. Newman died, was a psychiatrically trained nurse and had a number of years experience in managing people with depression. He said Mr. Newman was depressed after his failed escape. He was aware of Dr. Pargiter's diagnosis and described Mr. Newman as flat in affect. He agreed that if you coupled together all the factors about Mr. Newman, ie. the will, the transfer of money, the telephone calls to family, it did sound like Mr. Newman was putting a plan in place. He was unaware Mr. Newman was going to court in the near future. With that factor too it would have heightened his fear of suicide risk.

Nurse Shaw said that as part of his duties he would like to have known about all these matters. He said that it made his job easier the more information he could get. He said that custodial officers could be an extra set of eyes and ears and it would help if they passed information about an inmate on.

Staffing

Nurse Davidson gave evidence that at night there was only one nurse on duty in the prison hospital and that it was a bone of contention at the prison as to whether, if there were a need for a nurse for an inmate in the prison at night, that inmate should be brought to the hospital or the nurse should go to the main prison. If the latter occurred, then the hospital would be left without a nurse at all.

As to the day time, Nurse Davidson also pointed out that there was one nurse in the inpatients section and one in the outpatients. There used to be two in inpatients but when the Remand Centre was opened there was insufficient money and the second was pulled out. He said that the nurse was generally the first port of call for an inmate. If the inmate had a medical problem then the nurse would refer to the medical doctor. If it were a psychiatric problem, then the nurse would refer to the psychiatric CNC, psychologist or psychiatrist. Because there was only one nurse there, less time was actually spent at the bedside because of all the other jobs to be done.

[103] See exhibit 88(1)

Nurse Shaw gave some evidence about staff ratios in the prison hospital by comparison with those in the Royal Derwent Hospital and the psychiatric ward at the Royal Hobart Hospital. He said the staff/patient ratio in the prison was 1:25 while in the latter two places it was 1:4. He agreed however that the latter two places were Health Department facilities and that the wards were open in the sense that patients were not locked in at night.

Dr. Jager's treatment of Mr. Newman

It is clear from the evidence that Mr. Newman did not like Dr. Jager and that he had objected to being treated by him. However there was no evidence Mr. Newman took up any of the options for pursuing that suggested to him by Mr. DeBomford.

Dr. Jager was not apparently aware of all the elements raised in relation to Mr. Newman which it was suggested may have pointed to his suicide, namely observations of his behaviour by custodial and nursing staff, the finding of a will in his cell, the transferring of large amounts of money to family, the content of telephone calls and letters to family and Mr. Newman's requests. He was however aware of most of them and was clearly aware of stressors in Mr. Newman's life. His evidence was he tried to ameliorate any effect of those in that he was supportive of a return to the gardens and he made representations about the police dropping the escape charges. He also said he discussed the issue of suicidality with Mr. Newman.

Dr. Jager, even knowing of those stressors and that Mr. Newman was to appear in court on his escape charge the next week, read and took no action in relation to Mr. Newman's request to see him dated the 15/9/99. In the context of Dr. Pargiter's diagnosis of the 18/8/99 and all the matters about which Dr. Jager either did know or should have known about, there is concern about the adequacy of his response.

Conclusions

The cell in which Mr. Newman was housed provided him with an abundance of suspension points. Despite there having been a significant amount of money allocated for work in the prison hospital prior to Mr. Newman's death with the primary focus the removal of such points, the cell in which Mr. Newman died still had suspension points in it as at the 20/3/00, some 6 months after his death.

There was a failure by custodial staff to check Mr. Newman's cell with the frequency required. There was also a failure to check in a manner which would have brought to the attention of the officer checking that Mr. Newman was hanging himself. There was also an unacceptable response by staff who found Mr. Newman at 7.35 a.m. on the 18/9/99 in that they failed to check for any signs

of life before simply relocking the cell and walking away and failed to take a cut down knife to the cell after finding Mr. Newman was hanging.

The lines of communication to enable treating medical staff to have access to all and any information relating to Mr. Newman were inadequate in that a number of different people had pieces of information about Mr. Newman but there was no cohesive system for ensuring all that information was properly recorded in the one place and available to someone such as Dr. Jager who might need it.

I am satisfied also that in all the circumstances Dr. Jager's response to Mr. Newman's situation was not adequate.

CHAPTER 5 LAURENCE COLIN SANTOS

A Formal Findings

I find that Laurence Colin Santos ("Laurence") died in Cell 6, East Wing, Special Institution (Prison Hospital), Her Majesty's Prison, Risdon on the night of the 18th/19th October 1999.

I find that Laurence was a male person born in Tasmania on the 30th November 1978. He was aged 20 at the date of his death. He was at the time a detainee pursuant to the terms of the Mental Health Act 1993.

I am unable to make a precise and unqualified finding as to the cause of Laurence's death. He died while sleeping in his cell. I am satisfied that his death was not self inflicted and I am satisfied that no injury caused his death.

The possible causes of death canvassed in the evidence were

- suffocation as a consequence of sleeping with the head face down in a pillow combined with a depressed respiration caused by the dosage of Clozapine administered;
- seizure as a side effect of the dose of Clozapine being administered triggering a cardiac event; or
- sudden unexpected death associated with people suffering from schizophrenia.

Notwithstanding the extensive amount of evidence before me about Clozapine, I am unable to find that the dosage of Clozapine being prescribed by Dr. Jager to Laurence and the manner in which it was administered to him directly contributed to his death. However I am satisfied that the treatment by Dr. Jager of Laurence was conducted

1. not in accordance with the code of ethics of the Royal Australian and New Zealand College of Psychiatrists,
2. in an environment where
    a) staff were inadequately trained in the management of patients receiving Clozapine,
    b) there was inadequate monitoring of symptoms of such patients
    c) there was inadequate monitoring of the effects of the drug in particular the dangerously high blood Clozapine levels found in Laurence's blood post mortem
    d) insufficient regard was had to the requirements of the CPMS protocol in regard to patient consent in that Dr. Jager intimidated Laurence into continuing with the drug when by his actions and words Laurence made it clear he did not wish to do so.

I am also satisfied that Dr. Jager commenced the administering of the drug Clozapine in the prison hospital without first ensuring any training at all was provided for staff in relation to the drug (the only training occurred some 4 weeks after Laurence began the treatment and it is clear few staff had it) and without ensuring that there were proper procedures and an environment for the administration of a drug conceded to have unexpected death as a side effect.

B. Discussion of Evidence Relating to Death

History

Laurence Santos was 18 years old, unemployed and living with his parents at Bicheno when he was first admitted to hospital with psychiatric problems in April 1997. He had been regularly using marijuana. He had begun to be aggressive and erratic. He became alienated from and frightened of friends. In about February 1997 he began to believe his parents were poisoning him. He believed the television was speaking to him and watching him, that the local lighthouse was an alien ship and that aliens were operating on him and changing his body. He felt unsafe in the house and was living in his car. He was admitted to the Launceston General Hospital under an emergency order under the Mental Health Act by his local doctor on the 3/4/97.

The presumptive diagnosis was a drug induced psychosis. He was managed on medication and discharged on the 1/5/97. The discharge summary indicates that the range of his psychotic symptoms and the predominant change to his affect suggested a diagnosis of schizophrenia may be more appropriate. He was readmitted to the hospital on the 25/12/97 and remained there until the 2/2/98. He and his family were said on discharge to have accepted the diagnosis of schizophrenia and he was to have fortnightly injections to control it. He was at that time offered the drug Clozapine but he and his mother were ambivalent about the regular blood tests which were an integral part of a treatment regime involving that drug.

Laurence returned to the Launceston General Hospital in July 1998 under a treatment order to expire in January 1999. He agreed while there to begin taking Clozapine and was eventually admitted to the hospital under the care of Dr. Rosemary Schneider, a psychiatrist, on the 19/8/98 to commence that. Both Laurence and his parents were required to watch a video about Clozapine and sign consent forms for its use. Laurence told his mother he was frightened of taking the drug because he knew it could kill him.[104] He was given an initial dose and discharged with a weeks supply. Laurence's parents returned him to the hospital on the 29/8/98 because he would not take

[104] See affidavit of Judith Ann Santos sworn 24/2/00 - exhibit 131

his medication and was becoming psychotic. He was eventually discharged on a dose of 400mgs of Clozapine each day. He again became non-compliant and was readmitted to hospital on the 10/11/98 to prevent further deterioration in his condition. He was discharged again 2 days later.

Laurence's treatment order was revoked on the 14/12/98 because of reports of non-compliance with his drug regime. Bicheno Police were notified he was required back at the hospital. On the 30/12/98 Laurence attacked and killed his father. He also injured his mother and a police officer. Laurence was arrested and remanded in custody on charges arising out of these events. He was admitted on the day of that remand in custody to the prison hospital at Risdon Prison where he remained until he died. He was tried in respect of the offences in July 1999 and found not guilty by reason of insanity on the 23/7/99.

A judge of the Supreme Court ordered that he be detained at Risdon Prison pending his admission to an institution and advice was sought from Dr. Alan Jager, the Director of Forensic Services, about what institution he would recommend Laurence be housed in. On the 7/9/99 Dr. Jager advised

> *"I write to inform you that Mr. Santos suffers from Chronic Paranoid Schizophrenia. In the absence of a purpose built Forensic Psychiatric Unit, or an existing arrangement for such a person to be treated in mainstream psychiatric facilities, I recommend that Mr. Santos be detained at the Special Institution, Risdon Prison where he can receive essential medication and basic nursing care."*

At the time that advice was given, Laurence had been in the care of Dr. Jager since February 1999 and Dr. Jager had commenced Laurence again on a Clozapine treatment program.

An order was made by the Attorney General on the 21/9/99 providing for Laurence to be formally detained at the Special Institution at the prison hospital at the Risdon Prison. Laurence died less than a month after that order was made.

The last treatment for Laurence prior to his admission to the prison hospital was the prescribing of Clozapine. Laurence appears to have last taken that in late November and perhaps early December 1998. He was however non-compliant and there was evidence of his hoarding quantities of the drug while he was receiving it in the community and without daily supervision.

Treatment at Prison Hospital (from 31/12/98 to 4/5/99)

Laurence was admitted to the prison hospital on the 31/12/98. The Forensic[105] and Medical[106] files relating to him became part of the evidence before the court and provided a picture of how Laurence was dealt with there.

Laurence was treated by Dr. Lopes, the then prison forensic psychiatrist, from the date of his admission until the middle of February 1999. He was prescribed a drug called Olanzapine in this period and appears to have been receiving 10mgs at night when Dr. Lopes ceased to deal with him. Dr. Lopes retired in February 1999 and his position was taken by Dr. Alan Jager.

In January 1999, Dr. McCarthy and Mr. Balmer visited Mrs. Santos in Bicheno because she remained too ill to visit her son and was distressed. Mrs. Santos raised with them the issue of Laurence's taking Clozapine and said he did not want to take it. Mr. Balmer told Mrs. Santos that the prison did not have a Clozapine clinic and was unlikely to have one.

Laurence was first seen by Dr. Jager on the 15/2/99. After that the Forensic file notes attendances by Dr. Jager on Laurence and discussion of Laurence in ward rounds. Evidence was given that ward rounds did not necessarily involve the presence of the patient but did involve a forensic team discussion of the patient.

On the 15/2/99, Dr. Jager continued the medication prescribed by Dr. Lopes but doubled the dose. Dr. Jager saw Laurence on the 18/2/99. Laurence was then the subject of a ward round discussion on the 23/2/99 at which Dr. Jager noted

> "*responding to meds. May be a candidate for Clozapine.*"

Laurence was again the subject of ward round discussion on the 26/2/99 and was seen by Dr. Jager on the 27/2/99 and 2//3/99. Dr. Jager then noted from a ward round on the 5/3/99 that Laurence remained unwell. There is a ward round note by Dr. Jager on the 26/3/99 which says

> "*On Olanzapine for over 8 weeks now without resolution of symptoms. For review.*"

A note has been added to this by Sister Barwick which reads

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[105] Forensic file - exhibit 137
[106] Medical file - exhibit 125

"Prompt consent for Clozapine (hopefully starting next week). Appt with Dr. Jager on Saturday 27/3/99"

There is nothing on the files presented to the court to indicate that Dr. Jager actually saw Laurence on Saturday the 27/3/99 nor was Dr. Jager asked if he did.

Dr. McCarthy told the inquest Dr. Jager spoke about setting up a Clozapine clinic very soon after he started work. She told him of her discussion with Mrs. Santos about Laurence not wanting to have Clozapine and she said his response was that it was the best medication for Laurence, it was out of her hands and she did not have the expertise to consider it.

The next entry appears as a Ward Round note by Dr. Jager on the 16/4/99 where he says

"To be reviewed with regard to consent to CZP"

On Sunday the 18/4/99 Laurence was seen by Dr. Jager. Dr. Jager has noted in the Forensic file

"Continues to display gross psychosis, complains that his spine has disappeared and that the poison from his parents & LGH caused it. Also says his penis has shrunk."

There is no indication in that note or anywhere else on either the forensic or medical files to indicate that Dr. Jager discussed with Laurence that day his consent to treatment with Clozapine. However there is a consent form on the forensic file dated the 18/4/99 which bears Laurence's name. That form is described as a Patient Consent Form for Treatment with Clozaril and says

"I Laurence Santos declare that I have been informed by Dr. Jager of the nature of the drug Clozaril and the potential benefits and risks of it's use.

Dr. Jager has also explained to me the procedures that must be followed with Clozaril treatment and the associated Clozaril Patient Monitoring System (CPMS).

I have been given an opportunity to ask Dr. Jager questions about Clozaril and the CPMS and I understand and am happy with the replies I was given.

I understand that the following information will be held at the database and used to monitor my blood counts while I am on Clozaril: my age, sex, blood group, initials, dose and the results of all my blood tests. This information may be used in the future in order

to perform research on Clozaril and may also be published. I will in no way be identified in any publications resulting from such research.

I hereby signify my freely given consent to undergo treatment with Clozaril; then associated blood tests, examinations and monitoring. I reserve the right at any time to:

- *Seek further information from my doctor concerning Clozaril; and*
- *Withdraw my consent and terminate my use of Clozaril at any time and I understand that this will not affect the medical advice in the management of my health, now or in the future."*

Laurence's name is printed beneath this as is that of the person who witnessed Laurence's signature. Under that is what is supposed to be Laurence's signature, namely the single word "*Laurence*". The form then continues with a part to be completed by the doctor indicating that he has given the advice referred to in the consent. Dr. Jager's signature appears under that as does the same date, that is the 18/4/99.

As to that form, Dr. Jager said it was not signed in his presence and that despite the brevity of his notes he canvassed Laurence's situation with him that day including the issue of his consent. He was asked about the form of the signature and he said it did not occur to him to stop and consider whether Laurence's consent had in fact been given.

Dr. Jager was asked about Laurence's capacity to consent to a particular treatment regime. This question was asked in the context that Dr. Jager had been of the view that until at least late June 1999 Laurence was not fit to stand trial, one reason being he was unlikely because of his mental state to have been able to understand and take advice from Counsel. Dr. Jager expressed the view that Laurence fully understood the advice he was given about the use of Clozapine and that the issue of fitness to stand trial was an entirely different one from understanding advice from a psychiatrist as to a form of treatment and giving a consent following that advice. There is an obvious and inherent inconsistency in this evidence.

Dr. Jager was also asked if he understood about Laurence's rights about consent. He said he understood Laurence could consent or not consent to the treatment at any stage during it. However he went on to say that in his mind the fact that Laurence point blank refused (this being what Dr. Jager was faced with on the 4/5/99) the medication was not sufficient as a termination of consent and that all it would indicate is that further discussion and evaluation was required. He said it was his job to help patients reconsider.

A Ward Round note by Dr. Jager on the 23/4/99 indicates Laurence began the Clozapine treatment that day. The drug charts on the medical file show that the starting dose that day was 12.5mgs. It was increased to 50 mgs. the next day and continued at that level to the 29/4/99. It was increased again to 100 mgs. on the 30/4/99. The drug was administered at 5 p.m. in a single undivided dose.

On the morning of the 2/5/99, it is noted in the medical file that Laurence appeared unwell. His pulse was down, his complexion grey. The note says

> *"Refused evening Clozapine"*

Laurence also refused his medication on the 3/5/99.

I was unable to understand why, on Laurence's medical file, there were what appeared to be 2 sets of progress notes relating to Laurence for the period February, March, April and up to and including the 4/5/99. No explanation was provided to the court for this. The entry of the 2/5/99 only appeared in one of them. The entry for the 3/5/99 was different in each. In that which had no reference to the 2/5/99 on it, a note, the author's name for which was illegible, appeared as follows

> *"Refused Clozapine this p.m. unresponsive to counselling - claims medication is having unexpected effects on his head - refer to Dr. Jager"*

There were different entries on each set of notes for the 4/5/99 on the medical file. One said simply *"Slept well"*. The other had 2 entries by Nurse Norris which read

> *"4/5/99 Refused blood test this a.m.*
>
> *4/5/99 S/B Dr. Jager. Laurence agreed to re-commence Clozaril Rx 150mg. Nocte. Blood test attended. Tearful during interview with Dr. Jager. Remains on Cat C."*

On this second set of notes, the notation "Slept well" was repeated.

Dr. Jager's note of that consultation which appears in the Forensic file (as opposed to the medical file referred to above), read

> *"Point blank refuses to take Clozapine in any dose. Refused last 2 doses and today's blood test. After much persuasion he had the blood test. ⇑ Clozapine to 150mg. Nocte. Add Amitriptyline 25mg. Nocte. See 1/52. "*

Dr. Jager said in his evidence that he actually saw Laurence twice on the 4/5/99, the first time for about 20 minutes early in the afternoon and the second time later in the afternoon for about 90 minutes. This was not reflected in any file notes. There was no fresh form of consent signed by Laurence following this consultation despite the clear and repeated refusals over the previous 2 days. Further, following the events of the 4/5/99, Dr. Jager immediately increased Laurence's dose of Clozapine to 150 mgs. notwithstanding that Laurence had only been on the 100mgs. previous dose rate for 2 days instead of the intended 4 and there had been no drug taken for the last 2 days.

The events which occurred on the 4/5/99, despite there being some confusion arising out of the evidence of Sister Barwick and Nurse Norris, became known as the "syringe incident" and I will deal with the evidence relating to that under a separate heading.

"Syringe Incident"

Sister Barwick gave evidence [107] that she attended a regular team meeting of the Forensic team on about the 12/4/99 after the Easter break. Easter began on Good Friday 2/4/99. The 12th would have been the Monday following Easter Monday. She said

> *"… Dr. Jager described to all present how he convinced Laurence into going on to the Clozapine program. He described how he approached Laurence with the biggest needle and syringe he could get his hands on to convince him to continue Clozapine. Dr. Jager laughed as he relayed to everyone present that Laurence's delusions included injections into his spine which Laurence believed as the alternative. Dr. Jager described this incident in detail and stated there was many ways to achieve a goal and how his way was one of the best. He stated that Laurence would have Clozapine one way or the other, or words to that effect. Dr. Jager added that he could be very convincing when he wanted to."*

Sister Barwick said also that she had been present at consults between Laurence and Dr. Jager and knew of Laurence's reluctance. Laurence had previously become agitated with the suggestion of Clozapine. He did not want it and told staff that.

Sister Barwick was unable to say when she understood the incident with the syringe to have occurred. However she went on to say that Nurse Norris mentioned the incident to her and some other staff members before Dr. Jager arrived for this particular meeting. She also said that she reported the matter to Mr. DeBomford, the Director of Nursing, and to Mr. Ian Balmer around

[107] See affidavit of Sandra Kathleen Barwick sworn 3/5/00 - exhibit 304

lunchtime that day [108]. She then reported it to her director of nursing in Community Health about a fortnight later. That supervisor told her "*formalise it or go away*". Sister Barwick acknowledged she did not formalise it and when asked why she said

> *"Because I was having a lot of problems with Dr. Jager at the time. I knew that mental health were bending over backwards to attract and keep him. I knew that nobody would believe what the nurses were saying, because Dr. Jager seemed to have such a wonderful reputation at that time. I had other issues in my life that were going on that were causing me a lot of stress and I didn't feel strong enough to go through the whole procedure of questioning a senior colleague and then having to prove what I was saying, without having that proof available to me."*

Sister Barwick was cross examined extensively by Counsel for Dr. Jager. In the course of that examination that Counsel made quite concerted efforts to discredit Sister Barwick and to persuade me that she held an active dislike for Dr. Jager and that she would lie to cause him harm. The implication was that the entire story was a fabrication. Sister Barwick clearly had disagreements with Dr. Jager during the course of the months they had dealings with each other. My observations of both of these parties would suggest that they each have strong personalities and I can well understand they may have clashed.

One particular attempt to discredit Sister Barwick involved questioning of her by Counsel for Dr. Jager about a complaint to a professional review tribunal.[109] Sister Barwick answered the questions put to her admitting to the complaint, that she was convicted of professional misconduct and reprimanded and directed to undertake a course in legal and ethical issues. No detail of the complaint was elicited during this questioning nor was the actual decision shown to the court. It was left to Counsel for the DHHS to place the actual decision of the review board in evidence[110] which placed a distinctly different slant on Sister Barwick's behaviour than that which Dr. Jager's Counsel had attempted to project. Counsel for the Department asked Sister Barwick to read a passage from the decision which was as follows:

> *"The Tribunal accepts that Mrs. Barwick's conduct in this matter was an aberration from her normal practice. Her references write glowingly of her professionalism and her sensitivity to ethical issues. It would appear that she lost her ordinary objectivity in this case because of a belief that her sister and her niece's children may have been at some risk from "*

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[108] See transcript page 3621 and continuing
[109] See transcript page 3649
[110] See exhibit 308

Generally Sister Barwick was not moved in her evidence about the "syringe" incident despite rigorous cross examination by Counsel for Dr. Jager.

Nurse Norris then gave evidence [111] that early in April she believed and on a Thursday afternoon she was present in the treatment room opposite the roundhouse in the inpatients area of the hospital. Dr. Jager had asked her to be present at an interview with Laurence Santos which she was. She said

> *"I think the nature of the interview was because Laurence didn't want to continue taking his Clozapine. He had started it but didn't want to continue.*
>
> *There was a discussion between Laurence and Dr. Jager from memory I think that the Clozapine made him sick. Dr. Jager attempted to persuade Laurence to continue taking it.*
>
> *In Laurence's presence Dr. Jager asked me to go and get the biggest needle and syringe that I could find. I didn't question the doctor at all. I had no idea what he was going to do.*
>
> *I went from the inpatients area to the outpatient ….. I ..obtained a 20ml syringe …and either an 18 or 19 gauge needle…I then returned to the treatment room…… I gave the needle and syringe to Dr. Jager….Laurence was sitting at my right hand side and Dr. Jager on my left. I stood inside the room just to the side of the entrance door.*
>
> *Both the syringe and needle were packaged. Dr. Jager undid the packaging and attached the needle to the syringe. He also took the plastic cap off the needle.*
>
> *Dr. Jager held up the syringe and needle towards Laurence, he was about a metre and a half away from him. Laurence could quite easily see the needle and syringe.*
>
> *Dr. Jager said words to the effect of "See this needle, if you don't take the Clozapine you will get a needle of this size every fortnight." Dr Jager spoke in a stern voice and it certainly appeared threatening to me.*
> *I can't remember whether Laurence said anything but he certainly started to cry…..*
>
> *I have never discussed this incident with Dr. Jager. I am aware that Dr. Jager raised this matter at a Monday morning meeting at the hospital. The persons present at the meeting would have been Estelle McCarthy, Ian Balmer, Sandra Barwick and others who I do not recall. This is the only Monday morning meeting with this format that I attended…*

[111] See affidavit of Victoria Georgina Norris sworn 4/5/00 - exhibit 310

I have spoken to Dr. E. McCarthy, Dr. J. Beadle and I think Sandra Barwick concerning the incident…"

In the course of Nurse Norris' oral evidence which followed her affidavit being taken into evidence, a syringe and needle the size of those she referred to were placed before the court as exhibit 311. Nurse Norris believed that Laurence was already taking Clozapine when this incident was said to have occurred although she had not been present at any earlier interviews and had not spoken to Laurence about his taking Clozapine.

Nurse Norris was cross examined at length by Counsel for Dr. Jager. She agreed that in fact (and contrary to when she said she thought it occurred in her affidavit) the incident she described with the syringe occurred on the 4/5/99 and read from an entry by herself in the nursing progress notes for that day. She also agreed that her understanding was Laurence was already on Clozapine when the incident occurred. She said she only had one meeting with Dr. Jager and Laurence that day.

Dr. Jager was questioned about what occurred on the 4/5/99. He agreed with Counsel for the Santos family that in refusing to allow blood to be taken for Clozapine tests on the 4/5/99 and refusing the medication Laurence had effectively withdrawn his consent to the drug and that the aim of the second consultation was to further assess Laurence and hopefully persuade him to continue. This was at odds with other evidence of Dr. Jager to the effect he did not consider Laurence's actions to be sufficient as a withdrawal of consent. Dr. Jager conceded[112] that he had to assess a number of matters at this second consultation and that all were critical. He agreed however not one symptom was noted from that interview. His explanation[113] was that there was less focus on documenting mental state changes because they had already been well documented in previous and subsequent assessments. He then had to agree there was nothing about symptoms in his notes of the 23/4/99 or 30/4/99.

Dr. Jager went on to acknowledge that on the 4/5/99 Laurence did not describe any hallucinations, there were no signs of bizarre behaviour, there were no threats to either he or Nurse Norris and there was no indication Laurence would cause himself any harm. He agreed Laurence cried he says *"at some time"* after the syringe was produced.

It was put to Nurse Norris the meeting she attended went for an hour and a half. She said she did not think it took that long. It was put to her Dr. Jager discussed Laurence's condition with him, why it was necessary to take medication, what would happen if he did not, that his psychotic symptoms

[112] See transcript page 3990
[113] See transcript page 3991

had returned and that he would have to be certified in order to have medication. She agreed that was the general thrust of the conversation but did not recall any reference to certification.

Nurse Norris also agreed that Dr. Jager was pointing out the options to Mr. Santos, that is continue with Clozapine or return to the injections he'd had in the past. She did not agree with the propositions put by Dr. Jager's Counsel that Dr. Jager was using the syringe as a symbol and that at no time did he hold it up. Nurse Norris was also asked about Dr. Jager's description of the incident at the team meeting. She agreed it was a serious discussion about patients and their needs. Sister Barwick's assertion that Dr. Jager laughed about the incident was not put to her.

Dr. McCarthy told the inquest about Dr. Jager's discussion of the incident in front of staff. She said[114] he said he was taking a bit of a risk because the disintegration of Laurence's spine was part of his delusions and he was only on the room with one nurse.

Dr. Jager swore three affidavits relating to the death of Laurence Santos. In none of these is there any reference to the incident described by Nurse Norris. When Dr. Jager gave his oral evidence he conceded [115] that at the consultation with Laurence Santos on the 4/5/99 he did ask Nurse Norris to get the biggest syringe and needle she could and he agreed it was probably the same size as that which became exhibit 311. Dr. Jager also conceded that he removed the cap from the needle

"showed it to the patient and placed it on the desk in between the patient and myself"

Dr. Jager demonstrated how he did this and the demonstration was similar to that given by Nurse Norris. It was not a situation where the needle and syringe were simply handed to Dr. Jager and then immediately placed on the table. Dr. Jager also conceded that he said to Laurence Santos at the same time he was holding the needle and syringe in front of him words to the effect

"Stopping Clozapine and not taking any medication is not a realistic alternative for you.".

Dr. Jager also agreed that you would not even give an injection with a syringe and needle the size he used on this occasion, you would use it only to take blood.

Dr. Jager said that he told Laurence Santos that he considered him certifiable and that it was highly likely that he would end up back on injections every second week. He held up the syringe and indicated that would be a realistic alternative to stopping Clozapine. Dr. Jager was then asked what

[114] See transcript page 3175
[115] See transcript page 3946

injection he was going to give Laurence with a 20ml syringe and a 19 gauge needle every two weeks. His response was [116]

> *"The syringe was symbolic of syringes - the size of the syringe. I asked for a large syringe and a large needle in order for the symbolism to be maximal."*

Dr. Jager knew that Laurence did not like injections. He eventually conceded after some pressing that he had read a letter on Laurence's file from Dr. Elizabeth Christie from the Launceston General Hospital to Dr. Lopes dated the 31/12/98 in which she had reported that Laurence detested injections. Dr. Jager also conceded that injections featured as part of Laurence's delusions.

Dr. Jager was asked a number of questions about the effect that showing a syringe of this size might have on a person with Laurence's views. Dr. Jager's views as he expressed them [117]were unconvincing and appeared an attempt to justify his actions. Dr. Jager agreed there was inequality in the relationship between he and Laurence and that the only options he gave him were to take Clozapine or be certified and have injections neither of which Laurence would have liked. He did not give him the option of an alternative medication, Olanzapine, saying it did not work. He did not tell him Clozapine may not be any better. Dr. Jager then however confirmed to the inquest that the Forensic file notes showed Laurence was responding to Olanzapine as at the 23/2/99, there was only a minor change in Laurence's symptoms between the 15/2/99 and the 7/6/99 and that he was not achieving any remission of symptoms with the Clozapine.

Dr. Jager was referred to three paragraphs in the Royal Australian and New Zealand College of Psychiatrists code of ethics[118] which read

> *"Psychiatrists shall seek informed consent from their patients before undertaking any procedure or treatment*
>
> *The patient shall also be informed of alternative indicated procedures and treatments and their respective purpose, nature, benefits, side effects and risks. In providing information about alternatives it shall be done in such a way as to give the patient a full opportunity to choose between them."*
>
> *A psychiatrist shall ensure that patients consent to treatment freely and without coercion."*

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[116] See transcript page 3950
[117] See transcript pages 3952, 3953, 3954
[118] See exhibit 325

Dr. Jager maintained that he did not coerce Laurence into taking Clozapine and that he did not discuss Olanzapine with him because it was not an option.

There appears no doubt that the interview between Dr. Jager and Laurence Santos at which the syringe was produced occurred on the 4/5/99, some four weeks after Easter and that by that date Laurence had already begun to take Clozapine. As to Sister Barwick's evidence about this incident, save for when she said the meeting occurred when this was raised, her evidence largely accords with that of Nurse Norris. I say largely because Nurse Norris does not support Sister Barwick as to the manner in which Dr. Jager spoke to the staff. However I would have to say that is probably irrelevant because the evidence about the incident itself is quite clear.

I am satisfied that during the course of a consultation between Dr. Jager and Laurence Santos on the 4//5/99 Dr. Jager instructed a member of the nursing staff in front of Laurence to get the biggest needle and syringe she could find and that he subsequently unpackaged and assembled those items in Laurence's presence and then held them up in front of him knowing when he did so that

- Laurence had a fear of taking Clozapine because he thought it might kill him
- Laurence detested injections
- injections featured in Laurence's delusions about what was being done to his body
- there was no treatment likely to have been administered to Laurence should he cease Clozapine which would have involved him in having fortnightly injections with a syringe and needle of the size displayed
- Laurence had point blank refused to take Clozapine.

There appears to have been a complete lack of appreciation by Dr. Jager of the impact of his actions even if I accept his version of events. There is every likelihood Laurence Santos would have been quite traumatised by even being shown a syringe and needle the size of those produced and that he would have been intimidated by Dr. Jager. I say this because, in addition to the factors I have outlined above

- Dr. Jager was dealing with a patient in a prison hospital, that is that patient had no capacity to walk out of the room and walk out of the facility away from Dr. Jager. That fact alone created a significant imbalance as far as power was concerned in the relationship between Dr. Jager and Laurence. Laurence's capacity to exercise free choice was therefore already significantly affected.
- Laurence was severely psychiatrically ill.

I am also satisfied on the evidence before me that even if Laurence's refusal to take Clozapine on the 4/5/99 did not constitute a withdrawal of consent his "agreement" to continue taking it after that date was obtained by intimidation and in those circumstances compliance with the spirit of the

CPMS protocol was not present. Taking all these matters into account, Dr. Jager's behaviour on this occasion was wholly inappropriate and unacceptable for a treating professional.

Treatment at the Prison Hospital (4/5/99 to 19/10/99)

The drug charts on Laurence's medical file show a steady increase in the dosage of Clozapine given to Laurence by Dr. Jager from the 4/5/99 onwards. The increases and the times at which the drug was administered as shown in those charts were as follows:

4/5/99 to 11/5/99	150 mgs.	at 5 p.m.
12/5/99 to 19/5/99	200 mgs.	at 5 p.m.
19/5/99 to 25/5/99	250 mgs.	at 5 p.m.
26/5/99 to 31/5/99	300 mgs.	at 4 p.m.
1/6/99 to 8/6/99	300 mgs.	at time unknown
9/6/99 to 22/6/99	350 mgs.	at time unknown
23/6/99 to 28/6/99	400 mgs.	at 5 p.m.
29/6/99 to 5/7/99	450 mgs.	at 4.30 p.m.
6/7/99 to 13/7/99	500 mgs.	at 4.30 p.m.
14/7/99 to 20/7/99	550 mgs.	at time unknown
21/7/99 to 27/7/99	600 mgs.	at time unknown
28/7/99 to 3/8/99	650 mgs.	at 9 p.m.
4/8/99 to 24/8/99	700 mgs.	at 9 p.m.
25/8/99 to 31/8/99	750 mgs.	at 9 p.m.
1/9/99 to 7/9/99	800 mgs.	at 9 p.m.
8/9/99 to 14/9/99	850 mgs.	at 9 p.m.
15/9/99 to 18/10/99	900 mgs.	at 9 p.m.

Laurence was at all times given the drug in a single, as opposed to divided, daily dose. There is no record that the divided dose regime suggested in the CPMS protocol was ever even considered.

Early on the morning of the 5/5/99, Laurence was noted to be very pale, nauseated at breakfast and slightly tachycardiac. He was discussed in ward round on the 10/5/99. Dr. Jager has noted

> "*Remains psychotic. Colin to get involved*"

On the 11/5/99 there was a note to the effect that blood was taken from Laurence. On the 12/5/99 Dr. Jager telephoned the inpatients section and ordered an increased dose of the Clozapine. It was noted in the progress notes on the medical file that Laurence accepted this.

According to the progress notes, blood was again taken from Laurence on the 18/5/99, 8/6/99, 13/7/99 and 14/9/99. There was no other reference in the progress notes to blood being taken. There were however on the file Royal Hobart Hospital Haematology Department reports which indicated that samples of Laurence's blood were sent to that department for testing on the 18/4/99, 19/4/99, 27/4/99, 4/5/99, 11/5/99, 18/5/99, 25/5/99, 1/6/99, 8/6/99, 15/6/99, 22/6/99, 29/6/99, 8/7/99, 13/7/99, 21/7/99 27/7/99, 3/8/99, 11/8/99, 17/8/99, 25/8/99, 14/9/99 and 12/10/99. These reports dealt principally with the white blood cell and neutrophil counts in Laurence's blood and did not address the Clozapine levels.

Only one test did address the question of Clozapine levels in Laurence's blood and that was done on blood taken on the 27/7/99. The report provided consisted of 2 parts. It noted that the time of collection of the sample was unknown. The first part dealt with white blood cell counts and the second dealt with the levels of Clozapine in Laurence's blood. It noted

> *"S. Clozapine: 828 ug/L*
> *S. Norclozapine 202 ug/L*
>
> *CLOZAPINE*
> *Therapeutic rge: approx 100ug/L (37.5mg b.i.d.)*
> *200ug/L (150mg b.i.d.)*
> *100-800ug/L (2 hrs post 75mg dose)*
>
> *NORCLOZAPINE Therapeutic Rge.: 59 - 744 ug/L*
> *COMMENT: Trough concentrations are of most clinical value."*

Dr. Jager's notes on his Forensic file make some reference to blood tests. There was a note on the 23/8/99 *"CZP & Norclozapine not at toxic level"*. This can only relate to the test of the 27/7/99 since there was no record of any other such test having been done. Dr. Jager said he reviewed those tests after he got back from Germany on the 16th or 17th August. He said that in his mind the failure of Laurence's symptoms to ameliorate may have been due to non-compliance but he was satisfied on reviewing that test result that non-compliance was not an issue. He did not consider that the result indicated that he was simply not going to achieve with this medication what he hoped. Dr. Jager

also went on to say[119] that, while the test result set out above noted a reference range for Norclozapine,

> *"there is no reference range quoted for Clozapine and that tied in with my pre-existing knowledge that there is no accepted therapeutic range for Serum Clozapine."*

That is not consistent with what was actually set out in the test result nor is Dr. Jager's stated knowledge consistent with published material which will be further referred to or the evidence of other professionals.

As to the time of day at which blood was taken, on the 14/9/99 Dr. Jager noted that a blood test was done that morning. There was otherwise no indication in either the medical or forensic files of the time of day the bloods which were noted as being taken were actually taken. This was, as is apparent from the notation above and the evidence I heard about the time at which blood was taken relative to when a dose was administered, a particularly relevant factor in a Clozapine program.

Dr. Jager saw Laurence on the 17/5/99 and he was discussed in Ward Rounds on the 24/5/99 and the 31/5/99. The indications were that Laurence was taking his medication and that there were some positive changes in Laurence but progress was slow. On the 20/5/99 there was a note in the Forensic file from Colin Harris, a social worker. He said

> *"Asked by Dr. Jager to speak with client regarding reluctance in taking medication….Client states that recent medication prescribed by Dr. Jager has been successful in mediating many of his symptoms. Says he could do with more of the drug. States that he does not have any issues to discuss with social worker at this point"*

The position reported by Mr. Harris who subsequently gave evidence and clearly had no idea or training about the Clozapine program is totally at odds with the position taken by Laurence some 16 days before, a fact which Dr. Jager agreed was unusual. At the date Mr. Harris interviewed Laurence he had only been on the staff about a fortnight and had no experience with patients such as Laurence. He did not know about the syringe incident on the 4/5/99 and had no idea about the form of consent Laurence had signed. His capacity to perform any useful function in relation to Laurence in those circumstances must be questioned.

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[119] See transcript page 4060 and 4061

On the 8/8/99 nursing staff noted that Laurence complained of a severe headache and he looked unwell. He told staff he thought it was the extra Clozapine he was taking. At that time Laurence was being given his medication at 9 p.m. There was a note to watch him take his tablets.

On the 14/8/99, the nursing notes record Laurence was very lethargic on awakening, complaining of a headache. Nurse Thompson on this occasion wrote a referral to the psychiatrist for a *"medication review."* It appears Dr. Jager was away at this time and Laurence was seen by Dr. Pargiter. On the 19/8/99 Nurse Howell-Smith has noted about Laurence

> *"Very pale & looking unwell….stated he had pain…feeling nauseated and c/o headache. back to his cell. Lying down - ashen faced."*

On the 23/8/99 the nurse has noted only that the issue of medications was discussed with Dr. Jager. The dosage was increased that day.

On the 14/9/99, Dr. Jager notes in relation to Laurence that he had a headache, abdominal pains and diarrhoea and that Laurence told him he was getting headaches in the morning. On the same day there is an entry in the nursing notes which says

> *"Refusing to take all his medication- states he doesn't feel very well - advised to see Dr. Jager re this."*

Dr. Jager then saw Laurence but made no reference in his notes to the refusal by Laurence to take all his medication that day. He responded by increasing the dosage of Clozapine to 900 mgs.

On the 20/9/99, Dr. Jager noted that Laurence told him the day before that he did not like the high dose of Clozapine but was nonetheless compliant. On the 27/9/99, Dr. Jager noted on seeing Laurence

> *"…Thinks his spine is still adversely affected. Wants reduction in meds."*

On the 26/9/99 there was a further reference in the nursing notes of complaints by Laurence of nausea. On the 18/10/99 Dr. Jager noted that Laurence was sleeping excessively. There were regular notes in the nursing notes to the effect that Laurence slept very soundly. Dr. Jager in his oral evidence[120] in response to questions from his own Counsel said that he was monitoring Laurence for excessive sedation and that he observed no signs of it. In fact Dr. Jager said in his oral evidence

[120] See transcript pages 4124 and 4125

that Laurence was bright and alert on the morning of the 18/10/99. This is contrary to his own notes and those of nursing staff. It is also contrary to a concession he made when being examined by Counsel for the Santos family. Dr. Jager agreed that Laurence was sedated at night, was sleeping excessively and that that was consistent with heavy sedation.

The theme in Dr. Jager's notes until Laurence's death was that he remained psychotic. Save for 2 incidents there was absolutely no suggestion in any of the medical or forensic files that Laurence exhibited any aggression to any third person. There was an entry in the nursing notes on the 31/5/99 about an altercation with another inmate which resulted in Laurence being restricted to his cell. There was no indication as to whether Laurence was the aggressor on that occasion. The only other incident was that which involved Laurence and Fabian Long on the 18/10/99 and it appears to be accepted that on that occasion Fabian Long was the aggressor.

Events of the 18/10/99 and 19/10/99

The nursing progress notes for the 18/10/99 have two entries. The first said

> *"Seen by Dr. Jager - gave permission for Dr. Jager to ring mother, working as wardsman, sleeping very well, drooling associated with medication tolerable."*

The second said

> *"Involved in altercation with Fabian Long at approx 1600 hrs. Small graze to left ring finger- cleaned betadine and bandaid applied"*

CO Alan Smith said[121] he was approached by Laurence and another Inmate Adams about 3.55 p.m. on the 18/10/99. Laurence said he had been attacked by Fabian Long. He used the phrase "king hit" but did not volunteer where he had been hit. He was not agitated. CO Smith then spoke to Fabian Long who by then was sitting quietly in the exercise yard. He claimed Laurence attacked him but CO Smith observed his right hand was clearly swollen and a finger appeared from his description to be dislocated.

Acting Senior Custodial Officer Jackson was asked by the Unit Manager Mr. Hughes to investigate the incident.[122] He spoke to Laurence who said Fabian Long had kicked and hit him and he had retaliated. CO Jackson said he particularly observed Laurence and noted a cut on his finger which he

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[121] See affidavit of Alan Smith sworn 4/11/99 - exhibit 129
[122] See affidavit of Glenn Reginald Jackson sworn the 4/11/99 - exhibit 122

was trying to hide. CO Jackson said he checked Laurence's eyes, he checked for redness round the face, ears and eyes, there was no evidence of injury to Laurence's head, no slurred speech and he did not appear dazed. He just appeared agitated.

CO Jackson told Nurse Norris before tea parade about the incident and after tea took him to her to be checked. She saw Laurence for a period from about 4.30 p.m. She cleaned and dressed the cut on his finger and made sure he wasn't hurt anywhere else or hit on the head. He told her he was alright.[123] Laurence was locked in his cell after this visit with Nurse Norris.

Nurse Norris saw Laurence in his cell at about 7 p.m. He was lying on his bed, eyes open and looking at the ceiling. At about 9 p.m. Nurse Howell-Smith gave medications to those inmates listed to have them. Laurence was one of those. [124] He said the cell door was opened and Laurence came to the door with his own cup of water. He gave him 900 mgs. of Clozapine in the form of 9x100mgs. tablets and 50mgs Amitriptyline. He said Laurence swallowed the medication in front of him. He did not check his mouth after but was speaking to him. He asked Laurence how he was and he said *"Okay"*.

CO Smith said he saw Laurence at about 10 p.m. He was fully dressed and lying on his bed. He had his head and shoulders leaning against the wall. The light was off but a television was going. He said Laurence appeared to be awake. He assumed that but conceded he did not see movement.

CO Ian Smith came on duty for an 11 p.m. shift start. He said[125] CO Alan Smith told him at handover that Laurence had been "thumped" by another inmate. He did hourly checks of Laurence overnight. He had no specific instructions to do otherwise. These checks entailed looking into the cell and shining a torch in. He said there were no signs of any distress and Laurence was lying in bed with the blankets over him. He then said however that he and Nurse Howell-Smith took turns doing the checks that night but he did the 11 p.m. and 6 a.m. checks. He was shown a photograph taken of Laurence after his death and his response was

> *"…..imagine that's how he lying"*

CO Ian Smith could not say whether in fact Laurence had changed position during the night after his observation of him at 11 p.m.

CO Kirkby began work at about 6.30 a.m. on the 19/10/99. He was filling in that day and had no previous experience of Laurence nor had he worked in the hospital for some time. He understood all

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[123] See affidavit of Victoria Georgina Norris sworn 4/11/99 - exhibit 126
[124] See affidavit of Neville Winston Howell-Smith sworn 28/11/99 - exhibit 123
[125] See affidavit of Ian Gregory Smith sworn 14/11/99 - exhibit 130

cell checks at the hospital were to be half hourly. He checked Laurence's cell just after he started. He said the cell light was out but it was fairly light and Laurence appeared to be asleep with his back to the door. He could see Laurence's head and his body was under the blankets. CO Kirkby went back to the cell at about 7 a.m. He said Laurence was in the same position. He did not as he should have done unlock the Jackson lock at this point because he was unfamiliar with the routine. CO Radcliffe arrived for work at about 6.45 a.m. but he did not do anything about the Jackson locks either. At 7.35 a.m. the two officers went round to let the inmates out. When they got to Laurence's cell he was apparently still asleep. From the description given by CO Radcliffe, Laurence was in the same position he had been in at 6.30 a.m. and 7 a.m.

CO Radcliffe called out to Laurence who still did not stir. CO Radcliffe said it was not unusual to have to wake Laurence up to 3 or 4 times a week. It was usually sufficient to call out. The officers entered Laurence's cell. CO Radcliffe reached out and touched Laurence's leg. He said the leg felt stiff and Laurence still did not stir. He touched Laurence on the temple and he felt cold. His ear was blue. He told the other officer something was not right. They left the cell and relocked it. CO Radcliffe said that in his own mind he thought Laurence was dead then.

Two nurses then returned to the cell and examined Laurence. They said they thought he had been dead for some hours and could do nothing for him. The cell was relocked. Authorities and ambulance were notified but it was clear that Laurence had already been dead for some time when he was found.

Evidence Relating to Cause of Death

The cause of Laurence's death was a contentious issue. The theme of much of the evidence before the inquest was the role the Clozapine treatment program in which Laurence was involved at his death may or may not have played in his death.

Dr. Lyons conducted the post mortem on Laurence and prepared a report.[126] The post mortem revealed the presence of a number of minor injuries on the hands arms and legs but nothing major. There was no significant natural disease process. Histological examination of tissue showed no significant pathological processes which may have caused death. In this report Dr. Lyons outlined that toxicological examination showed the presence of the drug Clozapine

> *"at levels of at least 4.5mg/L which is greater than therapeutic……..It is possible that his death may be attributable to a Clozapine overdose……The most common reported*

[126] See affidavit of Timothy John Lyons sworn 15/2/00 - exhibit 229

symptoms of overdose include drowsiness to coma; respiratory depression; hypotension; hypersalivation and seizures."

In that report, Dr. Lyons acknowledged the management of treatment resistant schizophrenics such as Laurence was not his area of expertise and sought further information.

The toxicological report on which Dr. Lyons relied was prepared by Dr. Kathryn Campbell and issued on the 11/11/99. She in fact prepared a second report which was dated the 18/4/00.[127] She stated in that report

"Preliminary results indicated that Clozapine was present at a greater than therapeutic level. A quantitative analysis specifically for Clozapine confirms the preliminary finding."

The preliminary report showed a level of Clozapine of 4.5 mg/L as outlined in Dr. Lyons affidavit. The second report referred to a level of 3mg/L but still described it as "*greater than therapeutic*". Dr. Campbell went on to say

"Although the Clozapine blood level detected falls outside the reported therapeutic range for this drug, the signs and symptoms of intoxication are variable and high levels are not lethal in every case."

Dr. Lyons in his oral evidence[128] spoke about the estimated time of death of Laurence Santos. His evidence was that Laurence was likely to have died between 2 a.m. and 6 a.m. on the morning of the 19/10/99.

Dr. Lyons was also asked questions about a small amount of blood found on Laurence's pillow and around his mouth and nose where they were adjacent to the pillow. His conclusion was that this was not an unusual feature in a sudden death, that he found no specific site of bleeding and that it was not consistent with any suggestion of self harm or mutilation.

Dr. Lyons was asked about the bruising and abrasions he observed. He said in his opinion they were about 24 hours old. He was asked if they could have been sustained in the course of something of the nature of an epileptic seizure and he said that was unlikely. Dr. Lyons was asked to explain the mechanics of a death caused by an epileptic seizure. He said

"At - I mean, the word "epileptic seizure" refers to a situation where's there's overwhelming electrical stimulation occurring in the brain which can be triggered for -

[127] See affidavit of Kathryn Claire Campbell sworn the 18/4/99 - exhibit 236

triggered by a whole host of different mechanisms, and which is often associated with flaying of limbs, and then followed by a period of unconsciousness, and it is - if we take the group of people who are epileptics per say, it is well documented that those people can suffer sudden unexpected deaths. And one of the mechanisms which is said to be - cause this, is that you get - you can get stimulation of the heart, and you can trigger cardiac arrhythmia's, and that would trigger a fatal cardiac event. It is also - I mean it is well documented in that group of people who are known epileptics that - particularly in bed at night is that they can suffer a fit and during - following the fit there is a short period of unconsciousness and they can - they're said to suffocate from smothering themselves on a pillow or something like that, which are - which is another putative mechanism in epileptics who are found dead suddenly and unexpectedly."

Dr. Lyons then conceded that what he saw when he observed Laurence's body at the scene was

"at least consistent with seizure or fit and suffocation by face down in the pillow."

He also conceded the possibility of there being no seizure or fit but just suffocation face down on the pillow. He indicated as well that the first symptom of an epileptic seizure he noted, namely cardiac arrhythmia, would not be found on autopsy. Dr. Lyons also told the court that the blood sent to Dr. Campbell would have been taken from the femoral vein in the groin shortly after 10 a.m. on the 20/10/99.

Dr. Lyons was examined in detail by Counsel for Mrs. Santos. He initially put to Dr. Lyons that there were two most likely causes of death for Laurence and these were either an epileptic seizure or cardiac related. Dr. Lyons responded by saying

".....Well I was very cautious in deliberately not issuing a cause of death, because I think that there are several possible mechanisms that could have led to death. I mean, I think I need to answer the question in slightly longer than saying "yes" or "no". This man was a known chronic schizophrenic. Chronic schizophrenia is well documented to be associated with sudden unexpected death. So these people are found dead in bed, or in other situations unexpectedly, and the argued mechanism for that death, is a cardiac event, because for some reason, they've triggered an abnormal cardiac arrhythmia. This case was complicated by the fact that this man was receiving treatment with a drug, and the blood levels of that were high, and that, that particular drug is documented to be associated with epileptic form fits. And the mechanism of death in an epileptic form fit,

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[128] See transcript page 2391

is really the same mechanism that being argued for death with chronic schizophrenia, is that for some reason you've got increased electrical activity in the brain, and that you stimulate a cardiac arrhythmia. So if you like, there is a common pathway that you could argue, the actual final physiological event as being some sort of cardiac episode. But I didn't feel that I was in a position to say whether that was due to his schizophrenia, or whether it's due to a complication arising from a drug he was taking. It was my understand, that he hadn't been seen to have other epileptic events. He was also - but he was receiving an anti epileptic drug."

As to the time of death, under questioning from Counsel for Mrs. Santos, Dr. Lyons agreed that by reason of the imprecise nature of calculations about time of death, Laurence's death could have occurred as early as midnight and as late as 6 a.m. although his evidence clearly suggested it was closer to the earlier time than the later. Dr. Lyons was also asked a number of questions about different types of epileptic seizures. He acknowledged that seizures can occur without the flailing of arms he had earlier referred to and they can occur while people are asleep.

A number of professional witnesses gave evidence in relation to Laurence Santos' death. These were Professor Ivor Jones, Professor Kenneth Kirkby, Dr. Rosemary Schneider, Dr. Kathryn Campbell, Dr. Wilfred Lopes and Professor Stuart McLean. Dr. Jager also gave evidence about his treatment of Laurence.

This evidence centred largely around the treatment of Laurence Santos in the prison hospital environment with the drug Clozapine. The witnesses had differing opinions and it is necessary to canvass their evidence if I am to make any findings about the involvement or otherwise of this drug in Laurence's death.

A number of documents were placed before the inquest in relation to the use of Clozapine. The starting point should perhaps be the Clozaril Patient Monitoring System Protocol dated the 1/8/99 and shown as revision 4.[129] This was the protocol prepared by the manufacturer of the drug and which was expected to be observed by any doctor treating a patient with this drug. While the version of this protocol in force as at the date Laurence began to receive Clozapine from Dr. Jager in April 1999 was not put in evidence, it was not suggested by anyone that that protocol differed in any relevant way from that before the inquest.

To set the background for the evidence heard it is perhaps useful to set out the introduction which appears in the protocol. It reads

[129] See exhibit 223 (and 218)

"Clozaril is an atypical antipsychotic agent of the dibenzodiazepine class of compounds and represents a breakthrough in the treatment of schizophrenia. It is chemically and pharmacologically distinct from the standard antipsychotic drugs and has been shown to improve both the positive and negative psychotic symptoms in many patients with schizophrenia who are unresponsive to or intolerant of present day therapy, while producing minimal extrapyramidial side effects.

Soon after its release in the early 1970's, psychiatrists in Finland observed 16 cases of granulocytopenia among Clozaril patients, including eight fatalities due to agranulocytosis. (The footnote describes this as an acute condition in which there is a severe reduction in the number of neutrophils which are the body's defence against infection.) As a result Clozaril was withdrawn from several markets and it's availability since then has been limited to countries where strict controls are instituted to monitor the level of white blood cells in patients taking Clozaril. In a recent review of data from Australia and the USA, the cumulative incidence of agranulocytosis was found to be 0.9% and 0.8% respectively at 1 year.

In keeping with the Novartis Policy, the release of Clozaril in Australia and New Zealand is through a strict distribution system, the Clozaril Patient Monitoring System (CPMS), as detailed in this protocol.

This protocol was designed by Novartis in association with the Clozaril Advisory Board. The Advisory Board comprised members of the Royal Australian and New Zealand College of Psychiatrists, a hospital pharmacist and a consultant haematologist. The Advisory Board's role was to advise Novartis on the development of this protocol and the introduction and initial use of Clozaril in Australia. Advice on matters relating to the use of Clozaril, amendments to the Protocol and on action to be taken with respect to breaches of compliance with this Protocol is now provided by the Quality Assurance Committee…"

All patients, medical officers, pharmacists, centre coordinators and treating centres involved with the distribution of Clozaril must be registered with the CPMS. Patients deemed suitable for treatment with the drug are required to have their total white blood cell count (WBC) and neutrophil count assessed before treatment and subsequently monitored weekly for 18 weeks from the start of treatment, then at least monthly while on therapy.

All patients' haematological results are supposed to be transmitted to and monitored by a CPMS Database and audited daily to determine

- missing or unusual haematological data
- dangerous haematological trends (ie. WBC 3.0-3.5 x 10 -9/L and/or neutrophil count 1.5-2.0 x 10 -9/L ("amber count")
- unusual or missing dosage information.

The protocol requirements are such that it appears that the prison hospital was what is described in that protocol as an "Outlying Facility" with the Royal Hobart Hospital being the main centre. The protocol acknowledges that in such situations there is a higher than normal chance of logistical and communication problems. It lays down that the outlying facility must have continued access to a fax machine that should remain on, in the absence of the medical officer it must have another registered officer to cover for him or else appropriate arrangements made and the centre coordinator must be kept fully informed about the facility.

Laurence's file contained a Patient Consent Form as required by the protocol dated the 18/4/99. The file also contained evidence of a blood test being carried out that day and tests on a weekly basis for the 18 weeks after the 23/4/99 and approximately 4 weekly thereafter until Laurence died. The results of those tests do not appear to show results relating to white blood cell and nuetrophil counts which might have caused concern in the context of the protocol.

As to dosage of the drug, the protocol sets out that this should be individualised on clinical assessment subject to the lowest effective dose being used. The protocol recommends that an initial dose begin at 12.5mg once or twice daily on the first day, followed by one or two 25mg tablets on the second day. If well tolerated the dosage may be increased in daily increments of 25 to 50 mg achieving a dose level of up to 300mg per day within 2 to 3 weeks. Thereafter if required the daily dose may be further increased in increments of 50 to 100mg at half weekly or preferably weekly intervals.

The protocol also contains recommendations as to treatment. They provide

> *"In most patients, antipsychotic efficacy can be expected with 200 to 450 mg per day in divided doses. The total daily dose may be divided unevenly with the larger portion at bedtime.*
>
> *Because of the significant risk of agranulocytosis and seizure, events which both present a continuing risk over time, the extended treatment of patients failing to show an acceptable level of clinical response should ordinarily be avoided.*
> *For most patients the usual recommended maximum dose is 600mg per day. However, a few patients may require larger doses to obtain maximum therapeutic benefit, in which*

case increments of not more than 100 mg are permissible up to a maximum dose of 900 mg/day.

The possibility of increased adverse events occurring at doses of more than 450 mg per day must be considered.

After the maximum therapeutic benefit has been achieved, the minimum effective dosage should be used to maintain clinical remission."

The protocol also refers to a number of other matters amongst which are

- that the drug lowers the seizure threshold in patients. Patients are to be advised not to engage in any activity where sudden loss of consciousness could cause danger to them
- patients commencing treatment with Clozapine need to be under close medical supervision
- fatigue drowsiness and sedation are among the most common side effects observed with an incidence of about 40%. Dizziness and headache may also occur.

A number of research papers relating to Clozapine and related drugs were also placed before he inquest. These were

- "Clozapine Plasma Level Monitoring: Current Status" by Thomas B. Cooper appearing in the Psychiatric Quarterly 1996 Volume 67 at page 297[130]

- "Myocarditis and cardiomyopathy associated with Clozapine" by Kilian, Kerr, Laurence and Celermajer appearing in the Lancet Volume 354[131]

- "The Association Between antipsychotic drugs and sudden death" a report of the Working Group of the Royal College of Psychiatrists' Psychopharmacology Sub-Group - January 1997[132]

- "Plasma Clozapine Concentrations as a Predictor of Clinical Response: A Follow -Up Study" by Miller, Fleming, Holman and Perry appearing in the Journal of Clinical Psychiatry 1994 Volume 55 at page 117[133]

In the first of these articles the conclusions set out were that (and this paper came out in 1996)

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[130] See exhibit 220
[131] See exhibit 222
[132] See exhibit 219
[133] See exhibit 224

> *"Plasma level monitoring of Clozapine and metabolites is not recommended as a routine procedure. Many patients respond below the putative threshold of 350-420 ng/ml. Patients who do not respond to usual dosage levels should be monitored to make sure these patients are above this threshold before a determination of non-response to Clozapine is made.*
>
> ***Plasma level monitoring is recommended in any patient receiving more than 600mg/day to determine whether very high Clozapine plasma levels are present given the increased risk of seizure above this dosage.***
>
> ***Plasma level monitoring is recommended if other medications are given to monitor and , if necessary, adjust dosage in the case of drug interaction.*"**

(the bold emphasis is mine)

The last conclusion arose out of research canvassed which suggested that some drugs administered in conjunction with Clozapine affected blood Clozapine levels. In particular it was suggested that an anticonvulsant such as valproic acid (Laurence was taking this) had the effect of reducing blood Clozapine levels.

The authors of the second of these articles carried out a study of the correlation between cardiac related deaths and Clozapine after the death of two otherwise healthy young males. They had regard to the fact that as at March 1999 (Laurence began treatment in April) there were some 8000 patients registered with the CPMS in Australia. Their interpretation of the data they looked at was that Clozapine therapy may be associated with potentially fatal myocarditis and cardiomyopathy in physically healthy young adults with schizophrenia. They commented that prospective studies may identify plasma or electrocardiographic markers of cardiac damage in at-risk patients which may be useful in screening for these important adverse outcomes.

It should be noted in relation to Laurence Santos that, at post mortem, no indication was able to be found of any cardiac related cause for his death.

In the third of these articles, the authors summarised research in the United Kingdom on the association between antipsychotic drugs and sudden death. It would be fair to say that Clozapine received only passing mention in the article although it was clearly a drug of the type being dealt with. Clozapine was referred to directly in Appendix 7 which dealt with monitoring of antipsychotic drug levels. The authors said at page 38

> *"Therapeutic drug monitoring has generally been regarded as a disappointment. However a re-evaluation of this strategy has been more optimistic…..Thus it is useful when compliance is in doubt to take a spot sample for analysis.*

It is also proving useful with newer drugs such as Clozapine where relationships to response are being found. For example, plasma concentrations of over 350mg/l for Clozapine or 450mg/l for Clozapine plus its metabolite, demethyl Clozapine, is associated with a therapeutic response. Also, in patients attaining high doses of antipsychotic drugs it is wise to obtain a plasma concentration estimation lest the levels are in the toxic range.

To obtain valid and comparable drug concentrations post mortem, blood samples need to be taken as soon as possible after death from a peripheral vein."

(the bold emphasis is mine)

The report also referred to the possible effect of drugs dealt with by it on a patient's QT interval. There was evidence that such drugs increased that interval increasing the risk of potentially fatal cardiac arrhythmia.

In addition the report dealt with high dose treatment of antipsychotic drugs sounding a note of caution. The report outlined some suggestions for clinical management of such cases at page 33 saying in part

"Other medication that may increase the risk of cardiovascular reactions should be avoided. Such drugs include other antipsychotic drugs; tricyclic antidepressants….

The presence and severity of drug side-effects should be carefully assessed, to ensure that the persistent symptoms indicating a failure to respond are not a misdiagnosis of drug-related phenomena…and as a baseline for comparison with the high dose regime.

Discussion of the planned high dose therapy with a colleague, with a written summary in the clinical case notes. The drug dose should be increased gradually.

It is important to review such treatment regularly with measurement of blood pressure regularly (daily if there are any cardiovascular symptoms). Lowering the dose of high dose treatment after a four to six week trial would generally be appropriate. Either the patient has failed to respond, in which case continued high dosage is not justifiable, or there has been an improvement, in which case the dose should be reduced, at least temporarily to test whether further high dose treatment is necessary."

There was evidence that when he died Laurence was receiving a tricyclic antidepressant, Amitriptyline, although in a small dose.

In the last of the four articles (which came out in 1994), the authors, some of whose other research in Clozapine is referred to in the CPMS Protocol, indicated that in a study reported in 1991 they had found a positive relationship between Clozapine, its major metabolite Norclozapine and clinical response. They found that plasma Clozapine concentrations greater than 350 ng/ml and total plasma Clozapine plus Norclozapine concentrations greater than 450 ng/ml were found to discriminate between responders and non-responders. Reference was made to another study in which it was found that a Clozapine concentration of 370 ng/ml was found to be the optimal cut off for distinguishing responders from non-responders.

The authors said at page 120

> *"In conclusion the results reported here suggest that the determination of plasma Clozapine concentrations in treatment-refractory schizophrenics not responding to Clozapine may be useful. If a patient has unsatisfactory response and a plasma concentration less than 350 ng/ml, we recommend increasing the dose of Clozapine to achieve this "threshold" plasma concentration. However some patients may not be able to tolerate the side effects associated with increasing their dose to this extent. Also, because of the increased risk of seizures at doses greater than 600 mg/day, and particularly 900 mg/day, caution must be taken when increasing the dose above 900 mg/day."*

Different rates of measurement of blood levels appeared in the literature, documents and evidence provided to the court such as may have caused confusion. It is useful to set out those rates and their interrelationship:

mg/L - milligrams per litre
ng/mL - nanograms per millilitre
µg/L - micrograms per litre
µg/mL - micrograms per millilitre

1 x nanogram per millilitre = 1 x microgram per litre (ng/mL = µg/L)
1 x milligram per litre = 1 x microgram per millilitre (mg/L = µg/mL)

Professor Ivor Jones was asked to prepare a report in relation to Laurence Santos for the inquest. He did so and it was dated the 10/3/00. [134] Professor Jones is an Emeritus Professor of Psychiatry and maintains a clinical practice which involves principally medico-legal work but also some management of patients. He is not currently a registered Clozapine provider nor has he been since the CPMS was first set up in the early nineties. He was involved with the committee which set up the first Clozapine clinic in Tasmania, he then being the Professor of Psychiatry at the University of Tasmania. He did not ever run the program but was familiar with the drug and it's prescription.

Professor Jones had actually had dealings with Laurence early in 1999 he having been asked to assess him by his legal representatives prior to his trial. He was familiar with his background and past treatment. He was aware Laurence was "*relatively resistant to medication*". He knew Laurence had previously been treated with a number of different drugs including Clozapine when he was being treated out of the Launceston General Hospital. He said at page 2 of his report

> *"I would regard Clozapine as an appropriate treatment in this case, although not necessarily in the dosage prescribed. It's use is classically in chronic treatment resistant schizophrenia. It is not uncommonly effective in improving the symptoms but usually not effective in eliminating them in this class of patient.*
>
> *The dosage can be very variable but the dose range quoted by Dr. [McLean] - 200-450 mgs. per day with a maximum of 600 appears reasonable, although it should be said that individual practitioners do give higher doses and as he indicates there have been examples of recovery from much higher doses than this. The dosage recommended by the makers is usually the most common range, often one established in clinical trials as safe and effective. It is not one in which an authority says the upper limit should never be exceeded and in individual cases, the therapist may decide to exceed that range, but he does so with trepidation.*
>
> *Dr. Campbell describes the Clozapine level in the blood as within the lethal range. Probably this means the range at which death may occur. My understanding is that this is a dangerous level. This dosage is one to be used with trepidation and one at which it would be wise to assess blood levels of the drug and reduce the dosage if these are dangerously high. It is not clear that blood levels were assessed.*
>
> *..recently, that is in the last few months, it has become more widely appreciated that sudden death may occur with Clozapine and this maybe more common than had hitherto*

[134] See exhibit 216

been supposed. Sudden death has been known to occur occasionally with practically all treatments for schizophrenia. Probably from cardiac arrest from impairment of electrical conductions or impaired responsiveness of the heart. More recently myocarditis has been reported. The post mortem findings here did not show evidence of myocarditis. It is likely that this death was consequent upon direct effects on cardiac electrical conductivity.

From the material provided, I would consider that a dangerously high level of Clozapine was being used here but this should be viewed in the therapeutic context of a person who was extremely difficult to treat and had been shown to be over many years.

In retrospect it would have been preferable to accept incomplete control of his symptoms with a lower level of medications or access blood levels if a high dosage was being used.

I would agree that this dosage level is beyond the usual therapeutic level even though there is a great deal of variability in this."

Professor Jones amplified the matters covered by his report in his oral evidence and also gave his opinion about other issues not covered in it. At the outset, he indicated that he understood there had been a recent change in the recommended maximum dose of Clozapine from 600 mg to 900 mg. He was challenged about just how recent that change was by Counsel for Dr. Jager and he responded by saying that the change was reflected in the 1999 MIMS annual as opposed to the 1998 annual. Professor Jones conceded his involvement with Clozapine had not been close enough when he wrote his report to know what the recommended maximum dose was.

It was put to Professor Jones that the manufacturer had in fact increased the maximum recommended dose to 900 mg in 1995. Professor Jones expressed surprise at that. There was no evidence actually placed before the inquest to confirm that. The proposition also somewhat distorted what actually appears in the CPMS protocol which is that the maximum recommended dose is 600 mg but may be increased to 900 mg. Professor Jones acknowledged that were a therapists view to attempt to eliminate all symptoms, and the maximum recommended dose was 900 mg/day , a therapist may reach that ceiling before the delusions and other symptoms were stopped.

On the question of the efficacy of divided doses of Clozapine suggested by the manufacturer, Professor Jones said there were gains and losses. He said a divided dose would produce a lower mean level than the peak levels you get from one dose but it would increase daytime drowsiness which Laurence was already complaining about.

On the question of blood tests, that is to determine the level of Clozapine in the blood, Professor Jones said the level detected in July 1999 of 828 micrograms per litre suggested blood levels were getting very high and he would be very cautious about increasing the dose further. At that particular time Laurence was receiving a dose of 650 mg at 9 p.m. daily.

Professor Jones however acknowledged [135] that while he would not have increased the dose at that time other therapists may have a different view. He repeated this view at different times in his evidence. He said he would have accepted the symptoms Laurence was displaying as long as his behaviour was reasonably normal (and there was no suggestion it was not) while others may take the view they want to get rid of the symptoms at all costs because they are symptomatic of the disease. Professor Jones went on to say that had he increased the dose he would have liked regular blood testing.

Professor Jones went on to say that monitoring of blood levels may not necessarily tell you how well a patient was going just whether the levels were becoming dangerously high. He said however that the higher the dose of Clozapine the more risk of side effects there was and dangerously high blood levels might forewarn a therapist about that level of risk.

Professor Jones was also asked about the importance of the time at which blood was taken. He said that if blood were taken within an hour or two of a dose being given then there would be a peak concentration level while if it were taken just before a dose the level would be at a trough. He said it would be important for a nurse taking a sample to record the time at which blood was taken. It was apparent from the blood test results in relation to Laurence and his records that no such information was recorded when blood was taken from him on a regular basis to check his white blood cell and neutrophil counts. Director of Nursing DeBomford told the inquest that not all nurses even routinely note taking of blood itself and that there was no facility for recording the time at which blood is taken otherwise. He could only say generally that most blood samples were taken around 10 a.m.

In Laurence's case only one Clozapine blood level test was ever done while he lived, namely at the end of July 1999 and the result was a level of 828 μg/L. It was noted on that one test result by the laboratory which did the test that *"trough concentrations are of most clinical value."*

Counsel for Dr. Jager questioned Professor Jones about that finding. He put to him an hypothesis that the blood on that occasion was taken at about 9 a.m. He did so in an effort to obtain Professor Jones agreement to the proposition that the blood for that test was taken at a time when the cycle

[135] See transcript pages 2087 and 2088

of peak to trough was half way and that one could extrapolate that the level would have been much lower had the test been conducted on blood taken at a trough time, in fact down to about 450 ng/mL. Professor Jones disagreed with that proposition[136] but did agree the blood level may have been significantly lower than the 828 ng/mL found on that occasion. His comment in this regard must be viewed in the light of Counsel's definition of trough which Counsel said in the case of a single undivided dose per day situation was immediately prior to the next dose, that is just before 9 p.m. and not 12 hours after a dose which was the trough time referred to in literature and by Dr. Schneider.

There was nothing in either the nursing notes or Dr. Jager's notes to say when the blood for that test was taken from Laurence. The test result form shows it was received at the Royal Hobart Hospital at 3.52 p.m. on the 27/7/99. It is unlikely the blood was taken from Laurence before 9 a.m. by reference to hospital routine. However it could as easily have been taken at some stage over the next several hours. The hospital records also do not show an accurate time at which Laurence's medication was given on the 26/7/99. It was about that time the time of his medication changed from late afternoon to 9 p.m. Even therefore were the blood taken as early as around 9 a.m. on the 27/7/99, then having regard to the literature already referred to and Dr. Schneider's evidence to be canvassed later, the level is likely to have been considered a trough level for the purposes of comparison with the literature.

As to the carrying out of regular ECG's on a patient taking Clozapine, Professor Jones said in April 2000 that he may not have done such a test 12 months before he gave evidence but he would now. He said[137]

> *"It's also known that commonly people on these drugs in the ECG have a prolonged QT interval, that is an indication of cardiac conductivity. The drug or the condition, probably the drug, slows down that conductivity and makes it variable and in those circumstances sudden death becomes more probable, so it's that sort of thinking that has caused me from time to time, but I must say not as a routine, to do ECG's on people - on schizophrenic patients."*

Director of Nursing DeBomford gave evidence ECGs had been administered to inmates taking Clozapine since December 1999 when revised material had been received from the manufacturer.

The issue of observation of Laurence while he was taking Clozapine was also raised with Professor

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[136] See transcript page 2202
[137] See transcript page 2089

Jones. He did not agree with the proposition that observation through the cell window more often than hourly was required. He also said that even quarter hourly observations might not be sufficient were a patient to have a fit. He did however agree that were Laurence to have been in a hospital psychiatric ward, monitoring and observation would have been different because he would probably have been housed so he could be seen at all times.

The issue of training of staff dealing with patients taking Clozapine was also raised with Professor Jones. He agreed they should be trained to recognise the dangers associated with the drug and understood the drug manufacturer would provide any necessary training.

Nurse Victoria Norris said in her evidence that there was no formalised training for nursing staff when Clozapine was introduced. She said she had had some experience with it when she was a student 3 years or so before. Sister Barwick gave evidence that Dr. Jager raised with staff at a team meeting in March 1999 his intention to put some patients on Clozapine. She said she raised issues with him about this and he was dismissive. The first she knew of it's actual use in the hospital was when she walked into the nurses station one day and the hospital nurses asked for help taking Clozapine bloods because they were busy and the courier was waiting. She said she asked the staff if they had had any training or staff development in relation to Clozapine and they said no, they weren't offered any.

Nurse Howell-Smith said in his evidence that his first contact with Clozapine was when Dr. Jager prescribed it. He was asked what information he was given about the drug. He said there was an information sheet that came with the packet. He also said that some of the other nurses had had experience with the medication and they were advised they should read up about it. He had no recollection of any meeting of staff to discuss the use of the drug in the prison environment.

He said that sometimes drug representatives came in and spoke about drugs but he could not recall anything about Clozapine. He did not believe that there was any facility for ongoing training of nursing staff in the use of new drugs in terms of what side effects to look for. He in fact got hold of a version of MIMS from Dr. Beadle and read what it said about Clozapine. He was aware from his reading of some of the side effects. To his knowledge there were no changes in observation procedures of inmates in light of their having Clozapine.

Director of Nursing DeBomford told the inquest there had been no advice to him from Dr. Jager of his intention to introduce Clozapine to the hospital notwithstanding that it was a major protocol. When he became aware of it he instructed his clinical nurse consultant to arrange training and obtain relevant documentation for staff. That training was given by Dr. Milford McArthur and a nursing sister from the Clozapine clinic at the Royal Hobart Hospital on the 24/5/99 a little over a

month after Laurence Santos began taking the drug and after an incident arose on the 4/5/99 about Laurence's consent to take the drug. The training lasted about an hour to an hour and a half. There is no record of who attended that training and it appears clear from the evidence of a number of the nursing staff that several did not.

Professor Jones saw logistical problems with operating the prison hospital as a clinic for Clozapine because of the confined nature of the environment and the different staff. It appears it had not been so used prior to Dr. Jager coming to his position.

Professor Jones agreed that from his knowledge of Laurence his delusions, suspicions and paranoid ideas were directed exclusively to his parents and that when psychotic he represented a threat to them. He said that the level of threat to those around him in the prison would be small. This was notwithstanding he had stabbed a police officer because that was in the context of his being chased. Professor Jones felt that the nature of Laurence's delusions in the context of his being in prison should be a factor in considering his treatment.

Counsel for Dr. Jager asked Professor Jones to accept that Laurence had said he thought that his parents and medical staff had introduced a virus which caused his spine to dissolve thus suggesting that the pattern of his delusions had changed to include others apart from his parents.[138] Professor Jones responded by saying he would want to know to what extent medical staff had been incorporated in Laurence's delusions and what his ideas were about doing something about it.

A review of Dr. Jager's notes relating to his attendances on Laurence does not show any record that Laurence told him at any stage he thought his parents and medical staff had introduced a virus which was causing his spine to dissolve. There is an entry on the 6/9/99 by which time Laurence's medication was already at a level of 800mg/day which says

> *"Maintains delusions about spine but thinks a virus (in 1 or 2 injections) rather than poison was the cause"*

It is unlikely in any event that this refers to any then current treatment because Laurence was taking his medication orally as opposed to by injection.

That specific issue was not pursued by Counsel who instead went on to suggest that Laurence was in an environment where he was coming into contact with a number of different people and that if his

[138] See transcript page 2204

thought processes were still bizarre he might still be dangerous. Again Professor Jones responded by saying that you could never totally exclude dangerousness but you look for positive evidence of it.

The review of Dr. Jager's notes again shows no indication that Laurence was presenting as a danger to anyone and in fact an entry by Dr. Jager on the 18/7/99 reads

> *"No thoughts of harming self or others."*

Counsel for Dr. Jager further put to Professor Jones[139] certain matters to support a decision to continue and increase Laurence's medication. These included that his term of incarceration would hinge on the degree of improvement in his psychosis and the risk of suicide in individuals with psychosis in a prison setting. Professor Jones agreed it was a reasonable point of view but went on to say

> *"The objections I would have to it are firstly that the incremental benefits in high doses are doubtful and secondly that he's been committed only for a short time so there's plenty of time for anybody who's likely to release him."*

The opinion of a further expert who also gave evidence, Professor Kirkby, was also put to Professor Jones. That opinion was that there was evidence that the Clozapine dosage was increased to target severe psychotic symptoms which did not remit over several months at average treatment doses, that the course of action was pursued with the interest of the patients safety to himself and others and future well being as the central objectives and the death was not predictable in terms of literature and guidelines at the date of death. Professor Jones agreed that it was no doubt a sincere view but by that did not concede it was necessarily a correct one in this case.

The content of Dr. Jager's notes reflects that Laurence continued over the time Dr. Jager dealt with him to have delusions and to be psychotic. However when those notes are read together with the nursing notes there is nothing to suggest he was a danger to anyone or that he was other than generally quiet and well behaved. In fact in the nursing notes there are several references to Laurence mixing well with others. This was confirmed by Mr. Bain who said he had almost daily contact with Laurence until the 17/9/99 and had no recollection of his being antagonistic towards other inmates in the months leading up to that date. He said he did weights with other prisoners and was always polite

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[139] See transcript page 2209

Professor Jones was asked also specifically about the cause of death. His view was that the most likely possibility was impairment of cardiac function as consequence of the medication. He rated a seizure as the second most likely possibility and as the third that the death was unrelated to the medication.

Professor Kenneth Kirkby also gave evidence. He is a Professor of Psychiatry at the University of Tasmania. A letter dated the 7/4/00 which he wrote to Counsel for the DHHS was placed in evidence.[140] Professor Kirkby reviewed material relating to Laurence Santos and concluded that the dosages and increments in dose of Clozapine given by Dr. Jager to Laurence Santos were in accordance with the Therapeutic Goods Administration guidelines. Those guidelines are in fact what is in the CPMS protocol. He said

> *"..the prescribing of Clozapine ..reached but did not exceed the maximum dose of 900mg.."*

There is no doubt that the CPMS Protocol permitted doses in excess of 600 mg/day and up to 900 mg/day. However the maximum recommended dose according to the protocol was clearly 600 mg/day. Keeping in mind that distinction, there was no actual breach of the terms of the protocol in so far as it related to daily dose levels and increments. The issue is not so much whether Laurence's treatment was outside the protocol but whether that treatment in all the circumstances was a prudent or proper one for Laurence having regard to the entirety of the protocol and published research.

Professor Kirkby in his letter summarised two particular side effects arising with Clozapine and the recent research papers relating to it's use which have already been referred to. The first was the risk of epileptic seizure. He acknowledged that was more typically a problem when doses were above 600mg. He then went on to say that Dr. Jager managed this appropriately by prescribing Sodium Valproate. That was all he said about that particular side effect. He then dealt at some length with the issue of cardiac related side effects but notes that there was no evidence at post mortem of any such disease in Laurence.

Professor Kirkby then concluded that the use of Clozapine in doses up to 900 mg/day carried a low risk of dose dependent fatality. With respect it is difficult to see how he is able to make such an all encompassing statement based on the report that he wrote. Professor Kirkby then made a number of statements about the Clozapine serum level obtained at the end of July 1999. He said

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[140] See exhibit 221

"I presume that the blood test was taken the next morning and would therefore be at a trough level."

That statement was consistent with the literature he referred to and the testing regime outlined by Dr. Schneider although it was made in the context of some conjecture as to when the blood for the test was actually taken.

In his letter, Professor Kirkby cited some results from a paper he referred to, which in itself was exhibit 224. He said at page 3 of his letter about that paper

"In patients on a mean dose of 568.7mg (range 300-900mg) the mean serum level in micrograms per litre of Clozapine was 489.9, with a standard deviation of 292.4 and of Norclozapine of 760.9, standard deviation 412.4."

Professor Kirkby also noted that nanograms per millilitre equalled micrograms per litre. However, that is not in fact what was said in the relevant paper. It said at page 119

"During the 6-week trial, the dose of Clozapine was 384.5 ± 42.5 mg/day (range 250-450 mg/day, with 24 of the 29 receiving 400 mg/day). At follow- up, the dose was 568.7 ± 151.8 mg/day (range, 300-900 mg/day). Plasma Clozapine concentrations were 374 ± 233 ng/mL during the 6-week trial and 394.5 ± 229.3 ng/mL at follow up. Total plasma Clozapine plus Norclozapine concentrations were 489.9 ± 292.4 ng/mL during the 6 weeks and 760.9 ± 412.4 ng/mL at follow up."

With respect it seems that Professor Kirkby misinterpreted the results in that study. Its findings were in fact that in patients on a mean dose of 568.7 mg/day, the mean serum level of Clozapine was 394.5 ng/mL. ± 229.3 ng/mL. The figure of 760.9 Professor Kirkby quoted was a combination of Clozapine and Norclozapine levels and not a Clozapine level alone. Laurence's Clozapine level at the end of July 1999 was 828, that is significantly higher than that outlined in the study. This same paper also refers to blood being taken 12 hours after dose.

Professor Kirkby then commented on the result found post mortem. He referred to the figure of 4.5mg/L which equated to 4500 ng/mL (a much greater level than that found in July and a very much higher level than any described in the literature) and indicated he found that hard to reconcile with the literature. He said the only differences between the results in the literature and Laurence Santos' situation were that his dosage was 900 mg/day as opposed to the mean of 568.7 in the study and Laurence was also receiving two other drugs. He said he suspected the post mortem result was in part explained by it being closer to a peak than a trough value.

I reviewed the evidence given by Professor Kirkby when he was questioned by Counsel assisting, most particularly that given on the 18/4/00. The tenor of that evidence was that it is quite possible the post mortem Clozapine level was accurate explained by a combination of two main factors namely the undivided dose of 900 mg given at 9 p.m. and death ensuing not long thereafter.

Professor Kirkby also said [141] that generally if dosages are single doses you will get a higher peak level over 24 hours and a lower trough level. He also said that with high single doses there is a concern you may get particularly high peak levels and that may be accompanied by more side effects. Where there are divided doses, that is one morning and one night, the trough level would be the one taken just before the morning dose. He also indicated at page 2272 that if a level were a peak level the trough level would be round about a third of that although he did concede that was not his area.

Professor Kirkby said in his letter that

> *"In this case the evidence is that Clozapine dosage was increased to target severe psychotic symptoms which did not remit over several months…" and "In my opinion this course of action was pursued with the interests of the patients safety to himself and others."*

He was asked to say whether any symptoms post 1/8/99 indicated a risk to other persons in the prison or a risk to Mr. Santos himself. Notwithstanding his opinion Professor Kirkby was unable to point to any particular symptoms in Laurence which might have justified that proposition save his general knowledge as to Laurence's background which brought him to the prison. He referred to a general appreciation of risk. When it was put to him that may be a justification for prescribing Clozapine in the first place and taking the dose to say 450 mg/day but not for increasing it to 900 mg/day, he said[142]

> *"The average practitioner would not pursue treatment at this level. But many practitioners would. And the average practitioner dose not work in a forensic setting where people have committed murder for example or where the risk of suicide is far greater than in the general community….The risk of suicide was the one I was stressing…"*

This must be looked at against a background of a specific statement by Laurence late in July that he would not harm himself or others and his apparent equanimity in the hospital despite the stress of

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[141] See transcript pages 2254 and 2255
[142] See transcript page 2301

court proceedings and the ultimate court finding. Professor Kirkby's response suggested he had not seen the notes reflecting Laurence's behaviour.

Professor Kirkby was asked[143] whether Laurence's dose in view of a number of factors could have been maintained for a period at say 650 mg/day at the end of July 1999 as an appropriate treatment. He responded

> *"very much so and that's - I've indicated in my report that there are pros and cons of taking a more cautious approach with a lower dosage of medication and waiting. I see those as both arguable on the facts of this case and the range of decisions that would be made would be within the range of keeping the dosage even lower than that, keeping at a medium dosage or of going up to the highest dosage, and they can all be argued. In my view quite reasonably on the facts available that I have been a party to. There's a question of which of those is the more prudent course, which of them perhaps is the more heroic course and what the balance of risks are in waiting and going more slowly in that something untoward may happen in the meantime, particularly I would suggest the risk of suicide in this population as opposed to the risk of medication of going more, if you like aggressively…..In Mr. Santos' case there is no doubt that a more prudent lower dose regime would have been better insofar as his death may be attributed to Clozapine….which I think is a more reasonable proposition although by no means certain that it's related to the actual prescribed dose…"*

He was asked after this whether in his terminology the treatment was prudent or heroic. He said

> *"..if we put them on a line this is further up the heroism line than the-than further down the prudence line."*

Dr. Rosemary Schneider also gave evidence. She has been a consultant psychiatrist since 1986 and she is the Clinical Director, Mental Health North/North West in the state of Tasmania. She works out of the Launceston General Hospital. Dr. Schneider had treated Laurence Santos at that hospital during 1998. She and/or her registrar had in fact first commenced Laurence on the Clozapine program in 1998. She had reviewed Laurence's medical and forensic files maintained at the prison hospital prior to giving evidence.

Dr. Schneider currently prescribed Clozapine and had done so since 1993. At the time she gave her evidence she estimated she had about 20 patients currently on the program. Of the medical

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[143] See transcript page 2304

practitioners who gave evidence at the inquest about the use of Clozapine including Dr. Jager it could be observed that Dr. Schneider had by far the greatest up to date clinical experience with the drug, she being directly involved with a treatment centre. As such her evidence must carry significant weight.

She was questioned about matters relating to blood serum levels of patients on Clozapine. She said that the laboratory she was familiar with gave blood serum level reports which said that for a therapeutic response levels should be above 350 micrograms per litre. She said that laboratory had recently added an upper limit to the range of 1000 micrograms per litre as the limit for safety and efficacy. It can be noted in this context that at post mortem Laurence's Clozapine level was 3480.[144]

Dr. Schneider was asked to comment on what a Clozapine blood serum level of 828 micrograms per litre on a dose of 600 mg per day would say to a clinician. Her response was that that level was way above the requirement for a therapeutic response and that it was a high level. She was asked if, faced with that situation, she would increase the dose of Clozapine. She said she did not think she would ever do that. Her reason was that if you increase the dose you will increase the risk of side effects, particularly seizures and sedation. She said it was possible she would decrease the dose but she would take into account the clinical status of the patient. It was highly unlikely she would increase the dose.

Dr. Schneider talked about the times at which blood should be taken for serum levels. It was put to her that for blood serum levels to be of any use they must be determined at a trough level. She indicated she used a 12 hour level as a trough level. She said it was not the absolute bottom of the trough which would be just before the next dose but since the peak is at about 2 hours then the trough is about 12. She did agree that unless you knew the time the blood was taken to determine the serum level the reading would not be much use to you.

Dr. Schneider also gave evidence about the issue of divided doses. She said that with divided doses you never got such high peak levels after any one dose. There were circumstances where a clinician would consider an undivided dose and that was where the patient would not take the morning dose because of the sedation but is willing to have a larger dose at night. She would also not increase blood testing simply because she was in an undivided dose situation. She would do such testing if ever she got to a situation where she had a patient on 400 or 500mg per day and they were not responding. She said[145]

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[144] See evidence of Dr. Kathryn Campbell
[145] See transcript page 3121

"I would start asking myself why and I would probably want to do a serum level and just see if their metabolism was unusual before I went any further or whether they were just someone who wasn't going to respond. Not everybody does."

She indicated Clozapine effects tend to develop better over time, it being suggested even up to a year. She advocated leaving a patient on a dose for a period to see their response and noted Laurence had never had longer than a 5 week trial at any one level prior to going to the prison hospital.

She agreed that patients were individuals and where Clozapine was used it was more the exercise of clinical judgement than just following guidelines. She said that most competent psychiatrists faced with a serum Clozapine level of 828 micrograms per litre at a dosage of 600 mg would not continue over the next several weeks at a relatively rapid rate to increase the dosage up to an undivided dose of 900mg Nocte without the benefit of even one further serum Clozapine level. She also agreed that situation would be worse were the patient sleeping without stirring, hard to wake, wandering around in a daze, not under constant supervision, unable to advocate for himself and no threat to himself or others.

Dr. Schneider was also asked to comment on the issue of whether there was any urgency for resolution of symptoms in Laurence. She said it depended on how much Laurence was in immediate distress, if he was voicing suicidal thoughts or any other kinds of threats based on delusions. She said she reviewed Laurence's notes and there was no indication of any of these.

As to the prescription of Sodium Valproate for Laurence she repeated that risk of seizures increases with dose and since Laurence was up to 600 mg it was obviously decided there was a risk. However she then pointed out that the dose of Sodium Valproate given was unlikely to have been an adequate dose because it was that recommended as a starting dose for a child. She also pointed out that if you were trying to prevent seizures you would need to do blood levels to determine the appropriate level. None were done in this case.

Dr. Schneider described as risky continuing with a regime of increasing doses where there was no information about Sodium Valproate levels in the blood and one blood test showing a high Clozapine level. She was also asked to comment about whether she could ascertain Laurence's clinical condition from his file on the occasions his dose was increased beyond 600 mg. She said most of the comments she had seen just referred to the dose increase with no particular reason given as to why it was being done.

Her view was that a psychiatrist should provide an adequate clinical description of the patient from which you could derive how disturbed they were. She said[146]

> *"..you'd want to know things about their mood, the way they're relating to you during the interview, reports on their behaviour from the other people who can observe them through the twenty four hours, their thought content. If you've got for instance delusional thought content you'd want to know how much it's on their mind because people can have the same delusions but only think about them occasionally, or think about them a lot, or be virtually unable to think about anything else so they come spilling out the minute they talk. Any evidence of whether they're hallucinating by hearing voices in most cases or other kind of stuff like that whether they're thinking about suicide whether there are any thoughts of harming anybody else and whether you've established a rapport with them is such that you think they're telling you the truth for instance."*

Dr. Schneider's description of what little information did appear in Laurence's notes suggested a clear inadequacy in the information gathered to support the increasing dosages.

Counsel for Dr. Jager questioned Dr. Schneider about the practice of routinely doing Clozapine blood level tests pointing out it was not required by the CPMS Protocol. Dr. Schneider said in her treatment centre they were using such tests fairly routinely and that her personal awareness of psychiatrists around her was that they were doing quite a lot of levels. It was put to Dr. Schneider that doses exceeding 900 mg per day were not uncommon. She responded that they were in her experience but it may not be elsewhere.

Dr. Kathryn Campbell, the government analyst, told the inquest that post mortem drug levels in a body may vary depending on where the sample of blood tested is taken from. If blood is taken from within the body cavity it is more likely to have artificially elevated levels of drugs in it. Femoral blood is peripheral blood taken from outside the body cavity to reduce that problem.

She said that most reported literature refers to test results being based on plasma or serum tests. Their test however was based on whole blood testing. Plasma levels would be 1.16 times higher. Therefore the result she found of 3 mg/L was the equivalent of 3.48 mg/L (or 3480 ng/ml).

Professor Stuart McLean was an associate professor of pharmacy at the University of Tasmania and had undertaken teaching and research in pharmacology since 1973. He agreed that the time at which a blood sample for a Clozapine level was important.

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[146] See transcript page 3135

Counsel for Dr. Jager put certain questions to Professor McLean about potential inaccuracies in Clozapine levels taken post mortem. While Professor McLean agreed there could be problems he said that it depended where the sample was taken from and he understood that in relation to Laurence Santos would not be such a problem.

Dr. Jager gave evidence about these issues having had the benefit of all other evidence being taken before his. He was asked about whether he had ever obtained a second opinion in relation to his treatment of Laurence. He told the inquest that there were no specially allocated funds to enable him to obtain a second opinions but went on to say that he could get them anyway at no cost and without a special arrangement. He also said he did not talk to either Dr. Sale, Dr. Schneider or Dr. Lopes about Laurence but simply read Dr. Lopes' notes and the material received from the Launceston General Hospital. He said he discussed Laurence's case at a case conference with senior colleagues and senior registrars at the Royal Hobart Hospital in March 1999 and that when he was in Germany in August 1999 he spoke to a senior researcher from the company which manufactured Clozapine. He described that discussion as a secondary consultation with an experienced psychiatrist but agreed he did not have Laurence's file with him when this consultation occurred. There is nothing in Laurence's file to indicate advice on his case was sought on either of these occasions.

Dr. Jager also told the inquest that Dr. Pargiter had some dealings with Laurence when he acted as locum in Dr. Jager's absence. He described that as having had the benefit of the opinion of an eminent psychiatrist. However he went on to acknowledge that the "syringe" incident was not documented anywhere in his notes and he did not actually discuss Laurence's case with Dr. Pargiter. In those circumstances Dr. Pargiter could hardly be said to have had a full and accurate picture of the situation regarding Laurence such as to be able to give any form of second opinion nor was he ever asked for one.

Dr. Jager was also asked a number of questions about his treatment plan for Laurence. He acknowledged that there was nothing by way of a sophisticated management plan outlined in a separate note for Laurence and that his management plan would be seen in terms of a plan at the conclusion of each entry in the notes or most entries. He said his plan was to monitor Laurence's mental state and adjust the medication dose according to the clinical response, that is a combination of the therapeutic response and the development of adverse side effects. A review of Dr. Jager's notes would suggest this plan was not apparent on the face of the notes which would have made it difficult for any other professional from the notes to review the management of Laurence. That was the view of Dr. Schneider who reviewed the notes.

Conclusion

The evidence shows Laurence was suffering from schizophrenia and was treatment resistant. He had a brief involvement in a Clozapine program in 1998 which was unsuccessful. Laurence had no lengthy period during which he took Clozapine in 1998 which would have given any professional any information to gauge it's effectiveness on him.

Laurence entered custody at the end of December 1998 and was commenced on a drug Olanzapine. There is no doubt he remained severely psychotic until his death. However his behaviour throughout his time in custody in terms of how he behaved to others could not be criticised. There is no objective evidence he posed any threat to any inmate or staff at the prison. In fact he was described variously as polite and quiet. There can be no doubt having regard to the events that brought him into custody that he would be there on some basis for some considerable time to come.

On the morning of the 19/10/99 Laurence was found dead in his bed with his face pressed into his pillow. There were no signs he had suffered any violence such that it would cause his death and that was confirmed on post mortem examination. I am satisfied from that examination also that any blow which may have been administered to Laurence by Fabian Long on the 18/10/99 did not contribute to his death.

At the date of his death Laurence was being medicated on prescription from Dr. Jager with 900mgs of Clozapine per day plus a low dose of Amitryptaline and Sodium Valproate. The Clozapine was being taken at 9 p.m. each day as a single undivided dose. He had been commenced on the Clozapine program on the 23/4/99 a little over 2 months after Dr. Jager assumed responsibility for his care. I am satisfied that the dose of Clozapine was in excess of the recommended dose of 600 mg/day. While there was evidence that doses could be increased to 900mg/day if it were thought to be clinically advisable, there was also evidence that such doses should be divided. Divided doses kept the level of the drug in a patient's body at a more constant level.

In this case not only does it appear that divided doses were never a considered option but also there was nothing in the clinical notes of Dr. Jager or the situation of Laurence Santos which would indicate the course of action Dr. Jager adopted, namely a persistent and consistent increase in dose of this drug in almost the shortest possible time suggested in the CPMS.

I am satisfied that Clozapine was a very potent and effective drug with patients with treatment resistant schizophrenia and that an acknowledged side effect was that it could cause death. The drug was to be administered under a strictly controlled protocol instigated by the drug's manufacturer. It is clear that knowledge relating to the use of the drug and its potential side effects

was constantly being updated and varied as evidenced by the changes explained to the inquest over the last few years. It is also clear that the drug was usually dispensed through clinics where specially trained staff had control of the program.

I am also satisfied that Dr. Jager persisted in the administration of Clozapine up to a high level in a situation where

- Laurence Santos had exercised his right to withdraw his consent to the taking of Clozapine on the 4/5/99,
- Laurence had been intimidated by the threat of a syringe by Dr. Jager into continuing to take the drug
- Laurence had refused on other occasions up to the date of his death to take any or all of the Clozapine as prescribed by Dr. Jager
- Laurence had complained in writing to the Ombudsman about the Clozapine he was being given,
- while there was evidence of continuing symptoms there was no evidence that Laurence was violent or antagonistic to any staff or other inmates he being consistently described as quiet and polite,
- there being many references in file notes to excessive drowsiness

I am also satisfied the drug was administered in an inadequately controlled environment for the level of dose and single dose being administered because

- there was inadequate training of all staff required to deal with Laurence as to side effects to be alert for,
- blood serum levels for the drug, while not an essential requirement of the protocol, may have been prudent given the level disclosed on the test at the end of July 1999,
- the time at which blood was to be taken for serum level testing was an important element of such testing. Such information either was not known by Dr. Jager or if he did know it he took no steps to communicate that information to staff and ensure it was recorded,
- the forensic file contains no evidence of any plan of management of Laurence nor a recording of the symptoms which would justify the constant increase in dose levels

I am also satisfied that Dr. Jager intimidated Laurence Santos into continuing to take Clozapine in the face of an ongoing reluctance to take it and that Dr. Jager failed in the terms of the College code of ethics to ensure he had Laurence's informed consent to that treatment.

I accept that the post mortem levels of Clozapine found in Laurence's system were significantly outside what might be considered as non-lethal but that such level would have been aggravated by the fact that Laurence is likely to have died at a time when a close to peak level of the drug might

have been expected. The evidence cannot satisfy me that the very high level found would have caused Laurence's death

Experts who gave evidence agreed that persons who suffer from schizophrenia may suffer from unexpected death irrespective of any medication they may be receiving. Dr. Lyons said the drug Clozapine was associated with epileptic type fits. He told the inquest the mechanism for that was effectively the same as for sudden unexpected deaths in persons suffering from schizophrenia in that for some reason there was increased electrical activity in the brain which could stimulate cardiac arrhythmia. This would not show on post mortem examination.

There was a body of evidence sufficient to satisfy me that in the period leading up to his death Laurence was suffering from a known side effect of Clozapine which was excessive drowsiness.

However notwithstanding my conclusions drawn from the facts put before me about Dr. Jager's treatment of Laurence, I must conclude that the precise cause of Laurence's death may never be known. There is strong evidence to suggest that Laurence was heavily sedated on the night he died due to the dose of Clozapine he was receiving. It may be that his respiratory system was so depressed by the medication, that he suffocated while lying with his face pressed in a pillow. He may on the other hand have been the subject of the process outlined by Dr. Lyons either as a consequence of the Clozapine or his schizophrenic condition.

I can say that I am satisfied Laurence did not deliberately take an overdose of the Clozapine having hoarded tablets because

- Laurence was clearly reluctant to take Clozapine,
- he was afraid of the consequences,
- there were frequent cell checks and no record of any hoarded quantity of drugs being found in Laurence's cell, and
- staff were observing Laurence particularly on taking of medication

Whatever caused Laurence's death , it is unlikely that more frequent cell checks on him would have saved his life. As to his environment in which he was housed, were his death as a consequence of his schizophrenia it is unlikely to have made any difference. Were his death due to the medication he was receiving, there is every likelihood that a more controlled environment may have seen a different regime of treatment which may not have resulted in his death.

CHAPTER 6 FABIAN GUY LONG

A. *Formal Findings*

I find that Fabian Guy Long ("Fabian") died in Cell 42, E Division, Her Majesty's Prison, Risdon on the 10/1/00.

I find that he was a male person born at Hobart on the 28/12/78. He was aged 21 years at the date of his death. He was at that time an inmate of the prison, serving a sentence pursuant to which he might have expected release in or about March 2000.

I find that he died as a consequence of neck compression due to hanging. I find that he utilised a piece of torn sheet, one end of which he tied around his neck and the other end of which he tied to a towel rail in his cell. He then suspended himself from the towel rail causing his death.

On the evidence available to me, I am unable to find that Fabian suspended himself with the intention of taking his own life. There is evidence which could support both that finding and a finding that Fabian suspended himself for the purpose of obtaining some form of sexual gratification but went too far.

Whichever occurred I find that the following contributed to Fabian's death:

a) Fabian himself in that, whatever his intent, he knowingly and of his own volition suspended himself from the towel rail
b) The DJIR in the form of the Corrective Services Division in that it failed to provide adequate systems of care which may have prevented the death
c) The DHHS in the form of the FMHS in that it failed to provide adequate follow up care to a patient released from its care in the prison hospital into the general prison population.

B. Discussion of Evidence Relating to Death

The evidence relating to Fabian was presented in the form of a number of affidavits, the oral evidence of the makers of most of those affidavits and a number of other documents and files. One document I did not have available to me was the prison file. It may have assisted to confirm Fabian's movements within the prison system and the reasons for transfers between prison yards which occurred from time to time. Its absence does not in my view affect the substance of these findings.

History

Fabian had first been seen by a psychiatrist, Dr. George, in January 1996 when he was just 17 years old following a referral from his general practitioner with a query about schizophrenia. It was reported to Dr. George that Fabian had been using marijuana over an 18 month period and that he had tried amphetamines briefly some 8 months before. Dr. George's view then was that Fabian did not exhibit all the classic first rank symptoms of schizophrenia. He only saw him three times between January and May 1996. [147]

There was evidence from inmates that they had known Fabian "*on the streets*" back in 1996 and reference to drug use at that time. There was evidence from Fabian's mother of behaviour of his of the type consistently reported to the time of his death going back to when Fabian was in his mid teens.

Fabian appears to have first entered Risdon Prison on the 10/7/97 at the age of 18 years. [148]He was remanded in custody on two charges of wounding. The events were said to have occurred at the beginning of July and on the 8th July. Fabian was placed in the prison hospital when remanded into custody. He remained in custody until the 12/12/97 when he was sentenced in respect of the second wounding incident to a term of 9 months imprisonment to date from the 11/9/97 with 6 months of the term to be suspended. The presiding judge, having heard evidence from Dr. Ian Sale and Dr. Wilfred Lopes, expressed himself satisfied that Fabian was suffering from a mental illness and that the mental disorder was of a nature or degree that warranted Fabian's detention in a hospital for medical treatment and made a hospital order pursuant to the Mental Health Act 1963. The order provided for Fabian's admission to the Royal Derwent Hospital but that he remain at Risdon pending his admission.

It appears that Fabian spent only a few weeks in the Royal Derwent Hospital but otherwise remained at Risdon moving between the hospital and the yards through until September 1998. On the 17th September, he was sentenced in respect of the first of the July 1997 wounding incidents receiving a second suspended sentence. That sentence operated such that Fabian was released that day. The next day his parents took him to the Department of Emergency Medicine at the Royal Hobart Hospital because of his behaviour. His mother continued to report bizarre behaviour to Dr. Lopes under whose treatment he had been while in custody.

Fabian remained in the community until being charged with assault in May 1999. He was remanded

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[147] See Forensic file - exhibit 154
[148] See Community Corrections file - exhibit 180

in custody and admitted to the prison hospital. He remained there for about a week and was then transferred to H Division. Late in June or early in July Fabian was sentenced to a period of 4 months imprisonment for this assault. He was released from custody on or about the 20th August. On the 3/9/99 Fabian was however ordered by the Supreme Court to serve the 3 months of the jail term suspended in September 1998 and was conveyed to the remand centre. He was admitted again to the prison hospital from there with a self inflicted knife wound. On the 28/9/99 Fabian was ordered by the Supreme Court to serve the 6 months of the jail term suspended in December 1997.

This history shows that between July 1997 and the day he died, a period of approximately 30 months, Fabian spent just over 21 of them in custody of some description.

Dr. Ian Sale, an experienced psychiatrist, saw Fabian in July 1997. He also obtained some history from Fabian's mother because of the difficulty of obtaining that from Fabian. His conclusion was that Fabian had a significant psychotic illness characterised by disturbance of affect and thought disorder. He said a precise diagnosis had not been reached although it was thought a schizoaffective disorder may be present. He said it was unclear whether the illness was a direct consequence of heavy drug use, whether it was aggravated by drug use or whether the drug problems were secondary to an underlying psychotic process.

Fabian was treated with anti-psychotic medication by Dr. Benjamin (a registrar in psychiatry under the supervision of Dr. Lopes or Dr. Sale) in the prison hospital. The effect was that on review on the 22/8/97, Dr. Sale felt that Fabian was fit to plead to the charges he was facing. He was also of the view that Fabian was suffering from a schizophrenic illness characterised by affective incongruity, auditory hallucinations and thought disorder.

On the 15/10/97 Dr. Sale again reviewed Fabian. His opinion was Fabian suffered from a major psychiatric disorder, namely Schizophrenia of an hebephrenic type. He said then he suspected the illness had been developing for some time and was probably hastened by the drug use. He said then that he felt Fabian would have psychiatric problems for the rest of his life and would need treatment and assertive follow up. He indicated he may need supported housing and even trustee arrangements. Dr. Sale reiterated similar sentiments in a report he wrote in November 1997 which was one of the reports which resulted in the hospital order made by the Supreme Court in December 1997. Dr. Lopes also provided a report to the Supreme Court in December 1997. His diagnosis of Fabian was the same as that of Dr. Sale with whom he had consulted about Fabian.

Dr. Sale did not see Fabian again until September 1999. During the intervening period Fabian had spent a large portion of his time in custody. During that time he was in and out of the prison hospital. The records show a pattern of behaviour similar to that described by Dr. Sale. They also show episodes of self mutilation. During times spent in the community over this period, Fabian was

non-compliant with medication and it appears continued his drug abuse. Attempts were made to monitor him through the outpatient part of the FMHS at the prison hospital but Fabian did not always attend his appointments.

Dr. Jager saw Fabian for the first time on the 26/2/99 as an outpatient of the FMHS. Dr. Jager agreed he read Fabian's forensic file which included the reports of the psychiatrists and psychiatric registrar all of whom had previously diagnosed Fabian as suffering from schizophrenia. His view however was that Fabian was a severely personality disordered individual with an anti-social and narcissistic profile. His condition was likely to be a psychopathic personality disorder and unlikely to be schizophrenia. Fabian was next seen by Dr. Jager on the 9/4/99 although Sister Barwick as the community nurse with the Forensic service had been liaising with Fabian's mother and community corrections to try to get Fabian in for medication in the meantime. On this visit, Dr. Jager reported Fabian was not then psychotic and that diagnosis was uncertain beyond polysubstance dependence and personality disorder. He was to see Fabian again on the 19/4/99 but Fabian did not attend that appointment.

Fabian was not seen again by Dr. Jager until the 24/5/99 and then the 27/5/99 when Fabian was in custody. Dr. Jager confirmed his view that Fabian had a personality disorder, there was no evidence of psychosis and that his problem was polysubstance dependence. He noted that Fabian had been non-compliant with anti-psychotic medication for the month before that and at review on the 27/5/99 his system was clear of amphetamines. Fabian was as a consequence discharged from the hospital and sent to H Division. Dr. Jager referred Fabian to the social worker in the Forensic team, Mr. Harris. Dr. Jager wrote a report for the Court of Petty Sessions on the 29/6/99 which was based on his interviews over a month before and a report prepared by Mr. Harris from one interview with Fabian on the 28/6/99. There is nothing to indicate in either report that any check was made with custodial staff as to Fabian's behaviour in the yards during the month he had been there. For the purpose of his report Mr. Harris made no contact with any family member despite Dr. Jager indicating he had thought he would.

Dr. Jager's view then expressed was that Fabian suffered from Amphetamine Dependence, Cannabis Dependence and Antisocial Personality Disorder but not Schizophrenia. Dr. Jager in his oral evidence conceded that the absence of psychosis in the May visits in the context of non-compliance with anti-psychotic medication could have meant a remission in symptoms rather than a diagnosis other than schizophrenia.

Fabian remained in the general prison population until the 15/7/99 at which time he was returned to the hospital following self mutilation. He was treated and returned to the yard. On the 22/7/99 he was readmitted following concerns of staff about his hearing voices. The nurse who dealt with

him on admission noted descriptions of hearing voices, hallucinations, illusions about body wasting away and of attempts to hang himself to gain sexual gratification. Fabian was placed on suicide category B. Fabian's behaviour over the next few days was described by nurses as bizarre.

Dr. Jager reviewed Fabian and on the 26/7/99 took him of all categories and discharged him back to the general population. He was to be seen by the psychologist after that. There is no record of the psychologist seeing Fabian between the 20/7/99 and the 8/9/99 although it should be noted Fabian was released from custody about the 20/8/99.

Fabian was readmitted to the prison hospital from the Hobart Remand Centre on the 4/9/99 with a self inflicted knife wound and placed on S (segregation) category. Medical notes indicate he was placed on a suicide category on the 6/9/99 and that over the next few days his behaviour was bizarre and there were concerns he may commit suicide. A psychologist saw him on the 8/9/99 and referred him to Dr. Jager because of the concerns she had about him. Dr. Jager saw him on the 9/9/99 and confirmed his previous diagnosis. He also noted that Fabian had an extremely poor prognosis and that he was a likely long term suicide risk.

Dr. Jager saw Fabian again on the 12/9/99 and 16/9/99 and on the second occasion prescribed Modecate and Benzotropine (Cogentin). He saw him again on the 26/9/99 and then wrote a report for the Supreme Court. In that report it was indicated that it was possible but less likely that Fabian suffered from schizophrenia. Dr. Jager believed that Fabian was at high long term risk of committing acts of violence and possibly suicide.

Dr. Sale saw Fabian on the 20/9/99 and had a discussion with Dr. Jager about him. Dr. Sale disagreed with Dr. Jager's diagnosis describing Fabian's behaviour as clearly psychotic and unlikely to arise out of drug abuse because he had been in custody for some time by then. Dr. Sale said in a report of the 21/9/99 that Fabian represented a very difficult clinical management problem because of his lack of insight, his poor treatment compliance and his propensity to abuse drugs. He said he would need assertive clinical follow up, that is a mechanism to require him to attend for treatment to comprise regular administration of depot anti-psychotic drugs. While Dr. Sale disagreed with Dr. Jager's diagnosis of Fabian he said that the treatment Dr. Jager was giving Fabian, that is the anti-psychotic drugs, would have been what he would have done anyway. Dr. Sale did not see Fabian again.

Dr. Sale outlined in his evidence that a personality disorder as diagnosed by Dr. Jager was not actually considered a mental illness. Schizophrenia was. While the central plank of treatment for schizophrenia was likely to be medication, medication was only given to patients assessed as suffering from personality disorders to relieve short term distress. While therefore Dr. Sale remained

adamant that Fabian suffered from schizophrenia he agreed the medication prescribed by Dr. Jager to relieve what he perceived to be symptoms of distress in a personality disordered person was largely appropriate. Dr. Sale in fact agreed subject to some differences about the level of medication that the way Dr. Jager dealt with Fabian in the hospital was appropriate.

It is clear in relation to the issue of the disputed diagnosis that Dr. Jager himself appeared to be a little ambivalent about the actual diagnosis in reports and Dr. Kelsall , the pathologist who attended the scene of death on the 10/1/00, was quite clear that Dr. Jager had on that night described Fabian to him as being an unstable schizophrenic. Dr. Jager did not recall saying this to Dr. Kelsall. He thought he may have used the term borderline PD and said he was treating him for schizophrenic like symptoms.

Fabian remained in the hospital until the 4/10/99 when Dr. Jager approved his discharge back to the yards. Up to that date there had been nursing notes indicating self harm and a threat to kill himself. However when Dr. Jager reviewed Fabian on the 4/10/99 he found him not to be suicidal.
Fabian came back into hospital on the 14/10/99. The medical officer Dr. Beadle referred him to Dr. Jager saying Fabian was actively psychotic. Dr. Jager's response was that Fabian's psychotic and pseudo-psychotic symptoms persisted. He saw his self harming as that of a borderline personality disorder in crisis and believed it would continue. He said whether Fabian had schizophrenia or not was somewhat moot because he was treating his symptoms with Modecate although with little response. He then commented that time would be informative.

From the progress notes and forensic files it appears Fabian's behaviour in hospital continued to be erratic but he was calmer. Then about the 22/11/99 nursing staff began reporting that Fabian was having episodes of screaming, that he was apparently responding to auditory hallucinations and that he was crying and sobbing. He was saying the voices were driving him mad.

On the 24/11/99 Nurse Norris referred Fabian to Dr. Jager. She noted in the referral what her concerns about Fabian were and listed them as response to auditory hallucinations, olfactory hallucinations, nihilistic delusions, recent evidence of self mutilation and sleep deprivation. Dr. Jager saw Fabian on the 25/11/99 and said that Fabian had severe borderline personality disorder and was at on going risk of self harm. He said further that the situation was chronic and that there was very little that could be done. He suggested setting Fabian tasks and that he be given a job or pastime. He referred Fabian to Mr. Ian Balmer, the Clinical Nurse Consultant, Programs and Psychiatric Services, to look into this. Fabian's behaviour continued as before and some self harming behaviour was noted.

On the 2/12/99 it was reported that Fabian was responding to auditory hallucinations and slapping himself repeatedly. He was saying that voices were telling him to kill people. He was given medication to calm him. He was seen by Dr. McCarthy, the psychologist on the 3/12/99, she having discussed at length with Mr. Balmer on the 30/11/99 an activity program for Fabian. Mr. Balmer also asked Dr. McCarthy on the 2/12/99 to do tests with Fabian to confirm the presence or absence of psychotic thoughts. Dr. McCarthy did see Fabian but advised Mr. Balmer that she would need to see him for a few sessions to settle him down enough to do the testing because he was suspicious of questions. This never occurred.

On the 6/12/99 in a ward round it was indicated that the Education Department had said they would enrol Fabian in activities. Dr. Jager then saw him and reported some improvement. On the 13/12/99 Dr. Jager reviewed Fabian again. According to Nurse Thompson this review lasted no more than ten minutes. She had Fabian show Dr. Jager burns on his arms because she thought they had in fact been burnt again. Dr. Jager noted there were burn marks on Fabian's wrists (He referred to their being about 5 days old but Nurse Thompson said no time was mentioned and she believed they were much newer because they hadn't scabbed over), that he had taken part in education and there was a transient settled period. Fabian was approved for discharge back to the yards and went to H division on the 14/12/99. Fabian had asked to return to the yards. H division, as E division, was a protection yard and was generally used as an overflow yard.

Fabian was reviewed again by the Forensic team on the 16/12/99 and the 6/1/00. Between these reviews he was moved from H division to E Division on the 31/12/99. Dr. Jager noted on the 6/1/00 that Fabian had not progressed with the education program and there were hallucinations and preoccupations with his step father raping his friends. Dr. Jager noted that Fabian's symptoms were not adequately controlled and increased the dosage of Modecate. That increase was not however to take effect until Fabian's next injection was due which was not for some days.

The evidence from custodial officers was that they were given no information at all about Fabian's condition nor any risks which may have been associated with it when Fabian came back to the yards on the 14/12/99. They assumed he was fit to be there. When he went to E Division Fabian was housed in Cell 42 on E division. That cell was upstairs almost opposite that in which Chris Douglas had been housed. It was also a duplicate to all intents and purposes of Chris Douglas'. It had the same disused heater rails, a metal frame bed, bars on the front window and a towel rail above the sink and toilet.

Events of the 10/1/2000

Fabian had been in E yard only 10 days on the day he died. He had been moved there at his own request from H yard although the officer who processed the transfer had no idea why he wanted it. That officer, CO Barker, found Fabian easy going and happy. He had no idea why he was in what was agreed was a protection yard and did not think he had any enemies. CO Barker knew Fabian had been in the prison hospital but had no idea why. CO Lehner said that when Fabian arrived in the yards there was no information provided by the hospital, management or the forensic team about him. He thought the reason why no information was passed about anything including medication was privacy requirements but he did not understand why. He did not know of any diagnosis of schizophrenia.

SCO Van Leeuwen was the accommodation supervisor on the day Fabian died. He had been on leave. He knew Fabian from previous visits to jail and described him as a source of work. He said Fabian came to the attention of custodial officers regularly and it was almost as if he was not responsible for his actions. He would say he heard voices and he cut and burned himself. When SCO Van Leeuwen went on leave Fabian was in the hospital. When he came back to work on the 10/1/00 he said he was surprised to find Fabian in the yards.

At about 3 p.m. on the 10/1/00 SCO Van Leeuwen had a conversation with two inmates who told him that Fabian was not taking his medication but hiding it and swapping it for tobacco. Fabian had, according to records, attended both morning and lunchtime medication parades that day and collected PRN doses of Thioridazene.

SCO Gridley worked the 3 p.m. to 11 p.m. shift on the 10/1/00. He became the Operations Senior at or around 5 p.m. and was effectively then in charge of the jail. He saw Fabian at meal parade that day at about 4.20 p.m. and said he seemed in good spirits. Nurse Cassidy described Fabian at the afternoon medication parade as happy, bouncy and outgoing. He was given Thioridazene but no Cogentin at that time. Nurse Cassidy said he did not think Fabian was suicidal but described him as reckless. SCO Van Leeuwen said that when Fabian came to get medication at the afternoon medication parade he made sure he took it

CO Lehner was on duty in E yard from 11.30 a.m. on the 10/1/00. He locked Fabian in his cell at approximately 4.50 p.m. He said Fabian did not appear depressed or unhappy. In fact he said that Fabian seemed happier and was more polite than during other dealings he had had with him. He did not notice any bruising around Fabian's eyes that day.

Inmate Halliday saw slash marks on Fabian's chest and cigarette burns around his nipples in the period before he died. He said Fabian used to walk around the yard without his top and told Halliday he had made the marks himself. Halliday also said Fabian had black eyes before he died and that he had said he had done them himself. Halliday said the black eyes were there the day Fabian died although "*not as bad*". Inmate Bell also said that Fabian had a black eye the day he died although not a really bad one.

Inmate Bell described Fabian as being rather quiet on the day he died and said the last thing Fabian said to him was "*See you tomorrow Belly*". He also said Fabian said the day he died that he wished he'd never got off his medication. Bell said Fabian would talk about hearing voices in his head, he would slap himself at night and he saw him with cut marks on him.

Inmate Armstrong who occupied the cell next to Fabian said Fabian had cut and burnt himself in the days before he died and had also given himself black eyes. He said Fabian had told him the day he died that voices were taking over his body. He described Fabian as yelling out at night after lockdown and of hearing him slapping himself. Armstrong spoke of banging on the wall of his cell to get Fabian to stop.

Inmate McKenna, who occupied the cell on the other side of Fabian's from Armstrong, had known Fabian since meeting him on the streets in 1996. He said he lost touch with him but came across him again in E division in December 1999. He said Fabian appeared normal during the day but at night he would hear him slapping himself and crying out "*leave me alone*" and "*get away from me*". He said Fabian told him he was hearing voices. Inmate McKenna also noticed black eyes a couple of days before Fabian died and said Fabian had told him he had done it to himself because voices told him to do it. The black eyes he said were really just marks under the eyes. He also noticed cuts and burns on Fabian. McKenna said he mentioned these things to Custodial Officers Lehner and Morgan who told him that the prison "psych" had said Fabian was okay to be in the yard. Inmate McKenna also said that on the day Fabian died, he and Fabian had been making plans to have a party on their release from jail.

CO Lehner put the Jackson lock on Fabian's cell at about 5.20 p.m. and he said Fabian was okay then. He then walked past his cell again at about 5.55 p.m.. CO Lehner said in relation to that he had no independent recollection of seeing Fabian at that point but he was sure he would have noticed if there had been a problem.

Inmate McKenna said after lockdown he had heard Fabian slapping himself and after about 10 minutes he had banged on the wall and Fabian had quietened down. Fabian then turned his radio up

quite loud. It seems the last positive sighting of Fabian alive was by CO Lehner at about 5.20 p.m. although from Inmate McKenna's evidence Fabian was still alive shortly after 5.30 p.m.

At about 6.30 p.m. CO Lehner began a check of inmates in E yard. He got to Cell 42 (Fabian's cell) and looked in the window. He saw Fabian kneeling on the ground with his back to the window. He saw a white piece of cloth around his neck tied to something on the wall. CO Lehner was carrying an F yard personal alarm and he activated it. He had no cell keys. He called for help and a number of officers came. He had no recollection of who opened the cell. When the F yard alarm went off, it appears that CO Barker was in the mess room with CO Carnes. SCO Gridley was in the operations office doing paperwork. CO Barker ran to E Division and CO Carnes ran to main gate 1 to get cell keys. SCO Gridley left his office, unlocked the cross gates, entered the division front and went up the Cell 42.

SCO Gridley says that he was given the cell keys from main gate 1 at the cross gates by CO Carnes as they both headed towards E division. CO Carnes says she threw them to him outside cell 42 after she arrived there, she having first stopped en route to put her gloves on just in case there was a blood spill. This seems an extraordinary thing to have done given that as far as she knew the priority was to get the cell keys to the division. SCO Gridley, it then transpired, had cell keys already in that he still had the emergency keys in his possession which he carried as operations senior.

When CO Carnes arrived at the cell someone said that Fabian was hanging. She went downstairs to the division office to get the cut down knife and the resuscitation mask. SCO Gridley unlocked the cell and went in. SCO Gridley and CO Barker lifted Fabian and CO Lehner cut the material from which Fabian was hanging. Fabian was laid down on the floor. Both CO Barker and SCO Gridley said they checked Fabian's pulse and that there was none. CO Barker said Fabian was cold to touch.

SCO Gridley shook Fabian to see if he could get a response and then began CPR with CO Barker. Vomit was coming out of Fabian's mouth. CO Barker said he thought Fabian was still alive. SCO Gridley however said it was obvious he was dead. CO Barker and SCO Gridley were overcome by the smell of the vomit and CO Barker left the cell retching. CO Barker said that SCO Gridley had by then stopped CPR and said "*It's finished*". He also left the cell.

At that point Nurse Norris arrived from the prison hospital. She noted the time as 6.37 p.m. as she went from the hospital to the cell. She said there were a number of officers standing outside the cell. She asked "someone" to call an ambulance and Mr. DeBomford, the Director of Nursing. She entered the cell and checked Fabian's pulse and found none. She said he was blue in the face, his tongue was hanging out, he was cold to touch and there was vomit on the floor of the cell. She believed at that point Fabian was dead but commenced CPR anyway. Vomit continued to come out.

She stopped believing there was nothing further she could do and left the cell. She did not know then that CPR had already been attempted. Both CO Barker and SCO Gridley said they saw blue patches on Fabian's skin. All observers said that Fabian was only wearing underpants when he was found. There was a difference of opinion as to whether they were wet or dry.

Nurse Norris went from the cell to the E division office and telephoned Mr. DeBomford. She then returned to the hospital.

SCO Gridley said in the affidavit he swore [149]that after the nurse arrived he went to his office and made the required phone calls and that 15 minutes later he went back and secured Fabian's cell. In his oral evidence, he said that he actually went to main gate 1. He said he told the officer there, SCO Woisetschlager, to make all the required phone calls to personnel involved with a death in custody. He then added that he said "*on the action list*". He said he assumed that SCO Woisetschlager called an ambulance. SCO Gridley acknowledged that he did not at any time before that either call an ambulance himself or instruct anyone else to do so.

The evidence of SCO Gridley and SCO Woisetschlager was in conflict about what was actually said when SCO Gridley went to main gate 1 which it appears he did. CO Woisetschlager was adamant that SCO Gridley told him there had been a hanging and told him to call the on call officer and tell him about the hanging and call the police. SCO Woisetschlager said he asked, what about an ambulance, and was told that none was required.

I accept the evidence of SCO Woisetschlager over that of SCO Gridley in this regard. SCO Gridley's evidence about the sequence of events differed between his affidavit and his oral evidence. Further the steps he took on the night of Fabian's death would indicate that he was not thinking particularly clearly and his suggested clearly stated words to SCO Woisetschlager are just not in keeping with the rest of his behaviour.

In this regard I refer to the following matters. SCO Gridley stated he saw the E yard alarm when all other evidence was it was the F yard alarm which was activated. He left his office to go E yard and left his two way radio, his direct means of communication with main gate 1, in his office. He was the senior officer present in the prison that night and at the cell and yet had ceased resuscitation attempts or caused them to be ceased and left the cell before any nurse or doctor arrived. He then did not ensure that that nurse was made aware as it appears that she was not, that any resuscitation attempts had already been made. He then walked to the main gate 1 office to give instructions to SCO Woisetschlager rather than accessing the internal phone in the offices beneath the cell where

[149] See affidavit sworn 10/1/00 - exhibit 157

he was. He of course could not avail himself of the even quicker mode of communication namely his two way radio because he had left that in his office.

SCO Gridley's explanation for not taking his radio with him when he left his office was that it was on his desk and not on his belt because it tended to fall off when it was attached to his belt and he sat down. He said that getting to the division was uppermost in his mind. After some pressing by Counsel Assisting he did agree it may have been prudent to take it with him.

The end result was that no ambulance was ever called to attend Fabian.

It appears that kept in the main gate 1 office were what were described as "*action* " lists. One related to what to do in the case of a suicide [150] and one related to what to do in the event of a death in custody [151]. The effect of both is that an ambulance is only to be notified "*on advice from medical staff*". SCO Woisetschlager says he was never so instructed and so he did not call an ambulance.

A post mortem was conducted in relation to Fabian. The cause of death outlined by Dr. Kelsall in his report [152] was neck compression due to hanging consistent with suicide. He found multiple scars on Fabian's body consistent with the reported self mutilation. He found no other injuries and no signs of any disease. Toxicology results showed no evidence of any drugs or alcohol in Fabian's system save a therapeutic level of Thioridazene.

Issues Arising

Diagnosis of Fabian

The evidence relating to the difference of opinion as to diagnosis of Fabian has already been canvassed. In summary it appears that all professionals dealing with Fabian apart from Dr. Jager (all of whom were significantly more experienced in their fields than Dr. Jager and had more experience with Fabian than he did) believed Fabian suffered from schizophrenia.

I am satisfied that the correct diagnosis of Fabian was that he suffered from schizophrenia and that Dr. Jager incorrectly diagnosed Fabian.

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[150] See exhibit 158
[151] See exhibit 159
[152] See exhibit 307

Colin Baldwin, an officer with probation and parole who had no psychiatric qualifications, outlined many concerns flowing from problems with diagnosis in his affidavit[153]. While many of his statements were emotive and he was obliged to admit under examination from Dr. Jager's Counsel that many of his statements had been made without knowledge of what was in Fabian's forensic and medical files, there were valid concerns expressed by him about Fabian at times not being adequately helped by "the system". Mr. Baldwin expressed frustration in being unable when Fabian was in the community to ensure Fabian got what he and others perceived to be needed help. It was perceived that the most effective help for Fabian would be available to him within the prison system.

Notwithstanding the position relating to Fabian's diagnoses, the intent shortly prior to his death was that Fabian receive medication which was appropriate for him as a person suffering from schizophrenia. The significant detrimental effect on Fabian which it may be said flowed from the differences of opinion over diagnosis was that he did not receive the intensive type of care including controlled medication arrangements envisaged by Dr. Sale

Risk of Suicide/Risks in Release to Yards/PRN Medication In Yards

While Fabian was not housed in N Division at the date of his death he had been in earlier times. Dr. Jager agreed that the adverse effect of that division on a person who was acutely mentally ill would be significant.

Dr. Jager responded to a referral by Nurse Norris relating to Fabian on the 25/11/99 by saying

> *"Fabian has severe borderline personality disorder and I agree is at ongoing risk of self harm. This is a chronic situation about which we can do very little. I advise setting Fabian tasks and getting him a job/pastime. Ian Balmer should be notified of this please. When distressed use Thioridazene 50mg prn q2h."*

Dr. Jager responded in very similar terms to the medical officer at the prison on the 15/10/99 when that officer referred concerns about Fabian's psychotic state to him. Dr. Jager had previously stated in court reports that he considered Fabian to be at long term risk of suicide. He described his future as gloomy. Detective Gilbert gave evidence of a brief conversation he had with Dr. Jager on the 12/1/00 when Fabian was mentioned. He said Dr. Jager told him Fabian was potentially suicidal and that he had told prison authorities that. There was no other evidence as to the form in which that communication is said to have occurred nor of any such specific communication.

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[153] See affidavit sworn 3/4/00 - exhibit 179

Nurse Norris' view was her referral had not been given adequate attention by Dr. Jager. She however agreed that if regard were had to all the entries in the forensic file there appeared to have been quite constant steps being taken in relation to Fabian while he was in hospital. Nurse Norris' evidence highlighted two organisational problems. One was the maintenance of 2 files for each forensic patient within the hospital, one medical and one forensic neither of which contained the entire picture for a patient. Dr. Sale also adverted to this problem. The second was the apparent lack of day to day communication between staff not part of the forensic team but employed to care for forensic patients in the hospital and the treating psychiatrist. People such as Nurse Norris, a psychiatrically trained nurse, dealt with patients such as Fabian daily and clearly had a better opportunity to observe these patients than Dr. Jager did.

Fabian's behaviour between the 25/11/99 and the 13/12/99 when he was passed for release to the yards by Dr. Jager was not, according to both the medical and forensic files, markedly different from that which had caused both Nurse Norris and Dr. Beadle to refer Fabian to Dr. Jager. He was having screaming episodes apparently in response to auditory hallucinations, he was distressed, he was agitated, he still said his body was changing, he was slapping his face repeatedly and on the 2/12/99 he said he heard voices telling him to kill people. Dr. Jager however assessed on the 6/12/99 that Fabian was not using the PRN medication to excess and hence he could go to the yards given that he wanted to.

Dr. Sale said in his evidence [154] that the mere presence of a diagnosis of schizophrenia did not necessarily mean a patient had to be in hospital. He indicated a number of matters would need to be taken into account such as the patient's wishes, the degree of disorder, the particular sort of problem behaviour being exhibited, whether the behaviour was disorganised and the level of treatment being administered. He saw no particular problems with the prescribing of Modecate and Mellerill in the prison yards *"providing you make sure the dispensing arrangements are reasonable"* and *"you have fairly tight dispensing arrangement for the medication"*.

Dr. Sale was also asked questions about the use of PRN medication. He was asked if he could conceive of a situation where PRN medication might be prescribed for a person not subject to nursing observation. He responded

> *"Only in circumstances where you had a patient who had very good insight into their situation, and you knew them for a while, and understood that they were trustworthy, or if they were with reliable dependable family members or friends who could act as a sort of locum nurse. But not otherwise. No."*

[154] See transcript page 1678

When the dispensing arrangements in the prison yards were outlined to him, he said he would not be happy with that arrangement and he would want there to be more interaction between patient and nurse. He also expressed concerns about the voluntary nature of attendance by inmates at medication parade and the lack of formal protocols for notification to the treating doctor of a failure to take medication. He said he would want to know if only one dose of Thioridazene were missed.

Dr. Sale conceded that, while on the basis of his knowledge of Fabian and the entries in the files he would not have considered Fabian to be a suitable candidate for release to the yards, Dr. Jager as the person who actually saw him would be in a better position to make that assessment. However even Dr. Jager described Fabian as insightless.

Fabian was clearly an inmate at risk of some form of self harm when he returned to the general prison population on the 14/12/99. The question which arises is should he have been discharged to the yards in those circumstances and if so, were there sufficient safeguards in place to ensure, as far as it was possible to do so, that he did not harm himself while there. This is really one issue because it may be that, had sufficient safeguards been in place, it may have been appropriate to put Fabian back to the yards.

On the evidence I cannot be satisfied that it was a sound decision to return Fabian to the yards given his recorded behaviour and the recognition by Dr. Jager of the risk Fabian posed to himself which he, Dr. Jager, had recorded in reports and in response to Nurse Norris. He most certainly should not have been there at the date of his death. There are a number of reasons why.

Firstly, the evidence of the custodial officers dealing with Fabian in the yards on a day to day basis was generally to the effect that

- they were given no information by the hospital or forensic team about Fabian's mental state on his return to the yards,
- they did not know necessarily whether he was even on medication. If they did they did not know what it was or what it was for,
- they had no form of briefing as to any matters they should take note of in relation to Fabian which might suggest he needed further or other treatment,
- they generally assumed that because he had been sent back to the yards, Fabian was okay to be there.

Whether there was any particular reason for this lack of communication was not clear. I suspect there was not given the pattern which emerged from the evidence about the lack of communication generally between the hospital and the general prison. Dr. Jager referred during his evidence about

the need for patient confidentiality generally. This in my view must be balanced against the duty of care that both the DJIR and the DHHS have to inmates who remain in their care. To expect custodial officers to be alert for problems with Fabian when they had no idea what to look for was expecting the impossible.

Secondly, Fabian was discharged to the yards on a combination PRN and, for want of a better word, "compulsory" medication. PRN medication was to be had as required and, had Fabian been in hospital, would have been given in the discretion of nursing staff as needed. The drug charts applicable to Fabian in the last few weeks of his life [155] show that Fabian had PRN medication spasmodically and his "compulsory" medication irregularly. In fact in the early days of January 2000 there were at least 4 days according to Fabian's drug charts when Cogentin was not given and a number of times when Thioridazene was not given, both of which were "compulsory" medication.

The accuracy of the drug charts was called into question and Director of Nursing DeBomford conceded they were not always accurate because of human error. However in this case he believed they were in so far as they indicated a failure on Fabian's part to take "compulsory" medications because the failures were scattered over a prolonged period and they related to a range of medications and not just one. It was suggested to him that 2 clear errors in Thomas Holmes' drug charts might suggest Fabian's were also wrong. However I accept his view because of the reasons given for it which did not apply to Thomas Holmes.

Nurse Cassidy said in his evidence [156] that for PRN medication to be successfully administered a patient normally requires close nursing observation, a view Director of Nursing DeBomford agreed with. Nurse Cassidy agreed it would be very difficult to successfully administer such medication in the yards, in fact almost impossible to make a determination about need for the medication. However as far as Fabian was concerned, from his knowledge of him, he would come looking for medication rather than avoid it. Mr. DeBomford said that in his experience as a psychiatric nurse patients with schizophrenia were well known to be reluctant to take medication and it was only with long term stable inmates would nursing observation for PRN medication not be as critical.

Dr. Jager said that at the review on the 6/1/00 he could not remember if he had the drug charts with him. Given the evidence as to the fact that they remained stored in a drug charts folder while medication was being given it is extremely doubtful they were with the forensic file on that day. When asked if he knew whether or not Fabian was compliant with medication he responded that medication charts at the hospital were often an inaccurate record of the actual level of dispensing

[155] See exhibit 142
[156] See transcript starting page 1652

of medication. He went on to say that if the charts were wrong he would have no idea about compliance. He conceded that there was nothing in the files to give him any degree of confidence about the level of compliance and he had no advice from nursing staff about the issue. Notwithstanding that lack of knowledge Dr. Jager increased the dosage of Modecate.

Further in the knowledge that as at the 6/1/00 Fabian's symptoms were not being adequately controlled, the new Modecate dose would not be given for another few days and Dr. Jager had it seems no firm knowledge as to compliance with medication to that point, Dr. Jager did not check compliance at all after the 6/1/00.

It was conceded that there was no nursing observation of inmates in the yards (save perhaps for the brief moment if an inmate came to medication parade) and that attendance at the medication parade while an inmate was in the yards was voluntary. There was no protocol in place for the notification to a prescribing doctor that an inmate was not taking medication it apparently being in the discretion of dispensing nursing staff whether they brought such a matter to the doctors notice.

Nurse Edwards said in relation to such matters that there were so many inmates taking medication for psychiatric problems they did not see it as important to document a failure to take medication. He also added that the nurses dealt with so many inmates, implying it would be too much work anyway. The attitude displayed by this comment was less than professional.

In Fabian's case not only was the lack of medication not specifically ever brought to Dr. Jager's notice but also he, Dr. Jager, appeared to have doubts about the reliability of the drug charts generally. In that climate to rely on an inmate as erratic as Fabian to know precisely what he needed by way of medication was incomprehensible. Clearly however that is what Nurse Cassidy (in answering questions put to him by Dr. Jager's Counsel) suggested should occur. He agreed with the proposition that Fabian's use of PRN medication was an indicator of how settled he was. Given the quite distinct possibility that Fabian may not have actually been taking even the medication he was collecting, this would have been a dubious indicator.

Thirdly, Dr. Jager had expressed the view that Fabian needed to be occupied and had asked Ian Balmer to organise education. However the forensic file shows [157] a note by Dr. Jager on the 6/1/00 to the effect that Fabian had not progressed with his education program and maintained an ambivalent attitude to it. Fabian had been known in the past to say he self mutilated out of boredom. Combine the lack of activity specifically advised as needing to occur, the note on the 6/1/00 that Fabian's symptoms were not adequately controlled, the lack of nursing observation in

[157] See clinical notes 6/1/00 in exhibit154

the yards and the lack of knowledge in custodial staff that there could be a potential problem and why and you would have to ask why no warning bells were sounded about Fabian's safety.

Fabian spent the last 4 weeks of his life in the general prison population and without anything in particular to occupy him. As a consequence there was no observation of him on any regular basis by trained nursing staff. A number of custodial officers, nursing staff and inmates commented in evidence on whether, from their perspective of Fabian, he should have been in the yards. In very general terms, many did not think he should have been in the yards because of his self mutilation and his strange behaviour. This included the medical officer Dr. Beadle who said that based on what he observed on the 15/10/99 he would have said Fabian was not fit to be in the yards. Few actually considered him to be actively suicidal although most recognised his inherent instability.

Dr. Jager himself acknowledged that on the 6/1/00 he made no inquiry of Fabian about suicide, that he did consider on the 6/1/00 re-admitting Fabian to the hospital but did not do so because he did not think Fabian needed hospital supervision and he knew Fabian did not want to be there. Dr. Jager also conceded making a statement reported by staff that he thought Fabian would be dead by Christmas.

Cell Checks

There clearly remained confusion amongst custodial staff as to the times at which cell checks should be done. CO Lehner said that since Chris Douglas' death he had checked inmates half hourly if they were locked in their cell.

CO Carnes said there was confusion about this. She said she was taught standing orders stated hourly checks but that there was a memo saying checks should be half hourly. She said she checked hourly. Her evidence was there had been no changes to procedure after Chris Douglas died. She thought management were thinking about bringing in half hourly checks but it hadn't happened. The evidence of other officers also demonstrated the same level of confusion.

As far as Fabian was concerned it appears that it was not so much the timing of the cell check which may have helped him but the nature of it. The evidence was CO Lehner did go past the cell at 5.55 p.m. but he has no independent recollection of seeing Fabian alive. While there is no evidence as to precisely when Fabian died and evidence relating to other deaths suggests death from hanging can occur very quickly, it can only be said to be possible that had CO Lehner done a more thorough check at 5.55 p.m. he may have been alerted to Fabian's situation.

Communication Between Prison Hospital/General Prison Staff about Inmates

The evidence from custodial officers working in the general prison population was that they were provided with no information by the hospital, forensic team or management as to inmates sent from the hospital to the yards. It appears the only information such officers may have had was gained from their doing work in the hospital when an inmate was there or gossip.

Dr. Jager agreed in his evidence that there was no formal flow of information in relation to inmates from the hospital to the main prison and that it would be beneficial if there were.

Training of Custodial Staff

Clearly once an inmate is in the yards there is a dependence on custodial staff to recognise a psychiatric, psychological or behavioural problem of a nature that may require intervention. SCO Gridley, being the senior officer in charge on the night Fabian died, gave evidence he had no training in determining if someone were depressed.

CO Barker was asked about training to deal with the type of crisis he and other officers faced on the night Fabian died. He said he had had none. This was a feature of the evidence of many other custodial officers.

To rely on untrained staff to discharge duties under the Corrections Act is a clear abrogation of responsibility by the DJIR.

Auto Eroticism

There was evidence from both custodial and nursing staff that Fabian frequently was naked in his cell and that he had been observed to be masturbating several times in a day. When in the yard he would walk or lie around without a shirt. Both inmates and staff reported rumours of Fabian choking himself while masturbating to heighten his level of gratification. Nurse Cassidy gave evidence that he had been talking to a group of inmates about hanging or choking and that Fabian had said it was cool and he got a buzz from it. Nurse Norris who had had extensive dealings with Fabian described him as a sexual young man and an exhibitionist. He had earlier been described as reckless.

Fabian had been seen by staff to tie cloth around his wrist and tighten it until his hand started to go purple.

Standing Over of Prisoners for Drugs

A number of custodial officers and nursing staff gave evidence they had heard of this practice. One even named possible inmates responsible for it. Of those inmates who were named who gave evidence they denied they had been involved in that. There was no persuasive evidence before me that the practice existed or that, if it did, it was widespread. Custodial staff and inmates conceded illegal drugs were available within the prison.

Availability and Use of Two Way Radios

SCO Gridley's approach to the use of a radio has already been dealt with. SCO Van Leeuwen gave evidence that although he would normally have been issued with a radio, when he came back to work from leave his was being repaired. He was not supplied with a replacement. The only other radios in existence at the time were held by officers in management positions who effectively went off air at about 5 p.m.

The availability of a radio as a source of speedy communication on the night of Fabian's death may not have saved his life. However it is clear the overall process of getting medical help to his cell would have been speeded up if, as soon as SCO Gridley became aware he was dealing with a hanging, a radio was used to alert the nurse. The process would have been even faster if CO Lehner had had a radio with him.

The evidence was that custodial officers even at night were not issued with radios.
This remained the case at the time evidence was taken at the inquest starting in March 2000.

Action Lists at Main Gate 1

While custodial staff and nursing staff were quick to minimise the time taken to reach and unlock a cell in the event of a possible suicide, it seemed that, in so far as knowing exactly what they should do, staff acted haphazardly. The evidence disclosed there was no clear protocol dictating what officer had responsibility for what step. The collection of keys from main gate and the collection of a cut down knife were examples of this. There was confusion as to whose responsibility it was to request an ambulance. Because of that none was called.

It appeared that the action lists put in evidence only related to the duties of the officer in main gate 1 who apparently did not even know there had been a hanging until SCO Gridley walked there from Fabian's cell after waiting for the nurse. If as appeared to be the evidence the main gate 1 office is

the nerve centre of the prison at night priority should be given to notifying the officer there of what has occurred. Greater priority should perhaps also be given to the calling of an ambulance.

Action lists or protocols for both main gate officers and general custodial staff directing the steps each should take in the event of an emergency would be advisable.

Conclusions

Putting to one side the issue of Fabian's diagnosis, his care while in the prison hospital seems to have been appropriate. I am satisfied that the diagnosis by Dr. Jager was however wrong and that this mis-diagnosis had ramifications detrimental to Fabian.

I am satisfied that when Dr. Jager discharged Fabian to the general prison population, he was well aware of the risks inherent in his behaviour. I am also satisfied that having then released him, Dr. Jager did not make adequate arrangements for his ongoing monitoring and care. In particular he failed to ensure that a system was in place which would allow Fabian to be properly medicated.

As a consequence Fabian's bizarre behaviour was not checked and he was placed in an environment where suspension points were abundant and monitoring was almost non-existent.

CHAPTER 7 RISDON PRISON HOSPITAL/FORENSIC MENTAL HEALTH SERVICE

All the inmates whose deaths are the subject of this inquest were either current or former patients of the FMHS. The quality of care provided by that service to those inmates and inmates generally came under scrutiny. That scrutiny was perhaps closest in respect of Dr. Alan Jager the Clinical Director. There was clearly concern at times as to the relevance of the extent of the inquiries made into Dr. Jager's background and activities. It is important in this regard to refer again to Section 28(5) of the Coroners Act 1995 which mandates that I report on the care supervision or treatment of persons who die in custody.

A number of persons and entities had a role in the care, supervision and treatment of those people whose deaths are the subject of this inquiry. My report must not only deal with the role of those responsible for the day to day care, supervision and treatment of the deceased, such as Dr. Jager, but also with the role of any entity with overall responsibility for such matters. Clearly that includes the DHHS and the DJIR each of which departments had a role in the administration of the special institution/prison hospital and the prison including the provision of staff. Were there evidence which enabled me to find deficiencies in the manner in which any part of the prison or the special institution/prison hospital had been staffed, managed and/or resourced and that those deficiencies impacted on the care, supervision and treatment of any of those who died then I must report on those.

Comment should be made generally about some of the evidence I heard. From time to time some witnesses and indeed Counsel tended to focus on the provision of service by FMHS across the state. That was not the issue to be considered which was the level of service of the FMHS to inmates at the Risdon Prison Complex and in particular those who died.

I will try to canvass the evidence that I have heard under a number of headings, namely

1. Appointment of Dr. Alan Jager to and his Qualifications for the Position of Clinical Director
2. Operational Structure of Prison Hospital/Special Institution and Forensic Mental Health Service
3. Changes to Structure in 1999
4. Dr. Jager's management style/clinical practice
5. Impact On Prison and Response of Department of Health and Human Services
6. Conclusions.

1. Appointment of Dr. Alan Jager to and his Qualifications for the position of Clinical Director

Dr. Jager was appointed to the position of Clinical Director, Forensic Services in the DHHS effective the 8/2/99 for a period of 3 years. He was appointed under a special contract of service pursuant to Section 38(1)(b) of the Tasmanian State Service Act 1984. [158]

The position of Clinical Director had been advertised because of the imminent retirement of Dr. Wilfred Lopes who had held the position since July 1982. He had to retire due to his age on the 25/12/98.[159] A position description was prepared.[160] Certain qualifications were set out as essential qualifications for the position. Applicants were required to be either Specialist Medical Practitioners Class III or IV. Class III practitioners had to be registered under the provisions of the Medical Act 1959 and hold a specialist qualification accepted by NSQAC relevant to the appointment and have had at least 8 years experience in that speciality subsequent to the gaining of the specialist qualification. Class IV had the same requirements save for the level of post gaining of specialist qualification experience having to be 12 years.

The position description provided for the appointee to work a 38 hour week and specified the position to be

> *"Primarily office based at Risdon Prison, but will be required to provide a consultative service in other areas"*

There were also a number of what were described as desirable qualifications. Dr. Jager expressed interest in the position in or about September 1998.[161] He did not meet the essential requirements for the advertised position as he had not yet qualified as a specialist psychiatrist and was still completing the psychiatry training program through the Royal Australian & New Zealand College of Psychiatrists. Dr. Jager formally gained qualification as a psychiatrist late February 1999 after he took up the position of Clinical Director.

A decision was taken within the DHHS to enter into discussions with Dr. Jager in relation to his taking up the position of Clinical Director notwithstanding his ineligibility for the position as advertised. A staffing authority form [162] identified as relating to Dr. Jager perhaps highlights the reason for this in that it indicated that there were already several vacancies for psychiatrists within

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[158] See Contract of Service - exhibit 280
[159] See exhibit 278. I have presumed there is a typographical error here and that the reference in the first paragraph is to December 1998 and not 1999.
[160] See Position Description - exhibit 244
[161] See letter from Dr. Jager to Ms. B. Shaw - exhibit 245

Mental Health Services, there was no capacity for other psychiatrists to assist, a new inpatient facility was proposed as was the development of a forensic services policy both of which required clinical leadership and recruitment of psychiatrists in Tasmania was difficult.

In his initial expression of interest in September 1998, Dr. Jager asked a number of questions and raised a number of matters. One which became relevant in the context of how he subsequently acted in his role and it's impact on the care of the patients at the special institution/prison hospital was his expression of a vision for the service. He said[163]

> *"I have a vision of what I see as the important areas that we should be addressing with a forensic psychiatry service. This ranges from the practical issues of the day to day care of unwell prisoners and offenders to the assessment of unwell accused persons and dangerous non-forensic patients, to more general issues of interfacing with community problems such as violence in mental illness, spousal, child and elder abuse and issues facing the homeless, including alcohol and substance abuse. I am sure that these issues are of concern in Tasmania, just as they are in North America and mainland Australia.*
>
> *To address these issues, I believe it is important that we have a community-based focus and that we attempt to be proactive, rather than reactive. Fundamental to that philosophy is the requirement to initiate and participate in adequate data collection, research and treatment initiatives in order to intervene earlier in the continuum of illness, aggression, violence and offending. I am presently in the process of developing a research protocol to look at the important question of the temporal relationship between violence and young people with first episode psychosis. There is great interest, internationally, in this area of research and it could provide insights and significant benefits for the community. To that end, it is my opinion that forensic psychiatry needs to have a vibrant connection with general psychiatry and with academic psychiatry through the university. I have made initial contact with some of the senior academics in Hobart, who are very receptive to the idea of developing such an academic connection."*

The vision in itself was impressive. With the benefit however of the evidence I have heard and what is now no doubt hindsight, it is apparent the vision was ambitious beyond the capacity of the system upon which it was sought to impose it and perhaps the experience of the person seeking to impose it. Another issue raised by Dr. Jager was the proposition that he have a conjoint appointment with the University of Tasmania. His suggestion was that be at Associate Professor level. That also was

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[162] See exhibit 282
[163] See exhibit 245

ambitious given the very limited teaching experience Dr. Jager had and his limited professional publication history.

Dr. Jager was sent a response to his queries on the 5/10/98[164] and negotiations began. They clearly proceeded quickly because a telephone interview was arranged for the 21/10/98. The interview proceeded and a decision was taken to offer Dr. Jager the position. Approaches were made to his referees. A response was received from Professor Mullen in Victoria. It indicated that Dr. Jager's general psychiatric experience may be limited but that he had general practice experience. It said Dr. Jager was energetic, had academic ambitions, was training at a good centre in Canada and that he would have offered him a job if he had one. He also described Dr. Jager as a pain and bumptious but said he got on well with staff. While it appears a brief written response was received from Professor Arbolda-Florez who was Dr. Jager's supervisor in Canada it was not put before the inquest. He would have had the most up to date knowledge of Dr. Jager's experience in the field for which he was being considered.

The position was offered to Dr. Jager at the end of November and further negotiations resulted in the special contract of employment. Ms. Quinn acknowledged that Dr. Jager could not be appointed as a permanent employee to the position of Clinical Director as advertised because he did not meet the qualification criteria. While it appears some informal approaches were made to the University in relation to a conjoint appointment it was not until after his appointment to the department was finalised that the University offered Dr. Jager a position as senior lecturer. The letter from the Head of the School of Medicine to Ms. Melanie Allen dated the 5/2/99[165] suggests quite clearly that the DHHS did not adhere to agreed protocols to obtain the conjoint appointment because they appointed Dr. Jager to the Clinical Director position before arranging the other.

Dr. Jager's position was said to be a .8 full time position with the DHHS and a .2 position with the University of Tasmania. He was also given a limited right of private practice to be conducted outside the time to be allocated to the clinical director/senior lecturer roles. Dr. Lopes' position had been a .9 full time position with a right of private practice outside of that.

The curriculum vitae which Dr. Jager provided to his potential employer[166] was said to be current as at 1/9/98. It set out that Dr. Jager was then a fellow in forensic psychiatry at the Calgary General Hospital in Canada. It set out that Dr. Jager qualified as a medical practitioner in New Zealand at the end of 1981 and worked as a general practitioner there for a brief period before taking up short term positions in hospitals and as a locum until August 1983. He then practiced on his own account

[164] See exhibit 294 copy facsimile transmission Gerry Lampasona to Jager and attachments
[165] See exhibit 281
[166] See exhibit 246

as a general practitioner in Melbourne until April 1992. Dr. Jager then travelled to England where he worked for approximately 4 months as a senior house officer in psychiatry at a hospital in London. He then worked as a medical officer in psychiatry at 2 different hospitals in Melbourne before commencing formal training in psychiatry in February 1994.

In January 1998 Dr. Jager obtained a fellowship at a Canadian Hospital to work in the area of forensic psychiatry as part of his ongoing training which is where he still was when he expressed interest in the Tasmanian position. Dr. Jager was questioned by Counsel Assisting about his psychiatric expertise. In the course of that questioning he gave no indication of any level of involvement with psychiatric patients outside that related to his hospital and clinic training between 1994 and 1998. However when questioned by Counsel for the Santos family Dr. Jager asserted that while he was doing his psychiatric training he operated a private general medical practice and in that practice he dealt almost exclusively with psychiatric patients without supervision. He said that during that period he was also a registered Clozapine provider and had managed long term patients suffering from schizophrenia on that drug. When it was pointed out to Dr. Jager that none of that information appeared in his curriculum vitae Dr. Jager's response was to thank Counsel for drawing the oversight to his attention.

The omission of that information from his curriculum vitae given the position Dr. Jager was applying for does appear surprising. Given the somewhat flippant manner in which Dr. Jager responded to the particular line of questioning and what appeared to be his tendency to exaggerate his accomplishments, I treat with some reservation Dr. Jager's claims about his experience with psychiatric patients without supervision prior to his formal qualification as a psychiatrist.

The reference to an exaggeration of accomplishments arises out of evidence relating to Dr. Jager's publications and the interrelationship of them to his request to be considered for an appointment as an Associate Professor. Dr. Jager's curriculum vitae referred to one publication. He agreed that was not based on any research but was a case report. [167] He also agreed that at the time of his request he had no experience administering students within a university department and was not a qualified psychiatrist. He said he sought the position on the basis he had completed a 3 year research program which work had resulted in his masters thesis and dissertation for the College of Psychiatrists as his final assessment. While again it was not referred to in the curriculum, Dr. Jager said he had also done research in Calgary and had submitted 5 further papers for publication, 3 or 4 of which he believed had since been published.

[167] See transcript page 3914

Without canvassing the evidence in detail, Dr. Jager eventually after some detailed questioning conceded that in fact he had only one what might be described as a clinical paper published in a peer review journal as at July 1999.[168] As a consequence he also conceded that his previous evidence about this issue and his curriculum vitae which he had updated as at the 1/5/00 were wrong. Dr. Jager also conceded that he had represented to solicitors for whom he had prepared medico/legal reports that he was the author of clinical papers in peer review journals and that that was wrong.

Dr. Jager conceded that his only experience in forensic psychiatry up to the end December 1997 was the 3 months he spent during his training attached to the Rosanna Forensic Psychiatric Unit and that that work was at all times supervised. In 1998 at the forensic unit attached to the Calgary General Hospital, Dr. Jager again worked under supervision and the facility did not cater for long term prisoners with mental illnesses.

The evidence I have heard makes it quite clear that when Dr. Jager began work at the special institution he had no experience at all in forensic psychiatry save for a total period of at best 15 months all of which was under the supervision of other qualified and experienced psychiatrists. Dr. Jager himself acknowledged the special institution was unique in that it was one of the few remaining prison based psychiatric units and that it had a curious patient mix. The evidence also showed that Dr. Jager had no experience of any type working at the level to which he was appointed and none in effectively running the forensic part of the prison hospital. He had almost no experience to qualify him to manage the number of staff who worked under him and of working within a bureaucratic structure as he was required to do.

2. Operational Structure of Prison Hospital/Special Institution and Forensic Mental Health Service

In his position as Clinical Director, Forensic Services, Dr. Jager was clinically autonomous. Administratively he was subject to the supervision of Ms. Melanie Allen, the Southern Manager of Mental Health Services. She was responsible to the State Manager, Mental Health Services (who at the date of the inquest was Ms. Wendy Quinn). Ms. Quinn was responsible to the Director of Community and Rural Health, the Director was responsible to the Secretary of the Department who was in turn responsible to the relevant government minister.

Ms. Allen came to her position as Southern Manager, Mental Health Services, only approximately a month before Dr. Jager came to his. She had management and nursing training and previous experience as a line manager in government service of medical practitioners but not psychiatrists.

[168] See transcript page 4033

Ms. Quinn, her superior, told the inquest that Ms. Allen was required to manage Dr. Jager to achieve the tasks specified in the position description and in accordance with any subsequent discussions.

At the time he was appointed, Dr. Jager's position was based at the Risdon Prison Hospital and that was a fact that had been made clear prior to his appointment. That hospital was effectively a hospital operated by the Corrective Services Division of the DJIR as part of the Risdon Prison complex. It was staffed by people employed by the Corrective Services Division of that department. These were custodial officers, a part time medical officer and nursing staff. The nursing staff had various levels of training. Some were generally trained only and some had psychiatric training as well. The hospital was however also a Special Institution within the meaning of mental health legislation and as such was used to house persons found not guilty of crimes by reason of their mental state but ordered to be detained. Those persons were in fact patients of the FMHS and on a day to day basis were managed by staff from both Corrective Services and FMHS. The staff of FMHS were employed by the DHHS.

The hospital at any given time could house

- prison inmates with physical illnesses,
- prison inmates with mental illnesses,
- mental health detainees
- other inmates from the prison who for some reason were considered by custodial staff to be more appropriately housed in the hospital environment.

Hence what Dr. Jager described as a curious mix of patients.

When Dr. Jager took up his position, leaving aside that Dr. Lopes remained for a week or so after he started, there were 5 staff (including himself) employed by the DHHS constituting the FMHS. These were, in addition to Dr. Jager himself, a psychologist, a social worker, an administrative assistant and a community psychiatric nurse. Between when Dr. Jager expressed interest in the position and when he took it up 2 other staff left, these being a psychologist and a part time psychiatric registrar. It seems that Dr. Jager was not told in advance that the registrar's position was not a permanent funded position.

The FMHS was to provide the following services

- inpatient care at the hospital,
- outpatient care for inmates at the prison,
- outpatient care from the Glenorchy Community Health Centre
- outpatient care for Hayes Farm

- provision of reports to the Mental Health Review Tribunal and Parole Board,
- some inpatient care at the Royal Derwent Hospital,
- some other consultative work for community corrections and other statewide mental health services

The FMHS had rooms at the Glenorchy Community Health Centre which were used for consultations by the psychiatrist, psychologist and nurse. The FMHS administrative assistant was based at the prison hospital premises and records and paperwork for the team were maintained there.

In respect of each person housed at the prison hospital whatever their status, Corrective Services staff maintained a medical file. In respect of those persons within that group who were for some reason a client of the FMHS, that service maintained a separate file. While forensic team people wrote in the corrective service file the reverse did not occur. The result was shown by the evidence to be that there were in respect of each forensic patient 2 files and neither contained a complete picture of the subjects situation.

On the 2/2/99, Dr. Jager met with Ms. Allen and her then superior and discussed his position in broad terms. It seems generally agreed that the position description previously provided to Dr. Jager was the basis for the functions he was to perform. He was to be responsible for managing the FMHS both in terms of human resources and financial management as well as clinical direction. It was Ms. Allen's expectation that she would meet with him regularly, that he would report to her about significant issues and events and that that was how her management of the position would occur.

Dr. Jager was never given any specific directions about his position by the head of agency , a matter provided for in his contract of employment. He said in fact he gleaned from Dr. Lopes what his job entailed. The extent to which that process successfully gave Dr. Jager a clear picture of what he could and could not do was perhaps shown by Dr. Jager's comment[169] to the effect that it quickly became apparent to him that there were certain minor resources he could allocate but that he never clearly learned exactly what resources he could allocate.

Ms. Allen acknowledged that Dr. Jager was a difficult person to manage. She described him as dynamic and energetic and as time went by she enlisted help from her superiors in dealing with him as she said that as matters occurred they raised concerns about his management style. In or about February 1999, that is the month in which Dr. Jager commenced his employment, he prepared an

[169] See transcript page 3926

issues paper relating to a proposed restructuring of forensic mental health services.[170] Dr. Jager's proposals in that paper were in summary

- expand outpatient community focus of service
- have service become part of the Telehealth network to be delivered from the Glenorchy premises,
- terminate role in relation to Royal Derwent
- reduce reports for Parole Board

He also proposed that, instead of replacing the full time psychologist's position vacated late in 1998, there be 3 further psychiatrists employed each to conduct 1 session per week, one in Hobart, one in Burnie and one in Launceston and that there be a .5 psychologist position created. Additionally, he sought a replacement full time psychiatric registrar and an improvement in information systems and communications equipment. There was no mention of the relocation of the administrative base of the service.

In fact Dr. Jager considered some aspects of the FMHS a disgrace and said he believed it would be negligent not to move to change it quickly. He said he knew it was under-resourced when he started. He also agreed when it was put to him that the whole process of change to the service in 1999 had not gone well because of inadequate funding, the service being dysfunctional and conflict between members of staff.

3. Changes to Structure in 1999

Termination of Role of FMHS in providing care at Royal Derwent Hospital

Dr. Jager negotiated with Ms. Allen for the withdrawal of this service and the Department made alternative arrangements for it.

Decision Not to Replace a Full time Psychologist

This involved not proceeding with the process of filling the second full time psychologist position vacated in 1998 even though the position had been advertised and applications received but instead looking at hiring only a half time psychologist plus some part time psychiatrists to do limited sessions in Hobart, Burnie and Launceston. Dr Jager met with senior managers on the 2/2/99 before he even started his position and outlined his plan for the FMHS. The proposal about the psychology

[170] See part of exhibit 273

position was raised and as a result, the process of filling the position was halted. Ms. Allen in fact confirmed that to Dr. Jager on the day he took up his position. When that proposal was put by Dr. Jager he had not had any opportunity to familiarise himself with the day to day operations of the FMHS.

Ms. Allen said she expressed concern about the matter and told Dr. Jager that there needed to be time to examine his proposal and consult with stakeholders. She viewed those stakeholders as the remaining psychologist, Dr. McCarthy, her superior Mr. Cochrane, the principal psychologist with the Department, and the Justice Department with whom there was an agreement about the position.

Mid way through February 1999, both Dr. McCarthy and Mr. Cochrane wrote objecting to the proposed changes to the psychology position. Mr. Cochrane's view was that it would not produce a satisfactory provision of service. On the 23/2/99 Ms. Allen suggested to Dr. Jager there needed to be a consultative meeting with stakeholders about the psychology position.

Shortly after that Dr. Jager wrote directly to the Deputy Secretary of the DJIR, Mr. Richards, outlining his rationale for his proposal.

This and other changes to the FMHS proposed by Dr. Jager were discussed at a meeting of the state management group held on the 5/3/99. On the 9/3/99 Ms. Allen met with Dr. Jager to talk him through an acceptable approach to change management. She said she went through with him the many steps of contemporary management. She also spoke to him about making decisions without reference to her. She said she was satisfied he understood those principles. She said she met with him regularly about various changes in the service after that and always outlined processes to him. She believed he was following them. She said it wasn't until the move to the Glenorchy premises occurred as it did that it became clear he had taken no notice.

The meeting of stakeholders envisaged by Ms. Allen in relation to the psychology position was planned for a date in April. However it was cancelled because before it could be held Dr. Jager went direct to Mr. Richards and obtained his agreement to the arrangement. Ms. Allen told the inquest that she considered changing this decision and had discussions with her superior about it. She however agreed to let it stand having regard to the Justice Department's agreement to it.

Ms. Allen said Dr. Jager gave her to understand he had Dr. McCarthy's agreement to the proposal which was subsequently found not to be the case. Following Dr. McCarthy's letters to Ms. Allen about the psychology position, Ms. Allen had spoken to Dr. McCarthy and believed she may have conceded things could change. In the middle of April 1999, Dr. McCarthy sought an appointment with

Ms. Allen about the issue but cancelled it. Ms. Allen presumed that by that Dr. McCarthy was withdrawing any objection she had.

Dr. McCarthy said she did not in fact in her mind voluntarily withdraw her objection to Dr. Jager's proposal. She cancelled her appointment with Ms. Allen because Ms. Allen told Dr. Jager of it and Dr. McCarthy received a call from Dr. Jager very shortly after. She said he told her he knew of her contact with Ms. Allen and that in effect change would occur whether she liked it or not. In light of the concerns that she felt in dealing with Dr. Jager which I will address later, it was quite clear she felt intimidated by him and for that reason did not pursue the matter.

The reality however was that no psychiatrists were able to be appointed to the service in 1999 because none could be found. A half time psychologist was appointed in July 1999. In the meantime Dr. McCarthy, whose objection to the change being promulgated by Dr. Jager was largely the result of her own increasing workload since the loss of the second psychologist in 1998, was placed under increasing work pressure.

Dr. Jager agreed that the forensic service was degraded if neither the part time psychologist nor the 3 sessional psychiatrists positions could be filled. Dr. Jager also agreed that this failure to fill these positions coincided with an escalation in the prison population although he acknowledged that he was not even aware of that until August 1999. He was unaware when he advocated the changes in staffing profile that he did that there had been such a population increase. He agreed he should have been aware of it.

This issue demonstrates a lack of adherence to due process by Dr. Jager in that he achieved the result that he wanted but in the absence of an adequate canvassing of the views of persons who in Ms. Allen's terminology were key stakeholders. However some criticism should also be laid at the door of management in that they failed to ensure that those views were canvassed. This is particularly so in that they acquiesced in a proposal in the knowledge that they had available applicants for the psychologists position but would struggle given past experience to find applicants for the psychiatric positions.

Move of Administrative base of FMHS

On the 3/5/99, less than 3 months after commencing in his position as Clinical Director, Dr. Jager moved the administrative base of the FMHS from the prison hospital premises to offices at the Glenorchy Community Health Centre. This involved his moving his own office and that of the services' administrative assistant. It also appeared from the evidence of Mr. Harris the social worker

appointed in May 1999 that his office also went to Glenorchy. This move occurred at a time when Dr. Jager remained the only consultant psychiatrist in the service, there was still no psychiatric registrar at all and only 1 psychologist. The practical result was that Dr. Jager visited the prison hospital to attend to patients and conduct ward rounds as opposed to being based there. The move was also in the context that Dr. Jager's position with the Forensic Service was a smaller one than that held by Dr. Lopes, his predecessor. A comparison of the on the ground situation of the Forensic team at the prison hospital so to speak late 1998 as against immediately post 3/5/99 shows:

Late 1998	Post 3/5/99
.9 consultant psychiatrist based on premises	.8 consultant psychiatrist based off premises
2 psychologists	1 psychologist
1 part time psychiatric registrar	no psychiatric registrar
1 social worker	1 social worker
1 administrative assistant based on premises	1 administrative assistant based off premises
1 community based nurse	1 community based nurse

Ms. Allen said that she was aware that Dr. Jager had proposed moving his administrative base to Glenorchy but she was startled to get a fax on the day of the move saying the move had actually occurred. She said she understood until then the move was in the proposal stage because she was having ongoing discussions with Dr. Jager. She had as part of those discussions asked him to explore the availability of office space and the cost impact on the service of the move which she knew he had done. She said [171] she was working through a number of issues with Dr. Jager about his proposal to move but her expectation was that there was still a consultative process to be gone through with other interested parties. She said that she had previously told Dr. Jager about the processes to be gone through when change was sought which included the need to involve key people, consult with them, try to obtain their agreement or listen to their concerns and think about risks rather than just what he thought was the right thing to do. She expected he understood that that process was required before he could move his base.

On hearing of the move she consulted with her then superior and while they were concerned that the move had occurred without proper consultation and approval they saw no major problems with it. This is a somewhat similar response to that in relation to the psychologist position. Ms. Allen said that her response to Dr. Jager was to express surprise and alarm that the move had occurred without her knowledge and that she asked to be kept informed in the future.

[171] See transcript page 3575

Ms. Quinn acknowledged that the 1995 joint health and justice policy[172] in relation to the delivery of mental health services supported an increase in and the development of a community based focus for the FMHS. The idea behind this was preventative, namely to prevent people ending up in the prison system. This did not however automatically mean such an increase in focus was to be at the expense of service delivery to the prison.

Dr. Jager agrees he sought no formal approval for the move to Glenorchy. He said he was not aware any was needed and he would have expected his line manager to tell him if it were. He said Ms. Allen knew of the move from discussions he had with her and her superior. He described the move as a collective decision of himself and his managers and said he would be amazed if Ms. Allen had not known of the move.

It seems that on the morning of the move made by Dr. Jager he attended a meeting with Ms. Allen, her superior and finance representatives at which Ms. Allen says she tried to instruct Dr. Jager in departmental processes and to impress on him certain issues to do with finances and other forms of management. Dr. Jager made no mention of his move of office at that meeting. Ms. Allen's explanation for not following him up about it after the event was, in her words describing the meeting she had on the morning of the move, *"we felt already that day we had come the heavy on Alan…"*.

No inquiry was subsequently made by management to ensure that the level of service to be provided to the prison would not be adversely affected by the move. What the evidence about this issue discloses is

- Dr. Jager appeared to have little or no appreciation of the workings of the bureaucracy which employed him, or if he did chose to ignore them
- Dr. Jager did not define with his manager precisely the level of his administrative autonomy, or if he did know it as Ms. Allen appears to suggest, chose to ignore it
- communication between Ms. Allen and Dr. Jager was not sufficiently clear enough that Dr. Jager knew and accepted the limits of his authority
- once Ms. Allen was presented with the fait accompli of the move, the response appears to have been, well there are some good reasons behind it, it's done now so let's just accept it. No attempt was apparently made to explore with hindsight the totality of the ramifications of the move to ensure there was nothing which would cause problems for service delivery of the FMHS to the prison. Apart from ongoing meetings between Ms. Allen and Dr. Jager as part of Ms. Allen's management strategy, there seems to have been little attempt to impose any boundaries for Dr.

[172] See exhibit 274

Jager. Given the concerns already raised about the way in which the psychology position issue had been handled, this is hard to understand.

There was evidence from various witnesses as to the practical impact of this move on the service being provided by the FMHS. The issue for this inquest was not so much the impact of that move on the service generally but the impact in so far as the care, treatment and supervision of those in need of psychological or psychiatric care in Risdon prison and it's hospital was concerned.

Dr. Jager's move of his administrative base to Glenorchy may very well not have impacted on the overall time that he devoted to the FMHS but there can be little doubt that less of his overall time was spent in being in the prison hospital and directly available to staff, patients and potential patients there and at the prison. In the context of his position being in any event less than that of the previous director, there being an increased prison population and there being fewer professional staff available (due in part to difficulties in filling positions), the move has to be said to have impacted adversely on the care, treatment and supervision of forensic and potential forensic patients at the prison and by implication the persons the subject of this inquest.

Another aspect of the move which emerged from the evidence of Mr. Colin Harris a social worker in the team between May and October 1999 which reinforces this view was that the meetings of the forensic team which were held at the hospital began to be held at the Glenorchy office. Mr. Harris acknowledged that not only was there a lot of travelling involved because of this move but he personally found it difficult to develop a working relationship with other members of the team. The move also resulted in Ms. Browne, the forensic team's administrative assistant, while being based at Glenorchy, having to travel from time to time to the prison to deal with documents left there. It also appears from the evidence that files for patients of the forensic service were maintained at Glenorchy.

Clients being dealt with by the FMHS.

A third area of change said to have occurred by staff was disputed by Dr. Jager. This related to a suggestion that Dr. Jager had issued a direction changing the definition of patients who would be seen by the FMHS such as to place outside the reach of the service a number of potential clients from within the prison itself and in the community.

The evidence about this issue was sought from a number of witnesses. The perception from several, most notably Dr. McCarthy, was that the target group of the service had altered although the

evidence was not always clear as to exactly how. Dr. McCarthy came into conflict with Dr. Jager about this issue.

Dr. McCarthy agreed that FMHS patients were clients of Community Corrections with severe mental health problems and mental disorders. She said the people she and Dr. Jager argued about were people who had quite severe psychological problems but did not have schizophrenia, depression or bi-polar disease which was the definition of serious mental illness. She also said that Dr. Jager tended to describe patients as having personality disorders rather than mental illnesses. She continued to treat people with significant psychological problems whether or not they had a personality disorder as well.

Sister Barwick also gave evidence that Dr. Jager changed the type of patients to be seen by the Service although she did not detail precisely what the change was.

Ms. Allen said that she became aware of this matter through discussions she was having in November 1999 with Dr. McCarthy, Ms. Elida Assenheimer (a part time psychologist appointed in July 1999) and Sister Barwick about difficulties within the workplace. She understood that there appeared to have been a change in service provision to those suffering from axis one disorders.[173] She said that there had never been any formal ground rules laid down as to the target client base for the service. She also said that she had received no advice from Dr. Jager about any change of focus as far as clients of the service were concerned. Once however a manager was appointed for the service in December 1999, she attempted to relax the arrangement so that the previous target group of the service was being dealt with.

Ms. Allen told the inquest that there was no discussion with Dr. Jager about confining the FMHS to clients with axis 1 disorders but she said they did discuss his definition of a FMHS client. She actually wrote to him and asked him to define the client group. She said she had no reply. However subsequent to her giving that answer she was shown a memorandum from Dr. Jager to her dated the 12/7/99[174] in response to a query from her and in that Dr. Jager does attempt to define a client of FMHS. The definition however does not really resolve the change of focus referred to by other witnesses. It became clear that Ms. Allen's level of knowledge in 1999 about this matter was vague.

Dr. Jager denied that there had been any change of focus at all. However while the evidence is general two things point to there having in fact been a change of focus. The first was the persistent theme through the evidence of a number of witnesses to the effect that the focus had changed after

[173] See transcript page 3577
[174] See exhibit 309

Dr. Jager took up his position and the second was the evidence of Ms. Allen to the effect that late in 1999 the process was altered to allow the previous target group to be dealt with.

The practical impact of this issue was that there was a perception rightly or wrongly held by nursing and custodial staff that after Dr. Jager took up his position there were certain inmates who could not access the services of the FHMS. The result was that there were behaviourally difficult inmates within the general prison population who were very difficult to manage because of their behaviour whose care was being left with general custodial staff who had insufficient training to deal adequately with them.

Psychiatric Registrar's Position

This was not a change in the structure as such but a lack of change about which there was significant debate between Dr. Jager and the DHHS. The DHHS accepted the need for a registrar within the hospital. However the arrangement which had existed prior to Dr. Jager taking up his appointment was a temporary one only with no permanent funding. The existence of funding governed whether or not such an appointment could be made.

It seems that Dr. Jager had some well developed proposals for a sex offender program and believed he could use existing staff in that with some re-allocation of work loads. The DHHS were prepared to look at funding this program in such a way as to also fund a registrar. Late in 1999 Dr. Jager was asked to work up that proposal to a level where it could be formally put. He did not however come back to management until February 2000 at which time the funding was approved and the position advertised. As at the middle of May 2000 it had not been filled.

4. Dr. Jager's management style and clinical practice

A number of matters relating to Dr. Jager's management style and clinical practice were raised during the course of the inquest. In themselves they would not have been matters for this inquest. However where they impacted directly on the care treatment and supervision of any of the deceased or affected the overall functioning of the FMHS in the prison and as a consequence it's capacity to care for, treat and supervise clients, then they would be such matters. Some matters which come under this heading have in fact already been canvassed in the material relating to individual deaths.

Perhaps the first indication of Dr. Jager's management style came with his approach to the issue of the replacement of the second psychologist. Dr. Jager acknowledged that when he proposed this he did not fully appreciate the number in the prison population or that the number was on the increase.

He also did not apparently stop to consider the impact of his approach were psychiatrists not available for the positions he wished to create, as ultimately was the case. He had no process of consultation with Dr. McCarthy, the only incumbent psychologist in the forensic team and one who had been at the hospital for several years. He did not consult the principal psychologist in the department, Mr. Cochrane, at all about the issue nor indeed anyone else.

Dr. Jager's view was that the previous psychologist had spent nearly half his time travelling to service clients away from Hobart and therefore a half time position wholly based in Hobart would effectively mean no loss of service in Hobart. The service previously given by that psychologist in the north and north west was to be provided by the sessional psychiatrists Dr. Jager proposed to hire. Not only was Dr. McCarthy's evidence to the effect that the previous psychologist spent considerably less than half his time travelling (and I accept that evidence because she would have been in a position to know), but also of course the positions for sessional psychiatrists could not be filled.

Dr. McCarthy gave evidence which was not challenged about words used by Dr. Jager to her in a telephone call she received from him shortly after she contacted Ms. Allen for an appointment to discuss the psychology position in April 1999. The language used can only be described as intimidating, coming as it did from a person effectively Dr. McCarthy's superior.

The practical result of Dr. Jager's approach to this issue was an overworked and stressed Dr. McCarthy who in December 1999 to all intents and purposes walked off the job in protest at Dr. Jager's continuing behaviour in various areas refusing to return unless there was change, an action she said she had never before contemplated in her time in her position. She does not appear to have taken that step lightly. She gave evidence she consulted with Mrs. Hanke and Mr. Cochrane as early as May 1999 about difficulties she was having dealing with Dr. Jager in an effort to get advice about how best to do so.

Dr. McCarthy also had complaints about Dr. Jager's clinical practice. She said in her evidence [175]

> *"I seemed to have a succession of young men sobbing in my office because they had been - they felt that they weren't being listened to, they felt that their concerns weren't taken into account and they just felt that they weren't being treated in the way that they needed to be treated by a professional health person."*

[175] See transcript page 3174

She was asked if she had raised these matters with Dr. Jager. She said she tried but he was dismissive. She said this type of complaint arose fairly regularly in 1999. She also described Dr. Jager as bullying both staff and patients.

The Forensic team was a small one at any given time through 1999. Both Dr. McCarthy and Dr. Jager were members of that team. Dr. McCarthy perceived significant problems from the very beginning in her being able to deal with Dr. Jager arising in her view from his management of the service, it's members and patients. The mere fact of a team divided could not have produced the most efficient of forensic teams.

Sister Barwick, a forensic nurse, was another member of the forensic team already in place when Dr. Jager took up his position. She like Dr. McCarthy had worked with Dr. Lopes whom she described as experienced and caring. She said her relationship with Dr. Jager was not as sound as that with Dr. Lopes. She said of Dr. Jager that she didn't really have disagreements with him, he just wouldn't listen to what was being said, a remarkably similar observation to that of Dr. McCarthy.

Quite obviously from the evidence, Sister Barwick and Dr. Jager clashed from the beginning of their professional relationship. As I have already noted they are both strong personalities. I do not propose to canvass in detail the evidence relating to their various clashes. Suffice to say that Sister Barwick's descriptions of the manner in which Dr. Jager dealt with both staff and patients were consistent with those of Dr. McCarthy and the relationship between Dr. Jager and Sister Barwick was fractured to such a degree that each made complaints about the other to their management superiors. Further Sister Barwick was as I understand matters on workers compensation leave at the time of this inquest as a result of Dr. Jager's alleged approach to her.

Again while there may be no evidence of the problems in this relationship impacting directly on the care supervision and treatment of the deceased, there can be no doubt that the difficulties which existed between Sister Barwick and Dr. Jager could not have assisted the efficient running of the team itself.

There was also evidence from custodial staff and nursing staff about what was perceived to be Dr. Jager's attitude to concerns raised by them about matters. The description, dismissive, was often repeated. By the end of 1999 the result in practical terms of these difficulties was a breakdown in relations between members of the FMHS itself and a number of concerns expressed by staff about aspects of Dr. Jager's clinical practice and management style.

5. Impact on Prison and Response of Department of Health and Human Services

There was clearly concern within management levels of the department about Dr. Jager's management of the FMHS from early in 1999. However it was not until quite late in the year that any steps were taken to deal with those concerns outside of the ongoing management process being undertaken by Ms. Allen. There appeared to be a belated acknowledgment from both Ms. Quinn and Ms. Allen that this process did not work.

As outlined earlier the move by Dr. Jager of his administrative base from the prison hospital to Glenorchy occurred in a climate of increasing inmate numbers about which he was not aware. Ms. Allen had to rely on advice from Dr. Jager about such matters which she neither received nor apparently asked for. She did not become aware of that information until after the commencement of the Ombudsman's inquiry in relation to Risdon prison announced on the 20/9/99. When that was announced a departmental prison review working committee was established.

The evidence of Ms. Quinn and Ms. Allen was also that they did not become aware of the "syringe incident" until late October 1999 when Sister Barwick raised the issue in a meeting with Ms. Allen. Ms. Allen also said she was not aware of the decrease in Dr. Jager's time at the prison until about the same time. Thereafter a number of events occurred.

Ms. Allen met with a number of members of staff at the prison hospital in which concerns about Dr. Jager were raised. She and Ms. Quinn also visited the prison hospital and reviewed the environment, files and the filing system and talked about communications aspects within the forensic team.

Ms. Quinn told the inquest that discussions took place at a senior level within the department as to how best to approach these problems and in particular the "syringe incident". It was decided that that particular issue was a clinical issue and that it was not appropriate to deal with it as part of any human resources investigation. A decision was taken to recommend to the Ombudsman that a clinical audit be conducted as part of his review of the prison which would look at amongst other things the "syringe" incident.

On the 9/11/99, Dr. Jager was advised the clinical audit would be conducted. He said he welcomed it. Dr. Jager was told that day about concerns relating to his staff management but given no names or details. He said[176] there was a general message, a general mention that there may be concerns about his management but no specific complaints. Ms. Quinn conceded she was unsure if he was

[176] See transcript page 3775

specifically told of the syringe incident. He was certainly not asked to provide any explanations for anything. It appears he was told there would be an investigation to explore matters. Ms. Quinn said her understanding was that Dr. Jager would be given his opportunity to provide any explanations he wanted to give as part of that audit process. Dr. Jager was also told that day that Ms. Quinn and Ms. Allen would be working closely with him in relation to his management practices.

Dr. Jager told the inquest he was not aware until evidence was given at the inquest of the specifics of complaints against him.

From the department's point of view, advice was sought from Professor Ken Kirkby as to appropriate people to conduct the clinical audit. He recommended some names, the department agreed to provide some funding and the Ombudsman was asked to proceed. One of the persons to conduct the audit was Professor Ken O'Brien a forensic psychiatrist from Adelaide who had in fact originally suggested to Dr. Jager he apply for the position of Clinical Director.

On the 21/12/99 the Ombudsman wrote to the secretary of the Department advising there was no requirement for any critical intervention with regard to Dr. Jager's clinical practice. Ms. Quinn told the inquest that the Ombudsman's draft report was later made available and it became evident that the department did not receive the clinical audit they thought they were getting. She said we kept being assured that a clinical audit had occurred and it was not until the end of March 2000 that there was specific clarification of the Ombudsman's review process and it was found it had not covered issues of clinical incompetence and professional practice.

Why the Ombudsman did not conduct the audit sought by the DHHS was never explained.

Another issue in this period revolved around Sister Barwick. She was to return to work on the 19/11/99 after being on leave since August. There had been a history of difficulties between her and Dr. Jager and Dr. Jager had raised matters of complaint about her with Ms. Allen. Ms. Quinn became aware that Dr. Jager proposed to have a disciplinary meeting with Sister Barwick immediately on her return to work. Given what Ms. Quinn described as the level of unrest and already existing difficulties in communication between various members of the forensic team she directed that meeting should not occur. She and others met with Dr. Jager on the 22/11/99 about this and other matters and then received a letter from Dr. Jager summarising his account of the meeting and agreed actions. She said that what it set out was very different from what she understood the outcomes to have been. They met with him again on the 29/11/99 and Ms. Quinn said her view was the monitoring process of Dr. Jager was not having the desired effect as speedily as was needed.
On the 3/12/99 Dr. Jager wrote to Ms. Quinn outlining the history of his complaints against Sister Barwick and said he could no longer continue to be involved in any disciplinary process regarding

Sister Barwick because he had sought legal advice about her. On the 8/12/99 his solicitors wrote direct to Sister Barwick intimating legal action against her.

As part of this disciplinary process involving Sister Barwick, Dr. Jager supplied to his manager some letters from Colin Harris, the former social worker with the team, Dr. Ian Sale and Sister Philippa Chapman which contained matters of complaint about Sister Barwick. There was some surprise expressed when these letters were received because Ms. Quinn said what had been discussed with Dr. Jager was the obtaining of objective verification of alleged behaviour. The content of those letters was it appeared still the subject of a human resources investigation.

The history of the dispute between Dr. Jager and Sister Barwick is really only relevant from the point of view of the weight to be given to her evidence about issues. Because of the apparent ill feeling between the two I have not relied on Sister Barwick's evidence on any issue where it is the only evidence on that issue.

On the 7/12/99 reports were received by the Department from forensic staff involving allegations of intimidation and harassment in the workplace. That same day a request was made to the Director of Human Resources requesting advice about clinical and management practices of Dr. Jager. On the 9/12/99 Dr. Jager was advised of an investigation into his management practices and treatment of staff. On the same day Ms. Quinn wrote to Dr. Jager issuing him with a number of directives about management requirements. Within the space of the next few days Sister Barwick, Dr. McCarthy and Ms. Assenheimer the part time psychologist all refused to work with Dr. Jager.

In his evidence Dr. Jager generally attempted to downplay his awareness of matters of concern being raised by management. He suggested that the matters in Ms. Quinn's letter of the 9/12/99 came out of the blue and he considered resigning. It is clear however from the evidence of the meeting of the 9/11/99 and those after it and Dr. Jager's own solicitors letter to Sister Barwick that Dr. Jager was well aware of problems before the 9/12/99. His evidence to the contrary was unconvincing and in fact after some pressing he agreed[177] that the letter sent by Ms. Quinn to him of the 9/12/99 articulated with a degree of precision a number of matters of complaint in relation to his management.

The Department took a number of steps over the next few months in relation to the FMHS and Dr. Jager. These were as follows:

1. It appointed an acting coordinator for the FMHS on the 13/12/99 and that person began to visit the prison daily.

[177] See transcript page 379

2. Late in December 1999, it set up a mechanism by which second opinions could be obtained in respect of Dr. Jager's patients. In relation to this issue there was some doubt about the benefit of this process in that there did not seem to have been any communication to inmates that the facility was available. It seemed only to be a facility available to Dr. Jager should he be disposed to use it.
3. It set up a mentoring arrangement for Dr. Jager with Dr. Ian Sale. Further Dr. Sale was to conduct a review of all Dr. Jager's cases and discuss with Dr. Jager in detail his clinical management of them. This last process however because of the time of year did not commence until after Fabian Long died. From January 2000 Dr. Jager was also to have phone discussions with Dr. Rosemary Schneider twice a week.
4. A Prison Health Services Management Group was set up which met for the first time on the 1/3/00.
5. The department sent a letter to the Medical Council of Tasmania dated the 10/5/00 indicating evidence had been given to the inquest in relation to the "syringe incident" on the basis that the Council could decide if it were a matter it should consider.
6. It sent a letter to Dr. Jager dated the 10/5/00 suggesting he take leave and transfer to another position pending the outcome of the inquiry. As of the 13/5/00 Dr. Jager went on leave and another psychiatrist was appointed acting Clinical Director.
7. A notice pursuant to Section 4 of the Health Act 1997 was issued by the Minister approving a Community and Rural Health Division Credentials and Clinical Privileges Committee just set up as an approved quality assurance committee for the purpose of the act. Ms. Quinn told the inquest that notice was to be gazetted on the 17//5/00 and that the committee had been set up to review clinical matters related to Dr. Jager. It was established she said in response to the failure of the Ombudsman to include in his report a clinical audit.

Ms. Quinn was asked by Counsel for the Santos family why, notwithstanding the above steps was Dr. Jager permitted to continue clinical practice for as long as he did. Ms. Quinn's response was that until some of the evidence heard at the inquest all the Department had was unsubstantiated allegations, principles of natural justice required that they investigate those allegations and until the week of the 9th or 10th May 2000 all answers coming back from those investigations were that there was no requirement for action. The evidence to which Ms. Quinn was specifically referring was that given relating to the "syringe incident" given at the inquest in early May. She said in answer to other Counsel that the key issue was basically how far could the Department go on unsubstantiated allegations.

6. Conclusions

The evidence supports the view that the DHHS appointed a person to the position of Clinical Director who had inadequate training both professionally and in management to fulfil the role. I point to the following specific matters:

- Dr. Jager was not qualified as a psychiatrist when he was appointed
- The level of qualifications for the role of Clinical Director usually required a practitioner with between 8 and 12 years of experience as a psychiatrist post specialist qualification
- Dr. Jager's experience in psychiatry outside his formal training was questionable
- At best Dr. Jager's experience in forensic psychiatry was limited to some 15 months in environments wholly unlike that of the Risdon Prison and at all times under the supervision of experienced psychiatrists.
- No departmental representative actually met with Dr. Jager prior to his being offered the position save for one telephone interview.
- Inquiries with referees were sketchy and apparently included no personal discussion
- Dr. Jager had never held a senior position such as that to which he was appointed
- Dr. Jager had minimal management experience generally and none in managing any sort of facility or service such as that he was put in charge of
- Dr. Jager had little or no appreciation of the workings of the bureaucracy in which he was required to work
- in this background, Dr. Jager was provided with no formal mechanism for professional support and a level of management which failed repeatedly to exercise an adequate level of control over the manner in which he managed people and resources within the service.

Further the evidence supports the view that the consequences of that appointment were

- a FMHS which did not operate as a cohesive team indeed had so much internal conflict it is surprising it continued to operate at all
- a reduced level of service of the FMHS to the population within the Risdon prison complex
- a reduced level of communication between forensic, medical and custodial staff in relation to inmates
- a psychiatrist operating in an environment without regard for the rights of inmates and without exercising an appropriate level of care; I refer in particular to the intimidation of Laurence Santos by Dr. Jager with a syringe in May 1999, the lack of adequate controls on the care of Laurence Santos given he was receiving the type and level of medication he was and the failure of Dr. Jager to appropriately follow up significant medication prescribed by him to Fabian Long on discharge to the general prison population when on his own admission he did not have confidence in the accuracy of drug charts and in any event apparently made no effort to review them.

I do not accept that these problems were caused by factors external to the appointment such as increased prison numbers and the inability to fill professional positions. That is because the fact of the former and the probability of the latter were both matters which either were known or should have been known and taken into account in all actions of the DHHS and it's employees in 1999.

CHAPTER 8 DEPARTMENT OF JUSTICE AND INDUSTRIAL RELATIONS MANAGEMENT PERSPECTIVE

As I outlined at the beginning of this document both the DJIR and the DHHS have a role in the provision of services to inmates in the Risdon Prison Complex. A number of witnesses from each who were at managerial level or above the level of what I might describe as general staff gave evidence and I have already canvassed the management response from DHHS. I will deal in this chapter with the response of DJIR to issues.

Witnesses from DJIR were

- Mr. Denbeigh Richards, Deputy Secretary, Corrective Services
- Mr. John Dodd, Director of Prisons
- Mr. Graeme Harris, General Manager of Risdon Prison
- Mr Kevin Salter, Accommodation Manager, Risdon Prison
- Mr. Greg Jones, Operations Manager, Risdon Prison
- Mr. Paul DeBomford, the Director of Nursing
- Mr. Alan Burton, Manager of Security Unit, Risdon Prison
- Mr. Craig Hughes, Unit Manager of the Hospital
- Mr. Kenneth Bain, Unit Manager of the Hospital until 17/9/99.

Issues Arising

Suspension Points

Mr. Richards had held his position since February 1996 having worked in Corrective Services in Victoria for a number of years before that. At the time he gave evidence in April 2000 he had in fact resigned from his position and was about to leave the department to move interstate. He agreed that his principal area of responsibility had been Corrective Services generally and Risdon Prison in particular. He answered to the Secretary of the Department, Mr. Richard Bingham.

Mr. Dodd had held his position as Director of Prisons since August 1997. He had never been a custodial officer nor managed a prison before, his past roles being predominantly administrative in Community Corrections areas. Mr. Harris had been general manager of the prison for 9 years and a custodial officer for many years before that. All the other witnesses named had worked for long periods at the Risdon Prison Complex.

Mr. Richards was the most senior officer in the area of Corrective Services who gave evidence at the inquest. He was not unfamiliar with the role of giving evidence at an inquest as he gave evidence in 1999 at the inquest in relation to the death of Timothy Hayes who died at the prison in 1998. Mr. Richards also held his position when coronial findings were handed down in 1996 in relation to the death of an inmate by hanging. He was asked if he remembered those findings and he said

> *"Well I remember that they included recommendations about the removal of hanging points in the cells in the prison hospital"*

He was asked if he was aware of coronial findings in the deaths of inmates Crowden, Crowder and Kelly in the years before 1996. He said he was aware of these and agreed he believed they all contained recommendations about the removal of hanging points in cells. When asked what if any response there had been to any or all of these coronial recommendations over the last 10 years in relation to hanging points, he said that the response to the 1996 findings was that 15 cells in the prison hospital had the sprinkler heads modified to be recessed.

An examination of the prison hospital layout shows that there are more than 15 (excluding what are described as the observation) cells there. On the morning of the 20/3/00 (the day the inquest hearings began) an inspection of the cells in the prison hospital in which Thomas Holmes and Jack Newman died revealed there remained hanging points in those cells on that date.

Mr. Richards was actually asked what other response there had been to coronial recommendations about hanging points over the last 10 years. He replied

> *"Well given that all of those were prior to my occupancy of my current position, I'm unable, without going back through previous records, to be able to say what was done in relation to those previous matters."*

Mr. Richards gave his evidence on the 18 and 19th April 2000 approximately a month after the start of the inquest and had the benefit had he wished to have it of knowing what evidence had been given up until that date. The Department through its Counsel had had access to daily transcripts of that evidence. A significant issue in the Hayes inquest in which Mr. Richards gave evidence little more than a year before was suspension points in cells. There can be no doubt he was aware that an area of focus at this inquest would be the prevalence of suspension points in cells.

I found his attitude cavalier in that he made no attempt to find out clearly relevant information to assist the inquest. Further when he had the advantage of an adjournment from late one afternoon until early the following afternoon during his evidence he apparently made no effort to come back

the next day and say well look I have now made some inquiries and this is what was done. He simply said on the second day, if you want further information I can get it.

His attitude did not reflect well on the department nor did it reflect well on him in that he appeared to have little regard for the statutory obligations of the department in which he was a senior officer.

Mr. Richards and other witnesses were asked a number of questions about responses to coronial recommendations about suspension points and the reasons behind what appeared to be the lack of response.

The inquest was told that the operating budget for prisons statewide in the 1999/2000 year totalled some $17,600,000.00 and contained an allowance of some $112,000.00 for maintenance. That allowance in the previous year was only some $55,000.00. Such allowance was simply not sufficient to meet day to day maintenance costs and the costs of major works. For any major works grants had to be sought from the capital improvement fund maintained by Treasury. In February/March 1999 a management decision was taken to look at the refurbishment of all cells in the prison complex. However no bid was made for capital funds to achieve this, the bid only being made for funds to cover such work at the hospital and some other matters Mr. Dodd outlined.

The particular grant applied for in 1999 and obtained was for $400,000. Approximately $280,000 was to be spent on refurbishing cells at the hospital with the primary focus being the removal of suspension points. The work was to have been finished in March 2000 but had not been. The balance of this grant was to be used to upgrade the duress alarm system (the new system of which was still not operational at the time he gave evidence because of difficulties between the unions and management), to upgrade the closed circuit television system, to refurbish the ablutions block at the Hayes Prison Farm and to replace clothes washing facilities in the yards at the prison.

Mr. Dodd explained that no bid was put in for the refurbishment of cells generally because they prioritised projects and projects for which funding was sought were thought to be of higher priority. He conceded that no deaths had occurred as a consequence of any inadequacy in the washing facilities or the ablutions block.

Both Mr. Richards and Mr. Dodd said that a preliminary estimate of the cost of refurbishing all the rest of the cells in the main jail was put at $4,000,00.00 based on the costs of the hospital work but it seemed that no actual costing had ever been done.

Mr. Dodd was asked what had caused management to decide to look at refurbishing cells in the first place, he acknowledging that these deliberations appeared to have taken place prior to Coroner

Matterson's recommendations about the removal of suspension points in his findings into the death of Inmate Hayes handed down in June 1999. His response was that it was the state of the cells and the content of coronial recommendations. He couldn't say why it had taken management 3 years (that being the time passed since the coronial recommendation prior to the Hayes matter) to take note of a coronial recommendation.

Mr. Dodd said he was generally familiar with coronial recommendations that had been made in the past. He said that they would be responded to to the extent that recommendations were feasible and it was advisable. He agreed that a constant theme in the findings over a number of years was the removal of suspension points and the design and fit out of cells generally in both the hospital and the main prison. He also agreed that this was a common theme in other jurisdictions. He was also aware of a major report completed early in 1999 in relation to Victorian prisons. He had not read the whole report only the recommendations and he was conscious that issues such as cell design, levels of observation of inmates, isolation of inmates and communication and exchange of information between sectors within a prison complex were issues dealt with by that report. He agreed where deaths by hanging were being considered cell design was the issue of greatest priority.

It was apparent from the evidence that while there was an awareness by managers at senior levels of coronial findings there was often little detailed knowledge and certainly no formal protocols pursuant to which there would be discussion by such managers of any recommendations with a view to perhaps implementation of some.

As to suspension points, Mr. Dodd told the inquest that all cells in the hospital satisfied Australian Standards for fit out but agreed there had been no specific assessment as to their capacity to monitor mentally ill people.

Mr. Richards actually conceded [178] when he gave evidence that had Chris Douglas been housed in accommodation bereft of suspension points the probability was that he would still be alive.

The following exchange occurred between Counsel Assisting, Mr. Cooper and Mr. Richards which is instructive as to the approach apparently adopted by those in control of the prison [179]

> *"But you agree with me that if you don't ask you don't receive. Why haven't you asked for money from the Capital Improvement Program to eliminate suspension points in the prison, apart from the latest grant?.....A matter of reality about the extent of moneys that would be required, and if that were to be contemplated, there would be indications in the way in*

[178] See transcript page 2454 line 9885

which these matters are determined. There would be indications at a policy level that there was support for that as a priority as happened in the example of the Remand Centre that you used. It would be a similar - in very broad terms, a similar order of cost. The Remand Centre cost something like four million dollars. A complete modification of all the cells in the prison system to make fully would be the same sort of order of cost.

All right. So is it the case that the answer to the question is, "no, apart from the prison hospital grant we haven't asked for any money because we didn't think we'd get it".....A combination of "we didn't think we would get it" and "they were not the priority areas identified within the prison system". Well that work was not one of the priority areas.

What, the elimination of suspension points was not a priority identified within the prison service?……Not as of sufficient priority or not ranking in the priority with them - with the matters that were the subject of those bids for capital works money.

What's more important than keeping the prisoners that are under your care and custody alive?……Nothing is more important than that.

And does not the elimination of suspension points to the extent that that can ever occur go an enormous way to reducing the risk of prisoners dying when they're in the custody of your service?……It does certainly go a long way towards that, yes.

Yet your answer remains that, "We didn't consider that that was a priority", correct?……The answer was that it was not considered in each of those years as high a priority as the matters which were put before the capital works.

And what were those matters?……Well I've mentioned the ones, some of the ones that were undertaken last year.

So weather proofing a couple of yards, yeah, what else?……The work on N-division that I mentioned.

Yes, so that was an office?……Yes.

And putting power on, what else?……Well in previous years we have undertaken work of building a dining and or purpose area within A-division and - within the prison which

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[179] See transcript starting page 2448

became the medium security unit. Works to the shower blocks in that area. There's been other work been undertaken much more recently and modifications to electrical work in the system. The replacement of a switchboard for example that had failed, the provision of duress alarms, a number of other projects.

Not any of those projects could in anyway shape or form be said to have had any possible impact upon rates of deaths in custody could they?……No, that would be correct.

Part of the reason that you advance, or seem to be advancing, in relation to why no request has been made for capital improvement program for a grant to attempt to eliminate suspension points is, "It's too much money, it's going to be about four million dollars and we won't get it", is that fair?……Yes, something to that effect.

Would not it have been more likely to have found favour with those controlling the purse strings if the request for the grant or bid, I think the expression is, was pitched at a lower level? So rather than asking for four million if you ask for two hundred thousand would you consider you're more likely to get it?…….Yes, by and large.

And as it's happened the hospital has cost about two hundred thousand, two hundred and fifty thousand, has it?……That's right.

And that has led to the elimination of suspension points?……Yes, I certainly hope so.

Did it ever occur to anyone that a yard by yard approach might well have found favour with those controlling capital improvement program; that is to say, "We'll put in a bid and we'll attempt to eliminate suspension points in A-yard for example", did that not occur?…….Well the thought probably had occurred but the bids were not made.

You would agree with me, wouldn't you, that over the last ten years the deaths in custody have been confined to identifiable - deaths in custody by hanging, have been confined to identifiable areas in the prison?.....Yes, predominantly the hospital.

Predominantly the hospital. A couple in the old remand yard, which was H-yard.....Mm, Mm.

And more recently, a couple in E-yard.....That's right.

Steps have been taken obviously to attempt to eliminate suspension points in the hospital. Did it not occur to you, that a yard by yard basis, tackling those yards that house prisoners most at risk, might well have found favour with those controlling the purse strings?.....Well I answered earlier that, yes, the thought occurred but the emphasis in our approach was on managing that risk in ways other than spending the money on eliminating suspension points in the cells. "

The inquest was told in April 2000 that there were then proposals before cabinet relating to the Risdon Prison Complex. The alternative proposals were to build an entirely new prison to replace Risdon, build an entirely new prison and refurbish Risdon or just refit the cells at Risdon. He agreed that while the latter option would be the cheapest it would be very difficult to bring Risdon up to the standard of a modern prison and that qualitatively the result would be very different from a purpose built facility.

There is no doubt from the evidence I heard that numerous coronial recommendations made during the 1990's about the removal of suspension points in the Risdon Prison Complex were ignored by those with the responsibility for the care and wellbeing of the inmates at that complex. There is no doubt those same persons were aware that there was a percentage of inmates within the population at the prison complex more susceptible than usual by reason of their state of health, age or particular vulnerability within the prison to suicide.

The primary reason advanced by most witnesses for this consistent ignoring of recommendations was that there was no money available for such work. However there is clear evidence that the only possible source for it which was the capital improvements fund maintained by the government of the day for any capital works was not even applied to. The reason given for that was that the cost would be so great we did not think we would ever have a chance to get it. The yard by yard approach to refurbishment suggested by Counsel Assisting to Mr. Richards may well have been a possibility some years ago when the prison complex had not reached its present age. However from the evidence of the proposals now before cabinet it seems clear that was not in recent times considered economical to adopt this approach.

Mr. Richards argument was that in the absence of any moves to eliminate suspension points the risk of deaths in custody by suicide could be managed by identifying those inmates at risk and having them dealt with in the prison hospital. He said the procedure to identify that risk was the initial assessment of inmates on admission to the complex and staff within the prison identifying or responding to requests for further assessment at any point during incarceration. He agreed that

- this procedure relied on custodial officers making those assessments,
- those custodial officers had no training in making those assessments,
- the procedure relied on proper and adequate lines of communication between yard officers and the hospital and an expectation that a need for assessment and any referrals of person in need would be dealt with quickly and appropriately, and
- that if it did not operate properly the system would break down.

He also agreed that in Chris Douglas' case the system broke down because he asked for help, it was not given and he was then locked in a cell with an abundance of hanging points. The same system which let Chris Douglas down still existed 5 months later and did not recognise the problems with Fabian Long, he too being locked in a cell with the same abundance of hanging points as Chris Douglas was.

The system also did not work as far as Thomas Holmes and Jack Newman were concerned. They were actually in the hospital to which Mr. Richards said people at risk should go but were placed in environments again with an abundance of suspension points. Mr. Richards attitude as displayed while he gave evidence was a generally uncaring one.

A number of other issues were canvassed with these witnesses. These were

- The delivery of service by the FMHS to the Risdon Prison Complex and the response to problems with that delivery
- Inmate numbers and staffing levels within the prison complex
- Review of standing orders
- Cell Checks
- Files
- Access to Services at Prison Hospital
- Management Structure within prison hospital/staff
- Medication to Inmates/Drug Charts
- Role of Nursing and Custodial Staff (including training of such staff) in the prison hospital
- Carrying of Cell Keys at Night by Custodial Officers
- Radios
- Arunta Telephone System
- Personal Alarms
- Employment of Inmates within the prison complex
- Management of Prisoners
- Management Generally

Delivery of Service by the FMHS to the Risdon Prison Complex and the response to problems with that delivery

As I indicated earlier, there appeared to be a lack of recognition from some witnesses and indeed some counsel that this inquest was looking at the service being offered to inmates at the Risdon Complex and not at the general concept of service to be provided by the FMHS in the state of Tasmania. There may well be a national mental health policy which places emphasis on the extension of mental health services to the community and Dr. Jager may well have thought he was acting in accordance with that. However this inquest is dealing with the level and quality of service to prison and hospital inmates during a period in 1999.

It appears that Mr. Dodd and Mr. Richards met with Dr. Jager in March/April 1999 at which time Dr. Jager outlined a number of ideas he had for the Forensic service. Mr. Dodd said the proposed move of Dr. Jager's office to Glenorchy was discussed although Mr. Richards said he did not think it was. Mr. Dodd said he had no control over that anyway and all he was concerned about was the level of service. His understanding was that while there would be a change in the way service was provided the net result would not change.

As to the move Mr. DeBomford, the Director of Nursing at the hospital stated that, while there had been some informal discussion between him and members of the forensic team about it, the first he knew it had gone beyond the proposal stage was when Dr. Jager's secretary told him a couple of days before it happened that he should expect removalists at the hospital. He expected a formal process of consultation and was surprised this did not occur.

Mr. Dodd said that he , Mr. Richards and Dr. Jager discussed Dr. Jager's idea to remove the forensic team psychologist from a role in the classification process. Two aspects of this issue highlight the measure of the disharmony which came to exist in 1999 within the Forensic team and the lack of communication between custodial and forensic teams. These were that Dr. McCarthy the psychologist ignored Dr. Jager's directive in relation to her continuing role on the classification committee because she felt so strongly about its importance and Mr. Salter, the chairperson of the classification committee, believed her involvement was valuable. He was not apparently consulted about the proposal.

Another issue discussed at the April meeting was the contact time between inmates and the members of the Forensic team. Mr. Dodd agreed that he was aware that Dr. Jager's proposals involved a reduction in Dr. Jager's actual hours at the prison. He later conceded that there had been

a decline in 1999 in the hours members of the forensic mental health service team spent at the hospital which coincided with a dramatic increase in prisoner numbers at Risdon.
Mr. DeBomford said the issue of service delivery was only discussed after the move and at that point he was given the impression service would improve. He was told of the plans to remove the full time psychologist position and to appoint a half time psychologist, a registrar and 3 sessional psychiatrists. He realised that none of this happened. He said he expressed concerns about the state of the service to inmates to Mr. Richards and he also raised it with Dr. Jager. He believed inmates were not able to access the service quickly enough. At the time he raised that matter with Dr. Jager he said Dr. Jager was still confident he would get the extra staff he had foreshadowed.

Mr. DeBomford was of the view that the move of the offices of Dr. Jager, his secretary and the social worker to Glenorchy when combined with the lack of appointments of any proposed sessional psychiatrists and registrar resulted in a reduced forensic health service to inmates. His perception was quite clearly that whereas once the forensic team had been based at the prison hospital now what members it had only visited. His perception was clearly that Dr. Jager was less visible in the hospital than Dr. Lopes had been and certainly less accessible.

The evidence before the inquest however is that as far as the DJIR was concerned this was a health department problem and it was therefore not their responsibility to do anything. This is notwithstanding a clear acknowledgment that the DJIR ultimately had the legal responsibility for all inmates whether they be forensic service patients or not.

Mr. DeBomford referred to other matters he saw as impinging on the delivery of service. He described a practice which existed when Dr. Lopes was the forensic psychiatrist where he said there were daily meetings at the hospital attended by both nursing, custodial and forensic staff. Dr. Lopes did not necessarily attend all of these but he did attend at times. Mr. DeBomford acknowledged these meetings were not formally arranged nor at the direction of Dr. Lopes. However he perceived that they were a valuable exercise in exchange of information amongst the various people essentially dealing with the same inmates. They stopped when Dr. Lopes left. The implication from the questioning of witnesses by Dr. Jager's Counsel was that these meetings were never part of any formal structure that Dr. Jager was told of on arrival and that he was not actually responsible for stopping them.

As to Dr. Jager's knowledge of the meetings, a custodial officer who worked as second in command to the unit manager of the hospital, SCO Hughes, said he raised in Dr. Jager's presence about having the weekly meetings. Dr. Jager may very well not have made a conscious decision to stop these meetings but the fact of the matter is they stopped and what may have been a method of encouraging communication between disciplines was lost.

Mr. Dodd was asked whether he had had any specific complaints from staff at the hospital about Dr. Jager. He responded that all he ever had was a general impression that staff were unhappy with him but had no specific complaints. His impression was the unhappiness was a reaction to the change from Dr. Lopes. He said he had no formal comment from the Director of Nursing as to how things were going although there may have been informal comment that he could not define.

Mr. DeBomford described the difference between Dr. Lopes and Dr. Jager in terms of Dr. Lopes having a broader definition of "team" and encouraging an informal flow of information about inmates. He described Dr. Jager as being more formal and clinical, these not in themselves in any way derogatory descriptions clearly reflecting different personalities. However he said that while Dr. Jager said he liked to get information about inmates from custodial officers and nurses, he appeared to spend less time at the prison, when he was there he spent more time in his office and he would go to the inpatients area but have no interaction with staff.

Mr. Bain raised a further concern about service delivery. He said he perceived that it was not only that Dr. Jager was not often in attendance at the hospital it was also the times that he did come. He repeatedly came at meal times wanting to see patients and was told several times that this caused difficulties in providing meals for inmates. There were times when interviews simply did not happen because of this. There was evidence in a similar vein about visits by Dr. Jager on a Sunday when staff were simply not available to assist him.

Mr. Bain was also of the view the team approach broke down after Dr. Jager came to the hospital. He said all sections used to work together but after he came they seemed to fragment. He also said that all inmates were different but sometimes if you had a bit of information about their illness it made them easier to manage.

Mr. Dodd went on to say that in the last 3 to 4 months of 1999 he began to have concerns about the operation of the hospital in 2 areas being the apparent redefinition of the forensic service client group and the quantity of service to what had become a significantly larger group.

Mr. Dodd was unaware that Mr. Newman had written objecting to his being treated by Dr. Jager and that Laurence Santos had complained to the Ombudsman about the medication being prescribed by Dr. Jager.

Mr. Richards was questioned about whether any formal mechanism existed to enable his department to satisfy itself that the level of service of the forensic team to the inmates within the Risdon Prison Complex for whose wellbeing it was responsible was adequate. He referred to regular meetings he

had with Dr. Jager and Mr. Dodd but then said otherwise it was the responsibility of the Department of Health.

He said he became aware about October 1999 of concerns being expressed by prison staff that the forensic service was not accepting referrals from people who were not deemed to be mentally ill. He understood this was causing problems for prison staff properly managing these difficult inmates. Notwithstanding that, he was satisfied at the end of 1999 that the FMHS was providing an adequate level of service to the prison population. He was aware that the Department of Health appointed a manager for the service at the end of 1999 and also set up a system which allowed Dr. Jager to obtain second opinions. These steps did not however cause him to question his own level of knowledge about what was going on. He saw the steps as an augmentation of the service and said again, anyway it was the Health departments responsibility. His view of the adequacy of the service at the end of 1999 was not affected he said by the deaths in custody.

Mr. Richards interestingly given his senior position had no knowledge of any research about difficulties in the co-management of a forensic unit by health and justice interests because of priorities between clinical care and security issues. He also told the inquest that in the past there had been no senior level consultation about responses to deaths in the prison hospital between health and justice - each simply responded as they deemed necessary.

Inmate Numbers and Staffing Levels Within the Prison Complex

There can be little doubt that the increase in inmate numbers in 1999 also affected the ability of the Forensic team to provide the service to inmates it had supplied under Dr. Lopes. On Dr. Jager's own evidence that is not something he really even considered when he advanced his various proposals for change.

It appears that across Tasmania prison inmate levels rose from about 250 in August 1997 to about 390 in April 2000. There had been an increase in custodial staff numbers in the same period of 15, 9 of whom were based at the Hobart Remand Centre. The other 6 were all appointed on a full time basis in the maximum security yards at Risdon. This evidence was led by Counsel for the Secretary of the DJIR. However my impression of the evidence was that Mr. Dodd who gave it did not have a clear grasp on the figures and the evidence is at odds with the perception of almost every custodial officer who gave evidence at the inquest which was that custodial staff numbers had dropped. CO Fraser gave evidence in his capacity as a union representative for custodial officers. His evidence was that custodial manning levels were inadequate. Mr. Greg Jones, the operations manager of the prison over the period of these deaths also expressed concern that at that time staffing levels were inadequate after lock down of inmates.

Mr. Jones in fact went on to say that as at when he gave evidence on the 9/5/00 staffing levels had just altered in that one additional staff member had been rostered on the 3 p.m. to 11 p.m. shift in the yards and that was a chief custodial officer as a roving officer in charge. He acknowledged that this staffing change did not improve the numbers of officers actually rostered to patrol in the accommodation yards at night.

Mr. Harris was of the view that there was sufficient staff at Risdon, a view which suggests he was out of touch with the day to day workings of the prison.

Review of Standing Orders

Mr. Dodd gave evidence about standing orders within the prison which he said were his responsibility. He told the inquest that the general manager of the prison was then working on an extensive review of standing orders. He was asked what prompted that and he responded that it was prompted by the proclamation of the Corrections Act and the need to monitor generally with knowledge gained from experience. This evidence was given in April 2000. The Corrections Act came into force on the 1/8/98 and had been in the pipeline so to speak for many months before. The service's reaction time clearly left something to be desired.

It seemed in fact that there were three different "rules" governing processes at the prison. There were Director's Standing Orders, Standing Operating Procedures and Prison Rules. As part of this review it appeared that the last 2 and some of the first in so far as they related to the Risdon Complex were to be incorporated into one. Mr. Harris' evidence was that Standing Operating Procedures were being constantly monitored and amended where appropriate. It appeared only one was rewritten in response to any of the deaths under investigation and that was number 2.17 issued on the 13/1/00 in relation to cell checks to remove the confusion which clearly existed as to the timing of them.

Another change was approved on the 4/2/00 and that was to have an amendment recording sheet attached to Directors Standing Orders. The inquest was told such a sheet already was attached to Standing Operating Procedures.

Cell Checks

It was clear from the evidence of witnesses that their understanding of the timing of cell checks and the manner in which they were carried out differed greatly between officers. Management representatives insisted cell checks overnight were half hourly and often described the manner of a

cell check as being far more intrusive than it was clear any custodial officer on the ground did. It seems clear that steps need to be taken to ensure all officers know exactly what the rules are for the timing of checks and that that knowledge is regularly reinforced. The manner of a cell check also needs to be reviewed to determine it's purpose and to allow for different types of checks depending on the whereabouts of an inmate, his status and circumstances again with regular reinforcement.

Files

The evidence before the inquest demonstrated it was possible for there to be a number of files within the prison complex relating to an inmate. Were for example an inmate to be in the yards but be an outpatient of the forensic service, there would have been at least four files relating to him. These would be his prison file, his unit file and two files maintained within the prison hospital. One of these was a general medical file maintained by hospital staff relating to each inmate who was treated there. The other was a file maintained by the FMHS in relation to each of those persons who was also a patient of that service.

As to the prison and unit files they contained different information with some overlap. The accommodation manager, Mr. Salter, was responsible for the prison files with the assistance of a records clerk. Until shortly after the death of Mr. Newman the system was that if a file were taken from the records section that was recorded on a whiteboard. That system broke down in relation to Mr. Newman in that the file was found to have left the records section but there was no entry on the whiteboard. It was located and Mr. Salter has since implemented a system of recording file movements in a book.

A comment should be made about the prison files. I had an opportunity to inspect those tendered at the inquest. None contained an accurate record of the movements of the inmate it related to, his status from time to time or the reasons therefor.

Discussions have evidently taken place about the issue of reducing the hospital based files to one. It appeared that Dr. Jager did not disagree with that proposition. However the unresolved issue was which file would be maintained, Mr. DeBomford being of the view the medical file already existed and so it should be the one to be maintained. The files contained different information neither being a complete record of the inmates overall treatment

Access to forensic files also became an issue. Prior to Dr. Jager taking up his position, these were kept in a locked filing cabinet in the office of the service's administrative assistant at the hospital and the Director of Nursing had access to those cabinets. After Dr. Jager arrived, the files were

moved to another room and were placed in locked cupboards and locked filing cabinets. While the evidence was unclear as to whether those files were subsequently stored at Glenorchy, even if they remained at the prison and each member of the Forensic team had a key which would permit access, there is clear evidence such members were not always available at the prison and therefore access to forensic files would have to have been restricted to those times they were.

It follows that nursing staff did not necessarily always have access to what was written by Dr. Jager or any other member of the forensic team in it's own file relating to inmates being dealt with daily by staff at the prison.

In fact Mr. DeBomford indicated that simply because of staffing levels it was not always possible for Dr. Jager to see a client with one of his nurses present even though he may have asked for that. The result could be that Dr. Jager could see a patient without there ever being a note in the medical file. Dr. Jager might subsequently tell a nurse he saw inmate X. However that did not automatically guarantee an entry in the medical file and subsequent nurses on duty may be unaware of the consultation and would certainly be unaware of what took place.

This is clearly an unacceptable situation and one which hinders rather than promotes communication of information between disciplines. Director of Nursing DeBomford indicated the only way round it would be to have a nurse present at all forensic consultations (this would also allow for a better flow of information from nursing staff to the treating doctor). However clearly the problem would also be remedied if only one file were maintained.

A further comment should be made about the medical files tendered to the inquest. They consisted of a quantity of loose documents in manilla folders. There was no attempt to have documents secured in any manner at all and documents were certainly not kept in any order. To find anything it was necessary to just leaf through until it was found. There was in one case two sets of nurses notes for the same dates with different entries. The files generally were in an unsatisfactory state such that there was little way to tell that all relevant information was actually there. As such in my view they were an unreliable source of information and did not reflect well of the professionalism of those operating the prison.

Access to Services at Hospital

Director of Nursing DeBomford confirmed the evidence of earlier witnesses as to the manner in which inmates gained access to hospital services. He said it was gained by requests given to the nurse at the medication parades. Such requests came back to the hospital. Those directed to the

Forensic Service were passed on to them. Otherwise they were prioritised within the hospital and dealt with.

Verbal notifications were also recognised. If an emergency were identified the inmate would be brought direct to the hospital. If it was not an emergency, the inmate would be told to complete a request.

The Directors evidence was that there was a review being undertaken of this process with a view to recognising 3 methods of referral, namely an inmates written request, an officers referral and an inmate's verbal request.

Management Structure Within Hospital/Staff

The Director of Nursing was responsible for the nursing staff who delivered the care within the hospital and was himself responsible to the Director of Prisons. He was not responsible for the medical staff who prescribed the care in the form of Dr. Beadle the medical officer. He also had no responsibility for any member of the FMHS team who may work in the hospital (who in fact were the responsibility of another government department altogether) or any custodial staff. Custodial staff were the responsibility of the Unit Manager of the hospital. The Director of Nursing was also expected to coordinate services bought in to the prison such as dentistry, optometry and physiotherapy.

The Director of Nursing had two clinical nurse consultants responsible to him, one for medical services and one for programs/psychiatric. The latter's area was to organise programs for psychiatric patients.

Up to the end of April 2000 the nursing staff at the hospital consisted of one nurse in the inpatient area on an 8 a.m. to 8 p.m. shift and the 8 p.m. to 8 a.m. shift, one nurse in the outpatient area on a 7 a.m. to 7 p.m. and 7 p.m. to 7 a.m. shift on weekdays and 2 nurses in outpatients from 7 a.m. to 7 p.m. on weekends. That altered at the beginning of May 2000, that is during the currency of the inquest, to increase the nurse levels from one to two on the inpatient shifts. Mr. DeBomford told the inquest that this increase had been introduced because of an increase in the number of inmates in the prison and professional concerns of nursing staff about the delivery of service. He said there were concerns that nurses could not respond to all incidents that occurred and provide an acceptable level of care as well. The prime example of this was that where a nurse was called at night to an incident in the prison there was no nursing cover at all in the hospital.

The other aspect of staffing which was highlighted by the evidence was that the nursing staff had varying levels of training. Some were general nurses others had psychiatric training as well. It appeared that it was simply a case of who was rostered on a particular night and there were no guarantees that there would always be a psychiatrically trained nurse on duty to deal with psychiatric patients. It was also apparent that there were short term and casual appointments at times which resulted in staff at the hospital who were inexperienced. That may not be as significant a problem now that there are 2 nurses rostered together.

Mr. DeBomford also confirmed to the inquest that nurses shared cell checking with custodial officers at times.

Mr. DeBomford was asked about nurse/patient ratios in the hospital. His view was that they were worse than anywhere else he was familiar with and on occasions could be 1:22. Similar evidenec was given by nursing staff who had experience elsewhere. While questioning from some Counsel was directed towards ameliorating what on the face of it seemed an unacceptable level, the bottom line was that the issue was directly available nursing staff to care for patients and not the existence of other bodies who may or may not be there and whose full time role was not in any event hands on nursing. Mr. DeBomford pointed out that there were not always custodial officers with any experience at working in the hospital on duty and furthermore custodial officers generally appeared to have only minimal training in dealing with psychiatric patients. To his knowledge apart from recruit training there had been no hospital orientation course for custodial officers since 1992. This problem appears to have been recognised to a degree by the rostering of further nursing staff on the shifts working in the inpatients section of the hospital.

Medication to Inmates/Drug Charts

Medication was dispensed to inmates in the hospital at approximately 8 a.m., 12 noon and 4.30 p.m. By the time Laurence Santos died there was also a group who were receiving medication at 9 p.m. As to inmates in the general prison population, they received their medications at medication parades held at meal times. Nursing staff went into the prison with the various drugs already prepared for each inmate due to have medication and took with them the drug chart folder. Drug charts for each inmate were maintained as part of their medical file but while a prescription was current that chart was kept apart from the medical file in a drug chart folder.

When a nurse dispensed medication whether it was in the hospital or to an inmate in the general population, he or she was supposed to initial the drug chart to indicate the medication had been dispensed. There was evidence relating to Laurence Santos that in fact a nurse had initialled his

drug chart to indicate he had been given medication but that the particular entry related to a time after his death.

Attendance at medication parades was voluntary. If an inmate did not attend medication parade his chart should not have been initialled and that information would be available to the prescribing doctor at the next review of medication. The timing of such review might depend on the duration of the particular script. Were the non-attendance at medication parade deemed an urgent matter by the nurse, she could bring it to the doctor's attention by either writing a referral or seeing him personally.

Mr. DeBomford was of the view that if there were only one non-attendance then that would be left to the next routine review and only if non-attendances increased would a nurse report it. There were nurses daily reports maintained for the outpatients nurse where such matters could be recorded.

Mr. DeBomford also told the inquest that in fact there were three types of the PRN medication and the difference would not necessarily be apparent from the drug chart. These were medications given at the patients request, at nurses discretion or at nurse initiation.

There were clear errors in drug charts apparent on evidence given at the inquest.

Role of Nursing and Custodial Staff (including training) Within Prison Hospital

This is one of the issues which came up repeatedly during the course of the evidence.

Director of Nursing DeBomford saw the role of nurses not only to implement treatment as instructed by the medical officer or psychiatrist but also to advise the doctor if they thought treatment was inappropriate or needed to be reconsidered. His reasoning for the second arm of this role was that his nursing staff inevitably saw the inmates far more often than the doctors did.

As to custodial staff almost without exception those who gave evidence held the view Dr. Jager had no time for their views about inmates. Further, there was no specific training of custodial officers in relation to working in the hospital or managing forensic psychiatric patients. Such officers were obliged to depend on what they could pick up on the job and information gleaned from the nurse and the Clinical Nurse Consultant, Mr. Balmer. Mr. Bain, who was the unit manager at the hospital until the 17/9/9, told the inquest there used to be a course but it ended in the early 1990's, he believed because of lack of resources. Mr. Bain in fact raised the issue of training of officers in the

context of his move from the hospital to other duties saying he was given effectively no form of induction into those new duties.

Custodial officers for example were given no information as to any particular things about patients they should be alert for such as drug side effects notwithstanding that they often had the more frequent contact with inmates.

Carrying of Cell Keys by Staff at Night

Director of Nursing DeBomford held the view that security issues within the hospital could be addressed were cells allowed to be opened provided any two staff were present whether they be two nurses, two custodial officers or one of each. He recognised the need for cells to be able to be accessed urgently on occasions, that is more quickly than they could be should cell keys be required from main gate.

The view held by most senior custodial staff was that keys were not carried at night for 2 reasons. One was that a single officer might be overpowered by an inmate feigning illness (human nature being what it is they would be unable to restrain themselves from entering the cell alone) and the second was that it was protection for an inmate from any unwanted activity by a custodial officer. It was put to most that the whole problem would be resolved were there to be two officers patrolling together at all times. While most could see no reason why that proposition would not resolve the problem, there seemed a reluctance to consider it. General Manager Harris in fact said he did not personally see the need and basically argued against the idea on the basis of the difficulties in rostering. This was notwithstanding he agreed that the danger period for inmate suicide was after lockdown and therefore the proposition involved further staff only at night.

For an officer as senior as Mr. Harris, this reluctance to consider options in the face of clear inadequacies in a system seems incomprehensible.

Radios

General Manager Harris agreed that the function of custodial officers at night was to check on prisoners and maintain security in the prison and that in emergencies communication was vital. He was unable to explain why it was that custodial officers did not carry radios at night notwithstanding that without further expenditure those presently issued to management personnel who went off duty at around 5 p.m. could be reallocated.

He agreed the carrying of radios would enhance security within the prison. He told the inquest that Mr. Dodd had raised the possibility of officers carrying radios at the end of March 2000 that is after the inquest hearings began and 6 months after the first of the deaths in custody.

Arunta Telephone System

Until January 1999, the security unit was based in the maximum security complex where the Arunta telephone system monitoring equipment was housed. Any monitoring of the inmates calls was done by security unit staff when they had spare time to do so. In January 1999 the security unit was moved to a cottage outside the prison perimeter but the Arunta system remained where it was. Mr. Burton told the inquest that before the move staff monitored calls on the system for a period each day which they could do while they did administrative work. Since the move there was no daily monitoring.

He said that he had repeatedly raised the question of moving the Arunta system to where the security unit was but this had not found favour because of financial constraints. The system was a computerised one and only minimal training had been given to officers in its use. Again Mr. Burton said he had requested training but was told that budget and time precluded it. His view was that the monitoring of the system could be a valuable security tool.

He also told the inquest that he had made inquiries about the cost of moving the system and was initially told between $10,000 and $15,000. He was told at that cost it just would not happen. He later discovered that with the installation of some software at minimal cost the system could be monitored from the security unit's office. Mr. Burton said he passed that information on to senior staff and also raised logistical problems in monitoring.

Mr. Harris told the inquest he cannot recall anyone raising with him the difficulties associated with monitoring as a result of the move of security staff. He acknowledged Mr. Burton had told him about the availability of software to enable monitoring from the security unit office but said he did not recall any mention of it's being at minimal cost. I accept that Mr. Burton did indeed pursue this issue as he asserted.

Mr. Harris went on in his evidence to say that the system was primarily there to facilitate contact between prisoners and the outside in a controlled manner and that call monitoring was a secondary feature of the system. This attitude again seems somewhat incomprehensible. Why would the recording facility exist if his view were correct. It is difficult to accept such an attitude when it is clear on the evidence that in relation to Chris Douglas and Jack Newman had there been a culture of

monitoring of calls by personnel trained to be aware of implications of their content, both of these inmates may have been alive today. This is compounded by a situation where Mr. Newman's calls were indeed monitored and important information obtained through that process was passed to a senior officer and ignored.

Mr. Burton was questioned by Counsel for the DJIR about the hours of operation of the Arunta telephone system, the implication clear that it may be physically impossible to monitor all calls. That may be so. However that does not absolve the department from its statutory responsibilities to inmates and allow it to say that negligible monitoring is quite acceptable.

Again resources or indeed the lack of them seems to have been the determining factor in this situation.

Personal Alarms

It appeared that steps began in 1998 to change the system of personal alarms and as already indicated by the 20/3/00 while funds had been obtained and a new system installed it was still not operational. The new system had the potential for each officer on duty to carry an alarm and for the system to pinpoint within a matter of metres where that officer was.

Employment of Inmates within the Prison Complex

As at the 1/5/00, there were approximately 285 inmates at Risdon and there was employment for 109. Unless those not formally employed chose to become involved in education, they spent their days in their cells or in the yards. Mr. Salter agreed that inmates were far easier to manage if they were occupied. He said this level of unemployment had existed for some time and that while the industries manager had been attempting to find more work, his efforts had been unsuccessful. Mr. Salter did not know what efforts were then being made to broaden the industrial base of the prison.

Management of Inmates

Mr. Dodd told the inquest that while all incoming inmates go through an assessment process on entry to the prison system, only long term prisoners as opposed to remandees have any sort of case management or sentence plan. The effect as far as Chris Douglas and Fabian Long were concerned was that there was no cohesive plan as to how their time in custody would be managed. He said that

some consideration had been given to assigning custodial officers to case manage a particular group of inmates but that there had been a poor response to the idea.

It was recognised it would be a useful tool.

Liaison between Prison and Inmates families and friends

Mr. Dodd agreed there was no procedure to facilitate liaison between the prison and inmates families and that such liaison would be valuable. He also agreed that it was a facility in place in other prisons and that there was little cost involved in setting it up. He however said that there was a question of resources in terms of availability of staff to man such a service. He also conceded that the availability of such a process might have helped Chris Douglas' family communicate readily with the prison about Chris' failed suicide attempt on the morning of the 4/8/99.

Management generally

In terms of management of the prison Mr. Dodd acknowledged he had ongoing concerns. These were

* the increase in numbers of inmates,
* the range of challenging and bizarre behaviours of some inmates,
* the fact that such inmates were often classified as having no mental illness and returned by hospital staff to the general prison population,
* that the physical arrangements in the prison made it difficult to provide any form of separate accommodation for such inmates, and
* that correctional officers often lacked the skills to deal with such people.

Having said that Mr. Dodd was referred to the Forensic and Secure Psychiatric Review dated 1/6/95 being a report to the ministers for justice and community health. He said he thought he was aware of it but had not read it. He was referred to comments in Appendix 4 in that document where there was a reference to the Western Australian experience. It was said that if the forensic unit in that state were to be managed by both health and corrections there would be major difficulties on clinical care and security. Mr. Dodd was asked to comment by reference to Risdon in 1999. He acknowledged that there were differing priorities between clinical care and security at the hospital and that there was potential for conflicts. He also said that difficulties arose where there were different lines of accountability arising from parts of the service being attached to different departments.

Mr. Dodd agreed with a statement put to him by Counsel for the DHHS as follows:

> *There is probably nothing more frustrating to individual wardens than to be told by a clinician that an inmate who has repeatedly slashed his throat is not mentally ill, or that an inmate with a psychiatric history is not mad at the moment, just bad. All too often self-mutilating inmates and aggressively mentally ill are shuffled back and forth between regular prison units and inpatient psychiatric facilities. Unit staff keep referring them for treatment because they do not know how to manage them, and staff at the psychiatric facility keep refusing them because they do not meet standard criteria for inpatient care. Often the default options for such inmates is placement in restraint or administrative segregation, neither of which serves either the inmate or the institution well. These are temporary solutions at best but do nothing to address the underlying problem.*

and then went on to agree that there is continuing debate about how to deal with mental health needs of inmates in prisons. The statement Counsel referred to came from a 1993 report. The matters we are canvassing in this inquest occurred in 1999. The implication from the line of questioning appeared to be that those in authority could rely on the fact that there is "continuing discussion" about issues as a reason for continuing a system they acknowledge does not work. The statement set out above shows the problem has clearly long ago been recognised. It needs to be addressed in a practical manner.

Two management groups were referred to in the evidence of Justice Department representatives. These were the Prison Strategic Management Group and the Prison Health Services Management Group.

Mr. Richards said the former was set up in June 1999 although effectively it was a successor to a prison management group. The differences appeared only to be that meetings of the new group were more frequent and the chairperson was a more senior person, namely the Secretary of the DJIR. Mr. Richards said the group was set up to address the increase in the prison population, the prison riots which occurred in May 1999, the number of escapes and deaths in custody. He agreed however that the death of Inmate Hayes was probably the straw which broke the camels back and that the new group was in some way reactive to that. The inference from Mr. Richards evidence was that the group was doing little by way of making any final decisions until the completion of both this and an Ombudsman's report.

As to the second group as has already been noted that met for the first time at the beginning of March 2000. It was constituted by representatives from both health and justice and in Mr. Richards words he believed it would enhance communication between medical, psychiatric and prison

services. The very creation of that committee it seems recognises that such communication was not at a level which promoted successful cooperation between those services.

Conclusions

The cells in E Division where two of the deaths occurred continued to the date the inquest commenced to have an abundance of suspension points. The cells within the prison hospital also retained some although steps had been taken to reduce those and work was underway at the time of the inquest. However that work had only been recommended in the first half of 1999 some 3 years after the death of an inmate in 1996.

The evidence before me makes it abundantly clear that the DJIR, notwithstanding numerous coronial recommendations over a long period about the need to remove suspension points throughout the Risdon Prison Complex, made conscious decisions not to do so for budgetary reasons. Budgetary concerns took precedence over compliance with statutory obligations to provide care.

The suggestion was that other mechanisms were put in place by management to manage the risk posed by suicidal and behaviourally difficult inmates. These mechanisms relied on an inmates initial assessment on entry into custody and the recognition of problems by staff during the period of incarceration. It was acknowledged that custodial staff were inadequately trained to be alert for problems and that the system did not in any event allow for a speedy and appropriate response to recognition of problems anyway. Both Chris Douglas and Fabian Long may have been alive today if it had.

It was clear that lines of communication between different sections of the prison complex were at best adhoc and often non-existent and that training of custodial staff and record keeping were inadequate.

Policies which had been in place for some years such as that which required cell keys to be kept at main gate after lockdown and the lack of a comprehensive system of communication and alarms appeared to be still in place because of a lack of interest in consideration of reform and again budgetary considerations. Several officers including senior ones acknowledged that the security issue posed by cell keys being carried at night would be addressed by there being two officers patrolling together.

The Arunta telephone system which could be a valuable security and welfare tool was not adequately used because of the place in which it was situated and inadequate resources to monitor

it. Again both Chris Douglas and Jack Newman may have still been alive today had their calls been monitored and there existed a formal method of communication of concerns arising from the content of their calls to someone to help them.

The DJIR was responsible for the care welfare and wellbeing of all inmates at the complex wherever they were housed. Both Mr. Richards and Mr. Dodd seemed to hold the view that they had little direct interest in ensuring that the level of care provided by the FMHS to inmates was adequate taking the view that was a DHHS problem. Their level of supervision in this area seems to have been superficial at best.

In summary the DJIR has not discharged it's responsibilities as far as the care welfare and wellbeing of inmates at the Risdon Prison Complex is concerned and has not responded in any meaningful way to coronial recommendations about matters that have arisen over the years. A number of the concerns highlighted in these findings are not new ones.

CHAPTER 9 - RECOMMENDATIONS

I am conscious that many if not all of the recommendations I will make will have budgetary implications. However it is clear that the response to previous coronial findings affecting the Risdon Prison Complex has been dictated by budgetary considerations and the result has been 5 deaths, some if not all of which may have been avoided. I am also conscious that the ideal may be the construction of an entirely new prison and a review of the present arrangements under which mentally ill patients are kept at Risdon. If that is what occurs then I can only say to those whose responsibility it is to

(a) take note of the recommendations made,

(b) learn from the Victorian experience which saw the construction of a new prison at Port Philip with little or no regard to consideration of suspension points in cells and which culminated in the report of Coroner Graeme Johnstone in 2000 released following an inquest into deaths by hanging in that prison.

Recommendations

1. That immediate steps be taken to implement repeated coronial findings to remove from cells within the prison complex all identifiable suspension points or alternatively construct a new facility which does not have such points.
2. That the policy relating to the carrying of cell keys by custodial staff after lockdown be reviewed with consideration being given to their being carried together with the adoption of a requirement that at all times when cell checks are being done two officers work together. This would avoid both perceived security and safety difficulties.
3. That operational two way radios be carried by all custodial officers at all times.
4. That personal alarms be carried by all custodial and nursing staff with the capacity to identify where the person carrying it is or is supposed to be.
5. That all custodial officers and nursing staff be required to carry a cut down knife at all times.
6. That "action" lists be prepared for all custodial and nursing staff (and that all staff be made aware of their contents) to provide for what should be done in the event of an emergency and by whom.
7. That such action lists give priority to ascertaining the type of emergency and if it involves the health of an inmate the calling of medical personnel and an ambulance.
8. That the system of record keeping within the hospital be reviewed to
    a) remove the duplication of files relating to forensic patients,
    b) ensure there is at least one file for each forensic patient which contains all information relevant to them,
    c) improve the standard of files generally. The medical files with which I was presented were a disgrace containing loose scraps of often unidentified paper in no particular

order. There could be little guarantee that documents which should have been there were.

d) improve the standard of record keeping by nursing staff in particular in relation to the completion of drug charts.

9. That policy relating to the checking of inmates in cells by custodial staff be reviewed so that officers at every check take whatever action is required to ensure an inmate is alive and not in need of assistance.

10. That standing orders be reviewed to clarify precisely the obligations of custodial officers.

11. That all custodial staff receive immediate and intensive training

a) so that they are familiar with all prison rules and standing orders and any amendments made from time to time,

b) so that they are aware of indicia of suicide, depressive illnesses and major mental illnesses such that they have enough knowledge to enable them to assess whether an inmate in the general prison population is in need of help.

12. That the system of requests by which inmates obtain assistance for medical or psychiatric help be reviewed so that there is one method only and all such requests are directed to the appropriate professional without delay.

13. That there be an education program for all inmates to familiarise them with request procedures.

14. That consideration be given to an educational program within the prison for inmates to highlight the importance of recognising and acting on warning signs in the behaviour of other inmates which might suggest problems for them.

15. That the status of inmates entering the prison complex be given more detailed consideration when their accommodation is allocated to take into account

a) the need to avoid having young and vulnerable young offenders housed with offenders convicted of sexual crimes

b) an inmates age and criminal history

16. That a system be implemented to allow for the communication of any information supplied to any authority including the courts in relation to the risk of suicide of a person about to be admitted to the corrective system to that system at the point of entry and that if such information is supplied active inquiries are made to substantiate it and take it into account.

17. That there be a review of the category system for inmates in the prison hospital so that

a) the reasons for and the parameters of each category are well defined,

b) each staff member who may have responsibility for placing an inmate on or taking an inmate off a category is properly instructed in those reasons and parameters,

c) the recording of the placing of an inmate on or taking an inmate off a category is centralised and defined.

18. That the Department of Justice and Industrial Relations and the Department of Health and Human Services review the lines of demarcation of authority for the provision of service to forensic mental health patients to make it clear with whom the responsibility lies for accommodating and caring for such patients and that consideration be given to the setting up of a dedicated forensic unit independent of a custodial environment.
19. That the training of any nursing or custodial staff employed in the existing prison hospital/special institution be reviewed to ensure they have adequate and appropriate training to deal with the types of patients being cared for and any treatment regime being undertaken and that such staff have specific and detailed instructions as to the use of any extraordinary medications.
20. That the use of the drug Clozapine at all in the prison hospital environment be reviewed immediately having regard to the lack of systems and training presently existing in the hospital.
21. That any patient of the prison hospital with an unstable condition, whether it be medical, psychiatric or behavioural not be discharged to the general prison population without a multidisciplinary review and agreement as to that discharge and there being consideration as to the housing and care of such inmate in the yards. This should include communication to any custodial staff of the nature of the behaviour, the most appropriate manner to deal with it and if necessary any signs to be alert for to indicate a deterioration in the inmate's condition.
22. That no such inmate as referred to in the previous recommendation be discharged to the general prison population on PRN antipsychotic medication.
23. That there be mandatory reporting by nursing or custodial staff to the prescribing doctor of the failure of an inmate to take medication prescribed either as a consequence of a failure to attend medication parade or a refusal to take medication.
24. That the purpose of the Arunta telephone system be defined to include the monitoring of inmates calls and that a system be established which will allow monitoring of calls o the system even on a random basis as long as it is daily.
25. That a formal protocol for the communication of any information obtained from monitoring including any in relation to the welfare of an inmate to the appropriate section of the complex, for example security or the FMHS be established.
26. That in relation to the care of either psychiatric or medical patients within the prison hospital if the present system is maintained of having one psychiatrist and one medical officer, there be implemented a system which will allow
    a) review of decisions of such psychiatrist or medical officer by a peer,
    b) an inmate to obtain a second opinion as to their treatment.
27. That there be established within the prison system a system of liaison which permits a clear and user friendly line of communication between family and friends of an imate and prison

authorities and that such family and friends be encouraged to raise any concerns about the welfare or status of an inmate through that system.

28. That a system of case management for all inmates irrespective of their status be implemented which will provide for recognition of the possible vulnerability of, any problems associated with or other needs of an inmate and development of a sentence plan accordingly.

29. That the position of Dr. Alan Jager as Clinical Director be reviewed having regard to his actions, given that even if appropriate support networks may have been put in place public and patient confidence in Dr. Jager as a consequence of the evidence given at this inquest has been seriously undermined.

LEGAL REPRESENTATION AT THE INQUEST

(in alphabetical order)

Miss Kim Baumeler/Mr. Andrew Buckley/ Miss J. Hartnett	Mrs. Denice Mullan (mother of Fabian Long)
Mr. Roland Browne	Santos family
Sergeant Rod Carrick	Coroners Officer
Mr. Simon Cooper	Counsel Assisting
Mr. Michael Daly	Douglas family
Mr. Steven Estcourt QC	Mr. John Ramsey Secretary, Department of Health and Human Services
Mr. Terry Foulds	Mr. Richard Bingham, Secretary, Department of Justice
Mr. Robert McKay	Dr. Alan Jager
Mr. Stuart Worsley	Mr. Rafi Marchant (son of Jack Newman)

(Mr. Ken Procter and Mr. Daniel Zeeman appeared to a limited extent in applications brought by members of the media)

SCHEDULE 1: LIST OF EXHIBITS

1. Direction from Chief Magistrate Shott as to the holding of a single inquest
2. Plan of prison
3. Photographs - Chris William Douglas
4. Photographs - Thomas Patrick Holmes
5. Photographs - Jack Newman
6. Photographs - Laurence Colin Santos
7. Photographs - Fabian Guy Long
8. Affidavit of Stephen Charles Lawler in the death of Douglas sworn 5/8/99
9. Affidavit of Stephen Charles Lawler in the death of Douglas sworn 5/11/99
10. Directors Standing Order CO18 - Corrective Services Division
11. Directors Standing Order NOC01 - Corrective Services Division
12. Affidavit of John David King in the death of Douglas sworn 5/8/99
13. Affidavit of Hugh Goodwin in the death of Douglas sworn 5/8/99
14. Affidavit of Dale Ernest Fawkner in the death of Douglas sworn 5/8/99
15. Affidavit of Dale Ernest Fawkner in the death of Douglas sworn 4/11/99
16. Internal Memorandum -Final Cell Muster dated 5/8/99
17. Affidavit of Malcolm Scott Harris in the death of Douglas sworn 5/8/99
18. Affidavit of Alexander Cowley in the death of Douglas sworn 26/11/99
19. Affidavit of Brain John Thomas in the death of Douglas sworn 11/11/99
20. Affidavit of Brian John Thomas in the death of Douglas sworn 19/1/2000
21. Affidavit of Michael Keith Wildbore in the death of Douglas sworn 5/11/99
22. Affidavit of Michael Keith Wildbore in the death of Douglas sworn 19/1/2000
23. Affidavit of Donald Craig Lehner in the death of Douglas sworn 29/11/99
24. Prison Service Report of Donald Craig Lehner in the death of Douglas dated 7/8/99
25. Affidavit of Arnold Dick Van Leeuwin in the death of Douglas sworn 14/12/99
26. Affidavit of Blair Francis Saville in the death of Douglas sworn 7/12/99
27. Affidavit of Shane Andrew Lawrence in the death of Douglas sworn 26/10/99
28. Letter S. A. Lawrence to K. Bain dated 26/10/99
29. Affidavit of Darryl John Streets in the death of Douglas sworn 10/8/99
30. Affidavit of Dean Richard Fitzpatrick in the death of Douglas sworn 13/9/99
31. Affidavit of Daniel Luke Bennett in the death of Douglas sworn 10/8/99
32. Letter Chris Douglas to his family
33. Affidavit of Mark Rodney Jones in the death of Douglas sworn 10/8/99
34. Prison Request form completed by Chris Douglas dated 19/11/98

35. Affidavit of Robin James Clark in the death of Douglas sworn 13/9/99
36. Affidavit of Mark Anthony Riley in the death of Douglas sworn 10/8/99
37. Affidavit of Mark Anthony Riley in the death of Douglas sworn 26/1/00
38. Affidavit of Vickie Lee Douglas in the death of Douglas sworn 18/8/99
39. Notes prepared by Vickie Lee Douglas
40. 2 x audio tapes of telephone calls recorded on the prison Arunta system made by Chris Douglas to family on the 2/8/99, 3/8/99 and 4/8/99
41. Affidavit of Leonie Bronwyn McKay sworn 6/1/00, audio transcription typist, with transcript of tapes (previous exhibit)
42. Affidavit of Neville Winston Howell-Smith in the death of Douglas sworn 28/11/99
43. Affidavit of Sharon Ann O'Halloran in the death of Douglas sworn 19/1/00
44. Affidavit of Christopher John Welsh in the death of Douglas sworn 10/8/99
45. Affidavit of Timothy James McKenna in the death of Douglas sworn 13/9/99
46. Affidavit of Witness X in the death of Douglas sworn 7/12/99
47. Affidavit of Blair Saville in the death of Douglas sworn 4/8/99
48. Affidavit of John Lewis in the death of Douglas sworn 5/8/99
49. Declaration of Christopher Guy McKenzie containing Forensic Biology Report re Chris Douglas declared 16/8/99
50. " declared 8/11/99
51. " declared 18/11/99
52. Declaration of Pamela Jane Scott containing DNA Profiling report re Chris Douglas declared 7/1/00
53. Affidavit of Annette Gayle Marrington in the death of Douglas sworn 14/10/99
54. Affidavit of Simon Butterley in the death of Douglas sworn 26/11/99
55. Affidavit of Christopher Paul Wright in the death of Douglas sworn 1/9/99
56. Original Forensic Mental Health file re Chris Douglas
57. Original Prison Medical file re Chris Douglas
58. Copy Prison file re Chris Douglas
59. Affidavit of Winston Fairbrother in the death of Holmes sworn 22/9/99
60. Affidavit of Karl Woisetschlager in the death of Holmes sworn 17/9/99
61. Affidavit of Peter John Hughes in the death of Holmes sworn 17/9/99
62. Affidavit of Stephen Frank Davidson in the death of Holmes sworn 18/9/99
63. Affidavit of Victoria Georgina Norris in the death of Holmes sworn 5/10/99
64. Prison Health Record re Thomas Patrick Holmes
65. Affidavit of Christine Geraldine Webster in the death of Holmes sworn 6/10/99
66. Nurses Daily Report 11/9/99
67. Affidavit of Rosaleen Macaulay in the death of Holmes sworn 4/10/99

68. Affidavit of Peter Michael Holmes in the death of Holmes sworn 27/10/99
69. Affidavit of Brett St. Clair Berry in the death of Holmes sworn 10/11/99
70. Affidavit of Craig Douglas Mackie in the death of Holmes sworn 28/10/99
71. Videotape of police interview with Thomas Patrick Holmes on
72. Affidavit of Leonie Bronwyn McKay in the death of Holmes sworn 21/12/00 with transcript of the above tape
73. Nurses Daily Report dated 11/9/99
74. Affidavit of John George Ward in the death of Holmes sworn 17/9/99
75. Affidavit of John Lewis in the death of Holmes sworn 18/9/99
76. Affidavit of Tony Fox in the death of Holmes sworn 28/9/99
77. Affidavit of Debbie Jane May in the death of Holmes sworn 27/9/99
78. Affidavit of Michael Maksimovic in the death of Holmes sworn 11/10/99
79. Affidavit of Orlando Mazzone in the death of Holmes sworn 6/10/99
80. Prison medical file re Thomas Patrick Holmes
81. Affidavit of Gary J D Williams in the death of Thomas Patrick Holmes sworn 26/10/99
82. Affidavit of Kriss Ellison Lawler in the death of Thomas Patrick Holmes sworn 8/11/99
83. Affidavit of Sharon Fae Carnes in the death of Jack Newman sworn 18/9/99
84. Affidavit of Ian Gregory Smith in the death of Jack Newman sworn 18/9/99
85. Affidavit of John Mark Radcliffe in the death of Jack Newman sworn 21/9/99
86. Prison Service Report re cell checks at prison hospital - 18/9/99
87. Affidavit of Stephen Frank Davidson in the death of Jack Newman sworn 27/9/99
88. Medical files (x2) of Jack Newman
89. Affidavit of Victoria Georgina Norris in the death of Jack Newman sworn 18/9/99
90. Affidavit of Joanne Thompson in the death of Jack Newman sworn 18/9/99
91. Affidavit of " " in the death of Jack Newman sworn 25/1/00
92. Affidavit of Scott Darrell Shaw in the death of Jack Newman sworn 29/9/99
93. Affidavit of Ian Rex Balmer in the death of Jack Newman sworn 16/11/99
94. Affidavit of Russell Ashby Pargiter in the death of Jack Newman sworn the 26/11/99
95. Affidavit of James Graham Galloway in the death of Jack Newman sworn 7/12/99
96. Affidavit of Steven Roy Edwards in the death of Jack Newman sworn 26/11/99
97. Affidavit of John Frederick Cassidy in the death of Jack Newman sworn 18/11/99
98. " ' ' " " " " " " " 5/1/00
99. Request Form for consultation/treatment (15/7/99 - 18/7/99) in relation to Jack Newman
100. Request Form for consultation/treatment (13/8/99 - 16/8/99 & 18/8/99) in relation to Jack Newman
101. Affidavit of Gaye Elizabeth Browne in the death of Jack Newman sworn 5/1/00
102. Affidavit of Kim Maree Woodberry in the death of Jack Newman sworn 25/11/99

103. Affidavit of Kim Maree Woodberry in the death of Jack Newman sworn 7/12/99
104. Letter to Kevin Salter from Dr. Jager dated 3/8/99 relating to Jack Newman
105. Letter to Kevin Salter from Dr. Jager dated 31/8/99 relating to Jack Newman
106. Affidavit of John Philip Schofield in the death of Jack Newman sworn 4/1/00
107. Computer printout from computer of Gaye Browne
108. Affidavit of Richard Gordon Dickenson in the death of Jack Newman sworn 22/9/99
109. Audio tape of telephone calls made by Jack Newman from Risdon Prison on the 5/9/99 and 4/9/99
110. Affidavit of Leonie McKay in the death of Jack Newman sworn 25/11/99 with transcript of calls on tape which is exhibit 109
111. Audio tape of telephone calls made by Jack Newman from Risdon Prison on the 12/9/99, 13/9/99, 14/9/99 and 17/9/99
112. Affidavit of Leonie McKay in the death of Jack Newman sworn 4/1/00 with transcript of calls on tape which is exhibit 111
113. Affidavit of Humphrey John Gomes in the death of Jack Newman sworn 18/9/99
114. Affidavit of Andrew Staib in the death of Jack Newman sworn 18/9/99
115. Affidavit of Rodney Carrick in the death of Jack Newman sworn 20/9/99
116. Affidavit of Michael Maksimovic in the death of Jack Newman sworn 11/10/99
117. Affidavit of Debbie Jane May in the death of Jack Newman sworn 27/9/99
118. Affidavit of Adrian Leonard Abel in the death of Jack Newman sworn 23/11/99
119. Affidavit of Todd William Hildyard in the death of Jack Newman sworn 29/9/99
120. Warrant under Section 382 of the Mental Health Actin relation to Jack Newman
121. Deed Poll of Change of Name of Jack Newman
122. Affidavit of Glenn Reginald Jackson in the death of Laurence Colin Santos sworn 4/11/99
123. Affidavit of Neville Winston Howell-Smith in the death of Laurence Colin Santos sworn 28/11/99
124. Affidavit of Neville Winston Howell-Smith in the death of Laurence Colin Santos sworn 4/1/00
125. Medical Notes of Laurence Colin Santos
126. Affidavit of Victoria Georgina Norris in the death of Laurence Colin Santos sworn 4/11/99
127. Affidavit of Sharon Ann O'Halloran in the death of Laurence Colin Santos sworn 4/11/99
128. Affidavit of John Mark Ratcliffe in the death of Laurence Colin Santos sworn 4/11/99
129. Affidavit of Alan Smith in the death of Laurence Colin Santos sworn 4/11/99
130. Affidavit of Ian Gregory Smith in the death of Laurence Colin Santos sworn 14/11/99
131. Affidavit of Judith Ann Santos in the death of Laurence Colin Santos sworn ?
132. Copy letter to Ombudsman from Laurence Santos dated 24/9/99
133. Affidavit of Alison Clemency Gill in the death of Santos sworn 19/10/99
134. Affidavit of Nicola Scarley in the death of Santos sworn 19/10/99

135. Affidavit of Kevin Edward Smith in the death of Santos sworn 6/12/99
136. Affidavit of David Henry Jefferson in the death of Santos sworn 8/11/99
137. Forensic Mental Health Service file re Laurence Santos
138. Affidavit of Donald Craig Lehner in the death of Fabian Guy Long sworn 10/1/00
139. Affidavit of Donald Craig Lehner in the death of Long sworn 27/1/00
140. Affidavit of Kim Anthony Barker in the death of Long sworn 10/1/00
141. Affidavit of Victoria Georgina Norris in the death of Long sworn 19/10/99
142. Medical File, Prison Hospital - Fabian Guy Long
143. Affidavit of Sharon Fae Carnes in the death of Long sworn 26/1/00
144. Affidavit of Timothy James McKenna in the death of Long sworn 18/1/00
145. Affidavit of Karl Woisetschlager in the death of Long sworn 27/1/00
146. Affidavit of Arnold Dick Van Leeuwen in the death of Long sworn 26/1/00
147. Affidavit of Kenneth Maxwell Collins in the death of Newman sworn 18/9/99
148. Affidavit of Mark Thomas Armstrong in the death of Long sworn 19/1/00
149. Affidavit of Kevin Richard Bell in the death of Long sworn 20/1/00
150. Affidavit of Jason Steven Halliday in the death of Long sworn 18/1/00
151. Affidavit of Stephen Grant Randall in the death of Long sworn 20/1/00
152. Affidavit of Melissa Jean Baillie in the death of Long sworn 17/1/00
153. Affidavit of John Beadle in the death of Long sworn 2/3/00
154. Forensic Mental Health file - Fabian Guy Long
155. Affidavit of Steven Roy Edwards in the death of Long sworn 25/1/00
156. Affidavit of Basil John Fraser in the death of Long sworn 2/2/00
157. Affidavit of Steven Mark Gridley in the death of Long sworn 10/1/00
158. Protocol for Suicide Emergency (Main Gate)
159. Protocol for Death in Custody (Main Gate)
160. Affidavit of Michael James Smith in the death of Long sworn 25/1/00
161. Affidavit of Jo-Anne Thompson in the death of Long sworn 25/1/00
162. Affidavit of John Frederick Cassidy in the death of Long sworn 7/2/00
163. Affidavit of John Anthony Gilbert in the death of Long sworn 17/1/00
164. Video tape of interview with Denice Mullan conducted 14/1/00
165. Affidavit of Leonie McKay with transcript of interview on tape above in the death of Long sworn 25/1/00
166. Affidavit of Ian Michael Sale in the death of Long sworn 28/1/00
167. Report by Dr. Sale to the Legal Aid Commission about Fabian Long dated 29/7/97
168. " " " " " " " " " " " " " " 14/8/97
169. " " " " " " " " " " " " " " 22/8/97
170. " " " " " " " " " " " " " " 25/8/97

171. " " " " " " " " " " " " " " 15/10/97
172. " " " " " " " " " " " " " " 18/11/97
173. " " " " " " Wilson Dowd, solicitors, " " " " 21/9/99
174. Affidavit of Denice Erica Mullan in the death of Long sworn 28/1/00
175. Submission from Denice Mullan to Ombudsman dated the 25/11/99
176. Letter from Ombudsman to Denice Mullan dated the 7/12/99
177. Affidavit of Leanne Mary Millhouse in the death of Long sworn the 25/1/00
178. Affidavit of Elida Assenheimer in the death of Long sworn the 31/1/00
179. Affidavit of Colin Baldwin in the death of Long sworn the 3/4/00
180. Community Corrections file in relation to Fabian Long
181. Affidavit of Georgia Anne Hickman in the death of Long sworn the 31/1/00
182. Affidavit of David Brook in the death of Long sworn the 10/1/00
183. Affidavit of Rodney Harold Carrick in the death of Long sworn the 10/1/00
184. Affidavit of Annette Gayle Marrington in the death of Long sworn the 21/1/00
185. Affidavit of Brendan Anthony Smith in the death of Long sworn the 25/1/00
186. Affidavit of Konrad Peter Plachta in the death of Long sworn the 18/1/00
187. Affidavit of Sally Jane Marks in the death of Long sworn the 2/2/00
188. Affidavit of Kenneth Ross Bain in the death of Newman sworn the 29/9/99
189. Letter Jack Nwman to Wendy Oudermans dated 8/9/99
190. Letter Jack Newman to Rogan Thompquist dated the 9/9/99
191. Note starting "Last will' signed by Jack Newman
192. Letter dated 17/9/99 starting Dear Bev from Jack Newman
193. Letter dated 17/9/99 addressed "Dear Melody" from Jack Newman's cell
194. Letter dated 16/9/99 addressed "Dear Pierre" from Jack Newman's cell
195. Letter dated 14/9/99 addressed to "Mr. Butcher" from Jack Newman's cell
196. Letter dated 18/9/99 addressed to "Karen Costello" from Jack Newman's cell
197. Notes undated starting "Finally achieved" from Jack Newman's cell
198. Notes undated starting "If had accepted" from Jack Newman's cell
199. Note undated starting "(Inadequate) apologies" from Jack Newman's cell
200. Note undated starting "Clearly Jager" from Jack Newman's cell
201. Affidavit of Kenneth Ross Bain in the death of Newman sworn the 7/12/99
202. Affidavit of Kenneth Ross Bain in the death of Long sworn the 2/2/00
203. Unit Incident Report dated 1/2/98 and Internal Memorandum by Ken Bain dated 6/2/98 re complaint about Fabian Long
204. Affidavit of Craig Anthony Hughes in the death of Newman sworn 12/11/99
205. Affidavit of Alan Burton in the death of Newman sworn the 25/11/99
206. Affidavit of Alan Burton in the death of Long sworn the 10/2/00

207. Alarm Test Sheet A
208. Alarm Test Sheet B
209. Affidavit of Norman John Dodd sworn the 23/11/99
210. Affidavit of Norman John Dodd sworn the 2/3/00
211. Prison / Health Services - Diagram of departmental structure
212. Standard Operating Procedure No. 2.17 - Risdon Prison (Supervision of Prisoners/Detainees After Lock-up and before Unlock
213. Report dated the 20/3/00 by Professor Ivor Jones in the death of Douglas
214. Report dated the 23/3/00 by Professor Ivor Jones in the death of Holmes
215. Report dated the 10/3/00 by Professor Ivor Jones in the death of Newman
216. Report dated the 10/3/00 by Professor Ivor Jones in the death of Santos
217. Report dated the 27/3/00 by Professor Ivor Jones in the death of Long
218. Photocopy Clozaril Patient Monitoring System Protocol
219. Copy report "The Association Between Antipsychotic Drugs & Sudden Death" from the working group of the Royal College of Psychiatrists - January 1997
220. Copy article "Clozapine Plasma Level Monitoring: Current Status" in Vol. 67 1996 Psychiatric Quarterly at pages 297-311
221. Letter dated the 7/4/00 Professor K. Kirkby to Mr. S. Estcourt
222. Copy article "Myocarditis and cardiomyopathy associated with Clozapine" by Kilian, Kerr, Lawrence and Celermajer - November 1999
223. Clozaril Patient Monitoring System Protocol Revision 4 dated 1/8/99
224. Copy article "Plasma Clozapine Concentrations as a Predictor of Clinical Response: A Follow-up Study" Journal of Clinical Psychiatry Vol 55 1994 pages 117-121
225. Notice dated 23/12/99 from Novartis concerning Clozapine and Myocarditis
226. Affidavit of Timothy John Lyons in the death of Douglas dated the 23/12/99
227. Report of Death in the matter of Douglas
228. Affidavit of Timothy John Lyons in the death of Newman dated the 18/11/99
229. Affidavit of Timothy John Lyons in the death of Santos dated the 15/2/00
230. Affidavit of Jacob George in the death of Long dated the 9/2/00
231. Affidavit of Kevin Douglas Salter in the death of Douglas dated the 11/11/99
232. Affidavit of Kevin Douglas Salter in the death of Douglas dated the 6/1/00
233. Affidavit of Kevin Douglas Salter in the death of Newman dated the 1/12/99
234. Affidavit of Kevin Douglas Salter in the death of Long dated the 2/2/00
235. Unsigned letter to Mr. Salter
236. Affidavit of Kathryn Campbell in the death of Santos dated the 18/4/00
237. Affidavit of Graeme Harris in the death of Douglas dated the 17/1/00
238. Affidavit of Graeme Keith Harris in the death of Holmes dated the 28//9/99

239. Affidavit of Graeme Keith Harris in the death of Newman dated the 6/12/99
240. Affidavit of Graeme Keith Harris in the death of Long dated the 11/2/00
241. Affidavit of Wilfred Prazeres Lopes in the death of Newman dated the 19/11/99
242. Affidavit of Wilfred Prazeres Lopes in the death of Santos dated the 23/2/00
243. Affidavit of Wilfred Prazeres Lopes in the death of Long dated the 9/2/00
244. Position Description Dept. of Health and Human Services - Clinical Director/Forensic Services/Psychiatrist
245. Copy application for position dated the 25/9/98 Dr. Jager to B. Shaw
246. Curriculum Vitae Alan Deighton Jager revised 1/9/98
247. Affidavit of Paul DeBomford in the death of Douglas dated the 18/1/00
248. Special Treatment/Items Approval Notification
249. Handwritten Medication list E Yard
250. Internal memo dated the 7/7/99 from Paul DeBomford to senior custodial staff re Interim Dispensing Routines
251. Affidavit of Paul Kenneth DeBomford in the death of Holmes dated the 28/9/99
252. Affidavit of Paul Kenneth DeBomford in the death of Newman dated the 29/9/99
253. Affidavit of Paul Kenneth DeBomford in the death of Newman dated the 5/1/00
254. Affidavit of Paul DeBomford in the death of Long dated the 28/1/00
255. Letter from Jack Newman dated 2/5/99 headed "Why I Do Not Want Dr. Jager in Charge of My Case"
256. Letter dated the 10/5/99 Paul DeBomford to Jack Newman in reply to above
257. Copy request form dated 15/9/99 completed by Jack Newman to see Dr. Jager
258. Affidavit of Stuart Ramsay McLean undated
259. Letter Colin Harris to Dr. Jager dated 1/12/99
260. Letter Colin Harris to Wendy Quinn dated 21/12/99
261. Graph of Clozapine Dosage for L. Santos 1999
262. Affidavit of Estelle McCarthy in the death of Douglas dated the 4/1/00
263. Affidavit of Estelle McCarthy in the death of Douglas dated the 8/5/00
264. Affidavit of Estelle McCarthy in the death of Newman dated the 16/11/99
265. Affidavit of Estelle McCarthy in the death of Long dated the 4/2/00
266. Affidavit of Gregory John Jones in the death of Long dated the 29/2/00
267. Standing Orders Distribution List
268. Letter Witness X to Greg Jones dated 7/5/99
269. Prison Hospital Cell Search Check list
270. Affidavit of Wendy Joy Quinn in the death of Long dated the 23/3/00
271. Mental Health Services Structure Chart
272. Department of Health and Human Services Organisational Structure Chart

273. Report from John Ramsay to Assistant Ombudsman dated 6/12/99
274. Forensic and Secure Psychiatric Services Review - June 1995
275. Discussion Paper "Towards a National Approach To Forensic Mental Health" - December 1999
276. Chart Forensic Mental Health Services - Changes to Risdon Prison as at 27/1/00
277. Letter to Ombudsman from Wendy Quinn dated 21/1/00
278. Forensic Mental Health Services Staffing History Narrative - April 2000
279. Forensic Mental Health Services - Clinical Comparisons 28/4/00
280. Special Contract of Service - Dr/. A. Jager dated 22/12/98
281. Letter Prof. Carmichael to Ms. M. Allen dated 5/2/99
282. Staffing Authority Form (extract from personnel file of A. Jager)
283. Copy email from Fox to Jager dated 8/1/99
284. Copy email from Brown to Shaw re Dr. Jager dated 15/12/98
285. Schedule 3 in letter A. Jager to B. Shaw dated 16/12/98
286. Copy facsimile from B. Shaw to A. Jager dated 27/11/98
287. Copy email A. Jager to B. Shaw dated 26/11/98
288. Copy facsimile B. Shaw to Wendy Brown dated 30/10/98
289. Copy facsimile B. Shaw to Prof. P. Mullen dated 28/10/98
290. Copy facsimile B. Shaw to Prof. Arbolda-Florez dated 23/10/98
291. Copy email B. Shaw to A. Jager dated 16/10/98
292. Memo about phone interview to be held with Dr. Jager on 21/10/98
293. Copy facsimile L. Booth to A. Jager dated 9/10/98
294. Copy facsimile G. Lampasona to A. Jager dated 5/10/98
295. Copy letter A. Jager to W. Lopes dated 16/9/98
296. Report from Sister Chapman re Sandra Barwick dated 30/11/99
297. Copy letter Ian Sale to W Quinn dated 3/12/99
298. Copy letter A. Jager to W. Quinn dated 3/12/99
299. Forensic Mental Health Service Chronology
300. Copy memo W. Quinn to A. Jager dated 9/12/99
301. Copy letter John Ramsay to Registrar, Medical Council dated 10/5/00
302. Copy letter John Ramsay to A. Jager dated 10/5/00
303. Copy notice Pursuant to Section 4 of the Health Act 1997
304. Affidavit of Sandra Kathleen Barwick dated 3/5/00
305. Affidavit of George Robert Henry Kelsall in the death of Holmes dated the 16/11/99
306. Scene Description of Dr. Kelsall re death of Newman
307. Affidavit of George Robert Henry Kelsall in the death of Long dated the 8/3/00
308. Copy Notice of Decision under Section 66 of the Nursing Act 1995 re Sandra Barwick dated 2/11/99

309. Memo A. Jager to M. Allen dated 12/7/99
310. Affidavit of Victoria Georgina Norris in the death of Santos dated the 4/5/00
311. Syringe and needle
312. Affidavit of Alan Deighton Jager in the death of Holmes dated the 28/10/99
313. Copy internal memo P. DeBomford to A. Jager dated the 19/2/99
314. Affidavit of Alan Deighton Jager in the death of Newman dated the 22/9/99
315. Affidavit of Alan Deighton Jager in the death of Santos dated the 5/1/00
316. Affidavit of Alan Deighton Jager in the death of Santos dated the 8/1/00
317. Affidavit of Alan Deighton Jager in the death of Santos dated the 12/1/00
318. Forensic File (Vol III) Jack Newman
319. Copy letter Dobson Mitchell & Allport on behalf of Dr. Jager to Sandra Barwick dated 8/12/99
320. Copy memo J. Bullock to A. Jager dated the 22/4/99
321. Copy memo A. Jager to J. Bullock dated 3/5/99
322. Copy extract from The British Journal of Psychiatry dated February 1999
323. Copy extract from The British Journal of Psychiatry dated February 1999
324. Copy letter A. Jager to Griffits & Jackson dated 20/7/99 - medico legal report
325. The Royal Australian and New Zealand College of Psychiatrists Code of Ethics
326. Copy extract from 1996 MIMS annual
327. Copies of extracts from notes of consultations of Dr. Jager on the 20/9/99
328. Prison file Laurence Santos