STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Glennon Johnstone
Hearing dates:	6 November 2017
Date of findings:	20 November 2017
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords	CORONIAL LAW- Death in custody; death after a fall; care of geriatric prisoners
File numbers:	2016/94667
Representation:	Mr B Hart, Coronial Advocate assisting Ms Katawazi, Solicitor, Office of General Counsel for the Commissioner of Corrective Services, NSW

Findings pursuant to section 81 of the Coroners Act (NSW) 2009

Glennon Johnstone died on 26 March 2016 at Liverpool Hospital. He died from complications of subdural haematoma. Mr Johnstone's death was accidental, he had been injured when he fell in custody on 21 March 2016.

Recommendation pursuant to section 82 of the *Coroner's Act* (NSW) 2009

To the NSW Minister for Corrections

I recommend that Corrective Services NSW prioritise the establishment of specific residential facilities for accommodating aged and infirm prisoners in both metropolitan Sydney and in regional NSW, as a matter of urgency. These plans should include specific consideration of the growing number of aged prisoners whose classification is restricted.

Non Publication orders

Pursuant to section s 74 (i) (b) I order no publication of,

1) The names or contact details of Mr Johnstone's family or of any victims of the crimes that he committed.
2) No identifying information in relation to the Correctives Officers referred to in the Corrective Services file (exhibit 2).
3) The names of any other inmates held in the same area as Mr Johnstone.

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Introduction

1. Glennon Johnstone (also known as Ronald James Baker) was 87 years of age at the time of his death. He was serving a term of imprisonment, having been convicted on 14 October 2011 in relation to a number of child sexual offences. He had been remanded in custody since 22 September 2010. He was serving a term of ten years with a non-parole period of seven years.

2. Mr Johnstone was transferred to Kirkconnell Correctional Centre on 2 March 2016. He was placed in cell 3 of Unit One. The placement took into account his age and the cell's proximity to the health clinic. At the time of his death, Mr Johnstone was classified as a minimum security prisoner. His status was of limited association, at his own request due to the nature of his offending.

3. About 12.30 am on 21 March 2016, Mr Johnstone woke his cell mate, LC and told him that he had suffered a fall and had tried to clean up the blood. LC activated the "knock up button" or cell alarm and correctional officers attended soon afterwards to check on Mr Johnstone's welfare. They found that he had a cut above his right eyebrow and abrasions to both arms and his right knee. Simple first aid was provided and Mr Johnstone appeared to be lucid. He explained to officers present that he had fallen and struck his head on the metal tread in the day room of the unit. The after-hours nurse was called and Mr Johnstone was taken by ambulance to Bathurst Hospital. In all the circumstances, there does not appear to be any worrying delay in his transportation to hospital.

4. When Mr Johnstone arrived by ambulance around 2.25 am, he was able to walk and talk in full sentences. He was taken to have his wound sutured but began to deteriorate. He vomited and was subsequently transferred to a resuscitation bed. Testing began and he was found to have a large left sided acute subdural haematoma measuring 20mm in depth. An urgent neurosurgical review was recommended.

5. At 6.47 am Mr Johnstone was transported via helicopter to Liverpool Hospital. Mr Johnstone was unconscious and non-responsive during the flight. He was seen by Dr Jeremy Rajadurai, who conducted further testing and then recommended against surgery due to his age, co-morbidities and current clinical state. Mr Johnstone's next of kin was informed that a palliative care path was advised. A non resuscitation order was made the following day.

6. At about 1 am on 26 March 2016 Mr Johnstone was heard to breathe loudly and make choking sounds. At about 2.20 am a nurse entered Mr Johnstone's room and informed the corrective services officer who was guarding the room that Mr Johnstone was dead. He was officially recorded as deceased at 3.21 am on 26 March 2016.

7. A post-mortem examination was conducted on by forensic pathologist Dr K Bailey on 30 March 2016. She confirmed that Mr Johnstone's death was caused from "complications of subdural haematoma".[1] No other acute conditions or injuries were recorded and while toxicological testing detected multiple medications they were all in keeping with the documented therapeutic intervention.

[1] Autopsy Report, Dr Kendall Bailey, Department of Forensic Medicine, Sydney. NSW Forensic and Analytical Science Service.

The role of the coroner

8. The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death[2]. The coroner is also to address issues concerning the manner and cause of the person's death. In addition, the coroner may make recommendations in relation to matters that may have the capacity to improve public health and safety in the future.[3]

9. In this case there is no dispute in relation to the identity of Mr Johnstone, or to the date and place of his death. For this reason the inquest focused on the manner and cause of Mr Johnstone's death. It was also necessary to consider whether or not his death was in any way avoidable and if so what mechanisms, if any, could be put in place to help prevent such a situation recurring.

10. Where a person dies in custody, it is mandatory that an inquest is held. The inquest must be conducted by a senior coroner[4]. When a person is detained in custody the state is responsible for his or her safety and medical treatment. For this reason it is especially important to examine the circumstances of each death in custody and to understand how it occurred. The need for careful examination of the circumstances is particularly important when the inmate appears to have had few visitors and little contact with people outside the prison system.

11. Section 81 (1) of the *Coroners Act* 2009 (NSW) requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of Glennon Johnstone.

Scope of the inquest

12. A number of issues relevant to Mr Johnstone's death were identified prior to the inquest commencing. These issues included

    - Would aids that allow prisoners to manoeuvre around Unit One be effective in reducing the risk of falls?
    - What steps, if any, have been taken to ameliorate the risk of falls since Mr Johnstone's death?
    - Was Mr Johnstone the victim of violence from other inmates?

13. The inquest took place on 6 November 2017. A large number of statements were tendered, along with recordings, gaol and medical records. Sergeant Damien Babb gave short oral evidence. A short adjournment was granted to allow Corrective Services the opportunity to supply further material to the Court in relation to initiatives currently in place for caring for aged inmates.

[2] Section 81 *Coroners Act* 2009 (NSW)
[3] Section 82 Coroners *Act* 2009 (NSW)
[4] See sections 23 and 27 *Coroners Act* 2009 (NSW)

Background

14. Glennon Johnstone was born on 18 October 1928 in Turrella NSW. He appears to have had a difficult childhood and was living at Kings Cross independently from a young age. In about 1978 he became involved with JF and later lived with her in Miranda. In the 1980s they moved to Nambucca Heads and lived there together until JF died in early 2010.

15. Prior to the offences which brought him into custody in 2010, Mr Johnstone had a limited history of criminal convictions. He was first charged by police in 1947, at the age of 19 with stealing offences. In 1948 he was charged with rape, which was later dismissed. In 1964 he was charged with an indecent assault for which he was fined. In 1994 he was charged with aggravated indecent assault, which was also dismissed.

16. In September 2010, Mr Johnstone was arrested in relation to a number of serious offences including, sexual intercourse with a person under the age of 10. He was remanded in custody awaiting trial. Mr Johnstone was subsequently convicted. He spent the first years of his sentence at Junee Correctional Centre. He had limited contact with his step family whilst in custody.

Medical history whilst in custody

17. During his time in custody Mr Johnstone had some contact with Justice Health. The file reveals that a medical history had been taken on his reception and that Justice Health was aware of his prior conditions including hypercholesterolemia, Type 2 Diabetes and hypertension. Whilst in custody Mr Johnstone received various regular medications in accordance with his needs. Over the years he had eye surgery and an operation to remove a varicose vein from his right leg in 2010. No general care or treatment issues have been raised for consideration.

18. On entry into custody in 2011, Mr Johnstone was given a routine mental health assessment. There appear to have been no ongoing concerns in relation to this issue.

19. On 8 December 2015, Mr Johnstone presented to the MSPC clinic after nearly falling over. In preventing the fall he had sustained skin tears to his right elbow and hand. He was placed on a list for review by the general practitioner. On 21 December 2015 he presented at the clinic complaining of diarrhoea and vomiting. He was treated and later in the evening complained of muscular cramps as well. He was transferred to the Emergency Department at Prince of Wales Hospital, where he apparently experienced two syncopal episodes while sitting on his bed and some shortness of breath.

20. On 2 March 2016, Mr Johnstone was transferred to Kirkonnell Correctional Centre. He was placed in the bottom bunk of a two person cell, due to his age and frailty. He was placed in this area as it was close to the health clinic, should an emergency occur.

What steps, if any, have been taken to ameliorate the risk of falls since Mr Johnstone's death

21. Mr Johnstone did not use a walking stick or walker. His cell mate described him as "fairly good" for his age, stating that "he got around fairly well".

22. On 21 March 2016, Mr Johnstone appears to have fallen while walking back to his cell. The inquest considered whether there were steps which could be taken to have reduced the risk of falls in his environment.

23. The Court received a statement from Mark Kennedy, currently the Governor of Bathurst, Mannus and Kirkonnell Correctional Centres. At the time of Mr Johnstone's death he was employed by Corrective Services NSW (CSNSW) as the Manager of Security at Kirkonnell Correctional Centre.[5]

24. Governor Kennedy informed the court that as a result of becoming aware that Mr Johnstone had tripped and hit his head, he undertook an assessment and inspection of the area. On 22 March 2016, with the assistance of Overseer George Hancock he examined the route that Mr Johnstone had taken from the bathroom to his cell through the common room. As a result of this and later inspections, a number of hand rails were installed at the cell doors in the area. There was also a handrail installed at the step in the common area. It was decided that the lighting in the area was adequate.

Is there a need for a more coordinated response to making a safe environment for geriatric prisoners?

25. The Court was supplied with a report called "Old and inside; Managing aged offenders in custody"[6] The document is dated September 2015 and represents an attempt by CSNSW to acknowledge and plan for the ever-increasing aged population in NSW correctional centres. The report accepts that as demographic changes occur CSNSW is becoming a significant provider of aged care services to a growing cohort of aged and frail inmates, many of whom will die in custody.

26. The report was prepared by the Inspector of Custodial Services, assisted by two expert consultants. Four correctional centres in metropolitan Sydney, chosen to represent both specialized aged-care and mainstream centres were inspected. Kirkonnell Correctional Centre, where Mr Johnstone was housed was not specifically considered, although many of the general recommendations arising from the report would be applicable to that centre and to his care. Five key areas were examined in relation to the management and care of older inmates including correctional centre environments and facilities, centre regimes, relationships, healthcare and pre-release support.

27. Although specialist units exist, the majority of aged inmates are placed within mainstream correctional centres, in accordance with the CSNSW classification process. At present there is only limited capacity to provide specialist care in aged-care units for those who have mobility issues or are functionally impaired. As a result many aged prisoners are housed in physical environments that have not been designed with their specific needs in mind. The

[5] Exhibit 4, Statement of Mark Kennedy, Governor of Bathurst, Mannus and Kirkonnell Correctional Centres, dated 30 October 2017
[6] Exhibit 5, "Old and inside; Managing aged offenders in custody" – September 2015.

report acknowledges that there still a great deal to be done to improve conditions for aged prisoners to live and function with dignity in the correctional setting

28. I have carefully reviewed the report and the more recent responses to the recommendations that have been provided by both Justice Health and Corrective Services NSW. I do not intend to refer to them in specific detail. It is clear that a number of the significant recommendations made have been largely supported internally and that there have already been some changes. That is to be commended. However, some important reforms appear to have been delayed while funding can be identified.

29. Of particular relevance to this inquest, is the difficulty that can emerge for Corrective Services NSW when trying to find a suitable placement for an aged inmate who is somehow restricted by classification from being considered as suitable for a wide range of otherwise available options. Mr Johnstone was a convicted sex offender who was limited in his associations. He was also 87 years of age and in the community would have qualified for residential aged care or for various forms of government assistance and support. There is little doubt that there will continue to be a growing number of prisoners in this category. [7]

30. The level of care provided to Mr Johnstone in custody, in relation to his specific aged health care needs should have resembled the quality of care that any citizen would expect within the public system in the community. Unfortunately as the report makes clear, this kind of standard has not yet been reached across the board.

31. Recommendation 13 of the report looks to the need for creating new accommodation for aged and infirm inmates in the Sydney metropolitan area, either by building a new facility or by acquiring an existing aged care facility. CS NSW states that at February 2017, facilities outside the metropolitan area were being investigated for this purpose and that there is a long term plan for aged and frail inmates in the metropolitan area.

32. Making these proposals a reality is in my view an urgent task. Mr Johnstone died after falling. Falling creates a well-recognized risk of death or serious harm in the aged population generally. A well-planned aged care facility will be designed to minimize this kind of potential harm. While I accept that *ad hoc* changes have already been made to improve the precise area where Mr Johnstone fell at Kirkonnell Correctional Centre, a wider problem is clearly identified. CS NSW has limited facilities for the growing population of aged offenders it will continue to house. Housing an aged and at times frail population in facilities designed for an able population will continue to present ongoing risk, unless a real commitment is made to specifically addressing this growing issue.

Was Mr Johnstone the victim of violence from other inmates?

33. Mr Johnstone had placed himself on limited association as soon as he arrived in custody. Prison authorities had placed him in a segregated unit with inmates who had been convicted of similar crimes, as a matter of safety. There are no reported complaints on file to suggest

[7] There are a number of reasons why this category of prisoners is likely to grow, including increased reporting of these kinds of offences and the prevalence of historical offences, higher conviction rates and longer sentences. It is an issue that Corrections NSW is well aware of and recommendation 22 of the report suggests that a review of the current policy regulating residential restriction of sex offenders is called for.

that Mr Johnstone had been threatened or assaulted in custody. His step family were also unaware of any specific incidents of this sort.

34. After his death a member of his step family saw an article in the Sunday Telegraph[8] which stated that a white supremacist gang Willing to Kill (W2K), along with a newly formed gang "Eight Kings" had been "handing out its own form of justice", beating paedophiles and rapists at Kirkonnell Correctional Centre. The report stated that the problem was a "side effect" of overcrowding. It also stated that those responsible had been removed from the Centre and had their security classification increased. As a result of this information the Officer in charge of this coronial investigation was tasked with further investigations to ascertain whether this could have been an issue in Mr Johnstone's fall.

35. Detective Sergeant Damien Babb made a number of further inquiries and confirmed that there had indeed been a number of assaults at Kirkonnell, which had resulted in the moving some prisoners. However, there was no evidence that Mr Johnstone had been assaulted and there was no record of a still unidentified prisoner having been assaulted. Inmates who knew Mr Johnstone were re-interviewed and there was no suggestion that Mr Johnstone had been assaulted or threatened. I am satisfied that these incidents are unrelated to Mr Johnstone's injuries.

Conclusion

36. While appropriate local changes were made after Mr Johnstone's death, there appears to be a more general need to prioritise the provision of appropriate environments to house an aging prison population to mitigate the risk of falls and other preventable accidents. Comprehensive change will require commitment of significant resources by Corrective Services NSW.

37. Finally, I offer my condolences to those who cared for Mr Johnstone and to all those affected by his death.

Formal Findings

38. The findings I make under section 81(1) of the Act are:

Identity
The person who died was Glennon Johnstone.

Date of death
Mr Johnstone died on 26 March 2016.

Place of death
Mr Johnstone died at Liverpool Hospital, Liverpool, NSW.

Cause of death
Mr Johnstone died from complications of a subdural haematoma.

[8]Exhibit 3 "Sex Crime Prisoners Beaten by Inmate Vigilantes" by Lia Harris, Crime Reporter, The Sunday Telegraph, 8 May 2016.

Manner of death

Mr Johnstone's death was accidental. He had been injured when he fell in custody on 21 March 2016.

Recommendation pursuant to section 82 of the *Coroner's Act* (NSW) 2009

To the NSW Minister for Corrections

39. I recommend that Corrective Services NSW prioritise the establishment of specific residential facilities for accommodating aged and infirm prisoners in both metropolitan Sydney and in regional NSW, as a matter of urgency. These plans should include specific consideration of the growing number of aged prisoners whose classification is restricted.

40. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
20 November 2017
NSW State Coroner's Court, Glebe