CORONERS COURT

NEW SOUTH WALES

Note: Non-publication orders have been made in relation to photographs taken at the scene after the deaths.

Inquest:	**Inquests into the deaths of Nicholas Karayiannis & Tien Tran**
Hearing dates:	12 & 13 October 2015
Date of findings:	13 October 2015
Place of findings:	State Coroner's Court, Glebe
Findings of:	Deputy State Coroner HCB Dillon
Catchwords:	**CORONERS – Cause and manner of death –** Deaths in custody **–** Homicide/ suicide of cellmates – Whether mental health assessment reasonable – Whether prisoners safe at night – Whether remand prisoners sufficiently informed of self-harm protocols – Whether "culture of silence" among prisoners jeopardising prisoner safety – Whether "knock-up" alarm system sufficient protection for prisoners

File numbers:	2013/00098426 & 2013/00098427
Representation:	Sgt E Mulligan (Advocate Assisting) Mr P Murphy, Peter Murphy Criminal Law (Karayiannis family) Ms A Bonner instructed by Ms J de Castro Lopo, Office of General Counsel, Department of Justice (Corrective Services) Mr P Rooney instructed by Mr L Sara (Justice & Forensic Mental Health Network) Ms K Doust, Nurses and Midwives Association
Findings:	I find that Nick Karayiannis died on the night of 31 March – 1 April 2013 in cell 353 of Pod 11 in G Block, Metropolitan Reception and Remand Centre, Silverwater, New South Wales due to ligature strangulation inflicted on him by his cellmate Tien Tran while in the custody of the Department of Corrective Services. I find that Tien Tran died on the night of 31 March – 1 April 2013 in cell 353 of Pod 11 in G Block, Metropolitan Reception and Remand Centre, Silverwater, New South Wales by hanging with the intention of taking his own life while in the custody of the Department of Corrective Services. Note: Pursuant to s75(5) I direct that reports of the proceedings and findings may be published as being in the public interest.

Recommendations:	To the ***Minister for Justice*** I make the following recommendations: That the Department of Justice (Corrective Services) investigate and implement a system for ensuring the greater safety during B Watch of inmates being held in the Metropolitan Reception and Remand Centre, Silverwater by improving the capacity of correctional staff to monitor unsafe activity within the pods during that watch. That the Department of Justice (Corrective Services) give a Male Inmates Handbook to all male inmates received at the Metropolitan Reception and Remand Centre, Silverwater and that it implement a system of recording that each inmate has received the handbook. That the Department of Justice (Corrective Services) implement a system of recording entries to and exits from pods by correctional staff during B Watch.

IN THE CORONERS COURT
GLEBE
SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

Introduction

1. This is a joint inquest into the deaths of Nick Karayiannis and Tien Tran, both of whom were on remand at the Metropolitan Reception and Remand Centre at Silverwater at the time of their deaths. When a person dies in custody in NSW the Coroners Act requires that an inquest be held into the cause and circumstances of that death.

2. On 1 April 2013, both Mr Karayiannis and Mr Tran were found dead in the cell they had shared. The police investigation that followed found evidence that Mr Karayiannis had been killed by Mr Tran who then took his own life.

The coroner's functions and the nature of the inquest

3. An inquest is an independent judicial inquiry by a coroner. When a person to whom the state owes a particular duty of care dies in the custody of the state, questions can and should be asked. Loss of liberty is the greatest punishment that our society can impose on a member of this community or visitors to it. Courts are only permitted to deprive a person of their liberty if they are proven to have committed serious criminal offences or if they are suspected of having committed serious offences and the safety and welfare of the community is reasonably considered to be in jeopardy if they remain free.

4. The corollary of this extraordinary state power to detain people in custody is the responsibility to care for and protect prisoners. If, for whatever reasons, the system intended to protect prisoners fails to do so, s 23 of the Coroners Act 2009 requires that an inquest be held.

5. At an inquest, a coroner is obliged to make findings, if possible, as to the identity of the person who has died, the date and place of death, the cause of death and the manner or circumstances of death. In this case, it is the manner and circumstances of these deaths that raise the difficult questions. If it appears necessary or desirable to do so, a coroner may also make recommendations to relevant persons or organisations.

The background

Tien Tran

6. Tien Tran had been arrested by Australian Federal Police on 1 March 2013 and charged with attempting to possess a commercial quantity of imported drugs. He was received

at the MRRC on 5 March and was assessed by a mental health nurse on 10 March 2013 as being fit for normal cell placement.

7. Tien Tran had previous periods of incarceration dating back to August 1999. The assessment of Mr Tran on intake in 1999 was that he was suicidal and unwell as a result of withdrawal from a heroin addiction. During a subsequent period of incarceration it was noted on 21 September 2000 that ripped sheets were located in a cell hosing Mr Tran. It appears Mr Tran was appropriately managed by Corrective Services and Justice Health post these events.

8. Other than these notations, there is no other mental health history for Mr Tran during further periods of custody in 2000 and 2007 until 2011. Mr Tran received medical treatment for heroin use and Hepatitis C as well as other minor medical matters during these times. Corrective Services Case Management files covering all Mr Tran's periods in custody do not indicate a history of violence or any incidents of violence toward other inmates.

9. Shortly before the fatal incident, however, Mr Tran received bad news. His mother had died and he also had learned that another member of his immediate family, his sister in Vietnam, had died. It appears that these events may have been the trigger for his decision to take his own life. What he does not appear to have reckoned on was Mr Karayiannis thwarting his original attempt. How that happened we do not know but clearly it played on Mr Tran's mind because there was no previous indication of bad blood between the two men.

Nick Karayiannis

10. Mr Karayiannis was 42 at the time of his death. Many members of his family attended the inquest. He was obviously much loved by his family. He had two daughters, Maria and Nicoletta, and a son Michael, all of whom lived with him after he and their mother separated. Maria described him as "a very strong and confident man" who was healthy, socially active and "a good provider" with a passion for jet-skiing. He was in business selling boats and had previously been in cementing and had driven trucks.

11. He was arrested on 7 March by NSW Police and charged with manufacturing a commercial quantity of a prohibited drug. This was his first time in custody. He was also screened and found not to have any significant mental health conditions. Justice Health records indicate Mr Karayiannis did not present with any history of or current symptoms of ill health. He denied any mental health issues or drug misuse.

Tran's previous suicide attempts

12. The police investigation found that Mr Karayiannis had intervened in a previous suicide attempt (or perhaps two attempts) by Mr Tran. Mr Karayiannis spoke of this to his daughters Maria and Nicoletta, fellow inmate Melih Basturk, his lawyer and a friend Bellal El Saadi. The ripped sheets found in 2000 indicate that Mr Tran had probably made serious plans to take his own life at that time.

13. Mr Karayiannis told his lawyer Mr Van Houten that he intended to notify the pod manager of Mr Tran's attempt. He also told others that he had notified a correctional officer. Corrective Services has a very clear and strong protocol that is intended to deal with all indications of possible self-harm. Officers are required to treat such notifications as emergencies. It is possible that an officer was given some information by Mr Karayiannis but 'laughed it off'. If so, that would be a clear breach of the policy.

14. But whether Mr Karayiannis in fact told a correctional officer we do not really know. If Mr Karayiannis did say something to an officer, we do not know exactly what was said or how what was said was interpreted by the officer. It is also possible that Mr Karayiannis intended to inform an officer but changed his mind. It is unlikely that he was afraid of Mr Tran but perhaps he was in fact trying to be respectful of Mr Tran's privacy. It is also possible that Mr Tran had asked Mr Karayiannis not to report the incident or had threatened to harm Mr Karayiannis if he did so. In any event, no record of such a notification was found during the investigation. Neither inmate is reported to have given any indication to correctional staff that they had concerns for their safety or the safety of their cell mate.

15. At reception, it appears that inmates are offered a handbook that explains various aspects of gaol routine to them. Mr Karayiannis's property did not include such a handbook. While there is some evidence that many prisoners do not receive a handbook, the better evidence seems to be that they are available to prisoners but are not forced on prisoners. As there is a widespread culture of refusing to 'dob' or 'give up' other people in gaol, whether Mr Karayiannis would have followed the instruction in the handbook to report risk or incidents of self-harm can only be a matter of speculation.

The night of 31 March – 1 April 2013

16. On 31 March 2013 Mr Tran and Mr Karayiannis participated in the afternoon muster without incident. Both were secured in cell 353 by Correctional Officers. At the time the deaths occurred both Mr Karayiannis and Mr Tran were classed as 'Normal Cell Placements' and had no current alerts on the Offender Management System.

17. During the night, probably between 10.30 and 11.00pm, a remand prisoner in a cell beside cell 353 heard what he thought were the sounds of a fight coming from the cell in which Mr Tran and Mr Karayiannis were locked up. He and his cellmate heard screaming and banging. The prisoner who gave evidence said that he thought the noise was from Mr Karayiannis. He estimated that the fight had taken about one or two minutes. Although fighting and shouting was quite common in the wing, that prisoner said that he had not heard fighting in Mr Karayiannis's cell before that night and that both he and Mr Tran were "quiet".

18. As it now appears, the sounds that emanated from the cell were of Mr Karayiannis fighting for his life as he was being strangled by his cell-mate Mr Tran. Despite the desperate sounds that they heard, neither of the prisoners next to cell 353 pressed the 'knock-up' button to call for help. Nor did anyone else in the wing although the noise

must have been heard by others. At about 6.15am on 1 April 2013 during morning head check both Mr Karayiannis and Mr Tran were located deceased in cell 353.

19. The response by correctives staff upon locating Mr Karayiannis and Mr Tran was generally in accordance with the Deaths in Custody Protocol.

The issues

20. The circumstances of these two deaths raised the following issues that have been considered at this inquest:

- What was involved in assessing Tien Tran as suitable for normal cell placement?
- Was there a systemic failure to recognise the potential risks of placing Nick Karayiannis in a cell with Tien Tran?
- During the night, what was heard and should that noise have raised the alarm?
- Did MRRC staff who discovered the deceased respond in accordance with the Deaths in Custody Protocol?

Assessment of Tien Tran for normal cell placement

21. Mr Tran was seen by Registered Nurse Tolentino on his reception at the MRRC. RN Tolentino had no access to his previous files or history. This initial assessment process operates in much the same way as a triage system. All RN Tolentino had to go on was what he was told by Mr Tran and his own impressions and experience. Although Mr Tran denied any previous history of mental illness and denied being on any medication, Mr Tolentino formed the impression that he was slightly depressed and referred him for a further mental health assessment to RN Barbara Sullivan, an experienced mental health nurse. He also allocated Mr Tran to a group cell in case he was at risk of self-harm.

22. RN Sullivan saw Mr Tran five days after his initial assessment. He told her that he was in a good mood. She found no signs of major mood disorder, psychosis or thought disorder and he appeared to her to be at most slightly depressed about coming back into custody, a very normal reaction. He denied any suicidal ideation or planning. In her view, he was fit for normal cell placement.

23. Assessment of suicide risk is much more difficult than is generally recognised within the community. Many studies of psychiatric patients who have committed suicide have shown that it is virtually impossible to predict whether a person will commit suicide, even if that person is assessed as being at high risk. In many cases, the most significant risk factor is a previous suicide attempt.

24. In this case, Ms Sullivan did not know the history of Mr Tran's previous plans in 2000. She was not told about that episode by Mr Tran and she did not search through all his

files. Her evidence was that she had examined the most recent Justice Health files only and found nothing that would have raised a question concerning suicidal thinking.

Systemic failure in risk assessment?

25. In my view, an assessment of mental health status should take into account the *whole* history of a patient, as far as it can reasonably ascertained. This is standard medical and psychiatric practice. RN Sullivan did not explore Mr Tran's entire history. Whether it would have been reasonably practicable to do so is somewhat unclear. Certainly the records were not easily accessible in computerised form, an issue about which I will comment below. In any case, while it may have caused her to probe a bit more deeply, it seems unlikely that her assessment of Mr Tran's mental health in 2013 would have been significantly different if she had discovered the 2000 episode in the files.

26. One of the systemic problems that both RN Tolentino and RN Sullivan had to deal with was that the information and IT systems that they had to use did not efficiently bring together all the relevant information they needed to make the most accurate mental health assessments they were capable of making. To a very large degree, because of the inefficiencies of the information systems they were using, both nurses had to rely on their own experience and clinical judgments.

27. RN Tolentino had virtually no information, other than that supplied by Mr Tran, about the patient's history. We know that this history was inaccurate and incomplete in at least one significant respect and this raises the question whether it was inaccurate and incomplete in other significant respects. While in this case, RN Tolentino's judgment seems to have been appropriately conservative, in that he decided that Mr Tran should be assessed by a specialist mental health nurse, a less cautious and experienced nurse may not have taken that approach.

28. Similarly, RN Sullivan had an incomplete history both because Mr Tran did not supply her with all the relevant information himself and because she searched only the most recent file.

29. It is notorious that a large proportion of the gaol population of NSW suffers to, varying degrees, from mental illness. Presumably, of those, a significant number are suffering depression and adjustment problems due to being locked up. But significant numbers are also people with lengthy histories of mental illness of different types. Assessing prisoners at the reception stage and also during their periods of incarceration is a core function of the correctional system, involving both the Department of Correctional Services and NSW Health. That task is difficult enough for those whose responsibility it is to carry out without the additional burden of the inefficiencies of the patient / inmate information systems complicating the process.

30. To meet that responsibility adequately, it seems to me that a better patient information system than was available to RNs Tolentino and Sullivan is needed.

31. I understand that the patient record system is now being upgraded to a fully electronic system. Evidence was also given that warnings and notifications received by the

Department of Corrective Services concerning risk of self-harm are routinely notified to Justice Health. When implemented, this system will significantly reduce the current inefficiencies and should enable Justice Health staff to access a more complete patient history than is currently available.

Noise during the night?

32. Mr Karayiannis died resisting his attacker. His struggles were heard by prisoners but not by those whose job it was to protect him. After 9.30pm or so, the correctional officers who would ordinarily be monitoring the pod for disturbances or requests for help, were at the other end of the gaol.

33. Nobody in the pod alerted the correctional staff to Mr Karayiannis's fatal struggle. No one pressed a 'knock-up' button to call for help. According to Mr Basturk, who heard a disturbance and assumed that it was a fight, prisoners are reluctant to use the 'knock up' button to 'dob' on people fighting because of their fear of retribution. Prisoners are subject to disciplinary proceedings within the gaol system if they breach prison rules and regulations. The possibility of retribution for 'dobbing' is real. Mr Basturk also gave evidence that fighting and shouting in cells is common. Most prisoners ignore it.

34. It is one thing for the Department of Correctional Services to install 'knock-up' buttons. It is another thing to create a culture of using them in the kinds of circumstances that occurred in this case. It is true that 'knock-up' buttons are frequently used by prisoners. Sometimes this is for legitimate reasons, such as people becoming ill in their cells; but it is also common for prisoners to use them to play pranks on correctional staff.

35. Evidence was given by Mr Basturk that knock-up calls are sometimes ignored by staff. I do not accept this evidence. Obviously if no one is in the wing at the time to respond, it may be some period before the call is responded to as it has to be transferred to other locations. But the weight of evidence is to the effect that every call is responded to, notwithstanding the considerable number of nuisance calls.

36. The real protection for prisoners, however, is the capacity of experienced staff to monitor the sounds coming from cells. Senior Correctional Officer Scott Perkins told the court that from the pod office, located in the middle of the pod, officers can hear any shouting or loud noises and are able to distinguish between serious problems which require their immediate attention and more sociable noises, such as barracking for football teams.

37. Mr Tran was an experienced prisoner. It is reasonable to assume that he knew that, once the security check had been completed at 9.30pm, there were no correctional staff in the pod and that therefore there would be no one to intervene if he attacked Mr Karayiannis after that time and Mr Karayiannis made loud noises in a struggle. He also probably knew that it was unlikely that anyone in the wing would 'knock-up' the staff if his attack on Mr Karayiannis was noisy.

38. SCO Perkins told the court that the reason there were no officers in the pod after the security check was that there had been staff cuts so all the available officers on the

watch were gathered together in one location at the other end of the gaol. Whether there actually have been staff cuts is not clear. Assistant Superintendent Murray Stewart gave evidence that staffing levels on B Watch had been more or less constant for many years.

39. The end result of this combination of a culture of silence and absence of correctional staff is that Mr Karayiannis was left unprotected against Mr Tran.

The response to the incident

40. First Class Correctional Officer Lachlan Hilton and his colleague First Class Correctional Officer Damian Cooke made the dreadful discovery that Mr Karayiannis had been killed and Mr Tran had taken his own life only in the morning at about 6.15 am when they were conducting head checks. Mr Karayiannis was found tied to his bed and Mr Tran was hanging from a homemade ligature. Both men were beyond resuscitation. It is evident that they had probably been dead for several hours.

41. The scene was understandably very distressing for the correctional officers. They called other staff to bring a tool to cut down Mr Tran and Mr Hilton cut the bonds restraining Mr Karayiannis. Nurses were called as was an ambulance.

42. According to the protocol governing response to such incidents, correctional staff should also have immediately commenced CPR pending the arrival of the medical team. In the circumstances, while the protocol was not carried out in its entirety, this oversight did not make any difference.

Should more be done?

43. The deprivation of a person's liberty by the state brings with it the heavy responsibility of protecting that person while he or she is in the custody and care of the state. Although cells are fitted with 'knock-up' alarms, correctional staff know that this is not a complete answer to problems that the death of Mr Karayiannis (and, indeed, other killings in cells) raise.

44. Evidence was given by Assistant Superintendent Murray that if sufficient staff were to placed in the pods to be available to hear and respond to loud incidents occurring during the night more than double the current staffing levels would be required. His evidence was that to spread the available staff (usually 14) across the pods at night would be inefficient and risky.

45. That may well be so. Perhaps other less expensive, technological solutions to the problem of protecting prisoners at night are available. The problem, however, cannot be ignored and it will not go away. The state owes its prisoners a duty of care. It also owes a duty of care to correctional staff and cannot place them at risk.

46. Conflicting evidence about the availability of the handbook was given. I accept that the handbook is readily available but that some prisoners either do not receive it or do not take an offered copy. In my view, a copy should be handed to every prisoner on

reception and he should be made to sign for it or a record should be kept in some other way that it has been given to the prisoner.

47. One problem that arose during the police investigation of the incident was that there was no efficient way of identifying correctional officers who had entered the pod during the night of the incident. While careful records are kept of prisoners being brought in and leaving the pod, it seems surprising that the same stringency of record-keeping is not applied to staff coming and going. This appears to be a gap in the security of the system and, in my view, should be rectified.

Conclusion

48. This case is tragic and very unusual. Unfortunately, homicides in gaols happen from time to time. What is unusual, perhaps unique about this case, is that Mr Karayiannis seems to have died because he had previously successfully prevented another prisoner, his cellmate, from taking his own life. It is a paradox that mentally ill prisoners are often placed with others in cells so that they can be watched and their deaths prevented yet, in this case, it was the carer who first lost his life.

49. Mr Tran's suicide, much less his violence towards Mr Karayiannis, was not predictable. It is virtually impossible even for highly experienced psychiatrists to predict a suicide even in high risk individuals. He had not displayed signs to Justice Health staff or Corrective Services. While some prisoners knew of his attempted suicide that Mr Karayiannis had prevented, it is very unclear what, if anything, was known by correctional staff about this. Mr Tran had no significant history of violence either in gaol or in the community. That he would take such extreme measures against Mr Karayiannis could not have been foreseen.

50. What I think was foreseeable, although perhaps remotely, was that without a monitoring system in the pods during B Watch, someone could be attacked and hurt and that, given the culture against 'giving up', someone could be very badly harmed without protection.

51. Mr Karayannis was obviously much loved by his family and his friends. I hope that they will accept my sincere condolences and those of the coronial team.

Findings s 81 Coroners Act 2009

52. I find that Nick Karayiannis died on the night of 31 March – 1 April 2013 in cell 353 of Pod 11 in G Block, Metropolitan Reception and Remand Centre, Silverwater, New South Wales due to ligature strangulation inflicted on him by his cellmate Tien Tran while in the custody of the Department of Corrective Services.

53. I find that Tien Tran died on the night of 31 March – 1 April 2013 in cell 353 of Pod 11 in G Block, Metropolitan Reception and Remand Centre, Silverwater, New South Wales by hanging with the intention of taking his own life while in the custody of the Department of Corrective Services.

Recommendations

54. To the ***Minister for Justice*** I make the following recommendations:

55. That the Department of Justice (Corrective Services) investigate and implement a system for ensuring the greater safety during B Watch of inmates being held in the Metropolitan Reception and Remand Centre, Silverwater by improving the capacity of correctional staff to monitor unsafe activity within the pods during that watch.

56. That the Department of Justice (Corrective Services) give a Male Inmates Handbook to all male inmates received at the Metropolitan Reception and Remand Centre, Silverwater and that it implement a system of recording that each inmate has received the handbook.

57. That the Department of Justice (Corrective Services) implement a system of recording entries to and exits from pods by correctional staff during B Watch.

Magistrate Hugh Dillon
Deputy State Coroner