



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 19th, 20th, 21st and 22nd days of March 2007, and the 26th day of April 2007, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the deaths of Penelope Rae Christopher and John Trenorden.

The said Court finds that Penelope Rae Christopher aged 51 years, late of the 20 Jetty Street, Grange died at 2/6 South Esplanade, Glenelg, South Australia on the 31st day of January 2004 as a result of combined effects of blunt force head injury and asphyxiation.

The said Court finds that John Trenorden aged 53 years, late of 2/6 South Esplanade, Glenelg died at Yatala Labour Prison, 1 Peter Brown Drive, Northfield, South Australia on the 4th day of February 2004 as a result of asphyxia.

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

1. Introduction and reason for Inquest

- 1.1. Penelope Rae Christopher died on 31 January 2004. As the circumstances of the discovery of her body were regarded by police as suspicious, Forensic Pathologist Dr Allan Cala was asked to attend the scene. According to Exhibit C3a, which is copy of a post mortem report prepared by Dr Cala following a post mortem examination of Ms Christopher's body, he was shown into a unit at 6 South Esplanade, Glenelg by police. There he saw the deceased body of a female, later

identified as Ms Christopher, lying naked on the floor in the lounge room of the unit, with a smeared blood trail from the kitchen to the body. Dr Cala observed blood spatter on a wall above the lounge suite. He observed a set of hand weights or dumbbells on the floor of the lounge room. In the kitchen he observed that there had been an attempt at a fire, with burnt paper and other material present. Dr Cala's examination of Ms Christopher's body at the scene showed several lacerations behind the right ear, with a poorly defined line of bruising on both cheeks passing into the mouth and around the back of the neck. Petechial haemorrhages were present on each lower eyelid. Dr Cala found defence type injuries to be present on each hand, particularly the right hand. He observed other marks around the right upper arm and outer part of the ankle region, consistent with having been caused by cable ties or similar. Dr Cala gave the cause of death as being combined effects of blunt force head injury and asphyxiation and I so find.

- 1.2. Mr John Trenorden was born on 26 June 1950 and accordingly was aged 53 years at the time of his death which occurred between the hours of 11:00pm on 3 February 2004 and 1:50am on 4 February 2004. He was then a prisoner on remand at Yatala Labour Prison having appeared in the Adelaide Magistrates Court on 2 February 2004 on charges of murder and arson. Accordingly, Mr Trenorden's death was a death in custody within the meaning of the Coroner's Act 2003, and this Inquest so far as it related to Mr Trenorden, was held pursuant to section 21(1)(a) of the Coroner's Act 2003. The Inquest also examined the cause and circumstances of Ms Christopher's death, and that aspect of the Inquest was held pursuant to section 21(1)(b)(i) of the Act.
- 1.3. A post mortem examination of Mr Trenorden's body was carried out by Professor Roger Byard, Forensic Pathologist on 4 February 2004. The cause of death was given as asphyxia and I so find. Professor Byard commented that Mr Trenorden's death from asphyxia resulted from the combined effects of neck compression from hanging and suffocation from a plastic bag over the head. Mr Trenorden had been found hanging from a ligature fashioned from torn sheets attached to the hand railing of the upper part of his double bunk. He had a plastic bag over his head. I note that Professor Byard was not contacted by investigating police to attend the scene of Mr Trenorden's death at the Yatala Labour Prison. This is a breach of the protocol developed by the State Coroner with the Commissioner of Police in accordance with

the recommendations of the Royal Commission into Aboriginal Deaths in Custody. Unfortunately breaches of the protocol are not uncommon. No explanation has been provided by any member of the Police Force as to the reason why Professor Byard was not invited to attend the scene.

2. **Relationship between Ms Christopher and Mr Trenorden**

- 2.1. It appears that Ms Christopher and Mr Trenorden had been involved in a business relationship since approximately March 2003. It further appears that the relationship developed into a personal relationship from about September 2003.
- 2.2. According to a statement of Mary Lindblom which was admitted as Exhibit C7ac in these proceedings, she had known Ms Christopher as a friend for about fifteen years. She stated that in May 2003 Ms Christopher showed her a full page advertisement in the Sunday Mail. The advertisement sought business partners for a network marketing company. The advertisement had a picture of a man and a woman and Ms Lindblom later discovered that the man was John Trenorden. Ms Lindblom said that she understood that Ms Christopher went for an interview in response to the advertisement.
- 2.3. According to a statement from Jane Northey which was admitted as Exhibit C7x in these proceedings, she was a very close friend of Ms Christopher and had known her since they were schoolgirls. She regarded herself as a very close friend of Ms Christopher and stated that they would speak at least once a week and see each other most weekends. She said that in May 2003 she became aware that Ms Christopher had become involved in a business relationship with John Trenorden. According to Ms Northey, she and Ms Christopher had many discussions about this venture. Ms Northey was sceptical about the wisdom of Ms Christopher's participation in the business venture, and conveyed this to Ms Christopher, but the latter showed no concern.
- 2.4. According to Ms Lindblom¹ the relationship between Mr Trenorden and Ms Christopher had developed into an intimate personal relationship some three months after she learnt of the business relationship between the two. Ms Lindblom stated that at some time in September 2003 Ms Christopher had told her that

¹ Exhibit C7ac

Mr Trenorden had made a proposition of marriage to Ms Christopher which she had accepted. She later told Ms Lindblom that she regretted having agreed to the marriage proposal. Ms Lindblom stated that in November 2003 she went to Ms Christopher's house and helped her write an email to send to Mr Trenorden to inform him that their relationship was over. The email stated that Ms Christopher never loved Mr Trenorden and should never have agreed to marry him. However, it expressed a wish that the two of them would remain as business associates.

- 2.5. Ms Lindblom said that she became aware that Mr Trenorden was persisting in his attempts to maintain an intimate relationship with Ms Christopher, but Ms Christopher assured her that she was aware of what was happening and was not going to resume the relationship.
- 2.6. Ms Lindblom states² that she and Ms Christopher visited Perth for ten days in January 2004 returning to Adelaide on 24 January 2004. After their return from Perth, both Ms Christopher and Ms Lindblom were contacted by Mr Trenorden enquiring about what had occurred on the trip to Perth. Ms Lindblom stated that Mr Trenorden sent a further email at about this time requesting that Ms Christopher do some modelling for him. Ms Christopher agreed to this proposal. According to other statements, a modelling session took place on the evening of Thursday, 29 January 2004. It occurred in Mr Trenorden's apartment at 6 South Esplanade, Glenelg and a number of other persons were present.
- 2.7. Ms Lindblom became aware that Mr Trenorden was attempting to get in touch with Ms Christopher on the following day because she had left some makeup and other clothing at his apartment after the modelling session the previous night. She had a discussion with Ms Christopher about the makeup and clothing and whether the latter should attend at Mr Trenorden's apartment to retrieve them. Both Ms Lindblom and Ms Christopher regarded the situation as a pretext that Mr Trenorden would use to be alone in his apartment with Ms Christopher. According to Ms Lindblom she asked Ms Christopher not to go alone to the apartment to collect her belongings. Ms Christopher replied that she would ask Mr Trenorden to leave them outside. Ms Lindblom did not think he would do that. Ms Christopher agreed with this and said that perhaps if she had a chance she would telephone to ensure that Mr Trenorden

² Exhibit C7ac

was not at home and then use her own key to his apartment to go in and collect her belongings. This conversation took place on Friday, 30 January 2004.

3. Events of Saturday, 31 January 2004

- 3.1. According to a statement of Gareth John Williams, Exhibit C7f, he resided in another apartment in the same complex as that occupied by Mr Trenorden. On Saturday, 31 January 2004 he left his apartment at approximately 11:30am to go to work. He came out of his apartment and saw Mr Trenorden sitting in the courtyard at the rear of the apartments toward the car parks. Mr Trenorden was sitting at a glass table in his courtyard and was alone. He had a champagne glass with what Mr Williams assumed to be champagne in it. Mr Williams stopped and asked Mr Trenorden how he was. Mr Trenorden responded and said that he was “just sitting here waiting for my lady friend”.
- 3.2. According to Mr Williams’ partner, Jodi Coulthard³ she also saw Mr Trenorden sitting at the back of the apartments at approximately 11:45am. He told her that he was waiting for a lady friend.
- 3.3. In a statement made by Ellice Christopher⁴, the daughter of Ms Christopher, she states that she was living with Ms Christopher at Grange on Saturday, 31 January 2004. At about 12:00pm that day Ms Christopher told her that she was going out for a while. Miss Christopher was still sleepy when her mother left and did not really hear what her mother said. However, at approximately 2:30pm she telephoned her mother on the latter’s mobile telephone to find out where she was but there was no answer.
- 3.4. Miss Christopher said that the telephone did not answer and there was no further contact from her mother although she attempted to contact her mother via the latter’s mobile telephone between about 2:30pm and 6:00pm to find out where she was.
- 3.5. According to Ms Northey⁵ she spoke to Ms Christopher between 9:00 and 9:30am on 31 January 2004. They discussed the fact that a house opposite her house was to be auctioned that day and arranged with Ms Christopher that the two of them would attend the auction and possibly have a cup of tea. Ms Christopher undertook to be at Ms Northey’s house at approximately 1:15pm that afternoon. They agreed that

³ Exhibit C7as

⁴ Exhibit C7b

⁵ Exhibit C7x

Ms Christopher would be able to park her vehicle in Ms Northey's driveway. According to Ms Northey, Ms Christopher did not attend and Ms Northey became worried. She was worried because if Ms Christopher was not able to make an appointment she would invariably contact Ms Northey to let her know. At approximately 5:00pm that day she decided to drive to Ms Christopher's home and on arrival, found that Ellice, Ms Christopher's daughter, was there by herself and was worried because she had not been able to contact her mother.

3.6. Returning to Ellice Christopher's account⁶, she stated that by approximately 6:00pm that day she still had not heard from her mother and so telephoned a number of her mother's friends to see if anyone knew where she was. At approximately 8:30pm that night she attended at the premises of Harvey Norman's on Marion Road to see if she could locate her mother's vehicle because she was aware that her mother had been intending to visit that business earlier in the day. However the vehicle was not in the car park there, nor in the Marion shopping centre at which she also attended. At this stage she started to wonder if her mother had gone to Mr Trenorden's apartment at Glenelg. She knew where Mr Trenorden lived because she had once been there with her mother. At this time Ellice Christopher was accompanied by her friend, Sokheng Chau. Just before 10:00pm that evening Ellice Christopher and Mr Chau arrived at Mr Trenorden's apartment at 2/6 South Esplanade, Glenelg. There Ellice Christopher saw her mother's white Mercedes sedan parked in the car park of the apartments. She pulled up next to her mother's car and rang her mother's mobile telephone. After several attempts the telephone was answered but there was no voice on the other end. Miss Christopher could hear what she described as "ruffling noises" and then she heard something loud as if an object had been dropped. After about twenty seconds she hung up.

3.7. Ellice Christopher and Mr Chau tried to open the door into Mr Trenorden's apartment and found that they could not turn the handle. They did not go inside but instead left the vicinity and called Ellice's brother Lee Ellis and told him that they had found Ms Christopher's vehicle. Miss Christopher also rang a number of other people and then attempted to ring Mr Trenorden's mobile telephone and the telephone for the apartment. There were no answers to either of those telephone calls. She then returned to the apartment with Mr Chau and tried the door again. This time the door

⁶ Exhibit C7b

was open. She could hear a smoke alarm going off inside the apartment as well. She received a telephone call from her brother Lee to tell her that he was on his way but at that point she stated that Mr Trenorden came out of the front door of the apartment. She stated that Mr Trenorden looked straight at her but did not acknowledge her. He was approximately four or five metres from her and the light was good. She could clearly recognise him. He came out of the doorway and turned and walked down the side of the house to the back. Shortly after this, Miss Christopher's brother Lee arrived. At this point several of the neighbours, including Mr Williams whose statement has already been referred to⁷, were present and they could all smell smoke.

- 3.8. Mr Williams then attempted to obtain access to Mr Trenorden's apartment by means of the front door. However this door was now locked. Another neighbour, Benjamin Osborne was also present and Mr Osborne gained entry to the apartment by means of a front window which was not locked. He climbed through the window and Mr Williams followed him. Everything was dark inside the apartment, and Mr Osborne tried the light switch but the lights did not work. They went further into the apartment. Mr Osborne then produced a flashlight. They opened a door and discovered a room full of smoke. They could see that it was the kitchen and although they could not see any flames there was a considerable amount of smoke. They crouched down low and saw a person lying on the floor. They realised that it was a naked woman lying on her back with her feet towards the door. They attempted to speak to the person. Not obtaining a response, they each grabbed one of her legs and attempted to pull her from the kitchen. They moved her into the corridor. At this point Lee Ellis, Ms Christopher's son, had entered the apartment and went to his mother. Mr Ellis attempted CPR but it is clear that by that stage Ms Christopher was already deceased.
- 3.9. Shortly after this the police and fire service were summoned and attended at the scene. By this stage it was approximately 11:00pm on the evening of 31 January 2004.
- 3.10. I find, having regard to the post mortem report of Dr Cala⁸ that Ms Christopher's injuries could not have been self-inflicted. I find that, having regard to the nature of certain bruising found upon her body by Dr Cala, it is unlikely that the injuries which

⁷ Exhibit C7f

⁸ Exhibit C3a

proved fatal occurred by accident. Having regard to the whole of the evidence, there is nothing to suggest that any person other than Mr Trenorden was present in the apartment at or about the time that Ms Christopher suffered the fatal injuries referred to in Dr Cala's post mortem report.

4. The arrest of Mr Trenorden in the early hours of Sunday, 1 February 2004

- 4.1. Mr Matthew Fischer is a driver employed by Caltex Australia. At approximately 4:15am on Sunday, 1 February 2004 he was driving a Mack prime mover registration WRR-081 north-west along Diagonal Road, Warradale at approximately 60 kilometres per hour⁹. He saw a person on the western footpath of Diagonal Road about 200 metres ahead of his vehicle standing on the side of the road. The person walked onto the roadway of Diagonal Road at a normal walking pace. He kept walking very slowly into the right-hand lane of travel, the lane in which Mr Fischer was driving. Mr Fischer covered the brakes with his foot. The pedestrian was at that point facing the truck and standing in the very centre of the right-hand lane. Mr Fischer began to apply the brakes to slow the truck down. By now Mr Fischer was able to make out that the person was male. He began to run "flat out" towards the truck. Mr Fischer thought he was lining up the very centre of the bonnet of the truck and really running hard. He applied the brakes as forcefully as possible and the truck began to skid. The skid went for about 50 metres and the truck was moving at about 10 to 15 kilometres per hour when the male pedestrian lunged at the truck turning side on and collided with the front of the truck on his left side. The force of the collision propelled the man into the air and threw him back about 3 to 4 metres in front of the truck. Mr Fischer stopped the truck and used his mobile telephone to call for help. He then saw the man get up, stagger around and then wander back to the left-hand side of the road.
- 4.2. According to a statement of Rebecca Baranowski¹⁰ she was driving south along Diagonal Road, Somerton Park at about the same time. She noticed the Caltex petrol tanker of Mr Fischer with smoke coming from the front wheels. The truck was facing north and was in the right-hand lane for traffic travelling north. She noticed a person rolling on the ground in front of the truck and realised that the person was a male. She saw the male get up and run off in a westerly direction. She had a short

⁹ Exhibit C31a

¹⁰ Exhibit C32a

conversation with the truck driver in which the truck driver stated, "That guy just tried to kill himself by jumping in front of the truck. Follow that guy. I'm ringing the police". Ms Baranowski followed the male, in her vehicle, west along Wilton Avenue. Ms Baranowski kept the person in her sight and eventually he sat down on a low brick fence on the corner of Wilton Avenue and Muriel Avenue. After a short time a police car arrived and Ms Baranowski pointed the person out to the police officers.

- 4.3. Constable Thomas Jepps is a police officer based at Sturt Police Centre, Bedford Park. According to his statement¹¹ he was on uniformed mobile patrol at about 4:20am on Sunday, 1 February 2004 and attended at the corner of Wilton Avenue and Muriel Avenue, Somerton Park. He spoke to Ms Baranowski who drew his attention to the male person who she had followed after the incident involving the Caltex truck. Constable Jepps stated that he subsequently identified this person as John Trenorden.
- 4.4. According to Exhibit C41a which is a statement made by Detective Brevet Sergeant Mark Kinsley of Sturt CIB, he attended at the scene shortly after the arrival of Constable Jepps. He had a conversation with Mr Trenorden which commenced at about 4:30am. The conversation was recorded on tape and is attached as Exhibit C41b. During that conversation Detective Kinsley informed Mr Trenorden that he would be arrested for the murder of Ms Christopher. According to the transcribed record of the tape of the conversation which ensued, Mr Trenorden requested a blanket and at question 22, Detective Kinsley asked him, "You cold are you?" to which Mr Trenorden responded, "Just tried to commit suicide so pretty shaken."
- 4.5. When the officers had transported Mr Trenorden to Sturt Police Complex he was provided an opportunity to contact a solicitor. He did so. He contacted Michael Woods, Solicitor. Following that contact he declined to answer further questions. He was afforded an opportunity to make contact with his brother, Robert Trenorden. The detectives informed him that they would be making an application to carry out a forensic procedure under the Criminal Law (Forensic Procedures) Act 1988. The detectives informed Mr Trenorden that it would be necessary for an independent person to be present during the procedure. Mr Trenorden therefore contacted his brother Robert for a second time and requested that he attend for the conduct of the forensic procedure.

¹¹ Exhibit C35a

- 4.6. Some time later the detectives contacted Magistrate Deland and informed her that they had Mr Trenorden with them. They informed her that he was suspected of having committed the offence of murder and was what Detective Kinsley described to Magistrate Deland as “possibly a protected person”. Very properly, Magistrate Deland asked what Detective Kinsley meant when he described Mr Trenorden as a protected person. Detective Kinsley responded that after the offence was alleged to have been committed Mr Trenorden had tried to step in front of a truck. It should be noted that Mr Trenorden and his brother were both present when that exchange took place. Magistrate Deland subsequently granted the application for the conduct of the forensic procedure, and arrangements were made for the attendance of Police Medical Officer, Dr Clohesy for that purpose.
- 4.7. Detective Ian Talbot was also present during the events which transpired at the Sturt Police Complex. Detective Talbot gave evidence at the Inquest and stated that he had compiled a video recording of certain of the events which took place during Mr Trenorden’s detention at Sturt Police Complex. Of particular assistance was that part of the video tape which recorded events at the charge counter when Mr Trenorden was formally charged. That footage was accompanied by a sound recording of the charging process. Detective Talbot stated that Mr Trenorden’s demeanour, as depicted on that footage, was no different from his demeanour throughout the rest of this dealings with the detectives while at Sturt Police Complex. The relevant footage was played to the Court and depicts Mr Trenorden speaking quite calmly. Mr Trenorden can be heard describing his medication for gout, namely Zyloprim. He can be heard describing injuries to both of his feet and explaining that they were caused by walking a long distance without shoes. He also stated that, “I was swiped by a truck...fell on bitumen”. Detective Talbot stated that he was not concerned about Mr Trenorden’s welfare having regard to the latter’s personal demeanour. Detective Talbot and Detective Kinsley were concerned by virtue of the information that Mr Trenorden had been hit by the truck and the circumstances in which that reportedly occurred.
- 4.8. Having read the transcription of the dealings between Mr Trenorden and the officers at Sturt Police Complex, it appears to me that Mr Trenorden remained calm and polite at all times. This supports Detective Talbot’s impression as related in his oral evidence.

- 4.9. Dr Clohesy gave evidence at the Inquest. He is a Member of the College of General Practitioners and is presently a Police Medical Officer. He also practises in the Correctional Services system. He described his understanding of his role as a Police Medical Officer. He stated that his role is to do forensic work, to obtain blood samples and so on. He stated that he received a telephone call on the morning of 1 February 2004 to attend at the Sturt Police Complex. He could not recall any discussion with detectives before entering the room in which Mr Trenorden was being detained. He could not recall being asked anything other than matters relating to the forensic procedure requests.
- 4.10. Dr Clohesy stated that he could not recall being asked do to a mental state examination upon Mr Trenorden. He stated that if he had been asked to do such an examination he would have advised the officers to send Mr Trenorden to the nearest hospital for that purpose. He stated that some time prior to 1 February 2004 he had been involved in a situation in which he had carried out a forensic test and then subsequently saw the prisoner concerned at Yatala Labour Prison in the course of his practice as a Correctional Services doctor. He was then contacted by the prisoner's lawyer who protested that it was inappropriate for Dr Clohesy to act both as a gatherer of forensic evidence on behalf of prosecuting authorities, and as a treating medical practitioner for the prisoner. The result of this was that Dr Clohesy had a very firm view about his role when he was dealing with Mr Trenorden and was clearly of the view that he was there to conduct a forensic procedure only, and not to examine Mr Trenorden in any way.
- 4.11. Dr Clohesy could not recall being told that Mr Trenorden was suicidal and stated that he would have pursued such a matter further had it been raised with him. He stated that he would have told the officers to take Mr Trenorden to a hospital had he been told that. Dr Clohesy stated that he was told by Mr Trenorden that the injuries which were present upon Mr Trenorden's body were the result of an incident involving a truck. Dr Clohesy stated in evidence that he was of the impression that the collision with the truck may have been as a result of Mr Trenorden attempting to evade capture and did not regard it as evidence of an attempt at suicide.
- 4.12. In that connection I note that Exhibit C41b, which is the transcript of events at the Sturt Police Complex, includes an exchange at question 603 immediately after Mr Trenorden told Dr Clohesy that his injuries occurred when he crossed the road in

front of a truck. Dr Clohesy state “hit by a truck”, and Mr Trenorden responded as follows:

‘I sort of it only gave me a glancing blow. I was trying to make it across the, I didn’t actually throw myself under the truck, I was actually trying to make it across the road with these damaged feet.’¹²

- 4.13. It is significant that at this stage of the interview Mr Trenorden has changed his position quite considerably from the initial exchange which occurred at the corner of Wilton and Muriel Avenues earlier that morning. It will be recalled that at that point he admitted to having just tried to commit suicide and being “shaken”. By the time Dr Clohesy was called to attend, some four hours later, Mr Trenorden was expressly denying that he attempted to harm himself and was characterising the event as an accident. It will be seen from what follows that Mr Trenorden continued to deny any intention of harming himself from that time onwards while in custody.
- 4.14. Dr Clohesy described Mr Trenorden as calm and cooperative throughout the procedure.

5. Prisoner Screening Form

- 5.1. When Mr Trenorden was formally charged at Sturt Police Complex, Detective Kinsley and the arrest sergeant, Sergeant Edwards, completed separate parts of a Police Department form PD331 entitled “Prisoner Screening Form”. The form appears as part of Exhibit C41c. It also appears in other exhibits with additional notations which will be referred to in due course. The Prisoner Screening Form contains an arresting member’s questionnaire and a sergeant’s questionnaire. The arresting member’s questionnaire records that Mr Trenorden had some injuries, did not appear to be under the influence of alcohol or drugs, did not show signs of alcohol or drug withdrawal, did not appear despondent, did not appear irrational or disturbed, and was not in possession of any medication. In answer to the question “Has the prisoner given any indication that he/she may be a person at risk?”, an affirmative answer is given and the following notation is provided by way of explanation:

‘Information person stepped in front of a truck’

- 5.2. The form as completed by Sergeant Edwards provides the following information. Mr Trenorden was recorded as taking Zylprim medication for gout but not being on

¹² Exhibit C41b, page 58

any prescribed drug substitute such as methadone. In answer to the whether he had any serious medical (including psychological or psychiatric) problems, a negative response was given. A negative response was given to the question whether he had recently suffered a head injury or had recently suffered loss of consciousness. To the question “Do you have any other injuries?”, the answer given was “Yes” and the details provided are as follows:

‘Abrasions both elbows & both feet (elbows) hit by vehicle & fell onto road. Feet by walking without shoes.’

5.3. A statement was taken from Sergeant Edwards and was admitted as Exhibit C37a in these proceedings. In his statement he states that he requested that the Police Medical Officer assess Mr Trenorden as to his mental state. Sergeant Edwards subsequently received a PD348 – Medical Examination of Prisoner Form which had been completed by Dr Clohesy. That form indicated that Mr Trenorden had abrasions on the soles of his feet and on both right and left elbows. Another section of the form which provided an opportunity for the doctor to nominate any other care that the prisoner would require while in custody was left blank.

5.4. The evidence at Inquest did not reveal to whom Sergeant Edwards imparted a request that Mr Trenorden’s mental state be assessed by the Police Medical Officer. It is clear that no such assessment was conducted by Dr Clohesy. In my opinion, no criticism need be made of any person in relation to this issue because, notwithstanding the fact that Sergeant Edwards was thereafter under the impression that Dr Clohesy was of the view that Mr Trenorden was not suicidal and required no medical treatment apart from normal prisoner monitoring while in custody, he nevertheless stated:

‘I considered that even though the Police Medical Officer did not believe Trenorden was at risk, he was a person who could potentially cause harm to himself whilst in custody. I considered it prudent that he be constantly monitored whilst in Police Custody.’¹³

He endorsed the Prisoner Property Book and Register as follows:

‘Suggest constant monitoring as walked in front of traffic and was knocked down.’¹⁴

5.5. At 3:00pm on 1 February 2004, Sergeant Edwards handed over to Sergeant Mitchell who was rostered for the afternoon shift. He advised Sergeant Mitchell of the

¹³ Exhibit C37a, page 5

¹⁴ Exhibit C37a, page 5

circumstances of Mr Trenorden and his recommendation that Mr Trenorden be constantly monitored.

- 5.6. Sergeant Mitchell provided a statement which was admitted in evidence as Exhibit C39a in these proceedings. He stated that he was on duty for the afternoon shift on 1 February 2004 as Station Sergeant at Sturt Police Station. He confirmed that Sergeant Edwards advised him of the circumstances of Mr Trenorden's arrest and that he was found jumping in front of motor vehicles just prior to his arrest and was regarded as a person at risk. Sergeant Mitchell introduced himself to Mr Trenorden at the commencement of the shift and advised him that he would be in Sergeant Mitchell's care for that shift. Mr Trenorden acknowledged this by saying words to the effect "thankyou". He was quiet, well spoken, polite and cooperative.
- 5.7. Sergeant Mitchell stated that he required that Mr Trenorden be placed on a "high risk" priority, meaning that he would be continued to be kept under constant surveillance whilst in custody, thus maintaining the regime that had been instigated by Sergeant Edwards on the previous shift. To this end, Sergeant Mitchell requested Senior Constable Fuller remain in the cell area and maintain observations on Mr Trenorden at all times. Sergeant Mitchell had no further dealings with Mr Trenorden until about 7:22pm when a Sturt Patrol attended the cells to convey Mr Trenorden to the City Watch House in Adelaide. Sergeant Mitchell stated that he had endorsed the PD331 – Prisoner Screening Form that Mr Trenorden did not display any intention of endangering himself whilst in custody. He also placed on the bottom of the form in large letters "At risk prisoner" or similar, which he highlighted with a yellow highlighter pen. A copy of the form with that endorsement appears as an annexure to Exhibit C39.
- 5.8. It is worthy of note that according to a statement made by Senior Constable Jonathan Fuller (admitted as Exhibit C43a in these proceedings), he was on duty at the Sturt Police Complex on the afternoon of Sunday, 1 February 2004. He was told that Mr Trenorden was a high risk prisoner and had some interaction with Mr Trenorden during the shift. At approximately 5:40pm Senior Constable Fuller spoke to Mr Trenorden to ask him if he wished to have a meal, and if so, what his preference was. A short discussion ensued in relation to Mr Trenorden's welfare, his foot, his impending transfer to the City Watch House, and what might occur the following day in the Adelaide Magistrates Court. Senior Countable Fuller states:

'Trenorden continued the conversation with me and whilst I did not record the conversation we had it was words to the effect of:

He said: "My solicitor told me not to say anything about what happened."

I said: "Yes that's what all solicitors would tell you."

He said: "It's hard when you love someone and this happens. It's the worst thing that I have ever done and all I can say is it is a crime of passion."

I said: "You know that you don't have to tell me this, in fact I think its best we don't talk about what happened."¹⁵

5.9. One can draw one's own conclusions from this conversation.

6. Mr Trenorden's move to the City Watch House in Adelaide

6.1. According to an affidavit of Constable Dupree which was admitted as Exhibit C45a in these proceedings, she was responsible for conveying Mr Trenorden from the Sturt Police Complex to the City Watch House. She states that she removed Mr Trenorden from the custody of the Sturt Cells at 7:22pm on Sunday, 1 February 2004, and that he was taken into custody by the City Watch House at 7:44pm that evening. She further states that at no stage during her contact with Mr Trenorden did he give any signs that he might attempt to harm himself.

6.2. Constable Andrew White was on duty at the City Watch House on the evening of 1 February 2004 as cell guard supervisor. He made a statement which was admitted as Exhibit C49a in these proceedings. On Mr Trenorden's admission to the City Watch House, Constable White read the PD331 – Prisoner Screening Form which accompanied Mr Trenorden from Sturt Police Complex. Constable White noted that Mr Trenorden required medication for gout and as a result a locum doctor was called. He also noted that highlighted in colour pen on the PD331 were the words "At risk prisoner". Constable White stated that as a result of the above information he considered Mr Trenorden to be a high risk prisoner and he directed that he be placed in cell 228, which is an observation cell with a clear plastic wall directly opposite the cell guard's office window.

6.3. Constable White states that at about 8:30pm that evening, Sergeant Ransom attended the cells for an inspection. Constable White informed him of the status of all prisoners and in particular Mr Trenorden. Sergeant Ransom conducted a cell check

¹⁵ Exhibit C43a, pages 5-6

during which he had a three to four minute conversation with Mr Trenorden in which Constable White was a participant. According to Constable White's statement:

'During this conversation Trenorden stated that he was aware that police considered him to be suicidal. Trenorden stated that during the night he had lost the plot, gone for a walk and became disorientated. Trenorden stated that while disorientated he fell over grazing his elbows. He stated that he was in no way suicidal.

As a result of this conversation we accepted what he was saying but at the same time considered him high risk. We continued the management program on Trenorden as he was considered high risk. At the change of shift we passed onto the nightshift staff all of the above information.'¹⁶

- 6.4. Sergeant Ransom's¹⁷ version of this conversation appears in Exhibit C44a. It is consistent with the account of Constable White. Sergeant Ransom states:

'He (Trenorden) further said that the police think he got these injuries by throwing himself in front of a truck.'¹⁸

- 6.5. The implication that I draw from this is that Inspector Ransom considered that Mr Trenorden was trying to convey the impression that police were incorrect in their assessment of his possible suicidality. This clearly is also the impression gained from the conversation by Constable White. It is apparent that, consistent with his apparent resolve formed quite soon after his arrest¹⁹, Mr Trenorden continued to dispel any suggestion that he had suicidal thoughts. He took every opportunity available to him to reinforce that impression, including the conversation I have just related involving Inspector Ransom and Constable White. It is to the credit of these officers that, notwithstanding Mr Trenorden's easygoing calm and confident manner and his assurances about his own wellbeing, they continued to treat him as a high risk prisoner. This demonstrates a commendable concern for prisoner safety.

- 6.6. I take this opportunity to commend all South Australia Police officers involved with Mr Trenorden. A high level of care for his welfare was demonstrated by all of the officers. The very thorough investigation carried out by police in relation to his death in custody reveals a very high standard of care on the part of all members of South Australia Police that were involved.

¹⁶ Exhibit C49a, pages 3-4

¹⁷ I note that Sergeant Ransom now holds the rank of Inspector

¹⁸ Exhibit C44a, page 2

¹⁹ As demonstrated by his conversation with Dr Clohesy at approximately 9:00am that morning.

6.7. A locum doctor was called to attend to Mr Trenorden in relation to his gout medication. That locum was a Dr Koffman. Dr Koffman gave evidence at the Inquest. He also provided a statement which was admitted as Exhibit C98 in these proceedings. Dr Koffman stated that his understanding of the consultation was that Mr Trenorden needed a prescription for gout medication. He stated that he was left alone with Mr Trenorden which he found unusual because usually a police officer remains in the room. He assumed that the police did not regard Mr Trenorden as a violent person. Dr Koffman was not told about Mr Trenorden being at risk of self-harm, nor was he told about the incident involving the truck or anything else apart from the requirement for gout medication. He briefly examined Mr Trenorden's lacerated feet. He discussed the matter of gout with Mr Trenorden and gave a prescription for Zyloprim medication. He asked Mr Trenorden if he was on any other medications which Mr Trenorden denied. Dr Koffman said that he was not asked to check Mr Trenorden's general medical state, nor did he do a mental state examination. However, Dr Koffman did state that Mr Trenorden did not appear depressed or agitated such that he would have felt the need to look into the issue of Mr Trenorden's mental health. The consultation took no more than ten minutes and there was nothing in the course of the consultation that caused Dr Koffman to think that Mr Trenorden was at any risk of self-harm.

7. **Mr Trenorden's admission to Yatala Labour Prison**

7.1. On Monday, 2 February 2004 Mr Trenorden appeared in the Adelaide Magistrates Court. He was then transported to Yatala Labour Prison. Mr Mark Gibbs gave evidence at the Inquest. He is a Senior Correctional Officer and was working in the admissions area at Yatala on 2 February 2004. According to a statement made by Mr Gibbs, which was admitted as Exhibit C99 in these proceedings, he was told that Mr Trenorden was coming to Yatala prior to Mr Trenorden's arrival. He was told that Mr Mann, the Acting General Manager of Yatala Labour Prison, had directed that upon his arrival Mr Trenorden was to be placed on constant observations either in the infirmary or in 'G' Division. At about 1500 hours that day Mr Gibbs received a telephone call to reinforce the need to ensure that such a regime would be applied for Mr Trenorden. Mr Gibbs was not told why Mr Trenorden was to be placed on constant observations.

- 7.2. Mr Gibbs interviewed Mr Trenorden that evening and completed the Department for Correctional Services Form entitled “Reception checklist”. He also completed the DCS form entitled “Prisoner Stress Screening” for Mr Trenorden. That form sets out 31 questions. It is a standard form used by the Department for Correctional Services. It is intended to enable an assessment to be formed about whether a prisoner is at risk of self-harm. The form is designed in a manner which enables a score to be made of positive answers to questions designed to elicit the presence or otherwise of risk factors in connection with the prisoner. The possible maximum score is 31 points. The theoretical minimum score would be 0. In the interview Mr Trenorden gave only one positive response, and that was in relation to the question “Is this your first time in prison”, to which Mr Trenorden responded “Yes”. He responded negatively to all other questions. The result was that, for a person who had not been imprisoned before, he obtained the minimum possible score. The higher the score, the greater the risk, and a prisoner is to be considered as being at risk if his score is greater than 8, or if particular questions are answered as “yes” or “maybe”, or if regardless of the score the interviewing officer feels that a further opinion is warranted. The particular questions to which a positive response will cause a prisoner to be categorised as “at risk” are questions about whether the prisoner has thought about committing suicide since being arrested or imprisoned, whether the prisoner feels like harming himself, and whether the prisoner feels that those close to him would be better off if the prisoner were “no longer around”. Mr Trenorden responded negatively to each of those three questions. Mr Gibbs stated that his position was that regardless of what risk score was determined for Mr Trenorden according to the prisoner screening form, Mr Trenorden was always going to be placed on constant observations. Mr Gibbs did not regard himself as having any discretion in this matter because of the direction which had been received from Mr Mann. Mr Gibbs stated that Mr Trenorden was very calm and cooperative and did not appear to be stressed or suicidal.
- 7.3. To summarise Mr Gibbs’ evidence thus far, he considered himself – quite correctly – to be under a direction that Mr Trenorden would be placed on constant observations, whatever might be the outcome of his screening assessment on admission at Yatala. Mr Gibbs had no idea why that direction had been made. Mr Trenorden had responded negatively to all of the questions on the formal prisoners screening form completed by Mr Gibbs which would have indicated that he might be a person at risk. Against this background, the obvious question is whether or not Mr Gibbs saw the

PD331 document which should have accompanied Mr Trenorden to Yatala Labour Prison. If he had seen it, he would surely have noticed the yellow asterisked endorsement placed there by Sergeant Mitchell: “At risk prisoner”.

- 7.4. Mr Gibbs gave evidence that he had no recollection of seeing the PD331 which should have accompanied Mr Trenorden. Mr Gibbs stated that the PD331 is attached to every warrant when the prisoner comes in²⁰. Mr Gibbs was shown a copy of the PD331 which bore the endorsement to which I have referred upon it. He had no recollection of having seen it before²¹.
- 7.5. Mr Gibbs was cross-examined as to whether he questioned in his own mind the direction from management that Mr Trenorden be placed under constant observations, given the latter’s answers to the questions appearing on the Yatala Labour Prison screening form. Mr Gibbs simply responded that he did not question the direction in any way and did not consider it his job to do so.
- 7.6. Mr Gibbs agreed that if he had seen the PD331 with the endorsement to which I have referred upon it, he would more than likely have placed a note upon the Prisoner Stress Screening form which he completed stating that Mr Trenorden was “at risk”. He would have inserted this, in all probability according to him, under the section upon the form entitled “Information from police/transporting staff – notes and concerns from interview”²². Mr Gibbs acknowledged that he had ticked off on a reception checklist that the warrant of remand in relation to Mr Trenorden was validated²³. On the strength of this he acknowledged that it was more than likely that he would have received the PD331 in relation to Mr Trenorden given that the PD331 is invariably attached to the warrant²⁴. Mr Gibbs acknowledged that it was more than likely that he did receive the PD331²⁵. Disturbingly, Mr Gibbs stated that as a general rule, he does not place a lot of “stock” on the information which is contained in the police screening form PD331²⁶.
- 7.7. It is quite clear that the crucial information contained on the PD331 did not find its way to those persons who had any further care or responsibility for Mr Trenorden in

²⁰ Transcript, page 135

²¹ Transcript, page 139

²² Transcript, page 153

²³ Transcript, page 163

²⁴ Transcript, page 164

²⁵ Transcript, page 165

²⁶ Transcript, page 167

Yatala Labour Prison thereafter. The PD331 did find its way onto the Department of Correctional Services Dossier in respect of Mr Trenorden which was admitted as Exhibit C55m in these proceedings. However that document was filed in an administrative area within the prison and was not available to operational staff. Unfortunately, the only staff member who was operationally involved in Mr Trenorden's case and who, on the balance of probabilities I find sighted the PD311, was Mr Gibbs. Mr Gibbs failed to transcribe or record the information that police had assessed Mr Trenorden as being at risk by reason of having stepped in front of a truck – information that was available from the PD331 – onto any documentation that accompanied Mr Trenorden into the operational area of Yatala Labour Prison. This was to prove crucial as will be seen when I review the evidence of Dr Dayman.

- 7.8. In any event, Mr Gibbs made it clear that he spoke with the on duty infirmary nurse, Mr Thomas Mitchell, to discuss whether the infirmary would be prepared to accept Mr Trenorden or whether he would have to go to 'G' Division. Mr Gibbs said that Mr Mitchell agreed to receive Mr Trenorden in the infirmary and accordingly he was escorted to the infirmary shortly thereafter²⁷.
- 7.9. Thomas Mitchell gave evidence at the Inquest. He is a registered nurse employed within the prison system. It was he who assessed Mr Trenorden as part of the admission process on 2 February 2004, after having been processed by Mr Gibbs. Mr Mitchell said that he assessed 23 prisoners that day including Mr Trenorden. He said there was a note on a whiteboard in the infirmary when he arrived. The note contained a direction that Mr Trenorden was to be placed in the infirmary on canvas and on constant observations when he arrived. Mr Mitchell said that the note would have been placed on the whiteboard by nursing staff on duty during the morning shift. He said there was nothing in the note to explain the reason for the direction. However, Mr Mitchell stated that the general consensus among the nursing staff was that Mr Trenorden was to be given this regime of treatment because he was what Mr Mitchell described as a "high profile prisoner". He defined this to mean a well known person or a person accused of a crime which has attracted public attention. He said that high profile does not mean the same thing as high risk.

²⁷ Transcript, page 134

7.10. Mr Mitchell also made a statement. This was admitted in evidence as Exhibit C100. In that statement he describes the documentation which he was required to complete as part of his duties in relation to Mr Trenorden. Part of the admission clinical record that he was required to complete included questions relating to self-harm. Mr Trenorden replied negatively to the questions had he ever attempted self-harm, had he ever attempted self-harm while incarcerated, and did he have any thoughts of self-harm now. He gave a response that he had no psychiatric history of past mental illness and the only factors and stressors which were ticked positively by Mr Mitchell were that it was the first time for Mr Trenorden in prison and that he may be fearful. Mr Mitchell noted that Mr Trenorden's feet had lacerations on the soles. He was given to understand by Mr Trenorden that Mr Trenorden had suffered these lacerations when walking on the road without shoes. As it was a particularly hot time of the year Mr Mitchell readily accepted this explanation. He also understood that Mr Trenorden had been walking in between cars, but he thought that this was in a car park. He had no notion that Mr Trenorden had been involved in an incident involving a truck. Mr Mitchell did not have access to the PD331 document for the reasons I have already explained.

8. Dr Dayman's assessment of Mr Trenorden

- 8.1. Dr Gregory Dayman is a medical officer working within the Prison Health Services. He provided a statement which was admitted in evidence as Exhibit C101 and he also gave oral evidence. According to his statement, Dr Dayman examined Mr Trenorden at about 1315 hours on 3 February 2004 in the Yatala infirmary.
- 8.2. Dr Dayman saw Mr Trenorden for the purposes of what to him was a standard medical admission. He stated that it is necessary for each prisoner to see the doctor for a medical examination which includes a number of things including drug and alcohol assessment, medication issues, current injuries, as well as risk assessment and considering the patient's mental state and perceived risk of self-harm.
- 8.3. In the course of the consultation, Dr Dayman told Mr Trenorden that he was in the infirmary on canvas as a precaution against self-harm. He stated that Mr Trenorden responded by saying that he was definitely not considering any self-harm and that he was positive about his case. According to Dr Dayman, Mr Trenorden also made a joke in this connection by saying that if he had been considering self-harm he would

have eaten the Watch House food. In short, Mr Trenorden reassured Dr Dayman that he had no plans to do any harm to himself²⁸. Dr Dayman also stated in evidence that he had thought that Mr Trenorden was on observations and on canvas because he was a “high profile prisoner”, an expression which Dr Dayman understood to mean a person of celebrity status or high status in the community such that there has been media interest expressed in the case²⁹. Dr Dayman explained that in his mind the expression “high profile prisoner” was not the same as the expression “high risk prisoner”³⁰.

- 8.4. Dr Dayman did not have access to the PD331 document for the reasons referred to already and he confirmed this in his evidence³¹. However Dr Dayman did have the nursing admission notes prepared by Mr Mitchell³². On examination Dr Dayman concluded that Mr Trenorden was oriented, that he was alert, that he was cooperative and was not suffering from or displaying any signs of dejection or agitation. Dr Dayman felt reassured about the emotional content of what Mr Trenorden was saying about plans for the future and his current position³³.
- 8.5. Dr Dayman stated that because he was aware that Mr Trenorden had been on observation he spoke to the staff who had been keeping observations about whether there was any behavioural disturbance or concern. He was told that there was no such disturbance³⁴.
- 8.6. Dr Dayman decided that Mr Trenorden could cease being subjected to the canvas regime and no longer required constant observations. Dr Dayman suggested that Mr Trenorden may wish to stay in the infirmary overnight to permit ‘E’ Division staff sufficient time to work out a suitable accommodation for him having regard to his “high profile”. Shortly after this Dr Dayman became aware that discussion with ‘E’ Division staff had taken place and that Mr Trenorden was going to be transferred to ‘E’ Division immediately. Dr Dayman had written on the notes “Remain in infirmary overnight”, and on hearing this further information he crossed that notation out

²⁸ Exhibit C101, page 2

²⁹ Transcript, page 195-196

³⁰ Transcript, page 197

³¹ Transcript, page 198

³² Transcript, page 197

³³ Transcript, page 202

³⁴ Transcript, page 203

because he was quite comfortable with Mr Trenorden being transferred to 'E' Division immediately.

- 8.7. Dr Dayman never became aware of the content of the PD331 document until shortly before he gave evidence. He stated that had he been aware of the content of that form, it would have made a difference to his assessment of Mr Trenorden³⁵. Dr Dayman stated that PD331s are now routinely seen by doctors but this was not the case in 2004³⁶.
- 8.8. Dr Dayman was questioned about the Department for Correctional Services prisoner screening form which in this case was filled out by Mr Gibbs. Dr Dayman confirmed that a copy of that document is available for the doctor to review on the prisoner's health file and casenotes³⁷. Dr Dayman pointed out that he was well aware of the provision on that form for information from police or transporting staff or concerns from interview to be endorsed so that medical staff might become aware of them. Dr Dayman stated that he would have had regard to any such information had it been contained on the prisoner screening form when he was conducting his assessment³⁸.
- 8.9. Dr Dayman was asked about his reasons for assuming that a prisoner who in his mind was a "high profile prisoner" would be on canvas with constant observations. Dr Dayman could provide no really convincing explanation for this. It seems to me that the only basis for drawing such a connection would be if high profile prisoners are somehow to be regarded as more likely to be at risk than prisoners who are not high profile prisoners. This proposition was put to Dr Dayman, and he did not appear to grasp it. If that were not the basis of his logic in assuming that Mr Trenorden was subject to the regime of canvas and constant observations, I am left wondering what it was about the concept of "high profile prisoner" that caused Dr Dayman not to be curious that Mr Trenorden, a prisoner whose presentation demonstrated on the face of it that he was not suicidal or in any other way at risk, would be subject to that regime.
- 8.10. Dr Kenneth O'Brien, Consultant Psychiatrist, provided an overview to the Court in this matter. That overview was provided in the form of a letter dated 25 September 2006 which was admitted as Exhibit C103 in these proceedings. Dr O'Brien also

³⁵ Transcript, page 205-206

³⁶ Transcript, page 206

³⁷ Transcript, page 218

³⁸ Transcript, page 218

gave evidence at the Inquest. In his overview, Exhibit C103, Dr O'Brien suggested that it would have been desirable for Dr Dayman to have been a little more curious as to how Mr Trenorden sustained his injuries and perhaps to have made enquiries about the circumstances leading to Mr Trenorden's incarceration. This proposition was accepted by Dr Dayman³⁹.

- 8.11. Before leaving the events at the infirmary, it is worthy of note that a prison officer by the name of Daniel Wright provided a statement which was admitted as Exhibit C82a. He knew Mr Trenorden and became aware on the morning of Tuesday, 3 February 2004 that Mr Trenorden was at Yatala on remand after being charged with murder and was in the infirmary on constant observations. Mr Wright spoke with the Acting Manager of the prison, Mr Mann, to seek his permission to visit Mr Trenorden which was granted. At 0832 hours Mr Wright entered the infirmary and spoke with Mr Trenorden. Mr Trenorden was teary eyed, distressed and remorseful and said "You know Dan, you know that I am not capable of committing such a crime normally, but I was under a lot of stress and I just snapped".

9. Events after Mr Trenorden's transfer to 'E' Division

- 9.1. As I have noted, Dr Dayman certified Mr Trenorden suitable for transfer to a regime such as that which was available in 'E' Division. He was shifted to 'E' Division shortly after.
- 9.2. Exhibit C550 is a transcription of a telephone conversation between Mr Trenorden and, I think, his brother at 1523 hours on 3 February 2004. This telephone conversation took place after Mr Trenorden's transfer to 'E' Division. In that conversation, Mr Trenorden is quite business-like. After some preliminaries, he says, "Yeah what I want to say to you is important". He then proceeds to give directions of a financial nature in relation to his affairs. He states that the automatic deductions from his bank account for his rent money should be stopped. He also states that all of his possessions in his unit should be retrieved by his brother. He states, "So everything that's there is yours right". At another point in the conversation he says, "Yeah fair enough and the other thing I want to say to you is whatever happens here don't try and fix up my business dealings or my bank accounts or whatever right, don't take that responsibility on". He also states that his brother and relatives should

³⁹ Transcript, page 210

not attempt to assume responsibility for his debts. He says, “As far as I’m concerned all that stuff just keeps piling up in the letterbox”.

- 9.3. That conversation took place at 1523 hours, and Mr Trenorden was dead some eight to ten hours later.
- 9.4. Prisoner Officer Adam Jarvis gave evidence at the Inquest and also provided a statement which was admitted as Exhibit C102. Mr Jarvis stated that he worked in ‘E’ Division in February 2004. On Tuesday, 3 February 2004 he started work at 10.40pm. He carried out a patrol of Unit 1 soon after commencing work and walked past Mr Trenorden’s cell, shone his torch through the window in the door, and noted everything to be normal with nothing out of the ordinary. He began his second round of prisoner checks at 12:50am and at about 12:55am he walked to Mr Trenorden’s cell door and shone his torch through the window. Mr Jarvis could see Mr Trenorden hanging from the top bunk by a bed sheet. He immediately notified the control room by telephone and then notified the infirmary officer by telephone also. This was standard procedure as he did not have keys to gain access into the cells – the master key is held in the control room. At about 12:57am the officer in charge, Mr McLeod, attended at the door of the cell with the keys. By this time the two nurses from the infirmary and the infirmary officer had also attended. Mr McLeod opened the door of the cell. Mr Jarvis could see that Mr Trenorden was hanging from the iron hand railing of the top bunk by a bed sheet. The sheet was tied in a knot to the railing and then tied around Mr Trenorden’s neck. Mr Trenorden also had a plastic bag over his head. Mr McLeod handed Mr Jarvis the “cut down knife” and Mr McLeod took the weight of Mr Trenorden’s body so that Mr Jarvis could cut the sheet. He cut through the bed sheet and then Mr Trenorden was laid on his back on the floor. The plastic bag was removed from Mr Trenorden’s head and the ligature around his neck was removed. The nurses then commenced cardiopulmonary resuscitation and used the defibrillator machine. The nurses could not obtain a pulse.
- 9.5. Mr Jarvis notes that there was black bruising around Mr Trenorden’s neck and that his skin was cool to touch. Mr Jarvis formed the view that Mr Trenorden had probably been dead for some time at that stage. Mr Jarvis was not aware that Mr Trenorden had been in the infirmary on canvas. He stated that he was not aware that any special treatment was required for Mr Trenorden. He stated that if Mr Trenorden had been considered “at risk” he would not have been sent to ‘E’ Division.

9.6. Mr Wayne Gale, Unit Manager at Yatala Labour Prison also provided a statement which was admitted in evidence as Exhibit C104. He gave oral evidence also. He was the 'E' Division Unit Manager as at 3 February 2004 and worked the shift hours of 7:00am until 4:30pm that day. Mr Gale stated in evidence that there was no mention on the records he had that Mr Trenorden was considered to be at risk. Mr Gale was not involved in the discovery of Mr Trenorden's body because he had left the prison earlier that day. When he received notification of Mr Trenorden's death he attended at the prison to inspect the scene. He stated that a group of people had assembled in the officer's station some time in the early hours of the morning of 4 February 2004. Mr Gale overheard part of a conversation in which Mr Bill Power of the Department for Correctional Services was speaking to Ms Eva Les of that Department. They were talking about how Mr Trenorden had previously tried to kill himself by running out in front of traffic. When Mr Gale heard that information, he approached Mr Power and said words to the effect, "Why wasn't I told? Why isn't this information available?" Mr Power responded quite simply in words to the effect, "Well you should have known". The conversation finished there.

10. **Mr Trenorden's suicide notes**

10.1. Mr Trenorden wrote a number of suicide notes. These notes were admitted in evidence as Exhibits C55c to C55g inclusive. One of the notes was directed "To the Yatala Prison Authorities and the Coroner". I quote it:

'I wish to state my 'death in custody' was in no way the responsibility of the management nor officers of this facility.

I have found only total professionalism, courtesy and kindness at Yatala.

I make special mention of the young doctor who released me from "suicide watch" to the general prison.

Please Please in no way place blame on him for his professional standards. He was very thorough in his assessment, but he was up against JT – a man with nearly 40 years in building P.R. images for others – to convince him I was not a suicide risk was not difficult. If the politicians want to stop the 'rot' in the prison system – place maximum funding – simple!! You have a great team here. As always, JT would like to add some humour – if you want to blame this suicide in custody – place it squarely on the red beef, white cabbage and gluggy white sauce for dinner!!'⁴⁰

⁴⁰ Exhibit C55c

- 10.2. Another of the notes was directed “To my friends and business associates”. As this is directed to a reasonably wide group of people, I consider that it is appropriate and helpful to quote it also:

‘I know the last week has been totally unbelievable to you – and me too. Saturday was a daze – born in love – a total – all consuming love and passion that eventually consumed all before me –

I would like to assure you that I am not a serial threat to anyone – until Saturday. I believe the warm, good natured, humorous (mostly) and passionate man you knew was me.

If you want some form of explanation (and I am still trying to formulate that for myself to total degree) I can tell you there is something in all of us that we don’t know about until pushed to the limit. (I was so pushed and the “something” became very real) after that peak there is of course only great remorse. Thank you all for being friends in all walks of my life (radio, P.R. Mitsubishi, Speedway and S.F.I – the list goes on!)

Goodbye – stay safe – and please simply remember “JT” as the somewhat larger than life character he was. (After that it is simply a tragic blank).’⁴¹

- 10.3. These notes reveal much about Mr Trenorden’s personality and his need for approval from others. In the following section of this finding I refer to the report of Dr Kenneth O’Brien. Some of the opinions which he expresses about Mr Trenorden’s unusual personality resonate even more clearly in light of the content of the material I have just quoted.

11. **Dr Kenneth O’Brien**

- 11.1. As I have already said Dr Kenneth O’Brien provided an expert overview for the Court’s consideration in this case by letter dated 25 September 2006 which was admitted as Exhibit C103. Dr O’Brien carried out an extensive review of all of the relevant documentation. Dr O’Brien very helpfully expressed in his report some insight into Mr Trenorden’s personality which was gleaned from the statements of various friends and associates. Dr O’Brien refers to a statement made by Jacqueline Cox, a former partner of Mr Trenorden. That statement was admitted in these proceedings as Exhibit C14a. Dr O’Brien notes that Ms Cox stated that Mr Trenorden “really lacked confidence and got his confidence from drinking”. She also referred to his tendency to brag, coupled with his need to impress people. Dr O’Brien also referred to a statement provided by Mr Trenorden’s former wife Caroline Lever which was admitted as Exhibit C15a in these proceedings. Dr O’Brien noted that Ms Lever

⁴¹ Exhibit C55e

stated that Mr Trenorden “displayed bizarre behaviour right from the start. His drinking problem was an issue between us”. She described Mr Trenorden as “very needy. He needed me to tell him how great and successful he was”. Dr O’Brien regarded it as particularly significant that Ms Lever stated, “I am not surprised that JT committed suicide. With all these stories about his life that were bound to come out about his past, he wouldn’t have been able to face anybody and did it to save face”. Dr O’Brien also notes that management at Mitsubishi where Mr Trenorden worked for a number of years had become increasingly concerned about his drinking habits and work performance. As a result of those concerns Mr Trenorden was asked to leave Mitsubishi as an employee which he did on 26 April 1996.

11.2. Dr O’Brien notes that in the early part of 1996 Mr Trenorden was a patient at Kahlyn Private Hospital where he was treated for alcohol dependency. While he was there he was seen by Dr George Rawson, Psychiatrist. Dr Rawson wrote “alcohol dependency syndrome was confirmed. No psychiatry co-morbidity from the point of view of a depressive illness or psychosis, no current acute psycho social crisis and no severe psycho severe organic syndrome associated with alcohol abuse was confirmed”.

11.3. Dr O’Brien concluded as follows:

‘In summary, therefore, there is convincing evidence that Mr Trenorden was alcohol dependent and that this dependency was quite severe. Additionally, he had a Social Anxiety Disorder, significant lack of confidence and, furthermore at least in part, his drinking pattern appears to have been an attempt on his part to compensate for his social anxiety and lack of confidence. His mental health history also suggests that he may have suffered from a personality disorder with, in my view, evidence of narcissistic and dependent traits. Of interest, violence does not appear to have been a feature in his life. To people, other than those in close proximity to him and particularly to relatives of his several partners, he could be good company, extremely charming, and well-liked. However, judging by his relationship history, it would appear that he had difficulty in maintaining a stable relationship. He also appears to have had a need to move from one relationship to another, particularly when his current relationship was faltering and/or was about to end.’⁴²

11.4. Dr O’Brien considered Mr Trenorden’s treatment in Yatala Labour Prison, and particularly the consultation with Dr Dayman. Dr O’Brien commented that quite clearly, Dr Dayman was significantly disadvantaged by the absence of the Prisoner Screening Form PD331 prepared by South Australia Police officers. Dr O’Brien

⁴² Exhibit C103, page 3

observed that the information contained in the PD331, if taken in conjunction with the instruction that had been given by Mr Mann that Mr Trenorden be placed on constant observation (with canvas bedding) might have prompted Dr Dayman to intensify his questioning. Dr O'Brien noted that had Dr Dayman been concerned about Mr Trenorden's mental health, an option would have been to keep Mr Trenorden in the infirmary and to ask Dr Jennings to see him the following morning. Dr Jennings is a psychiatrist who attends regularly for clinics at Yatala Labour Prison on Wednesday mornings.

11.5. Dr O'Brien remarks:

'It is clear to me from reading the extensive documentation that Mr Trenorden used all his personal and professional skills to present quite a misleading image of his self-risk both to custodial and health staff (including Dr Dayman). This he acknowledges in his suicide letter (2/2/04).'⁴³

11.6. Dr O'Brien expresses the opinion that Mr Trenorden was a vulnerable and emotionally fragile man who was alcohol dependent. He had significant problems with self-image which he dealt with by the abuse of alcohol. At least part of his professional reputation was based on misleading information. Dr O'Brien describes Mr Trenorden's efforts to convince others such as Dr Dayman that he was not at risk as a "deception" which Mr Trenorden conducted "with skill and self-aplomb". Dr O'Brien stated that "from the time of his arrest, Mr Trenorden deliberately presented himself in a favourable light (and ultimately succeeded)".

11.7. Dr O'Brien concluded that taking all the circumstances into consideration he did not believe that it was unreasonable for Dr Dayman to act as he did, given the absence of vital information about Mr Trenorden's mental state. Dr O'Brien noted that in the day to day busy and demanding environment of a prison infirmary it is not always possible or practicable to conduct further investigations.

11.8. Dr O'Brien did comment that in his opinion an earlier assessment of Mr Trenorden's mental health prior to his arrival at Yatala should have occurred. With respect, I consider that the relevant South Australia Police officers acted quite appropriately in relation to Mr Trenorden. They had every right to assume that their efforts to protect Mr Trenorden while in their custody, which were documented, would become known to subsequent custodians of Mr Trenorden. Indeed, they were available because the

⁴³ Exhibit C103, page 6

prison dossier in respect of Mr Trenorden reveals as much. The plain fact is that the PD331 did not get noticed and read by the appropriate and necessary people. Counsel for the Department for Correctional Services explained that new processes have been put in place which ensure that the PD331 will be made available to infirmary staff. This should prevent a repetition of the circumstances of Mr Trenorden's case in future.

12. Conclusion

- 12.1. In my view the treatment of Mr Trenorden by the various South Australia Police officers with whom he had dealings was commendable. I have no criticism of any aspect of the custody afforded him by South Australia Police officers.
- 12.2. The major issue in this Inquest was the question of what happened to the PD331 at Yatala Labour Prison. Department for Correctional Services management had made some reasonable efforts to earmark Mr Trenorden as a person at risk⁴⁴. A direction was made to keep him under constant observations and on canvas and this was complied with. Mr Gibbs could not recall if he had seen the PD331 but agreed that in most cases it would be attached to the warrant of remand and a prisoner would not be received without a warrant of remand to establish lawful custody. There is no warrant of remand on the Correctional Services file in this case, but there is a copy of the PD331 and it contains the endorsement made by Sergeant Mitchell. Furthermore, other records made by Mr Gibbs record that the warrant was duly received. The implication is that the warrant and the PD331 were in fact received. I have found on the balance of probabilities that Mr Gibbs did receive the document. He was required to endorse the admission documents to reflect the information in the PD331. He should have put an endorsement on the comments from police and conveying authorities box containing the information from the PD331. He should have ticked the potential suicide box. Had he done so, the material would have been seen by Dr Dayman.
- 12.3. Having regard to all the evidence, it is clear that Mr Trenorden was bent on taking his own life from an early point after the events of Saturday, 31 January 2004. He was also astute to deceive all those in whose custody he was placed about his suicidal intentions. The plain fact is that while he was under close observation in police

⁴⁴ See Exhibits C64, C65, C66 and C70

custody, and in the infirmary at Yatala Labour Prison, he was unable to carry out his suicidal intent. However, within less than twelve hours of being in the mainstream prison environment of 'E' Division, he succeeded in taking his own life by tearing bed sheets and attaching them to the upper railing of his double bunk bed.

13. Other observations and recommendation

- 13.1. Counsel for the Department of Correctional Services tendered a letter from Alan Martin, Director, Finance and Asset Services, of the Department, which was prepared for the purposes of submission to the court⁴⁵. The letter states: "I have been asked to assist your inquest into the above matter with information concerning the steps taken by the Department for Correctional Services to improve the safety of prison cells." The letter attaches a list of projects the Department has undertaken since May 2003 to reduce ligature points in the South Australian prison system. The total expenditure as revealed in that list is \$1,056,030. The list covers projects undertaken since May 2003. I assume that the list is current as at the date of the letter, namely 21 March 2007. Thus the total period covered is just short of four years. On that footing, the total expenditure averaged on a yearly basis, is approximately \$250,000 per annum across the entire South Australian prison system.
- 13.2. One of the projects referred to in the list was the refurbishment of cell 20, unit 4 at the Adelaide Remand Centre. That was the cell in which Damien John Cook hanged himself on 3 March 2003. One of Deputy State Coroner Schapel's recommendations following the inquest into Mr Cook's death was that "the Department forthwith remove or modify the hanging points in cell 20, unit 4 identified in this Inquest so as to eliminate or minimise, to the greatest extent possible, the risk that they will be used by an inmate for the purpose of self harm or suicide". Mr Cook used a shower rose in cell 20 as a hanging point.
- 13.3. According to a report of the Department dated April 2006 and tabled in the Parliament as required by the Coroner's Act 2003 in response to Deputy State Coroner Schapel's recommendations:

'Removal of the hanging points in cell 20 unit 4, identified in the Inquest requires the removal of the pre-formed fibreglass shower enclosure, modification of plumbing work,

⁴⁵ The letter was admitted as Exhibit C106

tap ware and fittings, and replacement of the air-vent above the shower with a suitable alternative that maintains air exchange rates in the cell.

This work is being planned in conjunction with a complete refurbishment of cell 20. The aim is to remove all other obvious ligature points in the cell. The estimated cost of this work is \$48,000. This work is scheduled for completion by 30 June 2006.'

According to the list, the refurbishment of cell 20 was completed in October 2006 at a cost of \$52,200.

- 13.4. A further recommendation of Deputy State Coroner Schapel was that the South Australian Government reconsider an earlier decision not to accord priority to "safe cell" design principles in South Australian prisons. The Department's response was as follows:

'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.'

Of course, it is for the Government to decide its financial priorities. According to the Annual Reports of the Department for Correctional Services for the four years ending 30 June 2003, 30 June 2004, 30 June 2005 and 30 June 2006, the respective appropriations from Government to the Department for those years was \$110,595,000, \$120,321,000, \$131,064,000 and \$136,528,000. Thus, the average expenditure on projects for removal of ligatures as set out in the list provided by Mr Martin, amounts to a very small proportion of the Department's revenue from Government during those years – less than one quarter of one percent.

- 13.5. Mr Trenorden's suicide demonstrates how simple it is for a person to take his own life in the general environment at Yatala Labour Prison. Previous inquest findings have remarked upon this and I refer in particular to the finding of Deputy State Coroner Schapel in the matter of Damian John Cook. I respectfully agree with the Deputy State Coroner's remarks about hanging points in that finding, and I adopt them. I do not repeat the recommendations made by the Deputy State Coroner in that case. They have already been considered by Government and the response is referred to above.

Unfortunately, the fact of the matter is that it remains a relatively simple task for a person to take his life by hanging within the prison environment in South Australia today. Indeed, I would go so far as to predict that, while the prisons of South Australia continue to be kept in their current state, it is inevitable that there will be further deaths in custody. It must be recognised that this prediction is made in a context where it is a matter of common knowledge that the prison population is at a very high level, and that the capacity of the prison system is nearing its upper limits.

- 13.6. The letter from Mr Martin⁴⁶, also refers to a prototype bunk bed designed to eliminate obvious ligature points which was manufactured in the Department's prison industries workshop at Yatala Labour prison and completed for evaluation in April 2006. Several design alterations were identified. There was an engineer's assessment of the load bearing capacity. It was resolved that detailed engineering drawings would be required in order to seek quotes or call tenders for large volume manufacture of the beds. In November 2006 a design consultant was engaged. Final versions of the drawing were received by the Department in February 2007. The Department is now seeking quotes from manufacturers and the Department's prison industries workshop. The ability of the Department to replace existing bunk beds throughout the prison system with the new design beds will depend on "the estimated cost and the availability of funds".
- 13.7. I have seen these beds, built and designed (I understand) by prisoners at Yatala's prison industries workshop, when I visited Yatala Prison in 2006 on a routine inspection. I was very impressed with the initiative. This project seems to me to be very worthwhile. It is a pity that it is mired in the bureaucratic processes described above. I fully recognise and endorse the need to ensure that any new design is safe and can adequately bear the required loads. But it seems to me that this could be done much more speedily. It would be a pity if the beds could not be made by prisoners themselves.
- 13.8. There may be some virtue in exploring the possibility of issuing only non-tearable blankets and sheets within the prison system. I recommend, pursuant to section 25 of the Coroner's Act 2003, that the Minister for Correctional Services and the Chief Executive of the Department for Correctional Services give consideration to the issue of non-tearable blankets and sheets within South Australian prisons.

⁴⁶ Exhibit C106

13.9. Finally, at the close of submissions in this matter, I requested that the Crown Solicitor make certain further inquiries with a view to better informing me as to the Justice Information System (“JIS”), the Police Incident Management System (“PIMS”) and the extent to which those systems interact. At the time of writing this finding it has been more than four weeks since I made that request. I am disappointed that it has not been complied with in a timely manner. I have decided to hand down my finding despite the fact that this information has not been supplied, in order not to prolong this matter any more than necessary.

Key Words: Death in custody; Hanging; Screening procedures; Suicide risk - assessment of.

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

Seal the 26th day of April, 2007.

State Coroner