CORONERS ACT, 1975 AS AMENDED

*SOUTH*  *AUSTRALIA*

# FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 12th and 13th days of April 2005 and the 31st day of May 2005, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Ian McLeod.*

*I, the said Coroner, find that Ian McLeod aged 45 years, late of 11 Veale Street, Port Pirie, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 25th day of April 2002 as a result of bronchopnemonia and suppurative bronchitis complicating hypoxic brain damage. I find that the circumstances of his death were as follows:*

## 1. Reason for inquest

1.1. On Monday 15 April 2002, Ian McLeod appeared in the Port Pirie Magistrates Court charged with damaging property, failing to comply with a bail agreement, and failing to comply with a domestic violence restraining order. The court hearing was conducted at his bedside at the Port Pirie Hospital.

1.2. Mr McLeod was remanded in custody to reappear on 7 May 2002.

1.3. Accordingly, at the time of his death on 25 April 2002, Mr McLeod 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 Coroner's Act, and an inquest was therefore mandatory pursuant to Section 14(1a) of that Act.

## 2. Introduction

2.1. Ian McLeod was a 45 year old lawyer who had been remanded in custody by the Port Pirie Magistrates Court. He had been an inpatient at the Port Pirie Hospital, where he had been receiving treatment for alcohol withdrawal.

2.2. Following his remand, he was transferred to Yatala Labour Prison in Adelaide so that his treatment could continue in the infirmary. He arrived in the late evening of 15 April 2002. He spent 16 April 2002 in his cell in the infirmary and was checked from time to time. He was seen by a doctor at around 4pm-5pm.

2.3. At about 1am on 17 April 2002, Mr McLeod was found by Department for Correctional Services ('DCS') officers hanging by a torn bed sheet tied to the hinge of the door to the shower/toilet in his cell.

2.4. Emergency resuscitation measures were undertaken, and heart activity was restored. Mr McLeod was transferred to the Royal Adelaide Hospital, but his condition deteriorated further, and he died at 3:00am on 25 April 2002.

## 3. Cause of death

3.1. A post-mortem examination of the body of the deceased was performed by Dr R A James, Forensic Pathologist, at the Royal Adelaide Hospital on 26 April 2002. He found that the cause of death was bronchopnemonia and suppurative bronchitis complicating hypoxic brain damage. I accept Dr James' evidence about that, and find accordingly.

## 4. Background

4.1. Mr McLeod and his wife had been having severe relationship difficulties in the years preceding his death.

4.2. In an affidavit sworn on 2 July 2001, Mrs McLeod gave the following information

- She and Mr McLeod were married on 1 December 1990;
- They lived initially in Albury, New South Wales, but his behaviour became violent and abusive after he lost his job as a solicitor in 1996 as a result of excessive alcohol consumption;

- After leaving Albury, they lived in Darwin and then in Alice Springs. By 2000, Mr McLeod's behaviour had become so unpredictable that she feared for her life. She sought the assistance of a domestic violence counsellor in Alice Springs. A restraining order was made in Alice Springs, but was revoked because he convinced her that he wanted to start a legal practice in Port Pirie and a restraining order would prevent him from doing so;
- After moving to Port Pirie, his drinking and erratic and violent behaviour continued and he assaulted her on a number of occasions;
- She left him and went to stay in a women's shelter in Port Pirie. He was admitted to hospital after she found him unconscious;
- They moved into another house together, but his drunken and violent behaviour continued. On an occasion when he went to Adelaide to see a medical specialist, she left the house and sought a further restraining order, which was made on 5 July 2001. The order restrained him:

  'a) From contacting or communicating directly or indirectly, whether in person or otherwise with Olivia Mei Ling McLeod save and except through the services of a solicitor for the purposes of counselling and property settlement.
  b) From assaulting, harassing, threatening or intimidating Olivia Mei Ling McLeod.
  c) That a member of the police force is authorised to enter any premises in which any firearm in your possession is suspected to be and to search for and take possession of any such firearm.

  …'

  (Exhibit C15b, p1)

4.3. In a report dated 5 April 2001, Neuropsychologist Alison Ryan examined Mr McLeod on referral from the psychiatry registrar at the Royal Adelaide Hospital. She summarised her findings as follows:

> 'Summary
>
> Mr McLeod is a 44 year old man who has a history of alcohol abuse. He has consumed significant amounts of alcohol resulting in a recent detained admission to a psychiatry unit, and three detoxification admissions in the past nine months. He denies alcohol intake over the last 2 weeks, but his history on this does not appear to be completely reliable, and thus it is unclear what his more recent alcohol consumption over the last 2 weeks has been.
>
> On this occasion Mr McLeod was oriented and appeared to give his best efforts. He had a range of cognitive problems, which are consistent with the effects of chronic alcohol abuse. These include slowed thinking speed and reduced efficiency of mental processes, and at least moderately impaired attention processes. His new learning and memory

> functions were in general mildly to moderately impaired, and there was also significant executive dysfunction as noted by problems in planning, organisation, sequencing behaviours and verbal fluency.
>
> At this time the extent and severity of Mr McLeod's cognitive impairment would indicate that he is unsafe to practice in his profession as a lawyer. I have suggested to Mr McLeod that he consult with yourself to discuss treatment to assist him to remain abstinent, and to seek professional help in terms of his emotional problems and depression.
>
> I would be happy to review him in the future should he wish to return to his professional practice. I would suggest a minimum of three months of abstinence from alcohol, and depending on his progress possibly six months, before a review is considered. It is unclear at this stage to what degree he has permanent cognitive changes.'
>
> (Exhibit C6b, pp4-5)

4.4. On 1 January 2002 Mrs McLeod alleged that her husband grabbed her arms and shook her. He made a clenched fist and held it close to her face and threatened to bash her. He denied that he assaulted her, claiming that she had assaulted him.

4.5. This incident resulted in a further order which restrained him from being on the Fifth Street premises.

4.6. On 6 January 2002 Mrs McLeod returned to the home at Fifth Street, Port Pirie in company with police. In apparent breach of that last order, Mr McLeod was inside the house and refused to allow her to enter. He was arrested, and bail was refused until he appeared in court on 7 January 2002. After he was arrested, Mrs McLeod entered the home and found fire scorch marks in the lounge room as if an attempt had been made to burn the house down.

4.7. On 4 April 2002, Mrs McLeod alleged that her husband broke into the Fifth Street house and damaged it by denting walls with a hammer, spilling paint, kicking in windows and the like. Mr McLeod initially denied that he caused the damage. A shoe-print was found which matched his shoes. He later made full admissions that he caused the damage when he was intoxicated.

4.8. Mr McLeod was granted bail on this offence, a condition of which was that he not approach or enter the Fifth Street premises.

4.9. On 14 April 2002 Mrs McLeod reported that her car had been damaged in the driveway of her house. Footprints found at the scene matched those of sandals later found in Mr McLeod's possession.

4.10. Mr McLeod was arrested and conveyed to the Port Pirie Police Station and charged with the offences I have already mentioned. Police bail was refused.

4.11. At 4:35pm, a 'Prisoner Screening Form' was prepared by Constable Gregory Clemow in which he identified that Mr McLeod had an obvious head injury, and was slightly to moderately affected by alcohol. In the 'Sergeant's Questionnaire', Constable Clemow recorded the following information:

| | YES | NO | REFUSED |
|---|---|---|---|
| '1. Are you taking medication? | ☑ | ☐ | ☐ |
| If 'YES', medication: *Ampax (Aropax)* | | | |
| Reason prescribed: *Chronic Depression* | | | |
| Are you currently on any prescribed drug substitute eg. methadone? _____ | ☐ | ☑ | ☐ |
| If yes, where do you receive it? _____ | | | |
| 2. Do you have any serious medical (including Psychological/Psychiatric) problems? | ☑ | ☐ | ☐ |
| 1. *Chronic Depression* | | | |
| 2. _____ | | | |
| 3. _____ | | | |
| 3. Have you recently suffered a head injury? | ☑ | ☐ | ☐ |
| If 'YES', record date of injury: _____ | | | |
| If 'YES', how did injury occur? _____ | | | |
| *Hit by car about 7 or 8 days ago* | | | |
| 4. Have you recently suffered a loss of consciousness? | ☑ | ☐ | ☐ |
| If 'YES', record date: *As above* | | | |
| 5. Have you received medical treatment? | ☑ | ☐ | ☐ |
| If 'YES', where: *Treated/stiches & pain killers* | | | |
| 6. Do you have any other injuries? | ☑ | ☐ | ☐ |
| If 'YES', how was injury sustained? | | | |
| *Broken rib – fell over about 2 weeks ago* ' | | | |

(Exhibit C17c, p2)

4.12. Constable Clemow gave the following reasons for refusing police bail:

'2. It is likely that the applicant would abscond if released on bail for the following reasons:

(a) history of prior breaches of bail:

Has 2 current outstanding previous breaches of Restraining Order before the PP Magistrates Court - there was a 3rd breach on 6/4/02 & a report brief has been

submitted by SC Glazbrook ... this offence is the 4th known breach within 4 months …

Has been reported for 1 previous Breach of Bail on 6/4/02 - with this offence being the 2nd known breach of Court Bail.

(b) lack of social ties:

Lives alone ... is an alcoholic and suffers from Chronic Depression ... displays bursts of anger and is unpredictable when he has been drinking ... drinks continually until he becomes a common drunk with several recent injuries from falling down or walking into objects whilst drunk ... does not appear to be able to look after himself, very little evidence of food in his home which is filthy and unkept ...

(c) any other reason:

Was previously working as a solicitor, but unable to do so at present time due to alcohol & depression related issues ...

3. It is likely that the applicant would offend again if released on bail for the following reasons:

(a) prior offences:

Accused has indicated he still loves the victim and appears to be obsessed with her ... victim is frightened and scared of the accused after an 11 yr marriage failed due to alcohol and violence ... accused had indicated a total disregard for Court Bail and Domestic Violence Restraining Orders with his continual breaches ... accused damaged victims property on 6/4/02 and 14/4/02 with these matters reported to police - he has previously smashed up the house and other areas of the property where the victim has not taken police action for fear of the accused ...

(b) other reasons that make the applicant likely to re-offend:

Accused is obsessed with victim & asked arresting police to tell her how much he loved her ... accused denied offence - even when presented with crime scene evidence ... accused verbally threatened victim, then withdrew threat, however his behaviour is irrational and controlled by his alcohol intake … accused is an alcoholic who offends when he drinks ... if released he will drink and there is a strong likelihood he will re-attend and commit further offences at victims home address ... '

(Exhibit C15d)

4.13. Sergeant Terence Boylan prepared breakfast for Mr McLeod and another prisoner the following morning, 15 April 2002 at about 7:30am. At about 7:45am Sergeant Boylan noticed that Mr McLeod was standing and shaking slightly. Mr McLeod told Sergeant Boylan that it was part of his depression, and that he would need to take his medication that day.

4.14. At about 8am, Sergeant Boylan went to the exercise yard again, and saw that Mr McLeod had vomited. He took him to the Port Pirie Hospital to be medically examined, and left him there under guard.

4.15. At Port Pirie Hospital, Mr McLeod was seen by Dr Uche Onwuchekwa, a Medical Practitioner. Dr Onwuchekwa had known him since January 2002, and said he had been treating him for alcohol-related problems and depression. He had last seen him on 18 February 2002. Dr Onwuchekwa described his consultation on 15 April 2002 as follows:

> 'I went into the cubicle and spoke to Ian. He had symptoms of alcohol withdrawal with tremors and agitation. Because of his state and his previous history I felt that he could not return to police custody and should be admitted to the hospital for treatment. I completed and signed a police Medical Examination of Prisoner form given to me by the police.
>
> I then made arrangements for him to be moved to a ward to start treatment according to the Alcohol Withdrawal Treatment Protocol.
>
> I continued working in A & E and spoke briefly to Ian in 'A Ward' whilst doing my rounds about 1 hour later. I told him that a bedside court hearing was going to occur because he was now in hospital. Ian did not appear concerned by that.
>
> About 11:15am on that day I was advised that they had conducted a bedside court hearing and had remanded Ian in custody.
>
> I was made aware that he could not remain in Port Pirie Hospital however I was concerned that he should remain in a hospital situation for observation and treatment for his alcohol withdrawal. I wrote out a Request for Consultation addressed to the Prison Medical Officer at Port Augusta Prison. Later that day I spoke to the medical officer from Port Augusta Prison. We spoke about Ian and the treatment I wanted him to receive. She stated that they could not deliver that at the Port Augusta Prison but there was a prison hospital attached to Yatala prison in Adelaide.
>
> Given that was a hospital where he could receive the appropriate treatment I was happy for him to be transferred there.
>
> I redirected my Request for Consultation to the Adelaide Remand Centre and faxed this to the Port Pirie Hospital to go with Ian.
>
> I did not see Ian again.'
>
> (Exhibit C5a, pp1-2)

4.16. <u>Decision to transfer to Yatala Labour Prison</u>

Later in the morning, a sitting of the Port Pirie Magistrates Court was held in a conference room at the hospital. As I have already outlined, Mr McLeod was remanded in custody until 7 May 2002.

4.17. Sergeant Boylan had some negotiations with DCS about the proposed transfer. He said:

> 'Sometime after the court hearing I was advised that McLeod had been remanded in custody. I was also informed that because he was now in hospital he could only be released into another hospital.

> I contacted Group Four in relation to the transfer of McLeod from hospital to prison. I was later told that they did not handle such matters as he was considered 'damaged goods' due to him being in hospital.
>
> I later spoke to members of Correctional Services at Port Augusta Prison and I believe in Adelaide regarding arranging the transfer. I also spoke to a medical officer at the Port Augusta Prison. I told her what had happened. She stated she was not set up to handle such matters in prison. I believe I gave her the telephone number of McLeod's doctor for her to confirm his treatment.
>
> In speaking to a Correctional Officers member it became obvious that the only way McLeod was to be transferred was in an ambulance with a police escort - they had suggested that McLeod go to Port Augusta Hospital and be transferred to Yatala the next day. I told them it made more sense to do the transfer direct to Yatala and he agreed and said he would ring back if he could arrange it. About this time I went off duty.'
>
> (Exhibit C18a, pp3-4)

4.18. Senior Constable Brett Peterson said that he made the arrangements for Mr McLeod's transfer to Adelaide. He said:

> 'Dr Uche who admitted McLeod to the Port Pirie Hospital stated he was unfit to be conveyed by police.
>
> I then contacted several agencies. Group 4 stated it was not their policy to convey hospitalised prisoners. I then contacted the Yatala Prison who stated they would accept McLeod. I did not record the name of the supervisor I spoke to, but endorsed the prisoners charge book on what enquires had taken place.
>
> I then contacted the Ambulance service at about 5:00pm Monday 15th April 2002 for transport, and police communications Adelaide to arrange for a police officer to be present when the ambulance crews changed over at the cross-over point.
>
> At all times whilst McLeod was in police custody he had a police officer keeping guard on him, which included the Port Pirie Hospital. From 3:00pm Monday 15th April 2002, Constable Glazbrook was present with him at the Port Pirie Hospital until the time he left via Ambulance at 6:15pm, and was present with McLeod whilst he was transferred to the Ambulance from Adelaide which contained an Adelaide police officer.'
>
> (Exhibit C20a, p1)

4.19. Constable Glazbrook accompanied Mr McLeod in the ambulance to Lochiel, where a crossover occurred with a Adelaide ambulance crew and another police officer. Mr McLeod was then conveyed direct to Yatala Labour Prison.

4.20. Arrival at Yatala Labour Prison

There is some confusion about the time at which Mr McLeod arrived at Yatala Labour Prison. Mr Darrell Smedley, the Manager of the Intelligence and Investigation Unit of DCS, who investigated the incident for the Department, put the time at 9:55pm (Exhibit C28a, p2). The control Log Book notes the time as 2145 (9:45pm) (Exhibit

C15i). The time was not noted in the Prison Health Services ('PHS') clinical record. I reject the evidence of Registered Nurse Susan Ziniak that it was as late as 2235 (10:35pm) (T110).

4.21. Ms Ziniak said that she saw the letter from Port Pirie Hospital, entitled 'Transfer/Referral Summary', and the ambulance officers' report, which are both on file. She did not recall seeing Dr Onwuchekwa's 'Request for Consultation'. These documents are all in the clinical record (Exhibit C15p). From that information, Ms Ziniak made the following entry in the clinical record:

> 'T/F (transfer) down from PAG (Port Augusta Gaol) with alcohol W/Ds (withdrawals) and depression. Been given 60mgs Valium today and to commence on Valium regime 16/4. Takes Aropax 20mgs daily, Panadol and given Thiamine daily. Admit to Rm 1 but is not on canvas.'
> (Exhibit C15p)

4.22. Correctional Officer Glenn Hickman was the Security Supervisor for the first watch (afternoon shift) on 15 April 2002. He told me that he had been advised by telephone that Mr McLeod was being conveyed to Yatala Labour Prison by ambulance. He said that he did not recall that happening before, although it was not unusual that police might bring a prisoner at that time of night (T98-T99).

4.23. Mr Hickman met the ambulance and took possession of the Warrant of Remand and other paperwork; this would have included the police Prisoner Screening Form, although he could not remember that in particular (T103). When he spoke to Mr McLeod, he did not respond - he merely stared at him. He said Mr McLeod was dirty, he stank, and was still strapped to the barouche (T100). Mr McLeod was strip-searched, and he then showered and put on clean pyjamas. He was placed in Room 1 which is the observation room next to the nurses' station in the infirmary usually reserved for prisoners considered 'at risk'. Ms Ziniak denied that he was put there for that purpose, however. She said that she placed him there so that less disruption was caused to the other inmates in the infirmary (T110). I find this difficult to reconcile with Mr Hickman's evidence that Mr McLeod was given a canvas gown and canvas blankets (T102), since these rather unpleasant items are usually reserved for suicidal patients. It would seem that a breakdown in communication has occurred between them, and that they had different perceptions of Mr McLeod's level of risk.

4.24. Mr Hickman's further attempts to elicit information from Mr McLeod were unsuccessful. As a result, he did not fill out the requisite admission documents, and in particular the Prison Stress Screening Form ('PSSF'). This is a particularly important document which is used to assess prisoners at risk of self-harm. It has been discussed in many previous inquests (eg. Turner - 27/04, Varcoe - 2/03, Lindsay - 13/03). Mr Hickman was well aware of the importance of the form, but I accept that it was pointless filling it out in view of Mr McLeod's state at the time. Ms Ziniak told him that Mr McLeod had received 'loads of medication' that day (T102). Dr Holmwood confirmed that 60mgs of Valium is quite a large dose, and that Mr McLeod's condition on 15 April 2002 was probably due to that (T168).

4.25. Mr Hickman said that he mentioned the fact that the PSSF had not been filled out to Correctional Officer Patricia Jones, the incoming Supervisor for the night shift, during his handover to her (T102-T103). Ms Jones said that she mentioned it in her handover to Correctional Officer Daniel Wright, the incoming day shift Supervisor, the following morning (T142). Mr Wright told me that he had no memory of that. He said he would have drawn it to the attention of the Manager if he had been told that (T152-T153). Mr Smedley noted that Mr Wright told him the same thing on 22 April 2002 when his memory of the occasion was much fresher (see Exhibit C28a, p8).

4.26. I am doubtful that Ms Jones did mention this issue to Mr Wright on the morning of 16 April 2002. I am not in a position to make a definite finding either way, however.

4.27. It is most unsatisfactory that important information such as this was not documented properly at the time. It is notorious that reliance on verbal handovers in situations such as this is unsatisfactory. I note that Mr Smedley also reached this conclusion, and recommended:

> 'That all General Managers ensure that appropriate documented 'handover' processes exist for the transfer of information, particularly information relating to newly admitted prisoners, especially those admitted to an Infirmary and prisoners considered to be at risk.' (Exhibit C28a, p8)

I agree.

4.28. The clinical record notes that Mr McLeod slept throughout the night and for most of the next morning. Ms Ziniak was back on duty at 7am. She gave Mr McLeod his first Valium dose of 10mgs at 8am, and another at 2pm. She ceased duty at 3:30pm. Further 10mg doses were given at 8pm and 10pm. Neither Ms Ziniak nor the

'Admissions Nurse' who commenced duty at noon performed the usual admission interview with Mr McLeod, and nor was an Admission Clinical Record drawn up, as had been done in an earlier admission to prison in January. Ms Ziniak acknowledged that this should have been done (T120).

4.29. Ms Ziniak said that she spoke to Mr McLeod during the day. She passed on a request to the correctional officers that he be able to contact his lawyer. After the phone call she states that he told her 'I'm good now' (T117).

4.30. At between 4-5pm (again the time is not noted in the clinical record), Mr McLeod was seen by Dr Christopher Holmwood. Dr Holmwood is now the Director of Prison Health Services. In April 2002 he had only worked in a custodial environment for two months.

4.31. Dr Holmwood's record of the consultation is as follows:

'Pt Pirie Police Station. Arrest on Sunday 14/4/02. Bail denied.
Alcohol Intake
Says 2 beers/night over last week
Bottle of port 1-2 nights/week
Medication
Aropax 30mg/deceased for depression and anxiety-related problems
GP Dr Uche Onwuchekwa
PHx (Past History)
Alcohol withdrawal seizure (several months ago)
No alcohol related crime or violence
Denies other health problems
Family
Mother (80) & 2 sisters (50/40+) in Melbourne
O/E (On Examination)
Difficult historian
Oriented TPP (Time, Place, Person)
Not hallucinating
Tremulous but states he is always like this
BP (Blood Pressure) $^{110}/_{70}$ P (Pulse) 88 reg
Chest clear
Pupils 4mm ECCRWA
EOM ✓ (responses normal)
ABND HS dual º murmur (heart normal)
? Hepatic (liver) enlargement
(no signs chronic liver disease

For

CBE (Complete Blood Evaluation)
VEC/LFIS (kidney and liver function)
$B_{12}$/Folate levels tomorrow am
Thiamine 100mg/day
Diazepam as per A/W (Alcohol Withdrawal) schedule
Aropax 20mg/day
BD T/P/BP (observations twice per day)'

(Exhibit C15p)

4.32. Dr Holmwood said that Mr McLeod did not get his Aropax (anti-depressant) medication on 16 April 2002. He said that it has a stimulant effect, and was more appropriately taken in the morning (T173). It is not clear what effect this may have had on Mr McLeod's mood that day. It is surprising that the nurses did not seek an authority to dispense Aropax to him on the morning of 16 April 2002, since they had ample notice from Dr Onwuchekwa that he had been taking it. Indeed, Ms Ziniak's entry in the record immediately following Mr McLeod's admission refers to it.

4.33. What is clear from Dr Holmwood's notes is that he did not perform a mental state assessment of Mr McLeod. Although he made the notes sometime later, he acknowledged that if he had done so it is likely that he would have noted it:

> '… there were a whole lot of other things occurring within the infirmary, so it may be that I genuinely left it out, but I think that's pretty unlikely. I don't think I did it.' (T172)

4.34. Dr Holmwood said that at the time he was more concerned with Mr McLeod's alcohol withdrawal, since the history of a seizure suggested that his withdrawal may be complicated (T166).

4.35. In my opinion, this was a major oversight. If all the other assessments had been made, the PSSF by the correctional officers and the Admission Clinical Record by the nurses, perhaps this might not have been critical. But none of those assessments were made, and this should have been apparent from the clinical record. As a result, at no stage after Mr McLeod left Port Pirie did he receive any form of mental state assessment.

4.36. Another aspect of this issue is that as part of the Valium regime for alcohol withdrawal, Mr McLeod should have been assessed every two hours. This was done at Port Pirie Hospital during the 'loading' phase of the regime on 15 April 2002. On 16 April 2002, Ms Ziniak gave him Valium at 8am and 2pm, yet an assessment was

not made until 6:15pm that evening, when Valium was given. Further doses of Valium were given at 8pm and 10pm, and no assessments were performed at those times either.

4.37. The impression given by this information is that the handling of Mr McLeod's alcohol withdrawal was not competent. An alcohol withdrawal score should have been obtained at 8am when the first dose of Valium was given. It should have been done 2 hourly after that if the score was above 8 on the Drug and Alcohol Services Council system, or above 11 on the PHS system. It was not done until 6:15pm. At that time the score was 13. Nothing further was done.

4.38. At 8:25pm on 16 April 2002 a nurse wrote:

> 'Behaviour mildly anxious
> Conversation organised
> Needed supervision with hygienic needs
> Eating and drinking well.'
> (Exhibit C15p)

4.39. At about 11:30pm Registered Nurse Margaret Viceban spoke to Mr McLeod and he wanted a cigarette. This was refused. He was walking around his cell and saying he was bored.

4.40. At about 12:40am on 17 April 2002, Ms Viceban spoke to him again. She said he was tapping on the wall of the cell to attract her attention. He again requested a cigarette. Again she refused, and offered him warm milk instead. He eventually accepted a cup of tea and two books. She described him as 'slightly agitated' (T91).

4.41. After this interaction, Ms Viceban and Registered Nurse Kevin Abbott went to the medication room to prepare the dosettes for the next day. They were in there when Correctional Officer Amanda Patterson came and told them to come quickly, as Mr McLeod had hanged himself.

4.42. <u>Emergency response</u>

The circumstances of Mr McLeod's death were investigated by Mr Darrell Smedley, Manager of the Intelligence and Investigation Unit and Mr Stephen Johnson, Manager

of Custodial Systems of DCS. The sequence of events which followed Ms Patterson's discovery of Mr McLeod hanging in his cell have been set out in their report (Exhibit C28a). The significant entries are as follows:

'1:00am CO Patterson commenced her patrol of the Infirmary. When she checked cell 1 she saw Mr McLeod hanging by a sheet attached to the toilet door hinge.

She immediately called CO Gibson and the nursing staff.

CO Patterson unlocked the door to cell 1, and then ran to the officer's station and notified control via the office telephone of a 'code black'.

CO Gibson and medical staff entered the cell and CO Gibson supported Mr McLeod while RN Abbott cut the sheet with a safety knife that he obtained from CO Gibson. CO Gibson placed Mr McLeod on the mattress on the floor of the room. The prisoner was not breathing and CO Gibson could not detect a wrist pulse. Medical staff and CO Gibson then moved Mr McLeod from the mattress to the floor and nurses Viceban and Abbott then commenced CPR.

CO Patterson then returned to cell 1. CO Gibson then took over from RN Viceban in assisting with CPR and detected a pulse. He ceased performing heart compressions but RN Abbott continued to ventilate Mr McLeod.(only the marked entries)

1:04am OIC P Jones then entered the Infirmary and an incident log was commenced by CO Patterson.

1:08am Control contacted St John's Ambulance.

1:17am St John's Ambulance arrived at YLP.

1:19am St John's Ambulance arrived at the Infirmary.

1:22am Second ambulance arrived at YLP.

1:24am Second ambulance arrived at the Infirmary.

1:37am Both Ambulances leave YLP. Mr McLeod transported to RAH.

2:25am Control contacted by DCS escort officer who advised that Mr McLeod admitted to ICU at RAH.

2:30am Group 4 contacted by control to conduct hospital watch at RAH.

2:50am D Smedley and S Johnson arrive at Infirmary.'

(Exhibit C28a, pp2-3)

## 5. Issues arising at inquest

5.1. A number of issues were addressed by Messrs Smedley and Johnson in their report. Their investigation was confined to DCS involvement in the incident, and did not cover the PHS aspects of Mr McLeod's death.

5.2. Department for Correctional Services admission procedures

The report discussed Mr Hickman's role in Mr McLeod's admission, and the fact that the admission documents, in particular the PSSF, were not completed. Mr Hickman

said that he provided the 'medical notes', which presumably included the letter from Dr Onwuchekwa, to Ms Ziniak. He said that if the Police Prisoner Screening Form had been received (he did not remember seeing it), he would have placed it in Mr McLeod's dossier. The Warrant would have gone to records (T104-T105).

5.3. There was clear information in the letter and the Police Prisoner Screening Form that Mr McLeod was suffering from depression, was taking Aropax, and had suffered injuries in a fall and a minor motor vehicle accident in the past two weeks. To the extent that this information was supplied to the medical staff, Mr Hickman complied with appropriate procedures.

5.4. Mr Hickman said that his inability to complete the other documentation was brought to the attention of the incoming night shift Supervisor, Ms Jones. She agreed that she received the information, and said that she passed it on to Mr Wright the following morning. He had no memory of being told that when interviewed on 22 April 2002 by Mr Smedley, nor did he when he gave evidence before me.

5.5. As a result, no screening of Mr McLeod's mental state took place on his admission to Yatala Labour Prison. This is a significant deficiency in Mr McLeod's treatment on admission. I have already said that it was unsatisfactory that there was a verbal handover between shifts, and that it was overlooked that no screening had been done. I agree with Mr Smedley's recommendation that handovers should be 'appropriately documented'.

5.6. Emergency procedures

Messrs Smedley and Johnson concluded that in all respects, DCS staff complied with standard operating procedures in relation to providing first aid, securing the scene, and maintaining a log of movements in and out of the scene. I agree with this conclusion. Indeed, it is commendable that DCS and PHS staff took prompt action and were able to resuscitate Mr McLeod at the scene.

5.7. Cell design

In the time which elapsed between 12:40am when Ms Viceban gave Mr McLeod a warm drink and 1:00am when he was found by Ms Patterson, he had threaded a knotted sheet through the gap between the door to the toilet/shower cubicle and the wall. The sheet was anchored by being placed over and around the door hinge. It seems remarkable that he could do this in the observation cell with a window to the

nurses station and within a few feet of two correctional officers (Patterson and Gibson) chatting over coffee.

5.8. With respect, I do not agree with the conclusions of Messrs Smedley and Johnson that the hanging point was not 'readily identifiable' (Exhibit C28a, p11).

5.9. I suspect that the reason it had not been rectified previously was that the cell was an observation cell, with a large window between it and the nurses station. If the cell was being used as an observation cell because Mr McLeod had been identified as 'at risk', perhaps the degree of surveillance might have been greater. Mr Hickman thought that was the reason why he was in that cell, but Ms Ziniak apparently did not. The blind in the window was down, providing him with privacy (T45). The procedures by which these decisions were made were slipshod and ad hoc. This is totally unacceptable.

5.10. I agree with the recommendation of Messrs Smedley and Johnson that the hanging point be removed by removing the door and replacing it with privacy curtains which are so designed that they do not provide hanging points.

5.11. <u>Should Mr McLeod have gone to Yatala Labour Prison at all?</u>

I note that Messrs Smedley and Johnson have outlined in their report the series of events which led to Mr McLeod being transferred to Yatala Labour Prison in Adelaide. It boiled down to the fact that it was decided, after much liaison, that Dr Onwuchekwa in Port Pirie was not happy to discharge him unless he could be transferred to another hospital, or a DCS infirmary where the treatment for alcohol withdrawal could continue.

5.12. There followed an extraordinarily complex set of communications between Port Augusta Gaol, Port Pirie Police, Group 4, Dr Onwuchekwa, PHS Port Augusta, Yatala Labour Prison and the Adelaide Remand Centre. It was eventually decided that Yatala Labour Prison was the only realistic option having regard to the late hour, and the fact that it had a 24 hour infirmary. When questioned as to why the transfer could not wait until 16 April 2002, when Mr McLeod could be admitted during the day, Port Pirie Police advised that they did not have the resources to provide a hospital watch overnight (Exhibit C28a, p14).

5.13. As Messrs Smedley and Johnson point out, the large number of people involved in the various negotiations has resulted in some distortion of information. I have not analysed this process exhaustively since in my opinion it forms part of the causative background to Mr McLeod's death, rather than being a direct cause.

5.14. The process did, however, result in Mr McLeod's admission to Yatala Labour Prison in the late evening. That is no excuse, but perhaps some explanation, for what followed. Messrs Smedley and Johnson concluded:

> **'CONCLUSION**
>
> As stated earlier in this report, the review team is of the opinion that had Mr McLeod remained in hospital at Pt Pirie until the following day (i.e. Tuesday 16 April) or if he had been transferred to DCS at Pt Augusta and subsequently admitted to Pt Augusta Hospital, then regardless of the results of any assessment conducted by DCS staff as part of the admissions process, he would have been under constant observation by either SAPOL (at Pt Pirie Hospital) or by Group 4 (at Pt Augusta Hospital), until such time as he was medically discharged.
>
> The view expressed by Police that once the prisoner was remanded in custody he became the responsibility of DCS who should then arrange transportation of the prisoner from Police custody to the appropriate institution, appears contrary to the requirements of the warrant of remand. The review team also has concerns that police staffing at the time may have had an impact on this incident, given that Police indicated that they did not have sufficient staff to maintain a hospital watch on the prisoner overnight.
>
> The review team is of the opinion that the issue of the Department's responsibilities in taking custody of prisoners remanded by the courts, including those prisoners receiving in-patient care in hospitals, and the receiving of prisoners outside of the hours as stated in Regulation 5 of the Correctional Services Act should be the subject of legal advice.'
>
> (Exhibit C28a, p19)

5.15. I agree with that conclusion. The roles of all involved agencies must be clarified, and appropriate procedures developed so that such a situation does not occur again. The transfer of prisoners between country areas and the city, and between institutions, is a subject fraught with difficulty. Each time a transfer occurs, a new set of admission issues arise. In my opinion, SAPOL, DCS, Group 4 and the PHS must develop a clear and well understood set of procedures for the guidance of all concerned.

5.16. <u>Medical issues</u>

As I have already discussed, there were a number of deficiencies in Mr McLeod's treatment at the Yatala Labour Prison infirmary:

- He did not receive his daily dose of Aropax on the morning of 16 April 2002;

- Dr Holmwood did not perform a mental state examination during his consultation that day, even though the documentation from Port Pirie indicated that his anxiety level was $^{6}/_{7}$;
- An Admission Clinical Record was not completed by the nursing staff;
- Dr Holmwood was not aware of Mr McLeod's admission in January 2002 at Port Augusta;
- Dr Holmwood did not make an assessment of the risk that Mr McLeod might harm himself, even though the SAPOL Prisoner Screening Form indicated that he suffered from chronic depression and was taking Aropax, as did the entry in the clinical record of Ms Ziniak;
- Mr McLeod's withdrawal treatment was not monitored regularly as requested by the protocol. Ironically, he was transferred to Yatala Labour Prison because it was claimed that was the only place where it could be monitored properly .

5.17. The combined omissions in the admission procedures on the part of both custodial and nursing staff occurred before Dr Holmwood's consultation. If Mr McLeod had died before he had seen Dr Holmwood, these omissions might have been seen as causative. As it is, they provided the background for Dr Holmwood's own omissions. Had an appropriate PSSF, or an Admissions Clinical Record, or a nursing care plan, or regular withdrawal observations, been performed, Dr Holmwood may have acted differently.

5.18. But the responsibility was his, with the background information he had, to carry out an appropriate assessment of Mr McLeod's mental state, and he clearly failed to discharge that responsibility.

5.19. I note Dr Holmwood's evidence about the improvements in PHS procedures which have been introduced since Mr McLeod's death. Dr Holmwood said that:

- The Admissions Clinical Record form is now more detailed and thorough and specifically includes a self-harm risk assessment (T169);
- A new Admissions Clinical Record must now be prepared whenever a prisoner has been absent from the institution for more than a month (T162);

- Every prisoner, when first admitted to the infirmary, has a nursing care plan developed, which specifically indicates the frequency of observations, medications, etc (T163);
- All new medical staff now undergo an induction process which includes familiarisation with documents such as the Police Prisoner Screening Form so that the absence of such a document from the file would be noted and followed up (T164).

## 6. Conclusions

6.1. Mr McLeod was being treated for alcohol withdrawal at the Port Pirie Hospital when he was remanded in custody. What followed was an unedifying and convoluted set of communications between his doctor, SAPOL, DCS and Group 4 about where he should be placed. It is not my function to comment on the legality of his transfer to Yatala Labour Prison when he was remanded to Port Augusta Gaol.

6.2. However, the result was that Mr McLeod was transferred to Yatala Labour Prison, arriving late in the evening after the admission staff had finished work.

6.3. In view of Mr McLeod's state, particularly due to the amount of Valium he had consumed, ordinary admission procedures, including the preparation of a Prison Stress Screening Form, were not prepared. I make no criticism of DCS staff about this. There was ample evidence from the SAPOL Prisoner Screening Form, and the documents from Dr Onwuchekwa, to indicate that Mr McLeod should have been regarded as 'at risk'.

6.4. Even though Mr McLeod was placed in an observation cell in the Yatala Labour Prison infirmary, he was not treated by the nursing staff as 'at risk'. The usual DCS admission procedures were not completed next day, because the information that should have been passed from shift to shift was lost because handovers were conducted verbally, and not noted in the journal. Usual admission procedures were not performed by PHS staff either. I am unable to establish why not, and can only conclude that general laxity of procedures was the cause.

6.5. These omissions were serious. However, they were compounded by Dr Holmwood's omission to perform a mental state examination of Mr McLeod when he examined him. If he had done so, the earlier omissions would not have been important. His

failure was the final link in the chain of failures which led to the result that at no time during Mr McLeod's detention was a risk assessment carried out.

6.6. This is inexcusable. Yatala Labour Prison is the largest correctional institution in the state, and should have the capacity to receive prisoners safely and professionally at any hour. The need for appropriate and comprehensive admission procedures has been the subject of repeated inquests. It is notorious that prisoners are particularly at risk in the first few days after admission. It is completely unacceptable that admission procedures could fall down so easily because a prisoner is received at a late hour.

6.7. Whether the outcome would have been different had a proper risk assessment been conducted is a matter for conjecture. However, whatever chance there was of avoiding this tragedy was lost when a risk assessment was not performed.

## 7. Recommendations

7.1. Messrs Smedley and Johnson have conducted a thorough investigation of this incident from the DCS point of view. They have correctly identified a number of areas where procedures can and should be improved.

7.2. The main reason why DCS admission procedures failed here was because Mr McLeod was taken to Yatala Labour Prison at an unusual hour, and vital information was not passed on during verbal handovers at change of shifts.

7.3. Messrs Smedley and Johnson recommended as follows:

> 'That all General Managers ensure that appropriate documented 'handover' processes exist for the transfer of information, particularly information relating to newly admitted prisoners, especially those admitted to an Infirmary and prisoners considered to be at risk.'
>
> (Exhibit C28a, p8)

I agree. Mr Smedley told me that this recommendation had already been implemented by DCS. I accept that assurance. However, I think that more detailed instructions are called for as to what 'appropriate documented handover processes' are. Further, the expression 'especially those admitted to an Infirmary and prisoners considered to be at risk' suggests that written transfer of information is not necessary for other prisoners. I think that an appropriately documented handover is required

whenever there is information relevant to any prisoner. In my opinion, the recommendation should read:

> 'That all General Managers ensure that appropriate documented handover procedures exist for the transfer of information concerning any prisoner.'

7.4. I have made recommendations about cell design over the years in inquest after inquest and yet there still seems to have been no comprehensive approach to this issue. In Varcoe (2/03), I recommended:

> 'As recommended in Bonney in 1996, the design of cells in E division at Yatala Labour Prison, and indeed all older cells in the prison system in South Australia, should be the subject of a comprehensive review along the lines of the Victorian Building Design Review Project' (Recommendation 2)

In Lindsay (13/03), I recommended:

> 'The 'safe-cell' principles should be adopted and pursued in prisons throughout South Australia as a matter of urgency.' (Recommendation 9.3)

In Turner (27/04), I recommended:

> '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' (Recommendation 9.3)

7.5. I am unable to say how it could be that Room 1 in the Yatala Labour Prison infirmary could have such an obvious hanging point, especially since it is used for 'at risk' prisoners. I must therefore make a further recommendation that all infirmaries be assessed as part of a comprehensive review of cells controlled by DCS in accordance with the principles of the safe cell project.

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

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

*Seal the 31st day of May, 2005.*

*Coroner*