

SOUTH



AUSTRALIA

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Mount Gambier in the State of South Australia, on the 12th and 13th days of July 2004 and in Adelaide on the 6th day of August 2004, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Troy Phillip Turner.

I, the said Coroner, find that Troy Phillip Turner aged 36 years, late of Mount Gambier Prison, Benara Road, Moorak, South Australia died at Mount Gambier Prison, South Australia on the 2nd day of September 2001 as a result of hanging.

1. **Reason for inquest**

- 1.1. Troy Phillip Turner was arrested by Detective Senior Constable Warr of Mount Gambier CIB on 15 October 2000 on a number of serious charges. The charges included non-aggravated serious criminal trespass, assault with intent to commit an offence, false imprisonment, failure to comply with a domestic violence restraining order and firearms offences. He was refused bail and was admitted to Mount Gambier Prison on 16 October 2000.
- 1.2. Mr Turner was remanded on a number of occasions, the last of which was on 9 August 2001 when he appeared in the Mount Gambier Magistrates Court. He was remanded in custody until 29 November 2001.
- 1.3. Accordingly, on 2 September 2001 Mr Turner was ‘detained in custody within the State pursuant to an Act or law of the State’ within the meaning of Section 12(1)(da) of the Coroners Act, and an inquest was therefore mandatory pursuant to Section 14(1a) of that Act.

2. Background

- 2.1. Troy Phillip Turner was born on 29 August 1965. He had been married and there were three children of the marriage. The family lived in Naracoorte, South Australia.
- 2.2. Mr Turner and his wife separated in 1999, there was a reconciliation, and then a further separation in August 2000.
- 2.3. A report prepared by Dr Craig Raeside, Consultant Psychiatrist, in June 2001 (to determine his suitability for bail), discloses that Mr Turner 'experienced a number of alcohol related problems including memory loss, bouts of drinking, occasional fights, and offending all of which he said were alcohol related' (Exhibit C7m, p3).
- 2.4. Mr Turner had a number of convictions for more minor offences, apart from the serious ones associated with domestic violence. The less serious offences included drink driving, disorderly behaviour, assault, etc. It would appear that most were associated with alcohol abuse.
- 2.5. Mr Turner stopped drinking in early 2000 after he joined Alcoholics Anonymous. However, following the separation, his drinking resumed.
- 2.6. It is not necessary for me to describe in detail the nature of the matrimonial disputes between Mr Turner and his wife, except to say that there were a number of issues concerning property and access to children about which there was strong disagreement.
- 2.7. On 15 October 2000 it was alleged that following a bout of heavy drinking, Mr Turner broke into a house occupied by his wife and children at 4:30am by smashing a glass door. He was armed with a shotgun. There was a restraining order in existence which he clearly breached by this behaviour.
- 2.8. It was further alleged that Mr Turner detained his wife both in the toilet and in the bedroom of the house saying that he wanted to have sex with her. When she attempted to escape he grabbed her arm and pulled her back into a child's bedroom. Mrs Turner eventually managed to escape at about 8:45am.
- 2.9. At one stage during the incident Mr Turner discharged the shotgun into the roof of the house. Subsequent inquiries revealed that the shotgun was stolen.
- 2.10. Mrs Turner was not physically injured during the incident.

3. Admission and assessment

- 3.1. In accordance with established procedure at Mount Gambier Prison, Mr Turner was interviewed by Correctional Officer Hill on 16 October 2000. The interview was recorded on a proforma through a computer, and a number of significant answers were given. For example:

'19. Receiving any treatment/counselling?	Yes	Had contemplated shooting himself, also undertaken D&A [drug and alcohol] counselling. Last counsellor was Bernie Passure
20. Ever been treated for mental illness?	Yes	
...		
22. Ever used non-prescribed/or illegal drugs?	Yes	
23. Have/had an alcohol problem?	Yes	
25. Ever tried to/want to harm yourself or suicide?	Yes	
26. Ever been diagnosed with: a) physical disability? b) intellectual disability? c) personality disorder? d) behaviour disorder?	Yes	(no elaboration as to which one)'

The form then asks the interviewer:

'Do you think that this person is a suicide/self-harm risk? Yes
 If yes, why, and who did you refer him to? (Not completed)
 REFER THE PRISONER TO THE FOLLOWING AS NECESSARY
 Unit Manager, Duty Supervisor, Nurse, Social Worker, Lifeline,
 Drug and Alcohol Counsellor, Prisoner Listener Scheme, other.'

- 3.2. Confusingly, the form then states:

'Does this person warrant being placed under casual observation? No
 If SASH (suicide and self-harm notification) raised was:
 a) Duty Supervisor informed Yes
 b) Control Officer informed? Yes
 c) Member of SASH team informed? Yes'
 (Exhibit C13c)

The form is not signed by the interviewing officer, as required.

- 3.3. It does not appear that a Suicide and Self-Harm ('SASH') notification was raised by Hill. Shortly after the interview with Hill, Mr Turner was interviewed by Ms Judith Potter, a Social Worker, who recorded in the case file:

'Interview with Troy, his first time in prison. He said he is in a stable frame of mind. He said he had an emotional discussion with his father when feeling suicidal prior to court. His demeanour is congruent with his denial of a suicide ideation at the this time. He has attended D/A counselling with Bernie Passuer SE Community Health and the D/A counsellor will contact Bernie to assess if she wants to continue with him whilst he is here. His criminal and family court matters are being persued (sic) with Sharon Holmes his barrister 8723 3733.'

(Exhibit C13, p11)

- 3.4. When interviewed later by Messrs Smedley and Johnson, the Department for Correctional Services Investigators, Ms Potter explained why Hill did not fill out the SASH form:

'Ms Potter has since stated that as a result of interviewing Mr Turner she had no concern for his safety and advised the duty supervisor accordingly. Consequently the sash notification was not raised, however this was not recorded on the care assessment form.'

(Exhibit C13, p11)

- 3.5. Smedley and Johnson were critical of Ms Potter for failing to accurately record her actions on the care assessment form, and I agree with that criticism. However, in view of the time elapsed between Mr Turner's admission and his death, I do not think that this lapse was in any way causally related to his death.

4. Progress while in prison

- 4.1. Despite those initial concerns outlined above, it would appear that Mr Turner settled into prison life reasonably well. Dr Raeside described his progress as follows:

'Following Mr Turner's incarceration he experienced considerable anxiety and depressive symptoms. When I first saw him he told me that he woke frequently during the night with dreams centred around his worry about his children, such as having snakes bite them, thinking about how his wife was, and how his children were coping. Often he would wake during the night in a sweat. He reported feeling moderately depressed, but said that things had improved a little since he had been in gaol, despite not being prescribed any antidepressant medication. In particular, he reported normal energy, variable appetite, no weight loss, but said he had lost 26kgs in the three months after he commenced work at Naracoorte with increased energy and decreased drinking. He described poor concentration, often with intrusive memories about his family. He acknowledged occasional suicidal thoughts whilst in custody, but not recently. He did not describe any panic or other significant anxiety symptoms, nor had he experienced

any psychotic symptoms such as hearing voices, extreme paranoia, or disturbance of his thinking.

Since that time his mood has improved significantly and his energy is now directed into his criminal legal defence as well as ongoing Family Court matters. He indicated that his divorce was pending, but he was concerned that the matters were not being correctly done. He expressed a strong desire to be bailed, stating that if granted he would live in Whyalla with his parents on Home Detention Bail. Alternatively, he could live in his own home in Whyalla, which is currently being rented. He did not indicate any desire to contact his wife or children other than as allowed by the Court.

At the time of my first interview, Mr Turner was reactive in mood, being tearful at times talking about his family, but also obviously being angry at the situation in relation to his family. He did not display any psychotic features such as perceptual disturbances, delusional thinking, or psychotic thought disorder. He has subsequently become more reactive and no longer appears depressed. Indeed most recently he did not display any features of a psychiatric disorder.'

(Exhibit C7m, pp5-6)

- 4.2. Dr Raeside concluded that Mr Turner had been suffering from a Major Depressive Disorder, but this condition had been improving spontaneously since his period in prison. He offered the following opinion:

'Mr Turner appears to have been improving spontaneously during his period of incarceration. I would not therefore believe that use of antidepressant medication is currently warranted. However, he is facing a number of ongoing stressors including these current criminal matters together with his family court matters. He is therefore at risk of a relapse of his Major Depressive Disorder should these matters be perceived negatively. He therefore would benefit from occasional psychiatric follow up whether in custody or on bail to monitor his improvement and to intervene with treatment should his condition deteriorate.

If Mr Turner was to receive bail then abstinence from alcohol, ongoing drug and alcohol counselling, and occasional psychiatric follow up as indicated would be important in maintaining any improvement. He would be at risk of re-offending should he consume alcohol. It would obviously be appropriate that he not have contact with his wife in accordance with previous apprehended violence orders.'

(Exhibit C7m, pp6-7)

- 4.3. Dr Raeside saw Mr Turner and monitored his medication throughout his stay at Mount Gambier Prison. The clinical record discloses consultations on 21 November 2000, 19 December 2000, 13 February 2001, 10 April 2001, 29 May 2001, and 8 June 2001 for the preparation of his report.
- 4.4. Mr Turner was employed in the Industries area at Mount Gambier Prison. His supervisor noted in his case management record for 25 May 2001:

'Prisoner Turner is well and not experiencing any difficulties. He continues to attend his work in the Industries shed and he finds this helpful in passing the time. Troy has no

problems on the wing, he fits in well with the other prisoners and mixes with them freely.'

(Exhibit C13b)

4.5. On 2 August 2001, it was noted:

'Prisoner Turner tells me he has four court appearances this month, District, Magistrates, Family and Civil but he is quite calm and collected about the issues that have to be resolved. Troy is generally settled and in control although there are times when he gets a bit ratty. Working in the Industries shed is good for Troy, it gives him something else to focus on. There are no problems of consequence bothering him.'

(Exhibit C13b)

4.6. There was one incident in late August 2001 which indicated that Mr Turner was becoming somewhat agitated. On 25 August 2001 he was directed to cease smoking in the unit common area. Mr Turner became abusive, so he was secured in his cell (see Exhibit C13b).

4.7. On 28 August 2001, an entry was made:

'Troy is usually fairly loud and vocal on the unit, I think this is just his demeanour but comes across as arrogant and disrespectful. He is always polite to myself, and by all accounts is still working well in Industries.'

(Exhibit C13b)

4.8. Medication

Dr Raeside prescribed Luvox (fluvoxamine) as an antidepressant medication for Mr Turner in February 2001. He continued to use this medication until late March 2001, when it was discontinued at his request.

4.9. At the time of his death, Mr Turner was taking the following medications:

- Zomig (zolmitriptan) on an 'as needed' basis;
- Imovane (zopiclone) for insomnia on an 'as needed' basis;
- Demazin, a cold and flu tablet, on an 'as needed' basis.

5. Events of 1 and 2 September 2001

5.1. Correctional Officer Philip Glead said that at about 7:50pm to 7:55pm on 1 September 2001 he saw Mr Turner and issued him his medication. He said that Mr Turner asked:

'Is it lockup time?' (T17)

- 5.2. That was the last time any correctional officer saw Mr Turner.
- 5.3. Mr Gleed said that at about 7:05am on 2 September 2001, he was on his morning medication round and when he reached Cell 34 he heard Mr Turner call out 'no medication for me thanks Phil'. Mr Gleed said that he looked in through the 'trap' and queried it, and Mr Turner repeated the statement. He said that he did not see Mr Turner in the cell as it was still dark. He said that the shower was not running at that time (Exhibit C10, p2).
- 5.4. At 8:00am Correctional Officer Neil Stewart Orchard was conducting a mandatory head count of the prisoners in Block A. When he reached Cell 34, he looked through the spy hole and saw Mr Turner hanging in the cell. His description of what he saw is as follows:

'When I checked through the spy hole I could see him looking toward me, he was not moving at that time, and looking back I suppose I thought at that time he was already dead. I could see he had attempted to hang himself in the cell. I may have opened the trap for a better look which would have allowed me to see the floor under his feet, however I cannot specifically remember doing that. It was obvious to me on my first impression that the prisoner was in trouble and, that we would have to enter the cell to assist him.

I went straight to the office which is in the centre between the two blocks, I called to the other officer John Wootton who came immediately to me. I informed him Troy was hanging and to ring (rather than use the Radio to alert the whole prison), Control to advise them and to call a response, which means that another officer would attend the block for the purpose of assisting. John grabbed the ligature knife which I had told him to get and he followed shortly behind me to the cell door of number 34.

Contrary to policy I had entered the cell before John arrived. I could see Troy's eyes were open and staring, his face was slack and his tongue which was dark blue was sticking straight out of his mouth and pointing slightly down, his skin was a yellow colour. He was dressed in a brown suit with a white shirt and a tie. He had one wrist tied to an ankle, I think from memory it was his left wrist and left ankle.

I felt for a cardiac pulse on the wrist which was not tied. There was no pulse that I could find, there were no breath signs, his chest was not moving. It was my opinion that he was dead, but that is just an untrained observation.

The shower was turned on in the cell and Troy was actually hanging from the front of the shower stall. I stood on the toilet seat to reach over the stall to turn the water off. There are two vertical bars one either side of the shower. Troy had tied nylon packing tape similar to that used at the prison in the Industry shed, to each bar and then around his neck. I have no recollection of what he may have used to stand on prior to hanging himself, however I remember his feet were about 12 to 14 inches off the ground when suspended.

I had got down and was heading back out of the door when John arrived, before we could cut Troy down the duty supervisor Ken Cluse arrived. Ken took charge of the incident from that point and after determining that I had checked for signs of life it was his determination that Troy be left where he was. Ken also instructed me to secure the cell to preserve the scene. The door was locked at 08:10.'

(Exhibit C1a, pp1-2)

- 5.5. As requested, Correctional Officer Wootton telephoned the Control Room and spoke to Correctional Officer Wright. Correctional Officer Ken Cluse, who was the Operations Coordinator and Duty Supervisor that evening, was also present in the Control Room as were Correctional Officers Serdarovic and Gleed. Cluse, Serdarovic and Gleed all ran to the cell, and Serdarovic carried the defibrillation equipment with her. At Orchard's request, Gleed also brought the ligature knife with him.
- 5.6. When Cluse reached the cell, Orchard had already opened the door. He could see Mr Turner hanging by what appeared to be nylon timber strapping (of the type used in the prison industries area) in the shower entrance (T65).
- 5.7. Orchard sought a direction from Cluse about whether or not Mr Turner should be cut down. Cluse said that on the basis of Orchard's information that he could detect no vital signs, and his observations that Mr Turner's tongue was protruding from his mouth and was swollen so that it appeared to be taking up his entire mouth, the fact that his face and hands were turning grey, and on the fact that his body was cold and clammy to touch, he concluded that Mr Turner was dead and that it was pointless to commence resuscitation (T66).
- 5.8. Accordingly, Cluse directed that Mr Turner not be cut down, in order to preserve the 'crime scene'.
- 5.9. The police and ambulance were notified and arrived at 8:22am. According to a log maintained by Gleed, the ambulance officers entered Cell 34 at 8:27am and Ambulance Officer David Dewar examined Mr Turner's body and pronounced life extinct at about that time (see Exhibit C2a).
- 5.10. Senior Constable Brenton Jones, who was one of the first police officers on the scene, described what he found as follows:

'The deceased was observed to be hanging by the neck between the two support poles of the shower cubicle within the cell. Situated around the neck and above the deceased between the two support poles was white coloured webbing, approximately 20 millimetres wide. Staff of the prison identified this webbing as that used in packaging of

timber material in the timber shed of the prison complex. The deceased was reported to work in that area. One piece of this webbing was tied between the two support posts of the cubicle and a second piece was then tied halfway along the length of the first and then around the neck of the deceased, with the knot behind the left ear. The deceased was observed to have a swollen and protruding tongue through the mouth and the webbing around the neck was deep within the folds of the skin. He was dressed in a sports jacket, white button up shirt, blue jeans and tan coloured sneakers. It was also noted that the shoe lace of the left sneaker was wrapped around the left arm/wrist of the deceased resulting in the left leg being bent at the knee and supported by the left arm. The right foot was approximately 10 centimetres above the floor level. He was warm to the touch with no pulse and no other signs of life were evident. The deceased had already been certified life extinct. No signs of violence were evident upon the deceased or within the cell to suggest foul play.'

(Exhibit C8a, p3)

- 5.11. A note found pinned to the pin board on the western wall of the cell indicated that Mr Turner intended to take his own life. I accept the assessment of Senior Constable Jones, and that of Detective Senior Constable Slaven (see Exhibit C7b, p6), that this is what occurred.

6. Cause of death

- 6.1. A post-mortem examination of the body of the deceased was performed by Dr Andrew Sharard, Pathologist, at the Mount Gambier Hospital on 5 September 2001. Dr Sharard found nothing of significance apart from the presence of the ligature knotted below and posterior to the left ear. He concluded that the cause of death was 'hanging'. He added:

'The cause of death was consistent with suicide under the circumstances outlined by K G Slaven, Mount Gambier Police, and N S Orchard, Mount Gambier Prison.'

(Exhibit C3a, p1)

- 6.2. Toxicological examination of blood samples taken by Dr Sharard were carried out by Mr Peter Harpas, Senior Forensic Scientist, and he concluded that neither alcohol nor any of the common drugs were present in Mr Turner's blood at the time he died (Exhibit C4a).
- 6.3. I accept Dr Sharard's opinion about the cause of death, and find that the cause of Mr Turner's death was hanging.

7. Issues arising at inquest

- 7.1. Mount Gambier Prison was operated by Group 4 Correctional Services Pty Ltd (now GSL Custodial Services Pty Ltd) ('Group 4') pursuant to a contract with the South

Australian Government. That contract specifies standards to be met in the operation of the prison.

7.2. Monthly meetings are held between representatives of Group 4 and the Department for Correctional Services ('DCS'). These are called 'Strategic Planning Meetings'. I was informed by Mr Smedley that information about changes to procedures made by DCS is passed on to Group 4 at these meetings (T76).

7.3. Resuscitation

Mount Gambier Prison Emergency Order Number 3, created by Group 4, gives the following instructions in the event of the 'death/suicide' of a prisoner:

'ACTION BY STAFF AT SCENE

Any member of staff who finds, or has reported to them, a person apparently dead, will:

- Call for assistance by informing the Control Room - *if this can be done without delaying First Aid. Otherwise, inform as soon as possible.*
- Attempt resuscitation and apply first aid (if appropriate use ligature knife) until released by a medical person unless it is very clear that this is pointless (i.e. the person is decapitated etc).
- If the prisoner is revived, arrange for further medical treatment as soon as possible.
- Where no signs of life are confirmed by a qualified medical person, leave the scene untouched as far as possible.

All other staff at scene:

- assist with first aid/informing and updated the Control Room as required.
- pay particular attention to the speech and behaviour of any prisoner and note any suspicious movements amongst prisoners at, or near, the scene. If possible make notes and convey these observations to the most senior person present.
- note any possible indirect evidence in the area. Prevent destruction/contamination of scene as far as possible. Keep the Control Room informed of developments.

The priority must be:

- the administration of first aid and the resuscitation of the prisoner.
- Recognition that a crime may have occurred.'

(Exhibit C6a, pp1-2)

7.4. This Emergency Order is to be compared with the corresponding Standard Operating Procedure (SOP6) issued by DCS:

'12.0.2 Where death is self-evident (eg decapitation) the officer must notify the Control Room officer and continue to notify the Control Room officer of developments of the incident.

12.0.3 On accessing the incident scene, the officer must immediately administer first aid and attempt to resuscitate the prisoner.

- 12.0.4 Resuscitation of the prisoner must continue until such time as a qualified medical person confirms that the prisoner is dead.
- 12.0.5 Officers discovering a possible death must realise that a crime may have occurred.
- 12.0.6 If the prisoner appears to have attempted suicide by hanging, the officer must immediately cut down the prisoner and loosen or cut the neck noose. (To maintain evidence, the noose should be cut free and not untied. However, if an authorised rescue knife or similar cutting instrument is not readily available, then the priority will be the removal of the noose. The upper end of rope or material used by the prisoner must be left tied to the fixture used, until investigations have been completed.'

7.5. I have made recommendations in previous inquests on this subject. For example:

'That officers employed by the Department of Correctional Services receive further training which makes clear to them that, although the need to preserve the scene for evidentiary purposes is important, the need to resuscitate and take other steps for the health and safety of the prisoner is more important and takes precedence over the need to preserve the scene.'

(Blenkiron, Inquest 23/94)

'That the Department implement a number of exercises or drills designed to provide training and experience in relation to emergency situations they may face, with particular regard to the use of radios, communication within and from the facility, resuscitation and first aid, preservation of scenes, liaison with emergency services agencies and the like.'

(Jackson, Inquest 40/94)

7.6. In my opinion, Correctional Officer Cluse's direction that Mr Turner not be cut down and resuscitation not be attempted was inappropriate. He was in no position to determine that resuscitation was pointless:

- He had no idea how long Mr Turner had been hanging;
- It was pointless to look for a pulse while the ligature was still in place;
- The fact that Mr Turner's tongue was blocking his airway was due to the presence of the ligature – if he had been cut down the tongue would have retracted, or could have been pushed back, to clear the airway so that resuscitation could have been undertaken.
- The custodial staff took a defibrillation machine with them - if they were properly trained in its operation, the machine would have established if there was any cardiac activity - this was not attempted due to Cluse's direction.

7.7. Paradoxically, there was a defibrillator at the scene but not an Oxy-Viva machine. The fact that staff might have been required to manually apply cardio-pulmonary resuscitation to a prisoner for up to 30 minutes until an ambulance could attend may have been a disincentive to undertaking resuscitation. Oxy-Viva machines are widely available in DCS prisons, and DCS staff are trained in their use. Cardio-pulmonary resuscitation is much easier and less stressful when such machines are used.

7.8. Conclusion

It was argued by Mr Bailes, counsel for Mr Cluse, that the Mount Gambier Prison Emergency Order Number 3 was ambiguous, in that the presence of ‘etc’ after ‘decapitated’ suggests that there are other situations where it is ‘very clear that this is pointless’. A sensible reading of the Emergency Order suggests that any such situation should be equally clear. A body might be burnt beyond recognition, or there might be a large bullet wound or other obviously catastrophic injury. It would not be sensible to require resuscitation to be attempted in such circumstances.

7.9. But it cannot be argued that the situation confronting Cluse was like that. I cannot say that it is possible that Mr Turner might have been resuscitated. That will never be known. The problem for Cluse is that the opposite is also true – it will never be known that he could not have been resuscitated if cardio-pulmonary resuscitation had been attempted.

7.10. This is a very important matter and calls for the urgent attention of Group 4.

7.11. Availability of emergency medical care

It is noteworthy that there is no ‘after hours’ medical care available at Mount Gambier Prison. There is no nursing staff on duty after hours. The prison is situated some distance away from the city limits of Mount Gambier, and the earliest emergency help available would be via ambulance. In this case it took 22 minutes to attend.

7.12. This places a very great onus on the Group 4 custodial officers to provide treatment in an emergency before the ambulance can attend. A failure to provide such treatment, or to provide appropriate treatment, during that period could make the difference between life and death.

7.13. In my view this issue can be addressed in two ways:

- Make available nursing staff who are qualified to provide emergency treatment 24 hours per day, 7 days per week; or

- Ensure that the custodial staff are adequately trained to provide appropriate emergency care until an ambulance can attend. This would require a level of training roughly comparable with an Ambulance Officer, and should certainly include competence in the use of Oxy-Viva and defibrillation equipment.

7.14. Regular checking of prisoners

It is alarming to learn that there was no requirement at Mount Gambier Prison that prisoners should be sighted during the times when they were secured in their cells. Indeed, there were no counts of prisoners conducted between 8pm and 8am (see Exhibit C13, p9).

7.15. This was out of step with prisons controlled by DCS, where it has long been a requirement that patrols be conducted every two hours. The SOP was amended following the inquest into the death of Sturt (Inquest 41/00), to require that every prisoner is actually sighted during the two-hourly count, and that the times the patrols are commenced and completed, and any relevant observations, are adequately recorded (Exhibit C13, p10).

7.16. It is unacceptable that there should be different standards for the protection of prisoners in DCS prisons from those in Group 4 prisons. Their SOPs should be the same. In my opinion, it is the role of DCS to ensure that this is so.

7.17. In this case, Mr Turner spoke to Correctional Officer Gleed at 7am, although Gleed did not sight him. Consequently, it could not be argued that if two-hourly checks had been conducted, the outcome would have been different. I am therefore not able to make this issue the subject of a recommendation pursuant to Section 25(2) of the Coroners Act, 1975.

7.18. It is, however, an important issue and I draw it to the attention of the Chief Executive Officer, Department for Correctional Services.

7.19. Cell design

This is yet another case where the design of the cell has provided an easy hanging point to enable a prisoner to commit suicide. In Lindsay (Inquest 13/03) I quoted Recommendation 165 of the Royal Commission into Aboriginal Deaths in Custody which dealt with this issue, and, in particular, required that:

'... steps should be taken to screen hanging points in police and prison cells '

I also referred to recommendations in Goldsmith (6/96), Bonney (28/96), Carter (23/00), Nobels (43/00) and Varcoe (2/03).

7.20. I mentioned in Lindsay that I was told that South Australia had been involved with the Victorian 'safe cell' project, and that new accommodation would be built according to those standards (paragraphs 7.18 and 7.20).

7.21. Mr Smedley told me that in relation to this issue, the shower cubicles at Mount Gambier Prison were being rebuilt so that there will no longer be a hanging point available (T80). He said that this should be complete by the end of August 2004 (T83).

7.22. I accept Mr Smedley's assurance. It seems extraordinary that, so long after the RCIADIC, these issues would continue to arise. The South Australian prison system still seems to approach these issues piecemeal, rather than adopting a comprehensive approach as has been undertaken in Victoria with the 'safe-cell' project.

7.23. Availability of hanging material

The evidence suggests that the last opportunity Mr Turner would have had to obtain the strapping material he used to hang himself was on Thursday, 19 August 2001 when he last worked in the Industries area of the prison.

7.24. Messrs Smedley and Johnson recommended that strapping or tape used in that area should be cut into small lengths by the Industries Supervisor prior to being placed in the bin (Exhibit C13, p12). Detective Senior Constable Slaven recommended that:

'I would suggest that the authorities at the Prison look at installing a shredding machine in the industries shed and that any off cuts or unused lengths of strapping be shredded to a size that could not be used by another prisoner in using the strapping in a similar incident.'

(Exhibit C7b, p6)

7.25. I agree that prisoners should not have access to such strapping material from the Industries area. Group 4 should put whatever procedures are necessary in place to ensure that prisoners do not have access to such materials.

8. Recommendations

8.1. Pursuant to Section 25(2) of the Coroners Act 1975, being satisfied that to do so might prevent, or reduce the likelihood of a recurrence of an event similar to this before me, I recommend:

- That DCS and Group 4 review the language used in the relevant procedures to ensure that there is no uncertainty among custodial staff about their duty to resuscitate a prisoner in an emergency situation;
- That Group 4 either:
 - Provide a nurse qualified to provide emergency treatment to a prisoner should be available 24 hours per day, 7 days per week at Mount Gambier Prison;
 - Alternatively, Group 4 ensures that custodial staff are adequately trained and equipped to provide appropriate emergency treatment to a prisoner pending arrival of ambulance officers;
- That Group 4 take appropriate steps to ensure that, in accordance with principles developed in the 'safe-cell' project, cells used to accommodate prisoners at Mount Gambier Prison are designed to ensure that hanging points are kept to a minimum;
- That DCS and Group 4 put appropriate consultative procedures in place so that changes in DCS practices and procedures are implemented in Group 4-operated prisons without delay;
- That Group 4 put appropriate procedures in place to ensure that prisoners do not have access to hanging materials such as timber straps, etc.

Key Words: Death in Custody; Prisons (cell design); Resuscitation; Hanging; Suicide (prediction of)

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 6th day of August, 2004.

Coroner