DEATHS IN CUSTODY: MOVING BEYOND
A STATISTICAL ANALYSIS

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The boundaries of what criminologists study need to be somewhat flexible to allow the
discipline to play an appropriate part in the evolving concerns of the community in which it
operates. Clearly, deaths in custody occur within the boundaries of the present criminal justice
system and, therefore, it is proper that criminologists and others study the effectiveness and
efficiency of custodial programmes (as part of the criminal justice system). For example, the
Australian Institute of Criminology (AIC) has a role to monitor deaths in custody and has
been doing so since the tabling in 1991 of the final report of the Royal Commission Into
Aboriginal Deaths In Custody (RCIADIC) (see Dalton, 1998, 1997a, 1997b). The RCIADIC
recommended (No.41) that the AIC assume this role. The regular reports of the AIC provide a
comprehensive analysis of the trends in deaths in custody since the RCIADIC. Such study is
aimed at attempting to find out why prisoners die in custody and identify ways of reducing the
tragedies that such deaths represent. The present boundaries may, however, reduce the scope
of such inquiries because much of the work in the 1970s and 1980s has been directed towards
developing a statistical profile (an archetype) of those who may be considered at risk from
suicide. Other forms of death in custody have received little attention. It is thought that,
through applying a statistical profile to a received population of prisoners, those at risk of
suicide might be identified and successfully assisted through the difficult phase of entry into
custody. This approach developed primarily in the United States where a number of important
studies identified the much higher death rates in police and remand custody compared with
prison custody (see Hayes, 1983:467 - 468 for such a profile; Novick & Remmlinger, 1987;
Winfree, 1987; Frost & Hanzlick, 1988; Zevitz & Takata, 1989). The search for a statistical
profile has been criticised by Liebling (1992) who argued that vulnerability is a more
important concept and underlies suicide in custody and could be investigated through
studying those young offenders who had made serious self harm attempts. Through the work
of the AIC (Dalton, 1998), we know that a total of 99 persons died in custody and custody-
related police operations during the year ended 30 June 1998. Twenty-three of those deaths
occurred in police custody and 76 in prison custody and more people died in Australian
prisons during 1997-1998 than in any other 12 month period during the last 18 years. Sadly
deaths in custody are a feature of the Australian correctional landscape. My interest is not
only in prevention (many deaths in custody can, I believe, be prevented), but also in the
meanings attached to these deaths and the impact they have on other prisoners and staff and
the families and friends of the prisoners concerned. The usefulness of the coronial report in
this process will be discussed. This paper will summarise some of the research I undertook in
South Australia (SA) into the deaths of 38 prisoners in the SA adult prison system which took
place from 1 January 1980 to 31 March 1993.

Outline of study

It is argued that deaths in custody result from interaction of 'importation' factors (those
personal characteristics and experiences brought with the prisoner to the custodial experience)
and 'deprivational' factors, that is, those negative and unhelpful events experienced by the
prisoner within the prison system. The period of study was from 1 Jan 1980 to 31 March
1993, 13½ years.

Cases

Thirty-eight prisoners died in the SA prison system during the study period, 37 males and one
female. The coronial verdicts were: accident one (2.6%), homicide four (10.5%), natural
causes 19 (50.0%) and suicide 14 cases (36.8%), with hanging the most common means of
death (11 out of 14). None of the suicides were in special areas, although one drug-affected
prisoner was inappropriately locked away in his own cell. The 38 prisoners comprised seven Aborigines and 31 white or non-Aboriginal prisoners. That is, no other racial groups were represented. During the RCIADIC period (1/1/80 to 31/12/88), four Aborigines died in SA prison custody (3 natural, 1 suicide) and there were 18 non-Aboriginal deaths (11 natural, 1 homicide and 6 suicides, making a total of 22 deaths, or 7.86% of national total. The remaining 16 deaths occurred in the four years and three months following RCIADIC suggesting a crude death rate increase. Admissions in 1980/81 were 4988, 5221 83/84, 4501 84/85, 4670 87/88, 3999 88/89, 3897 89/90, 4147 90/91, 6586 91/92. In summary, admissions increased slowly over the decade. The average sentence for all prisoners over the study period was just over two months. The sixteen deaths since RCIADIC comprise six suicides by white prisoners, one suicide by an Aboriginal prisoner, five natural deaths (2 Aboriginal and 3 white prisoners), three homicides and one accidental death. Comparing SA from 1980 to 31 March 1993 with the national data base (RCIADIC) shows that, nationally, 45.78% deaths were self-inflicted (suicide?) while, in SA, 36.8% were suicides (coronial verdict), representing a difference of just - 8.9% and nationally 35.26% were of natural causes, compared to 50 % (+ 14.74 %) in SA. Accidental deaths nationally were 10.64 %, SA 2.6% (one death) and homicides in SA 10.5 % (4 homicides), national figure 16 (5.86%). It should be noted that the small numbers of deaths in this study therefore make the percentages suggest much larger variations between the various forms of death. The figures need to be interpreted alongside of the profile of prisoners, including age. The RCIADIC found that suicide was more common in younger prisoners: 70% under 30 years of age and natural causes, 61% over 40 years. The mean age for the RCIADIC prisoners was 34.2 years and, for Aborigines, 31.9 years. In SA the mean for Aborigines was 27.71 (between 18 and 40 years) and the mean for non-Aboriginal prisoners was 34, with a distribution between 18 and 66 years. For deaths from natural causes, heart disease accounted for 10 of the 19 deaths, a picture that was consistent with the general community. However, since 1993, cancer has become the major cause of death in the community. The location of the deaths was as follows: cells 21, dormitories seven and other 10, with eight out of 10 in public hospitals. The death rate in SA prisons was twice as high as in the community but lower than that suggested in much of the literature (Dawes, 1997, pp. 133 - 174).

Case Control Study

I compared the 37 male prisoners with 195 male prisoners, some five for each case, matched for date of admission and gender. The following variables were significant. Age was significant - those who died were nearly four years older than the control group, as was Aboriginality, seven cases (18.9%) and 24 controls (12.3%). Aborigines were over-represented at the less serious end of offending. The number of times in custody was significant with the cases having 3.44 admissions (none to 16) and controls 2.09 (none to 24). Other significant variables were marital status, time served, most serious offence, physical trauma, significant illness, psychiatric illness, medication and security measures being taken (Dawes, 1997, pp. 175- 205).

The picture of deaths in correctional custody that emerges in SA is similar to the research results presented in the literature. Deaths in custody occur in all age groups with deaths from suicide being more common among younger prisoners. Those who die in prison are almost always males, mostly born in Australia and are generally non-partnered individuals. The SA experience does not support a clear finding in the literature of suicidal deaths occurring in special holding areas, such as hospitals and disciplinary and isolation cells. In SA, nearly 46% of those prisoners who died were charged with, or convicted of, offences involving violence.
The result is similar to other Australian studies, but US jail studies have tended to show that prisoners who suicide are generally charged with, or convicted of, non-violent crimes. Those who died in SA custody were more likely to have a life-threatening illness, be unemployed at the time of their arrest and reception into prison, experience addiction problems, identify as having a serious illness at admission and take medications in prison (Dawes, 1997, p. 230).

**Coroners' Verdicts and Patterns of Deaths**

The third part of my study, and the section on which I will focus in this paper, concerns the work of the coroner and how this work might assist those who survive and are left to try and make some meaning from the death. Death is part of life (International Work Group On Death, Dying, And Bereavement, 1994, p. 65). Death is an enigma (Campbell, 1996, p. 186). Death is inevitable. No human can escape death. For most people, the death of a relative or close friend brings pain. Sometimes death can bring an end to a life of constant pain and such a death might be met with relief and thankfulness that the person's suffering has ended - but there still will be sadness (Dawes, 1997, p. I ). I am interested in the impact of prisoners' deaths on other persons and the concept of *disenfranchised grief* (Doka, 1989), the usefulness of the coroners' reports from the point of view of the survivors and patterns of deaths. With this in mind, I undertook an analysis of the coroners' reports of inquests for 36 of the 38 prisoners.

Before turning to this, it may be helpful to clarify some basic concepts about death, dying and bereavement. *Bereavement*: is the state of deprivation following the loss' (IWG, 1993, p. 53), *grief work* is the process in which people engage to resolve the disruptions caused by bereavement' (IWG, 1993, p. 53) and *mourning* is the manner in which the grief is expressed, culturally conditioned, it is the externalisation of the internal grief ' (Morgan, 1998). Worden (1991, p. 10) has identified four tasks of mourning:

**Task 1. To accept the reality of the loss.**

When someone dies, there is always a sense in which it has not happened. Having knowledge of the *facts* of the death is very important in this task. The coroner's report is an important way in which the facts of the loss can be made explicit, although the value of this can be diminished by the delays in reporting. Prisons are closed environments and it is not always possible to allow family members to see the place of death. I was only asked once to allow this. I did this personally and believe that it was helpful to them. This was after March 1993 and the case is not included in my study.

**Task 2. To work through the pain of grief.**

Worden (1991, p. 13) says it is necessary to acknowledge and work through the emotional and behavioural pain associated with the loss.

**Task 3. To adjust to an environment in which the deceased is missing.**

While we may never forget the deceased person, especially a family member, effective coping requires an adjustment to the fact of the deceased person no longer being present in the every day sense. This adjustment may be even more difficult in the case of children. We invest emotionally in our children. For parents of adult children who are imprisoned, those children may (nearly always do?) represent unfulfilled promise, shattered dreams and a profound sense
of loss. Prisoners are *demonised* in the press, but they remain sons, fathers, husbands and partners and probably remain sons longer than they remain in the other roles, as the inevitable consequences of long-term imprisonment break up other relationships. Survivors often have a need to speak about the loss and one tendency among the family members is to idealise the deceased prisoner. Staff and other prisoners may also grieve for the deceased prisoner who was a significant part of their daily lives, but whose loss is little acknowledged. Disenfranchised grief means that other prisoners may not be able to show their grief and participate in the funeral. The same restrictions may apply to prison officers, especially males.

**Task 4. To emotionally relocate the deceased and move on with life.**

Worden (1991, p. 16) suggests that one never loses memories of a significant person and it is necessary for the survivors not to give up the relationship with the deceased person, but to find an appropriate place for the dead person in their lives. The difficulty for the survivors of those persons who die in custody is that the grief is *disenfranchised* (Doka, 1989, p. 3). Disenfranchised grief means that the losses are not openly acknowledged by themselves or others, socially sanctioned or publicly mourned. How do you tell someone your adult child died in prison? Joining with others who have had similar experiences, in mutual aid groups and supporting one another through sharing stories, is one approach.

Gender issues are also important and can contribute to disenfranchised grief. Some male officers have told me that they felt sad at a prisoner's death, but could not show their feelings because they felt that these would be misinterpreted and they would be perceived as weak by their colleagues. The death of a prisoner is a stigmatised death. Homicides and suicides are more stigmatised than deaths from natural causes. Deaths in custody also represent concurrent losses. There are the cumulative losses of freedom, status, hope and life. During the 13¼-year period from 1 January 1980 to 31 January 1993, the only permanent authority established to investigate and report on deaths in SA correctional custody was the State Coroner. The Coroner is an independent judicial authority appointed pursuant to the *Coroners Act 1975* ss.7.1, which, when it was enacted, was regarded as socially advanced legislation (Waller, 1992, p.3). Waller (1992, p.2) described the principal role of the coroner as being to inquire into the identity of the deceased, the time and place of death and the manner and cause of death, and Hallenstein (1992, p. 177) added that is was to ensure the registration of the death (see *Coroners Act 1975*, s. 12). Sometimes 'riders' were added but did not form part of the coroner's verdict (Waller: 1992, p.3). The SA *Coroners Act 1975* ss.25.2 formally allows the coroner to make recommendations (or 'riders') to the various authorities, thus importantly providing the coroner with a legislative mandate to make suggestions and, more broadly, comment on the death and patterns of deaths. The RCIADIC (1991) suggested coroners should make recommendations following inquests. While the coroner examined the circumstances of prisoners' deaths and reported on such deaths, formal and open public inquiries, called inquests (*Coroners Act 1975* ss. 13.1), were not always held (cases 1, 2, 3, 5, 6, 7, 25 & 33).

The lack of formal inquests was criticised by Pounder (1986) who described deaths in custody as a 'blunt measure of the adequacy of health care'. The RCIADIC (1991 :vol. 1, p. 178) later echoed and strengthened these criticisms. As well, twice during the early 1980s, the author made submissions to Government urging an amendment to the *Coroners Act 1975* to make formal inquests mandatory following a death of a prisoner (Dawes, 1997). Under the law as it was, the Coroner exercised a discretion and most of the deaths of prisoners in the early 1980s were examined by the coroner, a post mortem examination was held and, of course, the
The coroner had access to the police reports of the deaths. But inquests were not held, especially for those prisoners who died of natural causes (Pounder, 1986, pp.208, 209).

Inquests have many functions such as affirming the importance of each person, establishing the identity of the dead person, assisting in the production of accurate mortality statistics, providing leads and evidence where negligence or malpractice is suspected and, very importantly, publicly identifying what was not involved in the death (Bray, undated circa, 1987, p.2). Inquests are also critical in assisting survivors come to terms with violent, unexpected deaths, including deaths in custody (Raphael, 1986, p. 103 & 1983, p.400). The lack of an inquest may be a public statement that the life of a prisoner is not valued. At least that is how some of the relatives of deceased prisoners may have seen the failure to hold formal inquests. In some cases reported on by the RCIADIC, relatives were not contacted and only learned of the death at some later date. An inquest may provide a message to the relatives that, although their loved one was a prisoner, the death should be properly scrutinised and the authorities asked to account for their actions and discharge of their duties under the legal doctrine of 'duty of care'. The holding of an inquest, especially if soon after the death, allows relatives more opportunity to complete a chapter of the grieving process and move forward with their lives (Raphael, 1986, p. 103).

The narrow focus on the medical cause of death and the circumstances of the death has led to the criticism that the work of coroners has resulted in the 'medicalisation' of deaths (Kozak, 1994, p. 49). The process of medicalisation has focused attention on the individual body or bodies in looking for the causes of death and not on the social milieu in which the individuals lived (Kozak, 1994, p. 49). The 'medicalisation' of prisoners' deaths also fails to pay proper attention and give appropriate weight to individual differences, health and life histories of prisoners, or importation factors.

A powerful criticism has more recently been made by the RCIADIC (1991) that coroners have reported on a series of individual deaths and that common themes and issues were not always identified (Pounder, 1986, p. 212; Hallenstein, 1992, p. 176). The AIC (Halstead, 1995) has recently examined this aspect of the work of the Victorian State Coroner, subsequent to Hallenstein (1992), and concluded that the Victorian coronial system still has some 'distance to go in moving from a fact-finding/warning-provision coronial role to one of actually initiating preventive action' (Halstead, 1995, p. 18).

A useful way of examining the work of the coroners in SA is to consider the period pre-RCIADIC and post-RCIADIC. It was hypothesised that coroners' reports post-RCIADIC were more likely to be comprehensive, including a discussion of the evidence and cross-examination of witnesses as well as recommendations made pursuant to the Coroners Act 1975, ss.25.2. Many of the reports by coroners on the deaths of prisoners in SA prior to the RCIADIC were about a page long and reported the minimum information necessary to meet the coroner's statutory duty. Reports of inquests into the deaths of prisoners in SA post-RCIADIC generally became longer and more comprehensive and, most recently, two reports on deaths of prisoners after March 1993 were 26 pages (Chivell, 1994, Inq 58/93) and 13 pages Chivell (1994, Inq 27/94). In both reports, the coroner made extensive recommendations pursuant to the Coroners Act 1975, ss. 25.1.
Accidental Death

Accidental death was found by Biles, McDonald and Fleming (1992b, p. 220) to be the third most frequent coronial verdict to describe deaths in prison in Australia, accounting for 20 (11%) of the total deaths (n = 273) for the period 1980-88. In SA, there was one accidental death of a prisoner, case 32, during the study period.

Accidental deaths in prisons can be sub-divided into two categories. The first category is individual but not self-consciously intended death. Dying from an overdose of an illicit substance may be found by the coroner to be an accidental death. The coroner would set out to establish whether intent to suicide was present. Leaving a note or previously speaking about suicide may indicate this and, if so, the death would probably be determined as suicide. If there was no intent to suicide and the deceased person had shown no signs of being suicidal or of suicidal ideation and those who knew the person attested to the deceased's apparent will to live and long-term history of drug usage, then a verdict of accidental death may seem appropriate. The death of the prisoner described as case 32 clearly fits this category. The Coroner's Inquest amounted to eight and a half pages and there were no recommendations pursuant to the Coroners Act 1975 ss.25.2 (Ahern, 1992, Coroner's Report, Finding of Inquest, Mark Desmond Briscoe, 4, 26 February, 20 March, 2 April 1992). Some deaths resulting from severe mental illness, where lack of intent is clear, may also attract a verdict of accident (ABS, 1994, p. 1; Barraclough & Hughes, 1987, p. 128). It is suggested that a self-inflicted death in prison is probably more likely to attract a verdict of suicide than a death in similar circumstances in the community (Barraclough & Hughes, 1987, pp. 90,104).

The second category of accidental deaths in prison is industrial (McCann, 1992, p. 16; Waller, 1982, p. 71) or catastrophic deaths. This verdict is appropriate when the circumstances causing death could not have been foreseen (McCann, 1992, p. 16). Such a death may occur through being crushed, falling from a height while working, being electrocuted or dying in a prison fire. There were no accidental deaths of this type in SA during the research period although eight (28%) prisoners died in prison fires from 1980 until 1988 elsewhere in Australia, making this form of accidental death second only to deaths from drug overdose as the most frequent type of accidental death (Biles et al. 1992, p. 223). Another form of accidental, or of not self-consciously intended, death can occur through attempting to escape either by sustaining a fatal injury (perhaps by falling from a prison wall) or drowning. Waller (1982, p. 71) also suggested that many hazardous recreational pursuits may lead to accidental death (as we have seen in the recent Sydney to Hobart yacht race). Industrial or catastrophic deaths can be further subdivided. A prisoner may be the victim of lethal force by being shot by a correctional or police officer. An officer can either aim to kill or alternatively to wound and stop the offender. The coroner may describe such a death as justifiable homicide depending on the circumstances at the time. There were no accidental deaths of this type during the research period, although a prisoner, case 36, was shot by the police during the commission of an armed robbery. This prisoner died a few days later in correctional custody.

A death can only be classified as accidental after a coronial hearing and, in 1970, three per cent of all deaths in the UK attracted this verdict (Barraclough & Hughes, 1987, p. 118) and in 1994, 1,959 such deaths occurred in Australia comprising 1.5% of the total deaths (ABS,1995a, p. 1). Barraclough and Hughes (1987, p.128) stated that accidents are, by definition, difficult events to explain and, it could be added, predict and prevent. This is certainly the case when considering the possibility of not self-consciously intended deaths following drug overdoses. There was only one such death of this type in SA, but the use of drugs and the drug culture and the difficulties of controlling drug trafficking will continue to
challenge correctional authorities for many years to come. Probably more can be done to reduce the amount of illicit substances within prisons, but almost certainly at the expense of amenity and humanity within prisons. For example, stricter procedures for checking visitors to prisoners may result in fewer visitors and more isolated and troubled prisoners and reducing the number of tables in the contact visiting area will mean either shorter visits or less frequent visits, assuming visitors are not deterred from visiting.

Good occupational, safety, health and welfare procedures, especially in relation to fire safety, should do much to minimise, if not eliminate industrial and catastrophic accidental deaths.

**Homicide**

Prison homicide is a comparatively rare event in Australia. Biles et al. (1992, p. 220) reported that 16 (6%) of the total deaths (n = 273) in Australian prisons for the period 1980-88 were homicides. During this period there were no homicides in SA prisons. The four SA prison homicides, representing 10.5% of the SA prison deaths, occurred after December 1988. There are few studies on prison homicides (see Wolfson, 1978). The extant literature focuses more broadly on violence in prisons and, when deaths in custody are discussed, suicidal death is the overwhelmingly major interest.

There were four homicides in SA during the research period. While four homicides is a small number and does not allow for generalisations to be made about the pattern of deaths, there is value in attempting to identify the patterns. All of the victims were prisoners, there being no staff or visitor deaths. There were no homicides followed by suicide of the assailant or assailants. Table 1 identifies the four prisoners by case numbers, shows their age at death and the date of death. Two homicides in SA occurred in the 20-29 age group, one in the 30-39 age group, and one in the 50-59 age group. Hallinan and James (1995, p. 4) calculated that 26.2% or 93 of the Australian homicide victims during 1 July 1992 to 30 June 1993 occurred in the 20-29 year age group (the age group with the highest homicide rate), 19.2% or 68 for the 30-39 year age group (the second highest rate) and 8.5% or 30 for the 50-59 year age group, the fourth highest rate. Thus the pattern of SA prison homicides with regard to the age of the victims is almost the same as that found by Hallinan and James (1995) for the wider Australian community.

One homicide occurred in winter and three in late spring-early summer. Wolfson (1978, p.32), in her study of homicides in US prisons, found homicides to be evenly spread across the months. Three of the homicides occurred late in the afternoon, a result which is similar to that found by Wolfson (1978, p. 34). Case 33 was killed during the evening or early morning and found dead at the opening up of the prison and the start of the day's activities.

Wolfson (1978, p. 36) found 28% of inmate homicides occurred in cells, 30% in the cell block or dormitory, nine per cent in the yards, eight per cent in recreation areas, four per cent in training areas or workshops, three per cent in dining rooms and three per cent in kitchens with the balance of 13% elsewhere (total 98%, n = 113). Wolfson (1978, p. 21) described the prisons in her sample as large.

Table 1 shows that two of the SA homicides occurred in high security settings, one at Yatala Labour Prison (YLP) in the B Division recreation yard and the second in James Nash House, a psychiatric prison hospital operated by the health authorities for the Department of Correctional Services (DCS). Only one DCS surf member, a Chief Correctional Officer, was employed at JNH and the remainder of the staff were nursing and medical personnel. All of the patients at JNH were prisoners in the custody of DCS.
Table 1
Homicide, by Age, Date, Time and Location of Death and Security Rating of Prison, SA, 1980 - 31 March 1993

<table>
<thead>
<tr>
<th>Case</th>
<th>Age</th>
<th>Date of Death</th>
<th>Time of Death</th>
<th>Location of Death</th>
<th>Security Rating of Prison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 22</td>
<td>26</td>
<td>13.7.1988 Wednesday</td>
<td>1700 hours</td>
<td>James Nash House, common space</td>
<td>High security, hospital prison</td>
</tr>
<tr>
<td>Case 25</td>
<td>34</td>
<td>12.10.1989 Thursday</td>
<td>1655 hours</td>
<td>B Division recreation yard, YLP</td>
<td>High security</td>
</tr>
<tr>
<td>Case 33</td>
<td>56</td>
<td>29.12.1991 Sunday</td>
<td>0800 hours</td>
<td>Deceased prisoner's single room, CTC</td>
<td>Open prison</td>
</tr>
<tr>
<td>Case 37</td>
<td>22</td>
<td>1.12.1992, Tuesday. Date of incident, 1700 hours on 29.11.1992</td>
<td>1525 hours</td>
<td>CTC, dining room of Sundowner dormitory</td>
<td>Open prison</td>
</tr>
</tbody>
</table>

Table 2
Homicide, by Number of Assailants, Weapon, Method of Killing and Legal Outcome, 1980 - 31 March 1993

<table>
<thead>
<tr>
<th>Case</th>
<th>Number of Assailants</th>
<th>Weapon</th>
<th>Method of Killing</th>
<th>Legal Outcome</th>
<th>Coronial Inquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 22</td>
<td>1</td>
<td>Fists</td>
<td>Strangled during fight</td>
<td>Assailant charged, not guilty, insanity, 20 June 1989</td>
<td>Inquest, 53 p. Recommendation to remove blind spots at JNH</td>
</tr>
<tr>
<td>Case 25</td>
<td>Unknown</td>
<td>Stabbing implement</td>
<td>Stabbed in heart</td>
<td>Nil</td>
<td>No</td>
</tr>
<tr>
<td>Case 33</td>
<td>Unknown</td>
<td>Stabbing implement</td>
<td>Stabbed</td>
<td>Prisoner charged with murder, no outcome as two key witnesses died before trial</td>
<td>No</td>
</tr>
<tr>
<td>Case 37</td>
<td>3</td>
<td>(1) screwdriver made from wire (2) Coffee jar (3) fists</td>
<td>Traumatic brain damage complicating a penetrating injury through the temporal lobe</td>
<td>Assailant (1) convicted of manslaughter Assailant (2) convicted of assault occasioning grievous bodily harm Assailant (3) no charges laid</td>
<td>Coroner’s Inquest 16.9.94 &amp; 11.10.94, 52 pages. No recommendations pursuant to Section 25 (2) of the Coroners Act</td>
</tr>
</tbody>
</table>
All four victims were white as were most of the assailants, where the assailants have been identified. Only two of the four homicides have been solved and assailants successfully charged and prosecuted. The Crown case against an alleged offender collapsed with the death of two key witnesses in the matter of case 33. One of the witnesses was the prisoner described as case 34, who died of natural causes in the Adelaide Remand Centre (ARC). Table 2 shows that Case 22 was attacked by a fellow patient in the hospital. Fists were used as the weapon and the victim was strangled during a fight. The assailant, who was serving a sentence for illegal use of a motor vehicle, was found not guilty by reason of insanity in the Adelaide Supreme Court on 20 June 1989 (Ahern, 1990, *Coroner's Report, Finding Of Inquest, Craig Anthony Bell* 29, 30 May, 9, 26 July, 2 August 1990; DCS 646/88).

Wolfson (1978, p. 27) reported that the single assailant scenarios (n = 49) tended to dominate inmate homicides. Table 2 shows that case 22 was a single assailant event and case 37 a multiple (3) assailant event.

In cases 25 and 33, the number of assailants is unknown. However, given the nature of the incidents, especially the method of killing by stabbing, it is likely that each death involved a single assailant. In case 25, where the victim was stabbed in a busy prison yard under surveillance from an officer in a guard tower on the wall, other prisoners may have been actively involved in the incident (*DCS Annual Report*, 1990, p. 2). Prisoners may have shielded the victim from the view of the guard in the tower, or made a noise or created an incident to distract the officer. These views are speculative. What is known is that the victim was stabbed which most commonly is the action of a single assailant.

In the death of prisoner described as case 33, it is possible that the victim was asleep and stabbed by a single assailant. The rooms for single occupancy at Cadell Training Centre (CTC) are small, barely larger than a traditional prison cell, often with additional furniture including television and sound systems, but large enough for a single assailant to be assisted by a second person. However, death by stabbing, particularly to the heart, suggests a planned and carefully staged killing, possibly a commissioned execution.

Wolfson (1978, p. 39) reported that 87 (77%) of the inmate victims were killed by stabbing, 10 (9%) by strangulation, with 16 (14%) by beating, burning and shooting with unknown comprising the remainder. The SA picture of three deaths by stabbing and one by strangulation is consistent with the pattern described by Wolfson (1978).

Wolfson (1978, p. 42) reported that, in 79% of the cases, cutting or stabbing weapons were used, seven per cent were blunt objects such as a club or hammer and two per cent were personal weapons, such as hands, feet and fists. In SA, stabbing implements were used in three (75%) of the deaths, although in one death (case 37), a coffee jar was used as a blunt instrument along with personal weapons (fists) and in another (case 22), personal weapons (fists) were used. In the community, only 30% of homicides result from stabbing, with firearms accounting for 25% and strangulation seven per cent (James & Hallinan, 1995, p.2).

Wolfson (1978, p. 122) reported that two-thirds of the prison homicide offenders were convicted for the offence, the same rate for the US as a whole. In SA, 50%, that is, offenders involved in two of the incidents, have been charged and convicted.

Wolfson (1978, p.58) reported direct victim precipitation if the victim resorted to physical force before the incident leading to death, or the victim possessed a weapon and the assailant
did not, if the victim's death resulted from an assault committed in the assailant's cell, if the assailant tried to escape and if the assailant was subsequently acquitted of homicide by reason of self-defence. 'The defining characteristic of direct victim contribution demand that the first physically aggressive or violent contact be perpetrated by the victim' (Wolfson, 1978, p.58). Indirect victim precipitation resulted from altercations precipitated by verbal taunts, insults, ridicule and non-physical threats.

The SA data does not allow absolute conclusions to be drawn in respect to victim precipitation. In relation to case 22, the coroner could not establish a link between victimisation and the prisoner's offence of unlawful sexual intercourse with a girl under 12 years of age (Ahern, Coroner's Report, Finding Of Inquest, Craig Anthony Bell, 29, 30 May, 9, 26 July, 2 December 1990, p. 1; DCS 646/88). This situation does not correspond with Wolfson's (1987) definition of direct victim contribution, but prisoners convicted of offences against women and children are often victimised by other prisoners. It is impossible to determine whether indirect victim precipitation was present. In case 25, it is likely that direct victim precipitation was a major factor in the homicide. The victim was a violent man who had a significant reputation for thuggery and bullying within the SA prison system. On 22 June 1982, the victim (case 22) was an assailant. He organised for a 12 gauge shot gun to be smuggled into the prison which he used to shoot another prisoner at close range, seriously wounding him (DCS 45 1/82).

It is highly likely that indirect victim precipitation occurred in case 33, where the 56-year-old prisoner was killed the day before his release. It is not known whether he was killed by a prisoner acting alone, a prisoner fulfilling a contract, a 'known enemy', or person or persons entering the open prison after hours. This man had served a life sentence for the murder of his brother. He had also been convicted of assault upon his wife. His death, therefore, may have been illegal and informal capital punishment.

In relation to case 37, there is evidence of direct precipitation by the victim. The assailant informed the coroner (Chivell, 1994, p. 2) that he had attempted to get some cannabis from the victim earlier, but the victim had begun 'ranting and raving'. The assailant alleged that the victim 'took a swing' at him, punching him in the back of the head. The assailant said they 'shaped up' to each other. Then the assailant said he saw the coffee jar and used it to hit the victim on the head. In sentencing the main assailant, an Aborigine, previously convicted of a 'brutal and wanton' murder, 'the learned judge accepted that the assailant and another man had not gone into the dining room with the intention of killing or grievously wounding' the victim. It was this evidence that enabled the sentencing judge to find the offence 'in the upper range of manslaughter, approaching murder' but not murder (Chivell, 1994, p. 3). The underlying motivation behind the assault and homicide related to drug use and trafficking by both the victim and the assailants, a scenario not considered in Wolfson's hypotheses. This may be because her study was conducted in 1973. However, it is likely that few US prisons in 1973, the year of her study, allowed contact visits with prisoners, possibly the major source of illicit substances gaining entry into prisons. Nevertheless, Porporino et al. (1987, p. 131) noted an increase from 9.4% (three homicides) in 1967-78 to 17.3% (nine homicides) for the period 1979-84 in Canadian federal penitentiaries which was attributed to drugs.

Wolfson (1987, p. 184) stated that single assailant homicides tended to be spontaneous and multiple assailant homicides planned. The argument is that multiple assailant events require discussion, planning and sufficient group cohesion for members to act together. Fear may also contribute to the development of group cohesion. It is difficult to draw firm conclusions from
the SA dam, but case 22, involving a single assailant, was probably unplanned or spontaneous. It is likely that the homicide of the prisoner described as case 25 was planned. This killing involved the use of a stabbing implement in a busy prison yard. The fact that the assailant or assailants have not been apprehended also suggests planning and the strength of the 'wall of silence' which faced police when attempting to identify the offender or offenders through their investigation. It is likely that the homicide of the prisoner, case 33, was planned. No assailant or assailants have been identified and a stabbing implement was used to cause death.

In the death of the prisoner described as case 37, the coroner referred to the sentencing remarks of the judge which have been cited above. Even though the homicide involved three assailants, the judge concluded that the killing was not premeditated and therefore was unplanned. This is contrary to Wolfson's (1987, p. 184) finding that multiple assailant homicides are planned events.

When homicides occur in the community, one common dimension researched is the offender-victim relationship. Sometimes three sub-types are identified: killing by one family member of another, by friends or acquaintances and by strangers (Palmer & Humphrey, 1980, p. 108). Decker (1993, p. 596) has suggested the use of six categories: stranger, acquaintance, friend, relative, romantically linked and unknown. In the US, Palmer & Humphrey (1980, p. 108) found that family homicides comprised 27% (spouses 13%), 54% were friends or acquaintances and 19% were strangers. A more recent Australian study over the period 1 July 1992 to 30 June 1993 (n = 326) identified that homicides among sexual intimates were 25.6% of the cases, family 30.7%, friends and acquaintances 32.9% and strangers 16.7% with unknown 11.6% and others 8.1% (James & Hallinan, 1995, p. 2). It is likely that, in the four SA prison homicides, the relationship between the victims and the assailants could be characterised as acquaintances and not strangers or family. Polk (1994, p. 108), in his major study of homicide in the state of Victoria from 1985 to 1989, established a different hierarchy of victim-offender relationships. In his sample of 380, 101 were homicides in the context of sexual intimacy, 40 were homicides originating in family intimacy, 84 were confrontational homicides, 61 were homicides originating in other crime which included two prison killings, 38 were conflict resolution homicides, 15 were the victims of mass killings, 22 were unresolved (and unclassifiable), 18 were special cases and one was a mercy killing (Polk: 1994, p.23).

Polk (1994) identified four specific scenarios of masculine violence. The first scenario involves the use of lethal violence in attempting to control the behaviour of sexual partners (Polk, 1994, p. 189). The second scenario Polk (1994, p. 189) described as 'confrontational' homicide drawing on the work of Daly and Wilson (1988). These killings start spontaneously and involve an honour contest and to an outside observer may appear to be 'trivial'. Violence quickly escalates and neither party appears willing to back off and disengage. The second scenario of 'confrontational' homicide may provide a way of understanding the killing of the prisoner (case 22) at James Nash House (JNH). Polk (1994, p. 190) suggested that the victim-assailant dichotomy does not adequately allow for the willing involvement of both parties. The third scenario involves the killing of a person in the commission of another crime (Polk, 1994, p. 190) and could be applied to a prison homicide where a prisoner killed a staff member in attempting to escape or during a prison disturbance such as a riot or hostage taking incident. None of the four SA prison homicides appears to fit Polk's (1994) scenario of homicide to control the behaviour of sexual partners. This scenario also was one of Wolfson's
(1978) hypotheses. The remaining three homicides (cases 25, 33, and 37) appear to fit Polk’s (1994) scenario where violence is used to control and resolve conflict.

Two of Wolfson's (1978, p. 4) hypotheses are not able to be discussed in a meaningful fashion in relation to Australian dams. Wolfson (1978, p. 14) hypothesised that the US victim was more likely to be non-white and that the death penalty is unlikely to deter homicide. Wolfson (1978, p. 221) found that, for 1973, 117 (94 %) prison homicides occurred in States which retained capital punishment and seven (6%) occurred in the abolitionist states. Wolfson (1978, p. 14) also hypothesised that the prison homicide rate is likely to exceed the rate of homicide in the community. No attempt has been made to calculate a homicide rate for SA prisons because of the small number of homicides in the 133-year period. However a comparison could be made between the four homicides and the number of prisoners in custody on the 30 June of each relevant year (DCS Annual Report, 1992-1993, p. 41). For case 22, who died on 13 July 1988, this was 871; case 25 on the 12 October 1989, there were 931; case 33 on 29 December 1991, 1152; and case 37, on 1 December 1992, 1159. James and Hallinan (1995, p. 2) calculated a homicide rate of 2.0 per 100,000 for Australia as a whole, with a SA rate of 3.7 (27) for males, 0.4 (3) for females and 2.1 (30) for the total. Thus Wolfson's hypothesis that the prison homicide rate is likely to exceed the community's would appear to be supported.

Natural Death

There were 19 prisoners who died from natural causes from 1 January 1980 until 31 March 1993. These deaths constituted 50% of the deaths in SA prisons. Table 3 shows the cause of death as determined by the coroner. The data have been extracted from the reports of inquests, except for prisoners described as cases 1, 3, 5, and 7, where the coroner's determinations were based on the autopsy and police reports (see Table 4).

The clear patterns to emerge from these data are that heart disease was responsible for 10 deaths or just over 50 % of the deaths from natural causes of SA prisoners. As well, one prisoner suffered from a stroke, one died from respiratory tract disease, two died from cancer and five died from other conditions. The Australian Bureau of Statistics (1995b, p. 1) reported that 26.6% of all deaths in Australia are caused by malignant neoplasms (cancer), ischaemic heart disease 24.1% and cerebrovascular disease (stroke) 10.1%. Two prisoners died from cancer, case 3, aged 43 years and case 26, aged 30 years. The Australian Bureau of Statistics (1995b, p. 3) reported that, for the age group 25-44 years, malignant neoplasms were responsible for 24 % of all cancer deaths in Australia.
<table>
<thead>
<tr>
<th>Case Number</th>
<th>Cause of Death &amp; (Age at Death)</th>
<th>Circumstances of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1</td>
<td>Spontaneous left cerebellar haemorrhage (21 years)</td>
<td>Complained of dizziness, collapsed on floor</td>
</tr>
<tr>
<td>Case 3</td>
<td>Metastatic malignant melanoma of the brain (43 years)</td>
<td>Admitted to RAH, treatment for terminal illness</td>
</tr>
<tr>
<td>Case 5</td>
<td>Heart attack (65 years)</td>
<td>Prisoner had suffered four strokes, brain damage, poor health</td>
</tr>
<tr>
<td>Case 7 * G F</td>
<td>Secondary brain haemorrhage (26 years)</td>
<td>Medical treatment inadequate, right-sided haematoma</td>
</tr>
<tr>
<td>Case 10 * G</td>
<td>Myocarditis (31 years)</td>
<td>Collapsed in cabin of truck, athero-sclerosis</td>
</tr>
<tr>
<td>Case 11</td>
<td>Acute myocardial ischemia (58 years)</td>
<td>Found dead, dressed and lying on bed</td>
</tr>
<tr>
<td>Case 12</td>
<td>Raised intracranial pressure caused by colloid cyst (36 years)</td>
<td>Prisoner died in hospital</td>
</tr>
<tr>
<td>Case 14 * G</td>
<td>Status epilepticus (30 years)</td>
<td>Massive internal oedema in the lungs, heart failure</td>
</tr>
<tr>
<td>Case 15</td>
<td>Cardiac arrest, previous heart attacks, brain damage (44 years)</td>
<td>Died in hospital, pneumonia, cerebral hypoxic damage</td>
</tr>
<tr>
<td>Case 16</td>
<td>Myocardial infarction (37 years)</td>
<td>Found slumped over bed at unlock time for evening activities</td>
</tr>
<tr>
<td>Case 17</td>
<td>Myocardial infarction (66 years)</td>
<td>Prisoner in adjoining cell heard gasping, raised alarm</td>
</tr>
<tr>
<td>Case 18</td>
<td>Cardiac failure (24 years)</td>
<td>Idiopathic hypertrophic obstructive cardiomyopathy</td>
</tr>
<tr>
<td>Case 19</td>
<td>Cardiac tamponade complicating ruptured aortic dissecting aneurism (31 years)</td>
<td>Transferred to hospital, died 1.5 days later</td>
</tr>
<tr>
<td>Case 21</td>
<td>Cerebral haemorrhage (40 years)</td>
<td>Became ill in prison cell, taken to RAH, died 2 days later</td>
</tr>
<tr>
<td>Case 26 *</td>
<td>Leukaemia (30 years)</td>
<td>Died in hospital, chronic mutilator</td>
</tr>
<tr>
<td>Case 27 *</td>
<td>Pulmonary oedema, acute myocardial infarction (40 years)</td>
<td>Delays in transport of prisoner from Mobilong, YLP infirmary, Modbury Hospital, RAH, Coroner critical of DCS and medical service</td>
</tr>
<tr>
<td>Case 30</td>
<td>Ischaemic heart disease with right coronary occlusion (61 years)</td>
<td>Prisoner taken from JNH to Modbury where he died</td>
</tr>
<tr>
<td>Case 34</td>
<td>Stroke (40 years)</td>
<td>Prisoner well at 2230 hours, found dead in cell in morning</td>
</tr>
<tr>
<td>Case 36</td>
<td>Respiratory failure (36 years)</td>
<td>Shot by police after armed robbery, transferred from police custody to DCS</td>
</tr>
</tbody>
</table>

Prisoners marked with * are Aborigines.  
The prisoner marked with F has also has his death investigated by Clarkson Royal Commission and RCIADIC.  
Prisoners marked with G have had deaths investigated by the RCIADIC.
In 1984 the major cause of death was ischaemic heart disease, but in 1994 data showed that, for two consecutive years, cancer replaced ischaemic heart disease as the major cause of death for men and women in Australia. This suggests that the pattern of causes for natural deaths among prisoners has been consistent with the rest of the community, except since 1994 when cancer emerged as the major cause of death for men and women in Australia.

In respect of prisoners who died of natural causes, Table 4 shows the prisoner by case number, the date of death, the type of report produced by the coroner, including length, and whether the coroner made any recommendations pursuant to the Coroners Act 1975, ss.25.2. It is beyond the scope of this paper to discuss in detail the circumstances of each prisoner’s death. Readers are referred to the coroners’ reports, the Clarkson Royal Commission report (for case 7) and the RCIADIC for cases 7, 10 and 14.

<table>
<thead>
<tr>
<th>Case Number</th>
<th>Date of Death</th>
<th>Coroner’s Report</th>
<th>Recommendations ss.25.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1</td>
<td>1 January 1980</td>
<td>Autopsy</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 3</td>
<td>5 February 1980</td>
<td>Autopsy</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 5</td>
<td>25 May 1980</td>
<td>Autopsy</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 7</td>
<td>23 July 1980</td>
<td>Autopsy</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 10</td>
<td>19 July 1982</td>
<td>Inquest, 13 pages</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 11</td>
<td>26 July 1982</td>
<td>Inquest, 13 pages</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 12</td>
<td>27 October 1982</td>
<td>Inquest, 12 pages</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 14</td>
<td>4 January 1983</td>
<td>Inquest, 12 pages</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 15</td>
<td>26 May 1983</td>
<td>Inquest, 2 pages</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 16</td>
<td>17 May 1985</td>
<td>Inquest, 22 pages</td>
<td>One recommendation</td>
</tr>
<tr>
<td>Case 17</td>
<td>6 June 1985</td>
<td>Inquest, 42 pages, Inquest recommended by author</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 18</td>
<td>8 January 1987</td>
<td>Inquest, 12 pages</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 19</td>
<td>24 April 1987</td>
<td>Inquest, 23 pages</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 21</td>
<td>5 Sept. 1987</td>
<td>Inquest, 22 pages</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 26</td>
<td>4 November 1989</td>
<td>Inquest, 3 pages</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 27</td>
<td>30 June 1990</td>
<td>Inquest, 12 pages</td>
<td>Three recommendations</td>
</tr>
<tr>
<td>Case 30</td>
<td>3 May 1991</td>
<td>Inquest, 12 pages</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 34</td>
<td>9 February 1992</td>
<td>Inquest, 23 pages</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 36</td>
<td>12 July 1992</td>
<td>Inquest, 8 pages</td>
<td>Nil</td>
</tr>
</tbody>
</table>
It is clear, from reviewing all the conditions or diseases responsible for the deaths of 18 of the 19 prisoners, that all of the conditions pre-existed their imprisonment and had their origins in early stages of life, inadequate care or diet, insufficient exercise or in the genetic endowment of each individual. There may be some doubt about the onset of leukaemia in case 26. In respect to the prisoner, case 36, the respiratory failure occurred after the prisoner was shot by police during an armed robbery and, most importantly, after he had been charged with the offence, remanded in custody and transferred to the custody of DCS. The latter stages of this process occurred at a bedside court sitting at the Royal Adelaide Hospital (RAH). The prisoner was never housed at the ARC.

It is argued, therefore, that dying of natural causes within prison is essentially the result of natural processes and death may have taken place anyway, irrespective of where the person was living. Sixteen (84.2%) of the case group prisoners who died of natural causes had a significant illness on admission. This problematical health status is, then, something these prisoners have imported with them into the prison. Bonta and Gendreau (1994, p. 49) have observed that imprisonment may have the fortuitous result of isolating the prisoner from a previous high-risk life style. It could also be argued, from a more positive perspective, that access to good health care and advice, adequate and nutritious diet, work and recreation may all induce heath benefits for a prisoner with potentially life-threatening illness. Whether this occurs or not is dependent upon the competency of the correctional authorities, especially health screening, and the length of sentence the prisoner has to serve. However, it is the prison which provides the context for these deaths and a number of important issues will be discussed which demonstrate the deprivational or situational contributions which have clearly been negative and may have prejudiced life for some of these prisoners.

Adelaide Gaol

Prisoners described as cases 3, 14, 17, 18, 19 and 21 were held at ADG. At the time of its closure on 4 February 1988, ADG was the oldest public building in use in SA. The first part of the complex was erected during 1840-41. Other sections of the structure were built during the following 20 years (see Griffiths, 1964). Finally, a cellblock known as the 'New Building' was built in 1870. The gaol was intended to accommodate 224 prisoners in 199 cells and a 25-bed dormitory. Before the commissioning of the ARC in August 1986, ADG was the reception centre for both sentenced and remand prisoners. It held almost 350 prisoners in July 1986. After that time, mainly sentenced prisoners were accommodated in ADG. Nevertheless, the Gaol's capacity was constantly exceeded until its closure. It was impossible to set reasonably contemporary standards for hygiene in a mid-nineteenth century building and to provide appropriate protection and standards that could be described as the minimum necessary for appropriate confinement. This gaol, which was unsewered and necessarily unhygienic and uncomfortable because of the difficulties created by the physical conditions, could not provide reasonable opportunities for prisoners to engage in appropriate work and recreation (Dawes, 1988, pp. 26,27). Given the enormous difficulties of living and working in ADG for prisoners and staff, it is surprising that there were not even more problems.

Mr John Highfold, case 14, died in ADG on 4 January 1983. The RCIADIC (1989a) report relating to his death contains very little comment that can be construed as critical of DCS officers, ADG procedures or the medical services provided to the prisoner at the time of his death. The RCIADIC (1989a) reported that the actions of the correctional officers in attempting resuscitation were 'exemplary' and that they acted with 'energy, persistence and humanity' (p.24). Later in the report, it is stated that 'there is no question of inadequate
medical care within the prison' (p.37). The RCIADIC (1989a, p.14) also made the point that the prisoner 'was safer in prison than in the outside world'.

The majority of the criticisms of the RCIADIC (1989a) were directed at the manner in which post-death investigations were conducted. The RCIADIC (1989a) highlighted deficiencies in the police investigation, the pathologist's analysis and investigation of the likely cause of death, and the lack of a suitable 'interface' between the coroner and the investigating police on such issues as possible negligence and unsafe systems which the coroner might need to address. The RCIADIC (1989a) did report on several aspects of the procedures within prisons and prison medical services that required attention. The correctional officers who gave evidence relating to the death of Mr Highfold were concerned about their lack of training and opportunity to undertake refresher courses in first aid and resuscitation techniques (p.25). The RCIADIC (1989a, p. 50) indicated that there is a need for formal procedures to ensure correctional officers know about prisoners with medical conditions, such as diabetes and epilepsy, so that appropriate action can be taken if health problems arise. It is worthwhile to note this recommendation in conjunction with the recommendation contained in the RCIADIC (Interim Report, 1988) suggesting that health services operating in prisons for prisoners and correctional agencies should be completely independent of each other, which was and remains the situation in SA. The RCIADIC (1989a, p. 15) also highlighted the need for prison medical authorities to attempt to introduce a system to ensure that a prisoner's medical history at other hospitals and medical centres is obtained and placed on the prisoner's medical records. The RCIADIC (1989a, p. 15) recognised that the consent of the prisoner would be required to enable such information to be obtained. It is pertinent in regard to this, and the previous issue, to note the RCIADIC (1989a, p. 19) comment that 'a balance must be kept between systems designed to ensure proper medical care of prisoners and the introduction of systems which create further inroads into a prisoner's privacy and self-reliance'. This is a difficult outcome to achieve. The RCIADIC (1989a, p. 19) also stated 'it would be wrong to express the view that the deceased should not have been placed in a single cell. That indeed may have been his preference'. The RCIADIC (1989a, p. 48) also indicated that Aboriginal deaths should be notified to the Aboriginal Community Centre as a matter of course, due to the difficulty that often occurs in attempting to locate family members. The RCIADIC (1989a, p. 49) was silent on which agency (Police or DCS) should assume this responsibility. Deprivational or situational factors were not major components in the deaths of prisoners described as cases 3 and 14.

With respect to case 17, a prisoner in an adjoining cell heard the dying prisoner gasping and raised the alarm at about 1750 hours. After the alarm had been raised, a nurse arrived within three minutes and an ambulance was called. Assistance came too late and the prisoner was dead when help arrived. It is difficult to say whether this man should have been housed in a hospital ward or allowed to remain in his cell. He had suffered from heart disease and this was known to the Gaol authorities. He was convicted of murder and awaiting sentence. He had been in custody for nine days. There was no infirmary at the ADG and he would have needed transfer to the infirmary at YLP. The other situational component was the lack of appropriate capacity to call for assistance. Prisoners called for assistance by shouting or kicking on the cell door and hoped that the noise created would alert an officer. He could not be resuscitated. Both the ARC and Mobilong Prison (MOB) institutions contain a cell call button that registers in the control room and enables the occupant to speak to the officer on duty. Times of calls are logged on a computer.
Similar comments are applicable to the events surrounding the deaths of prisoners described as cases 18, 19 and 21. Table 4 shows that, for all the deaths of prisoners by natural causes at ADG, the coroner's inquest reports averaged about two pages and, for case 3, no inquest was held. The coroner made no recommendations in any of these reports, pursuant to ss 25.2 of the Coroners Act 1975.

Adequacy of Medical Treatment

Prisoners described as cases 1, 7, 10, 12, and 27 were serving their sentences in nonmetropolitan prisons when they became seriously ill. These deaths raise issues about the timeliness, adequacy and responsiveness of both DCS and medical services to their emergencies. In respect to case 1, an autopsy was held. This man became ill at CTC after complaining of dizziness. He collapsed on the floor and was transferred to the RAH where he died one and a half days later. There were no situational factors involved that contributed to his death.

The death of Mr Gordon Semmens (case 7) on the 23 July 1980 has been subject to inquiry by the coroner (an autopsy was conducted but no inquest was held because of proceedings instituted against the assailant for manslaughter), the Clarkson Royal Commission (1981, p. 17) and the RCIADIC (1990b). The death of this Aboriginal man has highlighted many unsatisfactory practices that may have contributed to his death but there is insufficient space to discuss all of the debates surrounding his death. The reader is referred to the Clarkson Royal Commission (1981, pp. 17-21) and RCIADIC (1990b). Mr Semmens died from a secondary brain haemorrhage due to a right-sided subdural haematoma apparently sustained in a fight at a hotel a few days earlier. Two officers who were involved in his care were affected by the questioning by Royal Commissioner Clarkson, believing him to be biased against DCS. The Clarkson Royal Commission was extremely critical of DCS officers. Mr Semmens was detained for eight days because he was unable or did not wish to pay a fine. The officers believed that the medical practitioner who failed to adequately diagnose Mr Semmens' subdural haematoma escaped criticism and their view was reinforced by the report of Mr Semmens' death in the Royal Commission, where the doctor, having written a diagnosis 'may be slightly concussed', really fades from the situation, leaving DCS staff responsible for the prisoner and his health. In 1980 at Port Augusta Gaol (PAG), there was only one staff member on the first and second watches, that is, from late afternoon after the prisoners had their evening meal until 7.00am or 8.00am the next morning. Prisoners were locked down, and, if a prisoner became ill, the on-duty staff member had to phone the Keeper who then authorised an additional staff member or members to be contacted and called into work. There is no doubt that this was an appalling arrangement and constituted an enormous deprivational factor. Even if an officer was home and agreed to return to work, minutes would pass before he would be available to assist the one officer on duty. Sometimes it was necessary to phone a number of off-duty staff before someone could be located who would agree to return to work. The Keeper lived on the grounds of PAG and could return to the Gaol more quickly if he was home.

As a result of the Clarkson Royal Commission (1981), improved procedures were implemented at PAG, so that staff were made aware that certain prisoners could become ill and may need assistance during the evening hours. However, it was not until the second half of 1983, with the commissioning of new accommodation, that the institution's staff was augmented, and not until 1985 was a nursing sister appointed. In 1983, two staff were on duty after the close of the prison and were equipped with two-way radios to enable contact with each other on patrol.
In addition, the officers had control of the cell and barrier keys while patrolling, so a cell could be opened and entered and assistance given to a distressed prisoner with little delay. The RCIADIC (1990b, pp. 22,27) resulted, because of the very thorough examination of the work of the treating doctor and pathologist, in a shift of responsibility away from DCS staff to the health system.

In relation to another Aborigine, Mr Malcolm Buzzacott (case 10), Table 3 shows that his death has also been subject to coronial inquest and report by the RCIADIC (1990a). Mr Buzzacott died in the cabin of the PAG truck. He was with two other people, the officer, who was the driver, and another prisoner. They were collecting manure for the gaol garden. The major deprivational factor related to the response of the officer in deciding to return to PAG rather than drive his truck directly to Port Augusta Hospital, but, although the RCIADIC (1990a, pp. 21-23) determined that the Correctional Officer 'made an error of judgement'...he 'should not be criticised' as his actions had no effect on the outcome.

In regard to the prisoner described as case 12, there did not appear to be any deprivational factors involved in his death. The coroner's inquest report was one and a half pages long and the coroner did not make any recommendations.

The prisoner described as case 27 was subjected to extraordinary deprivational factors that may have contributed to his death. Due to a breakdown in communication between the correctional authorities and the local doctor, the prisoner was taken to an inappropriate medical centre. It could be argued that, if he had been taken directly from MOB to the RAH without delay, he would have received intensive medical care sooner.

Tables 3 and 4 show that the prisoners described as cases 5, 11, 15, 16, 26 were held in custody at YLP, case 30 at JNH and case 34 at ARC, and that coroners' inquests were held for all prisoners, with the exception of case 5 where an autopsy was conducted. The average length of the coroners' reports was two pages and a recommendation was only made in respect to case 16. There is nothing to suggest that any of these prisoners did not receive adequate and responsive treatment, although in cases 16 and 34 the prisoners were found dead in their cells. The prisoner, case 16, was well known to the medical authorities.

The general conclusion reached is that, with the exception of those clearly documented cases where things went wrong through negligence, ignorance and inadequate access to medical services because of the primitiveness of the correctional facilities, importation factors seemed to play a more substantial role in the deaths of prisoners who died from natural causes than deprivational or situational factors.

Suicides

It is postulated that, in suicidal deaths, more so than any type of death in custody, deprivational or situational factors are likely to play a more significant part in triggering or creating the circumstances where suicidal ideation is given effect. The remaining section of this paper will discuss, in some detail, each of the 14 suicidal deaths to identify the deprivational components with a view to developing a more comprehensive understanding of preventive measures. The mean age of the 13 male prisoners who suicided was 25.77 years, nearly two and a half years younger than the control group prisoners (28.26 years).
Table 5  
Suicides, Cause of Death and Circumstances of Death, 
Coroners’ Verdicts, SA, 1980 - 31 March 1993

<table>
<thead>
<tr>
<th>Case Number</th>
<th>Cause of Death &amp; (Age at Death)</th>
<th>Circumstances of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 2</td>
<td>Asphyxia by hanging (19 years)</td>
<td>Prisoner had been assaulted and raped</td>
</tr>
<tr>
<td>Case 4</td>
<td>Haemorrhage, shock and fractured skull (28 years)</td>
<td>Fractured skull, jumped from building</td>
</tr>
<tr>
<td>Case 6</td>
<td>Hanging, drug-taker (22 years)</td>
<td>Comato-asphyxia due to hanging against trap inside cell, used sheet</td>
</tr>
<tr>
<td>Case 8</td>
<td>Asphyxia due to hanging (25 years)</td>
<td>Found hanging from cell window bar, had used sheet</td>
</tr>
<tr>
<td>Case 9</td>
<td>Asphyxia due to hanging (27 years)</td>
<td>Committed suicide in his cell during evening of 1 Dec. 1981</td>
</tr>
<tr>
<td>Case 13</td>
<td>Asphyxia due to hanging (23 years)</td>
<td>Shared cell with his brother</td>
</tr>
<tr>
<td>Case 20* G</td>
<td>Asphyxia due to hanging (19 years)</td>
<td>Found hanging in cell. RCIADIC found that prisoner’s death to be accidental</td>
</tr>
<tr>
<td>Case 23</td>
<td>Hanging (36 years)</td>
<td>Prisoner found hanging in his room at NPC from curtain pelmet</td>
</tr>
<tr>
<td>Case 24</td>
<td>Hanging (25 years)</td>
<td>Prisoner found hanging by dressing gown cord</td>
</tr>
<tr>
<td>Case 28*</td>
<td>Hanging following transfer from JNH to YLP (18 years)</td>
<td>Suspended by sheet from pipe near ceiling in cell</td>
</tr>
<tr>
<td>Case 29</td>
<td>Hanging (26 years)</td>
<td>Hanged himself by cord from air-Conditioning duct. Breakdown in communication between ARC and YLP</td>
</tr>
<tr>
<td>Case 31</td>
<td>Heroin overdose (35 years)</td>
<td>Died in cell at MOB after taking a heroin tablet</td>
</tr>
<tr>
<td>Case 35</td>
<td>Suicide, found with throat cut (27 years)</td>
<td>Shared cell in E Division. On wake up found dead by cell mate</td>
</tr>
<tr>
<td>Case 38</td>
<td>Hanging by fencing wire, bail application refused (30 years)</td>
<td>Found hanging in cell</td>
</tr>
</tbody>
</table>

Prisoners marked with * are Aborigines.  
Prisoner marked with F has also had death investigated by the Clarkson Royal Commission.  
Prisoner marked with G has had death investigated by the RCIADIC.  

The Australian Bureau of Statistics (1994, p. 1) reported that, for Australia as a whole during the years 1982-1992 as a proportion of total deaths, suicides increased from 1.5 % in 1982 to 1.9% in 1992. During the same period, suicides accounted for in excess of 22,300 deaths, with more than 2,000 deaths from suicide being registered each year from 1987 to 1992. The number of male suicides is significantly higher than for females. Since 1982, 78 % of the total number of deaths by suicide were male. The Australian Bureau of Statistics (1994, p. 5) also
reported that, in the 25-34 year age group as a proportion of total deaths, suicides have increased from 18% in 1982 to 21% in 1992, and in the 15-24 years age group have doubled from 12% in 1982 to 24% in 1992. In regard to marital status, divorced persons had the highest average crude suicide rate over the period 1982-1992 with 34 deaths per 100,000 of the divorced mean population (p. 6). The highest proportion of suicide deaths for both males and females who had never married occurred in the 15-24 years age group (p.6).

It is argued that the 14 deaths by suicide of prisoners in SA demonstrate the same broad social and demographic characteristics as has been reported by the Australian Bureau of Statistics (1994), suggesting that offenders import significant factors into the prison system.

Table 5 shows, by case number, the 14 prisoners who suicided, the cause of death and circumstances of death as determined by the coroner, and the age of death. Table 6 shows the 14 prisoners by case number, the type of report produced by the coroner, including length and whether the coroner made any recommendations pursuant to the Coroners Act 1975, ss.25.2. In all cases, except case 6, the coroner conducted a public inquest and reports were produced. A trend did emerge for inquest reports to become longer post-RCIADIC, although such a trend became obvious from the inquest into the death of case 23, which was conducted on 13 January 1990. It was likely by then that coroners throughout Australia were conscious of the scrutiny and criticisms of their previous work by the RCIADIC (Interim Report 1988:58-64).

Prisoners described as cases 6, 8, 13 and 20 died at ADG, and cases 9, 28, 29 and 35 died at YLP. Case 4 died at the Security Hospital, case 23 Northfield Prison Complex (NPC) Cottages, case 24 NPC Women's Centre, case 31 MOB and case 38 MTG.

Case 2, Mr Christopher Paul Bowman died on the 17 January 1980 at YLP. There is no doubt that Mr Bowman was being sexually harassed and the prison authorities failed to respond to his distress (Clarkson, 1981, p. 17). These two factors amounted to a very serious deprivation.
### Table 6
Suicides, Date of Death, Coroners’ Reports, Recommendations, SA, 1980 - 31 March 1993

<table>
<thead>
<tr>
<th>Case Number</th>
<th>Date of Death</th>
<th>Coroner’s Report</th>
<th>Recommendations ss.25.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 2</td>
<td>17 January 1980</td>
<td>Inquest</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 4</td>
<td>11 Feb. 1980</td>
<td>Inquest, 32 pages</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 6</td>
<td>2 July 1980</td>
<td>Autopsy</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 8</td>
<td>29 June 1981</td>
<td>Inquest, 12 pages</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 9</td>
<td>1 December 1981</td>
<td>Inquest, 42 pages</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 13</td>
<td>6 November 1982</td>
<td>Inquest 12 pages, Inquest recommended by author</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 20</td>
<td>9 July 1987</td>
<td>Inquest, 12 pages</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 23</td>
<td>10 July 1989</td>
<td>Inquest, 3 pages</td>
<td>One recommendation</td>
</tr>
<tr>
<td>Case 24</td>
<td>4 August 1989</td>
<td>Inquest, 11 pages</td>
<td>One recommendation</td>
</tr>
<tr>
<td>Case 28</td>
<td>24 August 1990</td>
<td>Inquest, 15 pages</td>
<td>Seven recommendations</td>
</tr>
<tr>
<td>Case 29</td>
<td>16 Dec. 1990</td>
<td>Inquest, 13 pages</td>
<td>One recommendation</td>
</tr>
<tr>
<td>Case 31</td>
<td>22 Sept. 1991</td>
<td>Inquest, 3 pages</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 35</td>
<td>12 April 1992</td>
<td>Inquest, 42 pages</td>
<td>Nil</td>
</tr>
<tr>
<td>Case 38</td>
<td>27 January 1993</td>
<td>Inquest, 7 pages</td>
<td>Nil</td>
</tr>
</tbody>
</table>

Case 4, a prisoner, with a severe mental illness, jumped to his death on 11 February 1980 at the Security Hospital, located adjacent to YLP. He had made three previous attempts and was appropriately housed in the Security Hospital.

The coroner's report of three and a half pages did not identify any negligence or maladministration at the Security Hospital (Gordon, 1991, Coroner's Report, Finding Of Inquest, Peter Mogorov, 1 April 1981). This suicide was the only one which used jumping from a height as the method, although there were 11 similar suicides by patients of Glenside Hospital, a psychiatric facility, between March 1980 and April 1984 (Goldney, 1986). Eight of the 11 chose to suicide by jumping from multi-level car parks, two from commercial premises near the hospital and a third from a central city commercial building (Goldney, 1986, p. 122). Each of the patients had schizophrenia or schizoaffective disorder (p. 121). Goldney (1986, p. 121) argued that the reason for the spate of such suicides was probably multifactorial and indicated suggestion or contagion as one possible explanation. Adelaide car parks were modified by the fitting of barriers to stop impulsive jumping which is consistent with the 'closing the exits' theory postulated by Clarke and Lester (1989). All the correctional authorities could do in such a situation was to 'close the exits' by ensuring that it became very difficult, if not impossible, to climb onto the roofs of prison buildings.
Case 6, a 22-year-old prisoner, was found hanged in his cell at ADG on 2 July 1980. An autopsy was performed and the coroner reported the cause of death as hanging. The prisoner hanged himself using a bed sheet tied to the trap, a small opening in the cell door. No inquest was held. The records available in DCS relating to this man are minimal. It is clear that he died on day one in custody after having only served five hours. He had been remanded to face charges of shop breaking and larceny. The postmortem examination revealed he was drug dependent. This was probably not revealed by the prisoner on reception at ADG or not noticed by staff, or, if noticed, was not acted upon. The last two factors are deprivational, but a reasonable conclusion has to be that importation factors played the major role in this man's death.

Case 8, a 25-year-old man, was found hanged in his cell at ADG on 29 June 1981. This man had served 11 days after being remanded on charges of robbery. He also had a history of drug usage. An inquest was held and a report produced of one and a half pages. The coroner determined that the prisoner had died from asphyxia due to hanging. He had used a bed sheet to hang himself from a cell window bar. Like the situation with case 6, described above, there are few records relating to this man. The coroner's report (Ahern, 1981, *Coroner's Report, Finding Of Inquest, Mark David Duggan*, 5 November 1981) did not suggest any negligence or lack of care, but it could be argued that, as this prisoner had been in custody for 11 days as compared with five hours for case 6, the responsibilities of the ADG staff to know the prisoner's behaviour patterns must be considered to be greater, although the underlying dynamic is clearly one of importation.

Case 9, a 27 year old man sentenced to life imprisonment, who had served approximately four years and six months, hanged himself in his cell 'from the cell bars' on the evening of 1 December 1981. The coroner's report of inquest, of four and a half pages, made no recommendations (Ahem, 1982, *Coroner's Report, Finding Of Inquest, Daniel Stephen Patrick Ryan*, 12 August, 2, 23 September 1982). On the 4 June 1980, the prisoner was admitted to the Security Hospital following a suicide attempt and was discharged to YLP on 27 June 1980. On the 2 September 1981, he was once again admitted to the Security Hospital and discharged on the 10 September 1981. It is clear that this prisoner did have an underlying psychiatric disability or personality disorder and he had received some treatment while in prison. The medical officer found the prisoner difficult to treat, although correctional officers found him reasonably well behaved. The DCS records do not provide much information about his vulnerabilities or his life in prison (DCS 1691/87).

Case 13, a 23-year-old man remanded on a charge of robbery, hanged himself in a cell at ADG he shared with his brother. This man had served one month and two days. A coronial inquest was held which was requested by the author. The coroner reported his findings in one and a half pages (Ahern, 1983, *Coroner's Report, Finding Of Inquest, Klause Dieter Griesche*, 15 March 1983). The DCS records (DCS 1681/87) provide a comprehensive description of the finding of the deceased and efforts made by correctional officers to revive him. However, there is no background report of the prisoner and no known indication of vulnerability.

Kingsley Richard Dixon, aged 19, an Aborigine, died on the 9 July 1987 from asphyxia due to hanging (Ahern, 1987, *Coroner's Report, Finding Of Inquest, Kingsley Richard Dixon*, 29 September, 8, 22 October, 11 November and 3 December 1987). He was found hanged in his cell. His death was the first case to be considered by the RCIADIC, under Commissioner Muirhead, the first national Royal Commissioner (RCIADIC, 1989b).
Three views emerged about his death. His mother, Mrs Alice Dixon, maintained steadfastly until she died that her son had been murdered. Coroner Ahem (1987) determined that Mr Dixon had suicided by hanging and the RCIADIC (1989b, p. 57) found that his death, although by hanging, was accidental. The conclusion that will be reached in this paper is that Mr Dixon's death resulted from a complex entanglement of importation and deprivational factors and was probably suicide. While generally the findings of the RCIADIC (1989b) must be regarded as overruling those of the coroner (Ahern, 1987) because the RCIADIC (1989b) was the superior authority, this paper is about the work of coroners. From that perspective, Mr Dixon's death was regarded as suicide. The RCIADIC (1989b) did not thoroughly discuss the psychology of hanging and the possibility that some prisoner hangings may have resulted from autoerotic behaviour (Biles, 1994, p. 21; Liebling, 1992, p. 88; Saunders, 1989, pp. 82-91; Waller, 1992, p. 75 & 1982, p. 64). There is no evidence to suspect autoerotic behaviour played a part in Mr Dixon's death. Readers are referred to Ahern (1987), RCIADIC (1989b) and Mr Dixon's criminal record which was abridged in the RCIADIC (1989b, p. 10) report.

The following discussion will analyse the deprivational contribution to his death. The RCIADIC (1989b) report was critical of aspects of Mr Dixon's incarceration and care. The most severe criticisms were aimed at the behaviour of individual officers rather than the policies and procedures of DCS. The RCIADIC (1989b, pp. 47,49) did not conclude that Mr Kingsley Richard Dixon was killed through the direct agency of the officers who were criticised or any other person.

The conditions within ADG made it 'totally inadequate to serve as a modern correctional institution' (RCIADIC, 1989b, p. 9). The overcrowding and the absence of facilities necessitated the implementation of routines to maintain order and discipline among prisoners. These routines 'were likely to cause irritation and stress to ...prisoners and prison staff' (p. 8). It seems that the RCIADIC (1989b) viewed ADG, rather than the prison routines, as the major cause of stress. The RCIADIC (1989b, pp. 68-79) devoted considerable attention to the issue of drugs in prison and matters that have some relationship with drug minimisation strategies, such as strip searching and contact visits. The RCIADIC (1989b, pp. 12,68,69) accepted that a 'drug culture' existed at ADG and that Mr Dixon was under the influence of drugs when he was taken to his cell shortly before his death. The RCIADIC (1989b, p. 30) accepted that appropriate procedures had been put in place by the ADG administration in relation to the handling of prisoners whose capacities or state of mind were affected by drugs. Of major deprivational significance, the RCIADIC (1989b, pp. 35,58) stated Mr Dixon would probably not have died on 9 July 1987 if those procedures had been followed. The RCIADIC (1989b, p. 30) concluded that Correctional Officers S and S 'appear to have ignored' those procedures and, in doing so, did not treat Mr Kingsley Dixon 'with the care his obvious condition required'. The evidence given by those two officers before the Royal Commission, as well as the evidence given by Chief Correctional Officer F, indicated that they attempted to conceal the breaches of procedures from the investigation bodies.

The RCIADIC (1989b, p. 26) also indicated that a number of officers were unaware of the Manager's rule that strip searches were not to be conducted in 'A' Wing and reported (RCIADIC, 1989b, p. 80) that, at the time of Mr Kingsley Dixon's death, there was confusion and misunderstanding about the rules and procedures relating to prisoners who were affected by drugs or alcohol. The RCIADIC (1989b, p. 80) also suggested that 'strict guidelines for dealing with prisoners observed to be in distress or affected by drugs or alcohol need to be established'. DCS acted on this recommendation and new stricter rules and procedures were promulgated during January 1988 and forwarded to the RCIADIC soon after. The RCIADIC
(1989b, p. 69) accepted that drugs in prisons create difficulties for prison management and correctional officers and, by inference, rejected the view put to the Royal Commission that prison management tolerate drugs because of the supposedly pacifying effect they have on prisoners. While holding the view that the benefits of contact visits to both prisoners and their families are 'beyond dispute' (p.70), the Commissioner did not express an opinion regarding the submission made by an Aboriginal group at YLP (Sansbury Association) that contact visits should be a right rather than a privilege (RCIADIC, 1989b, p 99).

Having accepted the inherent value of contact visits, as well as the probability that this was the main avenue for drugs to enter prisons, the Commissioner was confronted with the dilemma which he barely discussed and does not resolve - the identification of non-intrusive security measures to prevent the entry of drugs into prisons. The Commissioner described strip searching as a humiliating process, destructive of policies designed to better relationships between prisoners and staff, and cast doubt upon the effectiveness of the process in achieving its purpose (p.85). The Commissioner's findings did not suggest an awareness of the intrusive nature of random urine sampling or that the small number of occasions upon which strip-searching has located contraband may be due to the deterrent value of the procedures. The Commissioner did not indicate the nature of what he referred to as 'scientific detection methods', his reasons for accepting that a drug culture existed in SA prisons (p. 82), nor for concluding that contact visits are the main means for that culture to flourish. However, although Mrs Dixon brought drugs to her son on the day of his death, he made no critical comment about the individuals who supply drugs to prisoners (RCIADIC, 1989b, pp. 15,69).

The RCIADIC (1989b, p. 74) did express the view that base grade correctional officers 'do not have the expertise to assess with accuracy either the health or mental condition of a prisoner or the extent of which a prisoner may be affected by drugs or alcohol. The RCIADIC (1989b, p. 18) reported that no signs of distress, depression or suicidal tendencies in the prisoner had been observed by his mother or the rest of his family, the ADG social worker, the prison medical officer or correctional officers in the period prior to his death. The report made the point that 'under particular circumstances persons who have exhibited no propensity to self-destruction, made no previous attempt, may so act' (p. 17). The point clearly made by the Commissioner is that an individual who is under the influence of drugs must be considered to be at risk of suicide or inflicting self-injury. As a result, the Commissioner commended the recommendation made by the Coroner that there be a blanket rule whereby any person suspected of or found to be in possession of drugs or affected by drugs be taken to a particular locality for observation (p.78). The Commissioner was not specific about the type of location for observation, but, bearing in mind the findings from the literature (Hayes, 1983, p. 481; Frost & Hanslick, 1988, p. 210; Greely & McDonald, 1992, p. 340; Spencer, 1989, p. 164; Zevitz & Takata, 1989, p. 085 and Winfree, 1987, p. 53) of the need for medical supervision, an appropriate place may be an infirmary or hospital ward, providing that appropriate custodial (not necessarily correctional) supervision is also provided (Burtch & Ericson, 1979, p. 42). The actions of the correctional officers in placing Mr Dixon in his cell while he was drug affected were the same as placing him in solitary confinement. The Commissioner (198%, p. 74) elsewhere in the report expressed doubts that officers have the sensitivity to exercise appropriate judgement when dealing with intoxicated or drug affected prisoners.

A lesser, but still important, deprivational experience for Mr Dixon was highlighted by the RCIADIC (1989b). The Commissioner was very critical of the manner in which his cell was searched just prior to his death. The cell was left in a most untidy manner and the prisoner
was not invited to be present during the search (p.85). The RCIADIC (1989b, p. 87) recommended that the rules relating to the appropriate means to conduct a cell search should be made known to all officers and suggested that reference needs to be made to the need for compliance with procedures and this should be enforceable under the Correctional Services Act, 1982.

Case 23, a 36 year old man, at the time of his death the State's longest serving prisoner (15 years three months completed of a life sentence), was found hanging from the curtain pelmet in his room within a cottage at NPC. He had almost completed his long sentence and was preparing for release. He had been described as a lonely man with few skills and institutionalised. He did not appear to have any friends outside the prison system and was not looking forward to release. His family had apparently abandoned him. He was found by two male correctional officers. The staff who found him expressed their shock, horror and disbelief at seeing the prisoner hanging. All of the prison staff were incredulous that a person they knew, or thought they knew so well, who they were trying to assist and who was so close to release, would suicide. Staff at NPC had invested themselves emotionally in caring for and assisting the deceased prepare for his release. The officers were saddened by his death. Channel 10, on the 13 July 1989, suggested in their television news report that staff were negligent in causing his death. The prisoner sought a transfer back to Mount Gambier Gaol (MTG), a higher security prison with a more structured regime. This was refused. This was the basis for the allegations of negligence, but the coroner's report (Ahern, 1990, Coroner's Report, Finding Of Inquest, John Anthony Poneros, 13 January 1990) quoted a specialist medical officer who was supportive of DCS in its approach to assisting the deceased prepare for his release. The coroner's report was three pages long and contained one recommendation to do with making the rules about resuscitation clearer for staff. The prisoners contributed to a wreath and a memorial service was held and, although some prisoners wished to attend a funeral service in the community and would have been granted leave for this purpose, this was denied them by the family of the deceased prisoner. Thus the grief of the prisoners and of some of the correctional officers was disenfranchised (Doka, 1989). It is difficult to determine the extent of the deprivational factors involved in the death of this man, but serving a long prison sentence can be destructive of self-esteem, self-direction, and supportive contacts in the outside world. Case 24, a 25-year-old female prisoner, was found hanging in her room at the Women's Centre, NPC on the 4 August 1989. Her death came just three weeks after the death of a prisoner (case 23) at the same prison. She had been remanded in custody and charged with murder. The allegations against her attracted considerable media attention. The coroner's report of the inquest is 11 pages long and contains one recommendation (Ahern, 1990, Coroner's Report, Finding Of Inquest, Kathryn June Capes, 27, 28 February, 1, 21 March and 17 May 1990).

Two serious deprivational factors occurred which must have increased her distress enormously. Firstly, the coroner found that some officers at NPC had made offensive remarks about prisoners, including the deceased, in from of other prisoners. NPC was a small community and staff were encouraged to interact with prisoners. It is inevitable in such situations for staff and prisoners to speak about other prisoners and staff, but expressing condemnation of a person because of her alleged crime is unjustified and unprofessional. Some correctional officers found it extremely difficult to relate to and accept prisoners as human beings, believing that, if they did this, they would somehow be accepting the crime or become contaminated by its awfulness or be overwhelmed by revulsion which might be experienced in relation to the crime.
The second deprivational factor occurred when the prisoner was told by her solicitor that, if convicted, she might receive a life sentence with a non-parole period of between 18 to 20 years. This would have been a major stressor and the solicitor should have conveyed to staff that he had discussed possible sentence lengths with his client. Deprivational factors probably played a major role in contributing to the death of this prisoner.

Case 28, an 18-year-old man was remanded in custody after bail was revoked and had served 14 days. He had been transferred from JNH and was found hanging in his cell at YLP on 24 August 1990. The coroner's report of 15 pages contained seven recommendations (Gordon, 1991, Coroner's Report, Finding Of Inquest, Michael Gordon Scholes, 15, 16, 17, 29 April and 25 June 1991). This prisoner should not have been transferred to YLP, but should have been held at JNH until a bed became available at the ARC. While there were considerable pressures on accommodation in the State's prison system, the transfer of this young Aborigine to YLP was inappropriate. The other deprivational factor was the lack of quality records about this young man and that information about his vulnerability was not passed onto the prison authorities at YLP, again highlighting the need for fail-safe communication channels between the health authorities who operate JNH on behalf of DCS and DCS.

Case 29, a 26 year old man, who had been returned to prison after breaching his parole, was found hanging in his cell in B Division YLP. He had used a cord to hang himself from an airconditioning duct. The coroner's report of 13 pages made one recommendation (Ahern, 1991, Coroner's Report, Finding Of Inquest, Andrew John Darling, 9, 24 July and 10 September 1991). The coroner wrote to DCS expressing his concern over a breakdown in communication between the ARC and YLP. Staff at the ARC had not filed incident reports dealing with two episodes of wrist slashing, so crucial information on this man's vulnerability was not passed onto staff at YLP.

On the day before his death the prisoner was observed to have a very noticeable red mark about his neck. The officer who provided this evidence to the coroner was not aware of the wrist slashing episodes at the ARC and accepted the prisoner's explanation that the mark was caused through shaving. It was really caused by a hanging attempt which might have been a rehearsal as the coroner believed it to be.

Case 31, a 35-year-old prisoner, was serving 15 years six months (non-parole period 10 years three months) for factory and clubhouse breaks and attempted escape. He had served four years and 11 months when he died in his cell at MOB after taking a 'heroin tablet'. The coroner's report of three pages did not contain any recommendations (Thompson, 1992, Coroner's Report, Finding Of Inquest, 27 October, 26 November and 16, 24 December 1992).

While many of the dynamics in this death are similar to the accidental death (case 32) the coroner formed the view that this death was consciously self-intended and therefore was suicide. Other prisoners at MOB were shocked by his death and, if the deceased prisoner had given signs of thinking about suicide, other prisoners were not aware of this. The deprivational factor most likely to have contributed to his death was access to heroin.

Case 35, a 27 year old man serving a sentence of 18 years for armed robbery and breach of parole, and having served four years and five months, was found dead by the other occupant sharing the cell in his bed in the upper bunk in E Division, YLP. The coroner found suicide: the man had cut his throat. The report of three pages made no recommendations. The prisoner left a note that contained religious delusional material and suggesting his own unworthiness.
This man's death and that of the prisoner described as case 13, discussed above, provide unequivocal evidence that sharing a cell is no protection against suicide, although it is conceded that it is impossible to tell whether sharing has protected others from this action. It could be argued that the other occupants of shared cells can be exposed to cruel and unusual punishment following a death. The cell-mate of prisoner, case 35, was regarded as a potential suspect for homicide for a number of days, separated from other prisoners and held in G Division, YLP. The primary factors involved in the prisoner's suicide were importation factors.

Case 38, a 30 year old man, remanded in custody at MTG, to face charges of assault occasioning grievous bodily harm and damage to property, and who had served 18 days, was found hanging by fencing wire in his cell. He had been refused bail on 27 January 1993, the day of his suicide. The coroner's report of seven pages (Thompson, 1993, *Coroner's Report, Finding Of Inquest, Joseph Michael Wikitera*, 20 July 1993) contained no recommendations although the coroner identified one matter which concerned him and lead to criticism of a DCS officer. Two correctional officers learned of the prisoner's unsuccessful bail application at 10.15 am, but the senior correctional officer decided not to give this news to the prisoner until it was confirmed by facsimile message at about 2.00 p.m. The prisoner was informed at 2.15 p.m. The prisoner had earlier been seen by a local medical practitioner who did not express concerns about suicide, but, rather, aggression towards staff if the bail application was refused. In evidence to the coroner's court, the prisoner's girlfriend said that, in a telephone call to her at about 10.00 am on the day he died, he had threatened to suicide if his bail application was refused. She said she discounted this information because she had arranged a firm time to visit him and he had accepted this arrangement. The prisoner had the advantage of hindsight and expressed the opinion that, if the prisoner had been given the bad news earlier in the day, there would have been more time to assist him to settle down before lock-down, late in the afternoon. Importation factors probably contributed more to this man's suicide rather than deprivational factors although the refusal of bail was probably a triggering factor.

**Summary**

In SA, coroners have used four verdicts to describe deaths in prisons. The act of using a verdict is an act of patterning or of summarising, or identifying common causes, in an attempt to bring order and understanding to events which, at a personal and familial level, are often extremely distressing because of their unpredictability and because they happen to people in the care of the state. Over the 13¼-year study period, coroners' reports developed into more lengthy documents often containing recommendations and capturing more useful information, although there was no known formal process for coroners to draw generalisations from a series of deaths.

Each of the prisoners who died was vulnerable. These vulnerabilities are described in the literature as importation factors. They are the personal differences (psychological, physical, familial, racial and social) which are unique to each of the 38 persons. Though these factors are unique to each individual, patterns did emerge. Overlaying and interacting with the importation factors are the deprivational or situational factors - the 'pains of imprisonment' - which provide the context of the deaths and which, in some cases, especially for those prisoners who suicided, made death more likely.

Certain conclusions can be drawn about this work of the coroners. In the one accidental death in SA, importation factors played a more important role than did deprivational factors.
although the difficulty for correctional agencies in minimising or stemming the flow into, and use of, drugs in prisons is acknowledged. In other forms of accidental death, such as deaths from fire, the role of deprivational factors could be much greater, and the responsibility of the state to provide safe accommodation, with modern fire safety facilities and good prevention strategies, is self-evident.

There were four prison homicides in the period under consideration and importation factors played a more significant role than deprivational factors in each of the four incidents. The very nature of homicides makes them difficult to predict and prevent and statistically profiling offenders would lead to over-prediction (false positives) because convictions for offences involving violence are common among those serving long sentences. The way prisons are managed is an important factor that assists in creating the macro environment or the climate of the individual prison and this varied in the three facilities through the research period. Institutional climate is dynamic and many factors impinge upon the way an individual facility is operating at any given time. In the very broadest sense, this is a deprivational or situational factor of great significance, but one which is very difficult to operationalise in terms of identifying factors at work in the three institutions where the homicides occurred and at the time they occurred. Certainly it is beyond capturing through a statistical analysis of profiles, but these can play an important role.

There were 19 natural deaths during the research period. Importation factors are very important in the causation of deaths from natural causes within prisons. Despite the importance of importation factors, deprivational or situational factors were also critical because of the context of these deaths - prisons. The research identified issues such as the adequacy and timeliness of medical assessment and care while in custody, access to hospital, especially from country prisons, communication between medical and correctional authorities and, in the early 1980s, insufficient out-of-hours staffing at PAG, which, in turn, meant an inadequate response to a critically ill prisoner. In three (16%) of the 19 cases (cases 7, 17 and 27) of dying from natural causes, deprivational factors were major forces contributing to the deaths. These deprivational factors were additional to the usual 'pains of imprisonment' and generally reflected a lack of care and professionalism by some front line staff and the poor facilities provided by the community at that time to manage prisoners.

There were 14 suicides by prisoners in the research period. It is with the suicidal deaths that the complex interweaving of importation factors, the person's vulnerabilities and the deprivational or situational factors is most in evidence. A number of the suicidal deaths were probably preventable and, in the most serious situations, official neglect and incompetence were apparent. In six (cases 2, 20, 24, 28, 29 and 38) of the 14 suicidal deaths (43%), deprivational factors were major forces in contributing to the deaths. In the suicidal deaths, perhaps more so than with deaths from natural causes, the need for sensitive and reflective care by correctional staff is crucial in responding to vulnerable individuals.

This detailed analysis of 38 prison deaths has shown a complex and challenging pattern of forces and events that surround each of the deaths. The work of coroners is critical in making these events and forces known. While not wishing to diminish the responsibility of the state and its agents to provide safe and humane custody, the paradigm that agents of the state, usually through acts of omission, caused the deaths is inadequate and simplistic. This is tantamount to suggesting that every death in custody represents an example of the correctional agency failing to meet its duty of care obligations. While clearly many deaths in custody are preventable and agencies must constantly improve the quality of their services and learn the
lessons from previous failures, many deaths are deaths that would have occurred no matter where the person was living.

Finally, because of the location of custodial deaths, in the care of the state and away from families and friends, the impact of such deaths on those left behind can be significant. Grief can be complicated for survivors because the full story of some custodial deaths does not become available for some time (months and years) after the death and grief can be disenfranchised. For families, the prisoner's stigmatised status can inhibit them from sharing their loss and seeking support and, for staff, it may seem inappropriate to grieve and they may feel concerned about the reaction of colleagues. For other prisoners, this study has shown that, in the early part of the eighties, they were discouraged, at least publicly, from expressing their grief, because the prison system did not acknowledge the lives of those prisoners who died in custody and therefore any celebration or memorial of a prisoner's life was forbidden. The importance of coroners' reports has been highlighted because they are a way of meeting the coroners' statutory duties, but also perform a valuable role in of assisting survivors come to terms with the death of a family member or friend. In capturing in a personal and detailed way, the conclusion to the person's life, it gives them the recognition and significance, that is a type of memorial, thus helping the survivors in the process of relocating that person's life and memory, so as to help the survivors to move on in life.

References


Channel 10, Adelaide, ADS Channel 10 News, 13 July 1989, 1800 hours, transcript (copy with author)


Justice and Equity, *Resources on the reconciliation process and social justice for indigenous Australians*, Australian Government Publishing Service, CD-ROM (This CD-ROM contains all of the RCIADIC reports)


Unpublished Documents


—— 1983, Coroner's Report, Finding Of Inquest, John Clarence Highfold, Adelaide, 8 June 1983


Dalton, V., 1997a, "The Monitoring of Deaths in Custody at the Australian Institute of Criminology: Trends Since the Royal Commission", *Paper delivered to Aboriginal and Torres Strait Islander Deaths in Custody conference/Forum/Workshop on Reversing the Cycle hosted by Queensland Aboriginal & Islander Legal Services Secretariat (QAILSS)*, Broadbeach, Queensland, 23-25 September 1997

Dawes, M., 1988, *Statement By Mr.M.J. Dawes, Executive Director South Australian Department Of Correctional Services To The Royal Commission Into Aboriginal Deaths In Custody On Friday 8 April 1988*, 2 Volumes, (Available in DCS library)


1994, *Coroner's Report, Finding Of Inquest, Paul Anthony Henry*, Adelaide, 2, 3 November 1993, 28 February, 1, 2, 3 March, 18, 19 April and 3 November 1994


**Department of Correctional Services Records**

Case 1 DCS 474/85 (167/80)
Case 2 DCS 472/85 (40/80)
Case 3 DCS 481/85 No evidence of earlier file, records from microfiche
Case 4 DCS 478/85 No evidence of earlier file, records from microfiche
Case 5 DCS 475/85 No evidence of earlier file, records from microfiche
Case 6 DCS 476/85 (416/80)
Case 7 DCS 479/85 No evidence of earlier file, records from microfiche
Case 8 DCS 1092/87 (496/81)
Case 9 DCS 1031/81 (1691/87)
Case 10 DCS 1668/87 (554/82)
Case 11 DCS 1690/87 (573/82)
Case 12 DCS 1689/87 (1061/82)
Case 13 DCS 1688/87 (1102/82)
Case 14 DCS 1667/87 (10/83)
Case 15 DCS 1687/87
Case 16 DCS 748/85
Case 17 DCS 856/85
Case 18 DCS 30/87
Case 19 DCS 639/87
Case 20 DCS 1120/87
Case 21 DCS 1348/87
Case 22 DCS 646/88
Case 23 DCS 634/89
Case 24 DCS 447/89 & 707/89
Case 25 DCS 921/89
Case 26 DCS 998/89
Case 27 DCS 579/90
Case 28 DCS 763/90
Case 29 DCS 1196/90
Case 30 DCS 464/91
Case 31 DCS 888/91
Case 32 DCS 907/91
Case 33 DCS 1163/91
Case 34 DCS 178/92
Case 35 DCS 54/92
Case 36 DCS 879/92
Case 37 DCS 1452/92
Case 38 DCS 112/93

Microfiche Records for 195 Prisoners forming the Control Group

DCS 45 1/82 Investigation of Shooting, 22 June 1982

Legislation

Correctional Services Act, 1982 (SA)

Coroners Act, 1975 (SA)