



## FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 31<sup>st</sup> day of May 2006, the 1<sup>st</sup>, 2<sup>nd</sup>, 5<sup>th</sup>, 6<sup>th</sup>, 7<sup>th</sup>, 8<sup>th</sup> and 9<sup>th</sup> days of June 2006 and the 18<sup>th</sup> day of October 2006, by the Coroner's Court of the said State, constituted of Elizabeth Ann Sheppard, a Coroner for the said State, into the deaths of Barry Michael Turner and Troy Michael Glennie.*

*The said Court finds that Barry Michael Turner aged 35 years, late of the Adelaide Remand Centre, 208 Currie Street, Adelaide died at the Adelaide Remand Centre, South Australia on the 9<sup>th</sup> day of February 2004 as a result of neck compression due to hanging.*

*The said Court finds that Troy Michael Glennie aged 28 years, late of Adelaide Remand Centre, 208 Currie Street, Adelaide died at the Adelaide Remand Centre, South Australia on the 27<sup>th</sup> day of September 2004 as a result of neck compression due to hanging.*

*The said Court finds that the circumstances of their deaths were as follows:*

### **1. Introduction and reason for Inquest**

- 1.1. A joint inquest was held into the deaths of Barry Michael Turner and Troy Michael Glennie because of the common features surrounding the deaths. At the time of their deaths, both men were on remand at the Adelaide Remand Centre (ARC) and had expressed thoughts of self-harm to staff. Having reviewed the police statements, I

find that both men were in lawful custody at the time of their deaths<sup>1</sup>. In accordance with Section 21(1)(a) of the Coroner's Act 2003 and the transitional provisions of the Schedule to that Act, because these deaths occurred whilst in custody, an inquest is mandatory<sup>2</sup>.

## **2. General similarities**

- 2.1. Mr Turner was found hanging in his cell on 9 February 2004, approximately six weeks after being placed in the ARC. Mr Glennie was found hanging in his cell on 27 September 2004, approximately five weeks after he was brought into custody at the ARC. Both men were at the time of their deaths housed in mainstream units in doubled up, shared cells. In both cases, the hangings took place when the respective cellmates had been removed to attend Court, leaving the other alone in his cell. Bed sheets were fashioned by both men into nooses, tied to the upper bunk in their cells.
- 2.2. When each man was discovered by correctional services officers, urgent attempts were made to resuscitate them, but those efforts were unsuccessful. On both occasions, officers who were first in attendance did not have at their immediate disposal, a Hoffman knife, which would have assisted in removing the ligature in a timely fashion.
- 2.3. Apart from the obvious on-going issue of "hanging points" in the ARC, one additional matter examined during the Inquest was the adequacy of measures taken by corrections managers and staff, prison medical officers and nurses to manage the risk of self harm and suicide of these men in the period leading to their deaths. Whilst neither Mr Turner nor Mr Glennie were serving sentences of imprisonment at the time of their deaths, I will refer to them and to other inmates of the ARC and other correctional institutions as 'prisoners' in the interests of consistency.

## **3. Summary of facts and circumstances surrounding Mr Turner's death**

- 3.1. Mr Turner was arrested on 23 December 2003 after he allegedly robbed a staff member of \$120 at a video store in Elizabeth South, wielding a screwdriver. Before being arrested, he was located sitting about 100 metres from the video store. Police could see sutures in both of his wrists, which represented a previous episode of self-

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<sup>1</sup> Exhibits C8a, C35d

<sup>2</sup> Part 16 Transitional provisions 25(3)

harm. It was clear that this man had mental health issues, but when he was taken to the Lyell McEwin Hospital, medical staff declined to detain him. Mr Turner had a long history of mental illness with numerous admissions to hospital. I have insufficient information to enable me to make findings as to the suitability of the assessment made of Mr Turner at the Lyell McEwin Hospital, or of the decision not to detain him under the Mental Health legislation.

- 3.2. Mr Turner was taken to the Elizabeth Police Station where he was questioned and arrested for the offence of aggravated robbery. Transcript of the police interview with Mr Turner indicates that he was disturbed and that he posed a potential threat to himself or others. He was kept overnight in the police cells. When he appeared in the Elizabeth's Magistrate's Court the following day, Mr Turner was remanded in custody, but a request was made by the Magistrate to have Mr Turner psychiatrically assessed as a matter of urgency and for possible transfer to James Nash House. This was to be Mr Turner's first time in custody.
- 3.3. Mr Turner was processed at the ARC and interviewed for the purpose of measuring his degree of 'stress'. An inmate was considered to be 'at risk' if the answers given resulted in a score greater than 8. Based on answers given about his previous attempts at self-harm and present thoughts of committing suicide, Mr Turner gave a score of 25<sup>3</sup>.
- 3.4. He was taken to the infirmary at the ARC for assessment of his mental state. Because Mr Turner expressed suicidal ideation during this assessment, he was placed under camera observation in a single cell in Unit 7, which is a separation unit. He was provided only with canvas sheets and canvas clothing to reduce the risk of self-harm. According to Registered Nurse David West, Unit 7 is generally used by correctional officers for behaviour management concerns, whereas medical staff referred patients there to enable 'constant observation' of high-risk prisoners<sup>4</sup>. The order formalising Mr Turner's separation in Unit 7 was signed on Christmas Day, 25 December 2003<sup>5</sup>.
- 3.5. Meanwhile, the infirmary staff at the ARC consulted with staff at Glenside Hospital to familiarise themselves with Mr Turner's extensive psychiatric history, documented in the hospital medical notes. Mr Turner's first admission to Glenside was in 1999 and

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<sup>3</sup> Exhibit C8u, page 32

<sup>4</sup> Transcript, page 613

<sup>5</sup> Transcript, page 225

from that time, he was managed intermittently in hospital during frequent and lengthy admissions as well as in the community, supervised by the Northern Mental Health Team. Mr Turner was diagnosed with chronic depression, anxiety and a personality disorder. His condition appeared to be resistant to various treatments, including medication and electroconvulsive therapy. At one stage, he had been averaging two or three self-harm attempts per month<sup>6</sup>.

- 3.6. By 26 December 2003, Mr Turner was assessed by Registered Nurse Jordan as no longer presenting such a significant risk of self-harm and he was transferred to the infirmary where he was observed by medical staff for the next two weeks. Dr Karpinski was the medical officer managing the day-to-day medical issues with prisoners in the ARC. He had no formal psychiatric training, but was very experienced in the general practice of medicine. When Dr Karpinski reviewed Mr Turner on 29 December 2003, he noted that Mr Turner had stopped his medication a few months ago. Dr Karpinski recommenced Mr Turner's anti-psychotic medication, Seroquel 200mg twice a day, and an antidepressant Avanza 30mg at night. Mr Turner also requested and was prescribed Chlorpromazine on an "as needed basis" to help him relax<sup>7</sup>.
- 3.7. Mr Turner was examined on 30 December 2003 by Dr Brereton, psychiatric registrar from James Nash House and then on 6 January 2004, by Forensic Psychiatrist, Dr Craig Raeside. On the latter occasion, Mr Turner presented as fearful and anxious. Dr Raeside noted his long history of severe borderline personality disorder, chronic depression and substance abuse. He noted numerous and various past treatment episodes which Mr Turner claimed were ineffective. Dr Raeside also noted chronic suicidal ideas, with attempts over a long period of time. He suggested that when Mr Turner was discharged from the infirmary, he would need daily nursing assessment<sup>8</sup>.
- 3.8. According to Dr Raeside, he considered that Mr Turner may need to be transferred to James Nash House (JNH) at some stage, but was conscious that only persons who are seriously mentally ill could be admitted to JNH owing to the pressure on beds following the introduction of the Mental Incompetence provisions of the Criminal

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<sup>6</sup> Transcript, page 326

<sup>7</sup> Transcript, page 331

<sup>8</sup> Exhibit C8u, Transcript, page 409

Law Consolidation Act. Dr Raeside made the disturbing observation that there are more psychiatrically ill persons in the South Australian Prison system than in the hospitals. He claimed that some of these people are more unwell than those in JNH because that is where many stable forensic patients are required to be accommodated after being found mentally unfit to plead or mentally incompetent to commit the offences they were charged with<sup>9</sup>.

- 3.9. Meanwhile, Mr Turner was gradually being exposed to other prisoners in the mainstream units during the day in a programme described as “daytime association”. Mr Turner is said to have responded positively to this programme.
- 3.10. On 12 January, 2004 Mr Turner was considered by medical staff to be suitable for transfer to a mainstream unit, but was to be assessed each day by a nurse from the infirmary. This was commonly referred to as placing a prisoner on a “yellow sheet”, being a reference to the yellow form used by nursing staff to enter their daily mental state assessment. The form was headed “Suicide Risk Assessment Care Plan”. Medical staff also generated a potential self harm notification (PSHN), a document placed in a prisoner’s case management file to alert Corrections Officers about Mr Turner’s potential risk of self harm<sup>10</sup>. This pro forma document listed the following signs to look for and to report with a view to medical re-assessment:

‘Severe agitation or aggressiveness  
 Expressions of hopelessness/helplessness’  
 Noticeable behaviour changes  
 Withdrawal from activities/other prisoners  
 Hoarding/accumulation of medication.’<sup>11</sup>

- 3.11. Mr Turner spent the following week in Unit 1 and then Unit 4 in doubled up accommodation and he was assessed daily by nurses. During an assessment on 18 January 2004, he revealed that he felt terrible and felt like “hanging himself all the time.” He was transferred back to Unit 7 under camera surveillance<sup>12</sup>. When Dr Karpinski assessed Mr Turner on 19 January 2004, he noted that there was an exacerbation of his depression and thoughts of self-harm. He referred Mr Turner to Dr Raeside who saw him the following day, at which time he recommended that

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<sup>9</sup> Transcript, page 415

<sup>10</sup> Transcript, page 336

<sup>11</sup> Exhibit C8u, page 33

<sup>12</sup> Exhibit C8u, page 18

Mr Turner remain separated in Unit 7 for the present because he told Dr Raeside that he feared the mainstream units and wished he was dead. Whilst in Unit 7, Mr Turner was assessed daily by the registered nurses.

- 3.12. By the time Mr Turner was reviewed again by Dr Raeside a week later on 27 January 2004, he said that he wanted to return to a mainstream unit because he was finding Unit 7 too oppressive. This is not surprising, given the harsh environment of Unit 7, which was inspected during the Inquest. When Dr Raeside examined Mr Turner, he found him to be a little improved and less immediately depressed. In evidence, Dr Raeside explained that the purpose of this assessment was partly to try to distinguish between Mr Turner's immediate risk of self-harm as opposed to his chronic ongoing self-harm risk. Dr Raeside considered that he did not pose a significant risk at that time, but still needed to be assessed daily by nursing staff. He made the following note in Mr Turner's prison health record:

‘Consider TF to different unit,  
Initially single cell - but could double up if ‘right’ cell mate.  
RV 2/52’.<sup>13</sup>

- 3.13. I understand the entry to mean that Mr Turner could be transferred back to a mainstream unit, firstly in a single cell, but if a suitable cellmate was available, then into a shared cell and that Dr Raeside would review him again in two weeks. Whilst Dr Raeside did not specify that the daily assessments via the yellow sheet regime should continue, he explained during the Inquest that it was his intention that they should continue. According to Dr Raeside, if he thought they could stop, he would have noted something like “yellow sheet to cease”<sup>14</sup>. I consider that it would be prudent for all reviewing medical practitioners to specify whether the daily assessments are to continue or cease at each review.
- 3.14. Dr Raeside was questioned about the existing policy which assumes that doubling up with cellmates is the best way to manage a person at risk of self-harm. Dr Raeside considered that for some people, being in close proximity with another cellmate can increase anxiety and distress<sup>15</sup>. A similar view was expressed by Dr Christopher Holmwood, the Director of Prison Services, except for some traditional or semi-

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<sup>13</sup> Exhibit C8u, page 16

<sup>14</sup> Exhibit C55, Transcript, page 428, 429

<sup>15</sup> Transcript, page 427

traditional Aboriginal prisoners. An extensive review in the United Kingdom is said to have revealed that of those suicides which occurred in a double up cell, half occurred when the cellmate was present<sup>16</sup>. The evidence suggests that the “double-up” policy has been brought about as a pragmatic response to the problem of self-harm, in the absence of more suitable prison accommodation. The demand for accommodation in the ARC is such that cells designed as single person cells are now mostly used as two person cells fitted with bunk beds. Single cells are rare and are allocated mainly to those prisoners who successfully request them as a special privilege, or sometimes on medical grounds following a recommendation from a medical practitioner.

3.15. Dr Raeside explained during evidence that he would have discussed his opinion concerning Mr Turner’s transfer with the Unit Manager, whom he believed to be Paul Robinson. According to Dr Raeside, his normal practice was to also discuss patients whom he had reviewed with the nurse on duty and Dr Karpinski.

3.16. On the day of this assessment, Mr Turner was transferred to a “double up” cell initially in Unit 1 and then Unit 3 with Justin Lawless. In accordance with legislative requirement, a notice of revocation of separation was signed by the manager of the Unit, Jim Konstad, which enabled Mr Turner to be returned to a mainstream Unit. The reasons stated in the notice of revocation are as follows:

‘You have been assessed by the psychiatrist (sic), You are suitable to return to the units as the threat of self-harm is no longer there. To be assessed on a regular basis by Medical Personnel (sic) to ensure there aren’t any thoughts of self harm are present and if there is appropriate action to be taken.’<sup>17</sup>

3.17. Mr Konstad claimed to have no recollection of discussing Mr Turner’s transfer with Dr Raeside and suggested that because of the wording in the form, it was likely that Mr Robinson would have been the person who received the information. He suggested that Mr Robinson probably prepared the notice of revocation and conveyed the effect of it to Mr Konstad for signing<sup>18</sup>. Mr Robinson also claimed to have no recollection about this incident, but conceded that he may have prepared the form for Mr Konstad to sign<sup>19</sup>. Mr Konstad explained that unit managers invariably followed the recommendations of medical staff concerning suitability for transfer. There is no

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<sup>16</sup> Exhibit C60, Transcript, page 668

<sup>17</sup> Exhibit C8t

<sup>18</sup> Transcript, page 234

<sup>19</sup> Transcript, page 532 and page 537

evidence to explain how Mr Turner came to be placed in a “double up” cell as opposed to a single cell.

- 3.18. There is no record of what advice was given by Dr Raeside and to whom, apart from a general entry made by Mr Konstad (or Mr Robinson on his behalf) in the Justice Information System data base (JIS) which reads as follows:

‘Turner assessed by psychiatrist and cleared to be transferred to mainstream unit and to be regularly assessed by Medical staff. Separation Revoked. Transferred to Unit 1.’<sup>20</sup>

- 3.19. I find that there was some form of communication between Dr Raeside and Mr Robinson concerning Mr Turner’s suitability for transfer back to a mainstream unit. The information on the notice of revocation and entry in the JIS suggests that Dr Raeside mentioned to Mr Robinson that medical staff would continue to monitor Mr Turner following the transfer.
- 3.20. I consider that it would be prudent for a record to be kept by Corrections Officers of specific advice given by medical staff when this information is relied upon for the issuing of separation orders and notices of revocation<sup>21</sup>.

#### **4. System failure**

- 4.1. Mr Turner’s name was omitted from the list of prisoners requiring a daily assessment by nursing staff from the infirmary. The last entry made by a nurse on Mr Turner’s yellow sheet is dated 26 January 2004. There is no direct evidence which explains how this omission occurred. Dr Karpinski speculated that because Dr Raeside noted that Mr Turner could be transferred to a single cell, some might have assumed that he was no longer considered at a high level of risk<sup>22</sup>.
- 4.2. A number of witnesses explained that the system then in place for daily “yellow sheet assessments” involved the removal of the yellow sheets from the medical records of those prisoners to be assessed. Nursing staff kept them on a clipboard to help them identify who needed to be seen<sup>23</sup>. When prisoners were due to be seen by the psychiatrist, a nurse would return the sheets to the individual patient file. It was suggested that after Dr Raeside examined Mr Turner on 27 January 2004, his yellow

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<sup>20</sup> Exhibit C57

<sup>21</sup> Transcript, page 539

<sup>22</sup> Transcript, page 368

<sup>23</sup> Transcript, page T263 and page 431

sheet remained in his file and was not placed back on the clipboard, which may explain why he was overlooked for daily assessment<sup>24</sup>.

- 4.3. At this time, Unit managers and Corrections staff were not informed about which prisoners were subject to the “yellow sheet” assessment requirement. This policy was in accordance with a desire to preserve some measure of confidentiality<sup>25</sup>. The names of prisoners required to be assessed were placed on a list and provided each day to certain officers whose task it was to collect the various prisoners and bring them to the infirmary and to return them to their unit following assessment.
- 4.4. On 4 February 2004, Mr Trenorden a prisoner at Yatala Labour Prison, was said to have committed suicide. This incident became the topic of discussion between cellmate Justin Lawless and Mr Turner, although according to Mr Lawless, Mr Turner spoke in general terms about how it might be done in a cell and gave no indication that he was intending to hang himself. Dr Raeside explained that after Mr Turner’s death, he questioned staff informally and examined Mr Turner’s medical file in an attempt to identify any trigger which might explain his subsequent actions. Nothing was identified during his inquiries.
- 4.5. At about 7:30am on 9 February 2004, Mr Lawless was removed from the cell in Unit 3 to attend Court. Mr Turner was last seen alive by corrections staff lying on the upper bunk of the bed in their shared cell. At approximately 8:00am, Officer James Hugo performed a visual inspection of cells in Unit 3 and when he came to cell 10, he saw Mr Turner hanging by a sheet from a rail on the top bunk. He called a “Code Black” over his radio to obtain urgent assistance. Mr Hugo unlocked the cell and when he approached Mr Turner he could see that there was no obvious sign of life. Mr Turner was hanging in such a way that his knees were 3 or 4 inches off the ground with his toes on the floor<sup>26</sup>. The sheet had about 8 knots, all of which had to be untied by hand by Mr Hugo before he was able to remove the sheet from around Mr Turner’s neck. Mr Hugo did not have a Hoffman knife, in his possession at this time. I say more about this later. Resuscitation measures were instituted with assistance from other officers, nurses from the infirmary and Dr Karpinski who arrived at the scene at 8:17am<sup>27</sup>. The attempts were unsuccessful and were ceased at 8:25am. I am satisfied

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<sup>24</sup> Transcript, page 263

<sup>25</sup> Transcript, page 116

<sup>26</sup> Transcript, page 107

<sup>27</sup> Transcript, page 329

on the evidence that the actions of the corrections officers and the attempts to resuscitate were appropriate and were conducted in a timely fashion.

## **5. Post Mortem**

- 5.1. A post mortem examination was conducted by Forensic Pathologist Dr Allan Cala who concluded that death was caused as a result of hanging. Dr Cala's findings revealed no indication of involvement in Mr Turner's death by any other person. Subject to the precise wording of the cause of death, I accept Dr Cala's observations and conclusions expressed in his post mortem report and find that the neck compression which caused Mr Turner's death was self inflicted by the application of a ligature<sup>28</sup>.
- 5.2. Analysis of a sample of Mr Turner's blood revealed therapeutic concentrations of mirtazepine and chlorpromazine<sup>29</sup>.

## **6. Changes to the "yellow sheet" system**

- 6.1. Following Mr Turner's death, the system was changed in an attempt to ensure that no prisoner who medical staff considered required daily assessment is overlooked. A separate record of those prisoners requiring daily assessment is kept in a diary in the infirmary<sup>30</sup>. The information is entered at the commencement of the yellow sheet assessment regime and when the assessments are ceased, that fact is now also noted in the diary and dated. The yellow sheets now remain at all times in the prisoner's health file. According to Dr Holmwood, the yellow sheet system has been changed marginally to enable all medical staff to make entries on the sheets, rather than just nursing staff, to remind everyone of the status of the person being assessed<sup>31</sup>.
- 6.2. One can only speculate about whether a daily nursing assessment of Mr Turner's mental state would have prevented what ultimately occurred thirteen days later, but given the chronic pattern of expression of thoughts of self harm and suicide, I consider that it would have been prudent to continue daily assessments until Mr Turner had demonstrated a prolonged period of improvement.

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<sup>28</sup> Exhibit C2b

<sup>29</sup> Exhibit C3a

<sup>30</sup> Transcript, pages 135, 263 and 264

<sup>31</sup> Transcript, page 637

- 6.3. As to the issue concerning the removal of one cellmate, leaving the remaining inmate alone, the Court was informed that the system for those prisoners subject to the “yellow sheet” regime was also changed in about September 2004, to ensure that they are never in a cell alone. Where a cellmate is removed, and medical staff informs a Unit Manager that the prisoner should be doubled up, he is placed with another prisoner or in the infirmary as an interim measure<sup>32</sup>.
- 6.4. The system has also changed to enable Corrections officers to immediately identify which prisoners are subject to the daily assessment requirement by way of a yellow tag on the cell door and yellow tags in the Unit offices on a board carrying a list of prisoners. Whilst there is said to be a perception by some prisoners that they are stigmatised by this type of identification, it seems a necessary precaution to take in the interests of their safety. I consider it essential that Corrections officers be made aware of the identity of those prisoners at particular risk of self harm under their supervision<sup>33</sup>.

## 7. **Questionable value of PSHN forms**

The evidence suggests that the potential self harm notification (PSHN) system has developed to the point where it is said to have become ineffective. For the majority of persons admitted to custody, including Mr Turner, a PSHN is generated following an assessment by medical staff, resulting in a red dot being placed on the prison file and a red tag placed next to the person’s name on the unit office board for the information of all officers<sup>34</sup>. It is not difficult to understand how most prisoners might display signs of distress when first taken into custody. According to Dr Holmwood, most prisoners settle down after a short time and do not require on going assessment. He described the PSHN as “useless” and argued for the development of a classification system which estimated the degree of risk of self harm<sup>35</sup>. There has been resistance to this suggestion by Corrections management because of the perceived complexity of the proposed changes<sup>36</sup>. Unless there is information which I do not have, it seems that there is no good reason for continuing the PSHN system in tandem with the yellow sheet system which is more targeted in its approach.

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<sup>32</sup> Transcript, page 44

<sup>33</sup> Transcript, page 113

<sup>34</sup> Transcript, page 239

<sup>35</sup> Transcript, page 657 and 660

<sup>36</sup> Transcript, page 725

## **8. Stepdown procedure**

Dr Holmwood explained that following the deaths of Mr Turner and Mr Trenorden, changes were instituted which meant that when an inmate has been in a high supervision environment, there is a slower “step-down” requirement which stipulates that they may not be transferred directly back to mainstream units when a prisoner claims to have settled, but are to be kept under supervision for a 72 hour minimum period<sup>37</sup>. These changes are said to assist clinicians in handling pressure applied to them by prisoners wanting more freedom in circumstances where they are still regarded at potentially high risk of self harm<sup>38</sup>.

## **9. High risk assessment teams**

According to Dr Holmwood, other improvements have been instituted involving the High Risk Assessment Teams (HRAT) which comprise regular multi-disciplinary group meetings including Corrections Managers to discuss persons at risk<sup>39</sup>. Dr Holmwood stated that it is the responsibility of this HRAT to supervise the downgrading of supervision of prisoners. Dr Holmwood explained that after prisoners are taken off the daily yellow sheet assessment regime, the HRAT continues to discuss them and arranges further assessment if alerted to a problem by a member of the Team<sup>40</sup>. As well as medical and nursing staff, social workers, Aboriginal liaison officers and clinical psychologists sometimes attend these meetings. The minutes kept of these meetings should provide a valuable tool in monitoring the status of prisoners considered at potential risk<sup>41</sup>.

## **10. Sharing documented information**

- 10.1. I note that information recorded in the Justice Information System (JIS) by Corrections staff, prison psychologists and social workers is not accessible to nursing or medical staff<sup>42</sup>. Dr Holmwood stated that it would be useful for medical staff to be able to access entries concerning a prisoner’s behaviour, significant events and entries made by Corrections officers, psychologists and social workers. I encourage the Department to consider ways of authorising medical and nursing staff to access this

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<sup>37</sup> Transcript, page 635

<sup>38</sup> Transcript, page 635

<sup>39</sup> Transcript, page 642

<sup>40</sup> Transcript, page 651

<sup>41</sup> Exhibit C59

<sup>42</sup> Transcript, page 683

information. It would also be prudent for psychologists and social workers to have access to the medical notes when they have professional interaction with prisoners. I endorse observations made by Investigations Officer Terrence Nelson to the effect that regular and comprehensive entries into this system concerning incidents and behaviour of prisoners should be made by Correctional service officers. A summary of this information could then be reported to the HRAT for the benefit of their discussion and supervision of each prisoner. In Mr Nelson's view, the case note entries for Mr Turner during his period in the ARC were "very scant"<sup>43</sup>. I agree with this observation.

- 10.2. I was impressed with the pro-active stance taken by Dr Holmwood as well as his obvious commitment to improving systems to protect prisoners in the care of the prison health service. Through his efforts and some key Corrections Managers, including Steven Raggatt, General Manager of the ARC, there has been some significant improvements and better sharing of relevant information.
- 10.3. The evidence from some medical practitioners during the Inquest indicated a level of uncertainty about the applicable procedures in the ARC for high risk prisoners. It will be necessary to monitor the situation and do what is possible to keep visiting psychiatrists up to date concerning the current systems in place. To minimise system failures, it would be sensible to have consistent procedures in all corrections facilities where possible.

## **11. Daytime association programme**

Dr Karpinski made reference to the fact that the daytime association programme which was so useful in integrating inmates into the mainstream areas of the prison is no longer available. Mr Raggatt stated in evidence that he was unaware of the programme and did not realise that it had been stopped<sup>44</sup>. I was impressed with Dr Karpinski's evidence in which he described the benefits of the programme. I urge the Department for Correctional Services to examine ways in which it may be reintroduced as soon as possible if this has not already occurred.

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<sup>43</sup> Exhibit C57, Transcript, page 557

<sup>44</sup> Transcript, page 722

## 12. **Mental health first aid training**

Dr Holmwood indicated that funding was provided two years ago for the provision of mental health first aid training for Corrections officers, but that there was some resistance to its introduction, possibly due to some industrial concerns<sup>45</sup>. I understand that the issue may now have been resolved and that training will be available<sup>46</sup>. Given the large numbers of prisoners in custody who exhibit signs of mental illness, the argument in favour of improving the standard of care through education is compelling.

## 13. **“Special Needs” units**

13.1. Dr Holmwood indicated that since the new procedures were put in place, there has been a reduction in self-harming behaviour. But for certain people like Mr Turner and Mr Glennie, Dr Holmwood considered that there is no safe environment available in the prison system where they may be kept for a prolonged period in a humane manner. To illustrate the problem, Dr Holmwood described the incarceration of a prisoner charged with murder, held in ‘G’ division for the past two years and who has similar issues to those of Mr Turner and Mr Glennie. With the harsh isolation and deprivation in ‘G’ division, Dr Holmwood regarded the situation as “completely unsatisfactory”. Dr Holmwood advocated the creation of a small number of cells in each institution to humanely house prisoners who for example from their history one could predict were unlikely to settle down. He estimated that a dozen cells in the ARC and Yatala and a smaller number in other institutions would make an appreciable difference in the management of those persons requiring this type of management.

13.2. Apart from accommodating people with chronic psychiatric conditions, according to Dr Holmwood, this type of unit would be suitable for those with intellectual impairment and other people considered to be particularly vulnerable<sup>47</sup>. These “special needs” units would need to be serviced during the day by nursing and medical staff skilled in mental health as well as drug and alcohol management.

## 14. **Circumstances leading to the death of Troy Michael Glennie**

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<sup>45</sup> Transcript, page 661

<sup>46</sup> Inquest 23/2006

<sup>47</sup> Transcript, pages 348 and 663

- 14.1. On 17 August, 2004 Mr Glennie was arrested and charged with assaulting his de-facto partner. He was remanded in custody and admitted to the ARC. This was the first time Mr Glennie had been incarcerated. Mr Glennie scored 16 in his stress screening assessment by Nurse Mitchell. He revealed thoughts of committing suicide and was so distressed that he was admitted to the infirmary for observation. Mr Glennie was reviewed by Dr Karpinski the following day but he was so aggressive that the doctor was unable to assess him until later that day when Mr Glennie asked him to arrange for a psychiatrist to examine him. Mr Turner was prescribed oral Chlorpromazine as a sedative on an “as needs basis”. The evidence suggests that he had not been seen by a psychiatrist previously.
- 14.2. Mr Glennie was seen on 20 August 2004 by social worker, Karen Butler to discuss domestic arrangements regarding his property in the residence where he and his former partner were residing. At Ms Butler’s request, prison psychologist Rene Meeuwissen attended upon Mr Turner. Mr Glennie was noted to be “very labile and emotional and said he was afraid he was schizophrenic”. The note continues as follows:
- ‘I discussed this with him and made the connection between his drug abuse using marijuana, speed and ecstasy.’
- 14.3. Rene Meeuwissen also noted the following in the JIS database:
- ‘I had a long session with him in which he was totally self focussed and broke into tears often and until I ignored these. I feel that there is a process of adjustment now as he is withdrawing from drugs and there were examples of mental thought aberrations that suggest an inadequate personality and/or some schizophrenic thought disorder. I will see him again.’<sup>48</sup>
- 14.4. Later this day, psychiatric registrar Dr Kim Chiew examined Mr Glennie in the infirmary. The notes of the psychologist’s observations were not available to Dr Chiew, because medical and nursing staff are excluded from the (JIS) records used by social workers and psychologists. In my view, this fragmentation of relevant information is most undesirable. Dr Karpinski acknowledged that it would be helpful for medical staff to have access to this information<sup>49</sup>.
- 14.5. Dr Chiew had been working with the Forensic Mental Health Services since April 2000 and subsequently commenced specialist training in psychiatry. When he

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<sup>48</sup> Exhibit C46

<sup>49</sup> Transcript, page 383

examined Mr Glennie, he was employed as a medical officer at James Nash House providing care to the psychiatric inpatients. Part of his role involved a weekly clinic at the ARC. At the time of this inquest, Dr Chiew was part way through his training in psychiatry<sup>50</sup>.

- 14.6. Dr Chiew explained that Mr Glennie was distressed, crying and begging for help when he reviewed him. Mr Glennie denied any past history of major mental illness, but conceded that he was a user of amphetamines. Dr Chiew noted that Mr Glennie protested his innocence of the charge against him and spoke loudly with broad and expansive, “theatrical” movements. Dr Chiew conducted a comprehensive examination of Mr Glennie’s mental state, noting his observations in the prison health notes. Mr Glennie denied any past self-harm or current suicidal ideation or plans. After examining for depression, psychotic symptoms or signs of thought disorder, Dr Chiew was unable to find any major mental illness, but considered that Mr Glennie may have an “adjustment disorder”. He considered that his presentation may have been related to the effects of ceasing amphetamine consumption following his admission to the ARC. Dr Chiew also detected some possible signs of “narcissistic traits as part of a personality disorder or dysfunction”<sup>51</sup>. Dr Chiew suggested that no psychiatric medication was necessary and that if Mr Glennie continued to settle down, he could be discharged from the infirmary in the middle of the following week. He also suggested that psychological intervention maybe helpful<sup>52</sup>.
- 14.7. On 23 August 2004, Dr Karpinski reviewed Mr Glennie in the infirmary and recommended that he commence a gradual exposure to mainstream Unit 1 via the daytime association programme. He also requested that arrangements be made for a psychologist to review Mr Glennie. Dr Karpinski reviewed Mr Glennie again the following day and on 25 August 2004, Mr Glennie was transferred to Unit 1. A suicide risk assessment care plan was commenced by Dr Karpinski which required daily mental state assessments by nursing staff with entries being recorded on the yellow sheets<sup>53</sup>. Some entries reveal that Mr Glennie was concerned about losing contact with his two children. He conceded that he originally had thoughts of self

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<sup>50</sup> Transcript, page 139

<sup>51</sup> Exhibit C50, Transcript, page 150

<sup>52</sup> Exhibit C35i

<sup>53</sup> Exhibit C35

harm in the ARC, but stated the he did not have them when reviewed by nurses on 26 and 27 August 2004.

- 14.8. When Dr Chiew reviewed Mr Glennie on 27 August 2004, he considered that he was much improved and was calmer despite claiming that his mood was low. He denied having any plans or thoughts of self-harm. Again, Dr Chiew's assessment is comprehensively recorded in the prison health notes. Dr Chiew was unable to find any sign of major mental illness or major depression but he noted "anti-social traits". He suggested that the "yellow sheets" assessments could cease<sup>54</sup>. Dr Chiew offered further psychiatric review if necessary, and repeated his suggestion that psychological assessment be arranged.
- 14.9. On 1 September 2004, Mr Glennie was moved to Unit 4 in a double cell with another prisoner. He was seen by a social worker this day and on several days subsequently to discuss issues concerning the "child protection" status of his daughters. Mr Glennie was reportedly angry during some of these discussions as the following entry for 2 September 2004 in the JIS database indicates:
- 'Vented re the injustice of him being here, doubled up etc. Not willing to accept any responsibility for his situation.'<sup>55</sup>
- 14.10. Other entries in the JIS database indicate that Mr Glennie was having legal aid arranged for him and that he was having contact with his parents. An entry dated 7 September 2004 by Corrections Officer Leonard Rowell, noted that Mr Glennie was struggling to cope with his incarceration<sup>56</sup>. The following day, a psychologist is said to have made the same observation. Later that morning when Dr Karpinski assessed Mr Glennie in the infirmary, Mr Glennie asked for help<sup>57</sup>. He said he had been crying all morning. He seemed anxious and depressed, but declined an offer of medication or a transfer to the infirmary. When he mentioned that he "wanted a bullet", Dr Karpinski decided to place Mr Glennie under camera observation in Unit 7 and to be reviewed by a psychiatrist as soon as possible. Daily nursing assessment via the yellow sheet system was reinstated.
- 14.11. Ultimately, Mr Glennie was admitted to the infirmary once he realised that Unit 7 was a harsher option. By the following day, Mr Glennie reported to Dr Karpinski that he

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<sup>54</sup> Exhibit C35i

<sup>55</sup> Exhibit C46

<sup>56</sup> Exhibit C46

<sup>57</sup> Transcript, page 382

was no longer having thoughts of self-harm. He was reviewed by Dr Chiew on 10 September 2004. They discussed the progress of a bail application being made by Mr Glennie and on this occasion, Dr Chiew found him to be “very settled”, denying having thoughts of self harm. Dr Chiew confirmed his previous assessment that Mr Glennie had an adjustment disorder with poor coping skills. Dr Chiew recommended that Mr Glennie be discharged from the infirmary and that his daily nursing assessment via the yellow sheet system cease. He did warn that Mr Glennie may threaten self harm again if his bail outcome was unsuccessful<sup>58</sup>. Dr Chiew stated in evidence that he did not regard Mr Glennie at that time to be at high risk of self-harm or suicide. He was unable to identify any triggers such as events or incidents which activated his periodic distress and according to Dr Chiew, medication such as chlorpromazine or valium was unlikely to be useful<sup>59</sup>. Mr Glennie was transferred back to Unit 1, doubled up with another prisoner.

- 14.12. On 12 September, 2004 Mr Glennie’s cellmate reported to staff that Mr Glennie had been talking about harming himself. The actions of the cellmate in reporting this were entirely appropriate. Nurse West performed a mental state assessment in the infirmary at 12 noon at which time, Mr Glennie denied having any thoughts of self-harm and appeared otherwise unremarkable. Nurse West advised that Mr Glennie remain doubled up as a precaution. With the benefit of hindsight, this was probably an opportunity to have the daily nursing assessments reinstated, although there is no way of knowing whether it would have altered the outcome.
- 14.13. Prison psychologist Rene Meeuwissen reviewed Mr Glennie again on 14 September 2004 and noted that he was “coping well” and could see no reason to see him again<sup>60</sup>.
- 14.14. On about 15 September 2004, Mr Glennie was moved to Unit 3 into a cell with another prisoner. On 16 September 2004, Mr Glennie appeared in the Holden Hill Magistrates Court where a bail application was made. The application was refused pending psychiatric and psychological assessment. The final decision was adjourned to 30 September 2004<sup>61</sup>.

## **15. Assessment by Dr Craig Raeside**

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<sup>58</sup> Exhibit C50

<sup>59</sup> Transcript, page 169, 170

<sup>60</sup> Exhibit C46

<sup>61</sup> Exhibit C35d

15.1. Mr Glennie was assessed by Forensic psychiatrist Dr Craig Raeside on 21 September 2004 for the purposes of assessing Mr Glennie's suitability for bail. A psychiatric report was prepared in which Dr Raeside concluded that there was no evidence of any formal psychiatric disorder. Essentially his views were consistent with those of Dr Chiew. Dr Raeside was unsure whether Mr Glennie qualified as having an adjustment disorder, because he appeared to settle down in less than two weeks. Dr Raeside did not believe that any psychiatric treatment was required. He noted the emotional disturbance following Mr Glennie's incarceration as well as his expression of thoughts of self harm followed by periods of observation and medical review. Dr Raeside described the subsequent improvement as follows:

'In recent weeks Mr Glennie appears to have made significant improvement. He told me that his sleep was much better, appetite improved, energy good, and he had not had any difficulty with his concentration. He denied any suicidal thoughts or psychotic features.'<sup>62</sup>

15.2. In essence, Dr Raeside expressed the view that there was no psychiatric issue which might be relevant to determining his suitability for bail. He explained that when making his assessment of Mr Glennie, he had the benefit of the medical notes from the ARC. He explained in evidence that he would not recommend a person for bail if there was a reasonable risk that they would harm themselves<sup>63</sup>.

15.3. Social worker Karen Butler had further contact with Mr Glennie on 22 and 23 September 2004 to discuss Centrelink payments for his former partner. Nothing is noted about any emotional issues on either of these occasions. This is the last entry in the JIS for Mr Glennie before his death.

## **16. Assessment by forensic psychologist**

16.1. On the 23 September 2004, forensic psychologist Mark Holmes spent two hours assessing Mr Glennie to assist the Court to determine Mr Glennie's suitability for bail. In his lengthy report, Mr Holmes concluded that there was no clinical evidence to suggest that Mr Glennie suffered from a psychotic illness, major mood disorder or an intellectual disability. Nor did he consider that Mr Glennie had a "pervasive personality disorder". Mr Holmes did not have access to the medical notes in the infirmary, but did not consider that it was essential to his task. He dealt with the

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<sup>62</sup> Exhibit C55b

<sup>63</sup> Transcript, page 449

question of thoughts of self-harm which Mr Glennie described as occurring when he was first incarcerated. Whilst Mr Holmes saw no evidence of major depression, he noted that Mr Glennie was availing himself of assistance when needed to cope with his incarceration<sup>64</sup>. Mr Holmes considered that Mr Glennie appeared to be fairly “settled” when he assessed him<sup>65</sup>.

- 16.2. Whilst no formal assessment was made by a nurse or doctor over the next few days, Mr Glennie was being administered his sedative medication each day. I accept that the medication rounds would not be a suitable time to adequately check on the welfare of those persons receiving medication.

### **17. Events of 27 September 2004**

- 17.1. At about 7:20am on 27 September 2004, Timothy Whiston was removed from the cell he shared with Mr Glennie to attend Court. Mr Glennie was seen at that time apparently sleeping on the top bunk. According to Mr Whiston, Mr Glennie had been “constantly upset” and “really fed up” when he had been with him, but he stated that he had no idea that Mr Glennie was intending to kill himself<sup>66</sup>.
- 17.2. Officer Richard Brooks was assigned to Mr Glennie’s unit that morning. Mr Glennie was released for breakfast and cell inspection shortly after 8:00am. According to Mr Brooks, he was not approached by Mr Glennie with any concerns. After lunch at about 11:40am Mr Glennie was locked back in his cell alone. Officers then went to lunch, leaving Mr Glennie’s unit unattended apart from camera surveillance of the adjacent association area. Each cell was equipped with an intercom to call for assistance if needed during this “lock down” period. There is no evidence that Mr Glennie sought assistance during this period.
- 17.3. At about 1:00pm Mr Whiston was brought back to his cell and when he looked inside, he could see Mr Glennie suspended from the top bunk with a sheet around his neck.
- 17.4. Officer Brooks immediately called a “Code Black” for medical assistance and unlocked the cell door. Mr Glennie was motionless and there was no sign of life. Officer Brooks and his partner Gregory Paine lifted Mr Glennie to take pressure off his neck and tried unsuccessfully to undo the knot in the sheet. Neither officer had a

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<sup>64</sup> Exhibit C53

<sup>65</sup> Transcript, page 304

<sup>66</sup> Exhibit C41a

Hoffman knife in his possession. Eventually, with the assistance of another officer, the knot was untied and cardio-pulmonary resuscitation (CPR) was commenced<sup>67</sup>. When medical staff attended, they continued CPR, however their attempts proved unsuccessful and were abandoned at 1:30pm.

- 17.5. Mr Paine explained in evidence that the Hoffman knife was in an office when they needed to use it. A knife was assigned to only one officer in each unit and during lunch breaks, it was left with other equipment in an office until the person to whom it had been assigned, re-equipped himself or herself before coming back on duty<sup>68</sup>. Whilst it may not have altered the outcome in Mr Glennie's case, I find that the present allocation system for these knives is inadequate.

## **18. Post mortem examination**

- 18.1. A post mortem examination was conducted by Forensic Pathology Registrar, Dr Karen Riches under the supervision of Dr John Gilbert on 28 September 2004. In Dr Riches report, the cause of death was said to be neck compression due to hanging. There was no evidence detected which would indicate the involvement of another person<sup>69</sup>. I accept the views expressed by Dr Riches concerning the observations made and conclusions reached. I find that the neck compression which caused Mr Glennie's death was self inflicted.
- 18.2. Analysis of a sample of Mr Glennie's blood revealed a therapeutic concentration of Chlorpromazine<sup>70</sup>.
- 18.3. The fact that Mr Glennie chose to hang himself when his cellmate was absent, suggests that his death may have been avoided if he had remained doubled up continuously. The evidence indicates that his decision was probably an impulsive one, occurring in the absence of any obvious trigger. If Mr Glennie had been kept on the yellow sheet assessment regime, it is possible that a nurse may have detected some problem if it had become apparent the previous day. Whilst I regard this as a possibility, the evidence does not enable me to find that an assessment is likely to have altered the outcome.

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<sup>67</sup> Exhibit C44, Transcript, page 49

<sup>68</sup> Transcript, page 87

<sup>69</sup> Exhibit C22a

<sup>70</sup> Exhibit C23a

- 18.4. Records provided to the Court suggest that Mr Glennie was the subject of discussion by members of the HRAT on a few occasions including 20 September 2004 where his current risk status was noted as “double up and PSHN”. It appears that the “double up” instruction was not then interpreted as double up at all times. I notice from the extremely brief minutes, that the 20 September 2004 meeting discussed the status of 35 prisoners and was completed within 10 minutes<sup>71</sup>. If this is correct, I wonder how useful these meetings really are for exchanging information relevant to an individual’s risk of self harm.
- 18.5. The subsequent changes to the yellow sheet assessment system would have ensured that if Mr Whiston was removed to attend Court, and Mr Glennie was still subject to the yellow sheet assessments, action would be taken to ensure that Mr Glennie was not alone. Whilst this is a fairly crude management practice, it appears to be one of the few options available at present to minimise self harming behaviour in cells.
- 18.6. I find that Mr Glennie received a considerable amount of assessment by medical practitioners and nurses as well as social workers and psychologists. He was able to carry out his actions unseen and without warning, because he was left alone for several hours in an unsafe cell with multiple hanging points. According to Dr Raeside, the more common type of suicidal event within the prison population is an impulsive act associated with some “immediate crisis, particularly in a relationship setting”. Dr Raeside emphasised the difficulty in this type of situation was that a person can change quickly without warning, for example after receiving a phone call which upsets them<sup>72</sup>.

## **19. Phone calls and letters to Mr Glennie’s mother**

- 19.1. According to Gloria Glennie, she had several telephone conversations with her son when he was incarcerated, in which he was crying and begging for help. He was said to go on at length sometimes and seemed irrational<sup>73</sup>.
- 19.2. The Court was referred to a collection of letters provided by Ms Glennie following her son’s death. These letters were received from her son on a regular basis and some were sent with instructions that they were to remain unopened until after his release so

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<sup>71</sup> Exhibit C59

<sup>72</sup> Transcript, page 456

<sup>73</sup> Exhibit C24a

that he could be reminded of what it had been like in custody. Whilst some of these letters refer to suicide, they are ambiguous in the sense that Mr Glennie stated that he would not do such a thing.

- 19.3. When the contents of these letters were considered by Dr Chiew and Dr Raeside during the Inquest, they conceded that they may have assisted them to assess Mr Glennie's mental state, but because they were undated, it was difficult to put them into context<sup>74</sup>. There is also the vexed question of maintaining confidentiality of letters sent to friends and family members. On the evidence presented to the Inquest, I do not consider it necessary to recommend any changes to the practices currently in place concerning prisoners telephone calls and correspondence.
- 19.4. I accept that corrections and medical staff have revised and improved their targeted safety measures in an attempt to prevent deaths in custody. But there is only so much they can do, given the physical environment in which the prisoners are accommodated.

## **20. "Safe Cell" Principles**

- 20.1. The most obvious issue arising from the deaths of Mr Turner and Mr Glennie is the availability of potential hanging points in cells which has been identified as a problem in numerous Coronial Inquests in this State and elsewhere. As a result of recommendations in the Finding by Deputy Coroner Schapel concerning the death of Damien John Cook in the ARC on 6 March 2003, a report was tabled in Parliament by the Minister for Correctional Services. The Deputy Coroner referred to earlier Findings which recommended the adoption of "safe cell" principles and requested the Department to reconsider an earlier decision not to give the implementation of these principles priority throughout South Australian prisons<sup>75</sup>. The Minister's report, in response to the Deputy Coroner's recommendations was provided to the State Coroner with a covering letter dated 20 May 2006. The following passages illustrate the attitude of the Department and the Government as a whole to this issue:

'Safe cell design principles are incorporated in all new cell accommodation. The refurbishment of existing cell accommodation to safe cell standards is beyond the current resources of the Department.

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<sup>74</sup> Transcript, page 176 and page 453

<sup>75</sup> Inquest 18/2005

The financial priorities of the Government are related to issues of health, education and police. The cost associated with upgrading all prison cells so they are consistent with 'safe cell' principles would be in excess of \$40m. Expenditure of such proportions would reduce the ability of the Government to provide the wider community with better security, education and health related services.

The Government is satisfied that targeted and other initiatives that the Department for Correctional Services has adopted to reduce incidents of death in custody, are the best way to address this issue. The construction of 'safe cell' accommodation in all new cells is part of those initiatives.

It is unfortunately not possible to change all existing cells to include 'safe cell' principles.'

## **21. Recommendations**

- 21.1. In accordance with the provisions of Section 25(2) of the Coroner's Act 2003, the following recommendations are made in anticipation that they might prevent or reduce the likelihood of or recurrence of events, similar to the events, the subject of this Inquest.
- 21.2. That on the assumption that the Government has no intention in the foreseeable future of providing funding for the upgrade of prison cells to comply with "safe cell" principles, the Minister for Correctional Services seek funding to convert a portion of the existing facilities in such a way as to provide safe and humane "special needs" units in each custodial institution for the accommodation of those prisoners requiring this type of management.
- 21.3. That all Correctional Service officers who have contact with prisoners in South Australian prisons and the Adelaide Remand Centre be provided with a Hoffman knife and have it in their possession ready for immediate use whenever they are working with prisoners.

*Key Words:* Correctional Services; Death in custody; Hanging; Monitoring/Observation of prisoners; Prisons; Psychiatric/Mental illness; Record Keeping/Clinical Records; Suicide risk - assessment of.

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

*Seal the 18<sup>th</sup> day of October, 2006.*

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*Coroner*

Inquest Number 17/2006 (0397/04 & 2943/04)