CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 8th, 9th, 10th, 11th and 12th days of February 2010, the 10th, 11th, 12th and 26th days of March 2010 and the 19th day of November 2010, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Laura Parker.

The said Court finds that Laura Parker aged 40 years, late of Adelaide Women's Prison, Grand Junction Road, Northfield, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 16th day of March 2008 as a result of hypoxic encephalopathy and epilepsy with diffuse fibrillary astrocytoma within the right occipital lobe. The said Court finds that the circumstances of her death were as follows:

1. Introduction

1.1. Laura Parker was a 40 year old divorced woman who died on 16 March 2008 at the Royal Adelaide Hospital (RAH). A post-mortem examination was carried out by Dr Cheryl Charlwood who is a forensic pathologist at Forensic Science South Australia. Dr Charlwood has concluded that the cause of Ms Parker's death was hypoxic encephalopathy and epilepsy with diffuse fibrillary astrocytoma within the right occipital lobe. I find that to have been the cause of Ms Parker's death.

1.2. The cause of death requires some explanation. Hypoxic encephalopathy is severe brain damage which in Ms Parker's case was the result of sustained interruption of circulation and the resulting deprivation of oxygen to the brain tissues. This had been caused by an unexpected collapse and cardiac arrest that had occurred the day before

her death. Resuscitative measures conducted by members of the South Australian Ambulance Service (SAAS) had been successful in restoring Ms Parker's circulation. However, the duration of the interruption of circulation and the consequent deprivation of life sustaining oxygen to Ms Parker's brain resulted in irreversible brain damage. When that irreversible brain damage was identified clinically within the Intensive Care Unit of the RAH a decision was made to withdraw treatment other than comfort care. Ms Parker was pronounced deceased at 11:12pm on Sunday 16 March 2008. The brain damage that Ms Parker had sustained was the immediate cause of Ms Parker's death, but the pertinent question to be posed is what had led to her cardiac arrest in the first instance.

1.3. It will be noted that Dr Charlwood's stated cause of death makes reference to epilepsy. Ms Parker had been diagnosed with epilepsy for a considerable period of time. From time to time she suffered from epileptic seizures notwithstanding the fact that she was, for the most part, medicated with anticonvulsant therapy. The epileptic condition in Ms Parker's case is believed to have been associated with an astrocytoma within Ms Parker's brain. This is a lesion that is known to predispose to epilepsy and the lesion in her case had been identified clinically during her life. It has not been necessary for me to expand upon the connection between that lesion and Ms Parker's epilepsy because it is clear from Ms Parker's medical history that epilepsy was a well understood disability in her case.

1.4. Ms Parker's cardiac arrest on Saturday 15 March 2008 was associated with an epileptic seizure that she experienced during the course of that afternoon. A cardiac arrest associated with an epileptic seizure is not an unknown circumstance. Sudden unexpected death in epilepsy (SUDEP) is known to occur with the incidence considerably higher in patients with chronic rather than acute epilepsy. Ms Parker was a chronic sufferer. It was said during the evidence presented at the Inquest that cardiac arrest associated with an epileptic seizure can be difficult to reverse even with timely and vigorous resuscitation. Resuscitation attempts in people who have experienced seizures and who have gone into cardiac arrest are often, if not generally, unsuccessful even under supervised circumstances [1]. In this regard, the situation is different from that where a person has gone into cardiac arrest as the result of

[1] Exhibit C37a, page 4 and Transcript, page 461

myocardial ischaemia (heart attack)[2]. Notwithstanding all of this, as I say, the efforts of the SAAS paramedics were in Ms Parker's case successful in restoring her heartbeat and circulation.

2. Reason for Inquest

2.1. The event that precipitated Ms Parker's death, namely her epileptic seizure and cardiac arrest, occurred while she was in custody as a remand prisoner at the Adelaide Women's Prison (AWP). For that reason it was mandatory for an Inquest to be held into the cause and circumstances of her death.

2.2. The alleged offence in respect of which Ms Parker was remanded in custody was disorderly behaviour for which she had been arrested by police on 26 February 2008.

2.3. The fact that Ms Parker had been in custody was not the only reason an Inquest into her death was considered necessary and desirable. The circumstances in which Ms Parker experienced her fatal epileptic seizure were unusual even taking into account her custodial circumstances. Ms Parker had a history of disorderly and difficult behaviour that throughout much of her adult life was thought to have been the product of bipolar disorder, but more latterly was believed to be the manifestation of borderline personality disorder. The possibility that her behaviour was at times calculated and attention seeking cannot be ruled out. Ms Parker was well known within psychiatric and mental health circles in the southern Adelaide suburbs. In the latter part of 2007 and the beginning of 2008 her behaviour also frequently attracted the attention of the police. Ms Parker had earlier been remanded in custody in the AWP between 14 December 2007 and 21 December. She had also recently spent time in the police cells at Christies Beach police station.

2.4. Ms Parker was again in custody in the AWP from 26 February 2008 until 15 March 2008 which was the day before her death in the RAH. At one point during that period the Christies Beach Magistrates Court had endeavoured to release Ms Parker on a good behaviour bond after she had pleaded guilty to the charge of disorderly behaviour but Ms Parker refused to acknowledge the bond. This refusal had then been followed by a further period of remand in custody at the AWP pending a psychiatric evaluation ordered by the Christies Beach Magistrates Court. It was

[2] Transcript, page 461

during that period that Ms Parker died. Ms Parker did not undergo that psychiatric evaluation before her collapse and death. Ms Parker's behaviour in February and March of 2008 within the AWP had to a greater or lesser degree been uncontrollable and this state of affairs was most acute in the days leading to her collapse. For that reason she had been kept separate and apart from other prisoners, in effect in solitary confinement.

2.5. Ms Parker was accommodated in a single cell in D Wing at the AWP which accommodates prisoners who are for whatever reason to be kept separate from other prisoners. The environment in Ms Parker's single cell had become incompatible with hygienic living insofar as it involved her urinating and defecating in her cell without using the lavatory provided. It had also involved Ms Parker distributing urine and faeces within the cell such that the cell became uninhabitable. There was a natural reluctance for staff to enter the cell and there had been a number of distasteful incidents when staff had attempted to do so. Throughout this period of custody Ms Parker rarely ventured from the cell if at all and indeed, from the time of her most recent court appearances at Christies Beach on 11 and 12 March 2008 that had involved her refusing to sign the bond that would have seen her release from custody, she had remained in the cell the entire time. Not only had the cell become extremely filthy, but Ms Parker's own personal hygiene and her state of dress left much to be desired. By any standard, her behaviour had become overtly bizarre. I do not say this disparagingly because regardless of whether her behaviour was the product of a psychosis or a personality disorder or was simply calculated to provoke a reaction, to any reasonable person it was clearly a reflection of a disturbed frame of mind.

2.6. Ms Parker's behaviour within the cell was being monitored by CCTV from the prison control room. Needless to say the scenario that had developed by Saturday 15 March caused correctional and medical staff at the AWP to become concerned. Yet the situation seems to have been tolerated at just about all levels within the institution for an inordinate period of time. More of that later in these findings.

2.7. On the afternoon before her collapse, Ms Parker's cell was hosed out through an opening in the cell door. Ms Parker was inside the cell when this took place. This had occurred after the development of something of an impasse between correctional staff and staff of the Prison Health Service (PHS) about whether Ms Parker should be removed from the cell for evaluation by PHS staff. There is a dispute about the

precise circumstances surrounding this incident and I will also deal with that later in these findings.

2.8. On the day of her seizure, which was Saturday 15 March, it had finally been decided to send Ms Parker to the RAH for assessment and possible ongoing detention under the Mental Health Act 1993 (MHA) in the hope that she would be accommodated in a more suitable environment having regard to her presentation and behaviour. This was a development that was very much long overdue. Correctional officers were preparing to enter Ms Parker's cell for the purpose of conveying her to the RAH when Ms Parker was observed on CCTV apparently to 'fit' and then to become unresponsive and motionless within her cell. While this state of affairs was detected by the control room operator promptly, and the correctional officers responsible for her custody were made aware of this set of circumstances, Ms Parker's cell was not entered by any person for in excess of 10 minutes. There was, to use a neutral expression at this point, an unwillingness on the part of corrections staff to enter Ms Parker's cell without protective clothing and footwear and there was a considerable delay occasioned, although perhaps only in part, by the obtaining and donning of this apparel. It was during this extended period before her cell was entered that Ms Parker was observed by the control room operator via CCTV not to be breathing. Even then there was a delay in entering the cell. Once her cell was entered it was established that Ms Parker not only was not breathing but that she had experienced a cardiac arrest and was dying.

2.9. Aside from the issue involving the delay in entering Ms Parker's cell and providing her with any meaningful assistance, there was a question as to whether or not standard procedures within the prison that dictated a regime whereby her cell should have been entered promptly and medical assistance delivered immediately were followed.

2.10. I also examined the issue as to whether it was at all appropriate for Ms Parker to have been kept within this environment for such an extended and uninterrupted period and whether a more timely decision to remove her from the cell may have altered the outcome. I also examined the question as to whether or not Ms Parker had been appropriately medicated having regard to her epilepsy and whether there were any other circumstances surrounding her incarceration and environment that may have contributed to her epileptic seizure.

3. Circumstances leading to Ms Parker's remand in custody

3.1. Ms Parker had a significant interaction with the mental health services over a number of years. Although the Court's attention was drawn to a number of aspects of her care in some detail, it was beyond the scope of this Inquest to examine the issue as to whether or not Ms Parker's physical and mental health needs had been adequately addressed over that time. I should say that Ms Parker was a woman who had once functioned perfectly properly despite her disability. She was raised by a family who cherished her and who were present for the entirety of this Inquest. She had undertaken a hairdressing apprenticeship between the ages of 17 and 21. She had at one time been happily married. She had a daughter.

3.2. It was thought that Ms Parker's behavioural difficulties and her epilepsy interacted with and complicated each other. In particular it was thought, as recorded in a management plan that was devised in December 2007[3], that in the past Ms Parker's mood disturbances had occurred as a consequence of erratic compliance to her anticonvulsant medication. Ms Parker had presented on many occasions at the Emergency Department of the Flinders Medical Centre (FMC) and at the Noarlunga Health Service (NHS). As I have earlier indicated, in the beginning Ms Parker had been diagnosed as suffering from bipolar affective disorder, but more recently this diagnosis had been revised to one of borderline personality disorder with dissociative features. I pass no comment about the accuracy of her diagnoses as the matter was not explored in any depth, and besides, in my view her true diagnosis matters not a jot when considering what should have happened to Ms Parker at the hands of the authorities in mid March 2008.

3.3. The management plan to which I have referred was devised by Professor Ross Kalucy, a psychiatric consultant at the Emergency Department of the FMC, together with a Mr Brenton Westall, an Acute Crisis Intervention Service (ACIS) clinical nurse consultant at the same Emergency Department. The management plan is dated 14 December 2007 and it was devised in order to provide some guidance in relation to the way in which Ms Parker should be handled within the community, particularly in circumstances where she might present to an emergency department of a public hospital. An assessment of Ms Parker's difficulty is contained within the plan and I

[3] Exhibit C23, pages 99-100

set this out as being exemplary of the way in which her behaviour came to be viewed in late 2007 and early 2008, almost universally it seems.

> 'In times of stress, Laura tends to cope with means that make sense to her such as adjusting her own medication, distracting herself with others problems & not acknowledging the full impact of the original stressor. When these strategies don't help, she experiences episodes of dissociation leading to situations that render her vulnerable to exploitation & impulsive acts. The consequences of these episodes further escalate the sense of being out of control & defeat. Her frequent presentation to ED's in search of admission is a way that she has learnt to seek support.
>
> Laura will present often in crisis usually wanting admission & "looking after". She has had lengthy admissions which have not been useful over the years, as the pattern of her stay included further dissociation with intrusive behaviour toward other patients. This inevitably led to detention & protracted stays in the Mental Health High Dependency Unit before a sense of control is regained, & has not been helpful in assisting her to manage her life in the community.' [4]

The plan also referred to Ms Parker engaging in inappropriate, disruptive and violent behaviour at both the FMC and NHS Emergency Departments in an attempt to force treatment. The following plan was set out in the document:

> 'It is suggested that if she presents to ED the following management should be followed.
>
> - MALE STAFF SHOULD BE CHAPERONED AT ALL TIMES.
> - If she presents with suspected overdose, physical injury or medical condition, she should be treated accordingly and then discharged, unless a medical admission is necessitated.
> - It is expected she should have initially made contact with her Community Mental Health Team or SACIS before accessing ED for mental health issues. (All efforts should be made not to refer her to the ED.)
> - Detention and admission for perceived mental health issues should be avoided wherever possible as it does not result in any meaningful improvement in her condition, and in fact may exacerbate it.
> - If she engages in disruptive, inappropriate or aggressive behaviour, this should be treated with zero tolerance and she should be asked to leave.
> - If after receiving appropriate treatment for the presenting complaint or being asked to leave as a consequence of her behaviour she refuses to leave the ED, security and/or SAPOL should be called upon to escort her from the premises.
> - If she assaults staff or damages property, SAPOL should be asked to charge her with appropriate offences.' [5]

This plan was eventually to make its way into the files of the PHS at the AWP concerning Ms Parker and it appears, at least in some manner, to have influenced the

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[4] Exhibit C23, Volume 4, page 99
[5] Exhibit C23, Volume 4, page 100

way in which Ms Parker was viewed within the PHS. For example, it was thought in some quarters within Corrections as a whole that Ms Parker's erratic actions within the AWP were 'behavioural' in origin as opposed to being the manifestation of a mental illness. In this regard I draw attention to the fact that within the management plan set out above, it was recommended that detention and admission under the MHA for perceived mental health issues be avoided wherever possible. As well, it was suggested that if Ms Parker were to have engaged in disruptive, inappropriate or aggressive behaviour, it should be treated with zero tolerance and 'she should be asked to leave'. Indeed, there were instances of Ms Parker having been turned away from hospital emergency departments. However, as a template for Ms Parker's management within a correctional or custodial institution, it was a document that would have been manifestly inappropriate insofar as it may have suggested to some that Ms Parker's behaviour could somehow be ameliorated, controlled or helped by her simply being ignored or, more ridiculously, being asked to leave whatever facility she might be in at the time.

3.4. Ms Parker's epilepsy was sought to be controlled by the administration of medication. By March 2008 Ms Parker had been prescribed the anticonvulsant Sabril at the rate of 500mg twice per day. By then Ms Parker was no longer taking Lithium for bipolar disorder, a diagnosis that was now being eschewed. Ms Parker herself had also indicated an unwillingness to take Lithium. By 15 March 2008, the day Ms Parker experienced her fatal epileptic seizure, her consumption of Sabril had become erratic and unpredictable. I do note, however, that the supplementary toxicological analysis that was conducted during the Inquest revealed that Ms Parker did have a sub-therapeutic level of Sabril in her bloodstream at the time of her collapse. This was established by analysis of an ante-mortem sample taken during her admission to hospital[6]. However, the evidence is clear that Ms Parker had missed at least the two doses that she should have consumed in the 24 hours before her collapse. The evidence was that irregular consumption of anticonvulsant medication is a matter that might place a person suffering from epilepsy at risk of seizure. Continued deprivation of sleep is another predisposing factor to seizure. By 15 March 2008 both of these elements existed as far as Ms Parker was concerned.

[6] Exhibit C27a, page 7

3.5. I have already referred to the fact that in December 2007 Ms Parker experienced an earlier period on remand in custody within the AWP. This period extended from 14 December 2007 to her discharge on 21 December 2007. During this period of custody Ms Parker was seen by medical staff within the PHS. It was noted that Ms Parker had a diagnosis of epilepsy for which she was being medicated by way of Sabril, 500mg, twice per day. She was not on Lithium. It was at that time that the management plan devised by Professor Kalucy was obtained and placed on the file. There were some behavioural issues during this period that involved Ms Parker failing to use the toilet within her cell and there were other behavioural difficulties. It was noted on 16 December 2007 that Ms Parker was refusing her medication and that she had no 'frank psychosis evident'. On 17 December 2007 she was seen by a doctor who noted Ms Parker's previous medical history of epilepsy and her medication of Sabril at 500mg twice per day. On 19 December 2007 it is recorded that Ms Parker was complaining of various symptoms, for the most part apparently exaggerated, and which were accompanied by a statement that she would collapse if she had a shower. She smelt of urine. There were other outlandish statements made by her. It is recorded that at this point she was housed in D Wing and was wearing canvas that is worn by prisoners at risk. It is also recorded by a registered nurse on this occasion that Ms Parker was somaticising and was fixated on convincing staff that she was unwell[7]. Nevertheless, at that point she is noted as eating and drinking well. On 21 December 2007 Ms Parker was released. There is no evidence of any seizures taking place during that period of custody although it is noted that on 15 December 2007 she had complained to correctional officers that she had suffered two seizures, a stroke, two heart attacks and a fatal haemorrhage. The reliability of claims of seizures unless witnessed or clinically confirmed would thus be questionable.

3.6. Between 21 December 2007 and 26 February 2008 Ms Parker, save and except for occasional periods in the Christies Beach police cells, was at liberty in the community. In the intervening period there were several incidents involving Ms Parker in which she had caused disturbances at a number of medical facilities including the Adaire Clinic, the FMC and the Noarlunga Hospital. There were disturbances at other places. The police made a number of arrests in this period. In addition, on 4 January 2008 Ms Parker was apprehended by police under Section 23 of the MHA and delivered to hospital where she was released the same day. A similar

[7] Exhibit C22, page 19

apprehension took place the following day and Ms Parker was released from detention the day after that. Police again apprehended Ms Parker under the MHA on 26 January 2008 following an incident at the Woodcroft Caravan Park. She was delivered by police to the staff of the Noarlunga Hospital who refused a detention order and so she was required to leave. When she refused to leave she was arrested by police. There were further incidents in January and February 2008 involving Ms Parker, including one incident where police are recorded as having not attended because they had formed the view that by then the hospitals would not deal with Ms Parker.

3.7. In the period leading up to Ms Parker's first custodial remand at AWP in December 2007, and in the period between her two custodial remands at the AWP, Ms Parker apparently experienced a number of epileptic seizures. On 15 November 2007 Ms Parker phoned the SAAS saying that she had a prolonged epileptic seizure. On 29 November Ms Parker had been found unconscious in bed by a male friend who believed she had a seizure. She was reportedly incontinent and had bitten her tongue. She experienced a further grand mal seizure in the emergency department of the FMC later that day. On 24 December 2007 it is reported that Ms Parker was conveyed from the Christies Beach police station to the Noarlunga Hospital after she had suffered a fit in the cells. She was there being kept in custody in respect of an incident that had occurred at the Noarlunga Hospital on 21 December 2007, the day of her release from her first period of custody at AWP. It was recorded that on the afternoon of 19 February 2008 Ms Parker was taken by ambulance to the Noarlunga Hospital having been described by staff of a Hackham hotel as disoriented as a result of an epileptic seizure.

3.8. There were other incidents in the intervening period that involved Ms Parker experiencing apparent or actual seizures while in police custody. It is recorded that on 29 January 2008 while being kept in the cells at the Christies Beach police station Ms Parker began shaking when her name was called out. On closer examination it appeared that she was having what appeared to be an epileptic fit in which her eyes rolled and she drooled and during which she became unresponsive[8]. The fit is described as lasting approximately 3 or 4 minutes. An ambulance was called but by the time of its arrival Ms Parker was no longer fitting. Nevertheless Ms Parker was conveyed to the Noarlunga Hospital. She was later that morning returned to the cells

[8] Exhibit C18aat

from the hospital. On the night of 24 and 25 February 2008 Ms Parker was again in police custody. In the early hours of the morning of 25 February 2008 Ms Parker was found on the floor panting heavily with vomit next to her face. She was unresponsive for between 30 seconds to a minute. This was followed by a period of lucidity and she returned to her bed. An ambulance was called notwithstanding and Ms Parker was conveyed to the Noarlunga Hospital for further assessment and medication. She was later that morning returned from the Noarlunga Hospital having been given some anticonvulsant medication including Sabril. Later that same morning shortly before 6am it is recorded that Ms Parker rolled off her bed onto the floor experiencing an epileptic seizure that lasted about 1 minute[9]. Irrespective of whether any of Ms Parker's behaviour generally could be identified as attention seeking, from those descriptions it would be impossible to say that any or all of the apparent recent seizures had been feigned. It is clear that any person assessing Ms Parker's risk of further seizures would seriously have to take that recent history into account.

3.9. While in police custody during this period there are a number of references to Ms Parker being medicated with Sabril.

3.10. During the afternoon of the day following the epileptic incidents on 25 February, Ms Parker was released from custody. Later on the day of her release, being 26 February, police attended at the Noarlunga Centre in response to an incident in which Ms Parker was found in the food court chanting religious statements and calling out for her husband who was not there. She was arrested for disorderly behaviour and she then remained in custody throughout.

4. Ms Parker is remanded in custody

4.1. On 26 February 2008 Ms Parker was taken first into custody at the Christies Beach Police Station. She was then transferred to the AWP having been remanded in custody by the Christies Beach Magistrates Court. I am not certain why Ms Parker was thereafter kept in custody. It may well be that her ongoing custody was the result of her not applying for bail. This does not explain why her release could not have been secured in any event. It would seem an extraordinary and inhumane response from an enlightened society such as ours that a person could be kept in custody for the next 2

[9] Exhibit C18aau

to 3 weeks for a relatively minor matter such as this, even taking into account Ms Parker's apparent incorrigibility.

4.2. When Ms Parker was remanded in custody, a SAPOL document known as a PD331, which is a Prisoner Screening Form, accompanied her to the AWP. This document related exclusively to Ms Parker's police custody on 26 February. Among other things, the document described a number of matters relating to her health and made mention of her epilepsy and the fact that she was prescribed Sabril. It mentioned nothing of Ms Parker's recent epileptic episodes that had occurred in police custody at Christies Beach on 25 February. The fact was that Ms Parker had been released from police custody earlier on 26 February and had been re-arrested. If her police custody had been uninterrupted, it would normally have been expected that any health issues that she had experienced while in that custody, including seizures, would have been drawn to the attention of the AWP staff either by way of the PD331 or by other accompanying documentation. The fact that her custody had been interrupted on 26 February meant that these recent episodes were not made known to AWP staff, simply by virtue of the fact that her most recent police paperwork did not contain any reference to them. I do not say this critically of police because their procedures were not designed to furnish information about a prisoner beyond his or her most recent period of police custody, but it would be far better if all recent incidents involving a prisoner's health that have occurred while the prisoner is in SAPOL custody were drawn to the attention of the staff of any other custodial institution to which the prisoner might be transferred, regardless of whether or not those incidents had occurred during the most recent period of SAPOL custody. As it was to transpire, AWP staff, including both corrections staff and medical staff, were not made aware of Ms Parker's most recent history of epileptic seizure that had occurred since she had last been remanded in that institution when such was highly relevant to her risk of seizure while in their care and custody. I intend to recommend that such an unsatisfactory state of affairs be rectified.

4.3. Ms Parker's custody in the AWP on this occasion had a worrying start. Her behaviour was such that she could not be properly inducted and assessed. She was immediately regarded as a prisoner at risk. At the manager's parade on the day following her arrival at the institution, Ms Parker was allegedly very aggressive towards the Unit Manager, Mr Richards, whom she pushed in the chest. It was also

alleged that overnight she had kept other prisoners awake with her constant yelling and abuse to correctional officers. The PHS file confirms belligerent behaviour on her part on 26 and 27 February 2008.

4.4. For these reasons Ms Parker was made subject to a regime of separation from other prisoners and was confined to a single cell. The imposition of this regime is permitted in certain circumstances under Section 36 of the Correctional Services Act 1982 (the Act). Generally speaking, a prisoner must not be kept separately and apart from all other prisoners in a correctional institution except in accordance with Section 36. The circumstances in which a person may be kept separately and apart are limited. The order for such separation may be made by the Chief Executive Officer of the Department for Corrections, a person not actively involved in the day to day running of an individual correctional institution. However, all of the Chief Executive's powers under the Act, including all of the powers under section 36, may be delegated.

4.5. One of the circumstances that might enliven section 36 is the need to keep a particular prisoner separate and apart from other prisoners 'in the interests of security or good order within the correctional institution'[10]. A direction for separation made on that ground had continuing effect until it was revoked by the Chief Executive Officer or that person's delegate. The direction was required to be in writing. In addition, the Chief Executive Officer, or the delegate, was obliged as soon as reasonably practicable after giving such a direction to furnish the Minister for Correctional Services with a report of the circumstances in which the direction was given. On receiving such a report the Minister was entitled to review the matter and confirm or revoke the direction.

4.6. In 2008 the section 36 powers were delegated to officers who were employed within an institution such as a Unit Manger or Officer-In-Charge of a prison on a given shift. There was nothing in the Act to suggest that an order for, or the reasons for, the effective solitary confinement of an individual prisoner, a deprivation of liberty that would be unlawful but for the section 36 exceptions, need ever be communicated to the Chief Executive Officer at the time of its imposition or operation. The Chief Executive's responsibilities in this regard were to that extent not so much delegated as abdicated.

[10] Section 36(2)(d) of the Act

4.7. The order that Ms Parker be kept separately and apart from all other prisoners was executed on 27 February 2008 and was said to have been made in the interests of security or good order within the correctional institution. This order was open ended in the sense that it did not have an expiry date and it remained in place until 16 March 2008, the date of Ms Parker's death. The effect of the order was that Ms Parker was kept in virtual solitary confinement within her cell in D Wing.

4.8. In Ms Parker's case a report to the Minister was prepared by Mr Greg Weir who was the Director of Strategic Services for the Department for Correctional Services (DCS). This document together with the separation order is attached to the affidavit of Mr William Ronald McLoughlin[11] who is the Supervisor of Operations at the AWP and who was at the time the holder of an appropriate delegation to make a separation order. He caused the order to be made in Ms Parker's case. The report of Mr Weir sets out the circumstances in which the separation order came to be imposed, namely Ms Parker's behaviour overnight and the incident involving Mr Richards, the Unit Manager, on 27 February 2008. Naturally the document could not predict what was to develop as far as Ms Parker's situation was concerned and it was in that sense a mere snapshot in time. One would have thought that if any communication was to be made to the Minister about Ms Parker, a notification concerning her circumstances as they existed in mid March would have been exceedingly more appropriate. A letter written for and on behalf of the Crown Solicitor that was tendered to the Inquest[12] informs me that in any case there was no record of the formal separation report having been received at the Minister's office. Therefore, the distinct possibility exists that the Minister was never informed of Ms Parker's separation from other prisoners, nor of the circumstances in which that separation came to be effected and maintained. If so, this would represent a highly undesirable state of affairs because it might mean that nobody in authority outside of the confines of the AWP would have known of Ms Parker's predicament in any meaningful detail or would have been in a position to do anything in order to mitigate the adverse affects of her solitary confinement or to otherwise question the appropriateness of her custodial regime and the dreadful conditions under which she was existing. A requirement that the Minister only be informed about the imposition of a separation order just the once at the very beginning of its period of operation, when such separation might be maintained

[11] Exhibit C43
[12] Exhibit C42

indefinitely, and during which the circumstances of the prisoner might change and not necessarily for the better, would seem in truth to provide a conspicuously inadequate framework for the humane oversight of prisoners who for whatever reason are deprived of the ability to fraternise with other inmates or at least to associate with people other than their gaolers.

4.9. Mr Richards, the Unit Manager, explained to me in his evidence that while he had entertained a concern about Ms Parker's mental health, he needed to be guided by the medical staff at the AWP and his belief was that the PHS had indicated that there was nothing that they could do as Ms Parker's presentation was 'behavioural'. He had hoped that Ms Parker might have been detained under the Mental Health Act. Mr Richards told me that he was aware of Ms Parker's deterioration in the few days before her death, and on 12 March he had inspected Ms Parker and her environment and had believed that Ms Parker would subsequently be showered. He told me that he also viewed the scene on 14 March. The only plan that he regarded as appropriate, taking into account the fact that medical had said that they were able to do little for Ms Parker other than what they were already doing by way of seeing her on a daily basis, was for her to be kept separated. Mr Richards told me that he had regular communication about Ms Parker with his superior, the Acting General Manager, Mr Kevin Baohm. Mr Richards was of the belief that the prison management group could have done little more to relieve the situation over and above what they were doing in respect of Ms Parker. He told me, however, that in hindsight he might have better utilised the services of the intervention team of social workers and psychologists. He did say that the High Risk Assessment Team had discussed Ms Parker at regular meetings. Mr Richards stated that he did not know of Ms Parker's epilepsy. In regards to the section 36 regime the instigation of which he himself had been party, Mr Richards agreed that it would have been difficult for it to be reviewed without information such as that surrounding the behaviour that manifested itself on Saturday 15 March, and the sleep deprivation issues, having been drawn to his attention which they were not. He did not work on that day. Finally, when asked as to how long the situation regarding Ms Parker was going to be tolerated, all Mr Richards could tell me was that it would have been raised at the next HRAT meeting where the PHS, prison psychologists and social workers would have been involved in making further assessments as to her ongoing management.

4.10. Mr Baohm was called to give evidence. He was the Acting General Manager of AWP. He stated that he had discussed the matter of Ms Parker with Mr Richards, but did not recall specifics. He did not have any direct dealings with Ms Parker's issues at AWP. It was pointed out to Mr Baohm, based upon HRAT meeting minutes that he had approved, that he must have had some detailed knowledge of Ms Parker's situation, but it has to be said that in my view the reports of Ms Parker in these minutes are in bland terms and in any event the most recent meeting had occurred on 11 March which was prior to the significant deterioration of Ms Parker's presentation. Mr Baohm told me he knew nothing of Ms Parker's cell becoming putrid with faeces and urine. If he had known about that, Mr Baohm suggested that the Yatala emergency response group may have been needed to remove Ms Parker from the cell in order to enforce a cleansing of her and her environment. Mr Baohm could not recall whether he knew of Ms Parker's epilepsy at the time. Mr Baohm's ignorance of Ms Parker's situation as of 14 and 15 March 2008 is nothing short of astonishing.

4.11. As it transpired, nobody at AWP assumed ownership of what by 15 March had become a very difficult problem in respect of Ms Parker, which was only tolerable and mitigated to the extent that it could physically be contained within the four walls of a cell, when plainly what was required was fresh oversight by and intervention from persons in authority both inside and outside the institution.

5. <u>Ms Parker's medical management while in the AWP</u>

5.1. It is necessary to say something more about Ms Parker's management during her first period of custody at the AWP from 14 to 21 December 2007. On that day she was seen by the nurse, Mr Tony Reynolds, who noted that he was unable to assess Ms Parker properly due to her behaviour. He noted her history of bipolar and borderline personality disorder and contacted the Noarlunga Mental Health Team to obtain information about her medication and treatment. The nurse noted that she was on 1gm of Sabril. Ms Parker was placed in D Wing on canvas for camera observation. Mr Reynolds specifically noted that the Department for Correctional Services, as distinct from the entity he worked for which was the PHS, were aware of her epilepsy and behavioural component. Individual officers at AWP told me in evidence that they had no such awareness in March 2008.

5.2. According to the PHS notes, with the possible exception of 18 December Ms Parker was seen on a daily basis either by a member of the nursing staff or by a doctor. Certain behavioural issues were noted that included observations of feigned disorientation and exaggerated claims of medical episodes including seizures. There was also a notation that Ms Parker was urinating on the floor. There was a refusal of medication on 16 December 2007 and also a noted observation of poor hygiene.

5.3. On 17 December 2007 Ms Parker was seen by Dr Srimal Nawana. Dr Nawana was a senior visiting medical officer with the PHS on a part-time basis. Dr Nawana recorded that Ms Parker's previous medical history included epilepsy and borderline personality disorder and she noted the fact that Ms Parker was medicated with 500mg of Sabril, twice per day, but with no Lithium for 3 to 4 weeks because Ms Parker was refusing it. Dr Nawana noted that hospital admissions had been unhelpful. This was the only occasion on which Ms Parker was seen by Dr Nawana during this period of custody. Dr Nawana gave evidence at the Inquest. She told me that Ms Parker appeared somewhat dishevelled and was wearing a canvas smock on this occasion. Ms Parker had not said anything to Dr Nawana about her having experienced seizures. Dr Nawana decided that Ms Parker should continue on her Sabril medication, presumably in the dosage already identified and that the next step in the plan was to order a psychiatric review which in the event did not take place because of Ms Parker's release on 21 December 2007. There was no further medical review by a doctor during this period of custody. Prior to Ms Parker's release there were other notations made in the PHS notes wherein Ms Parker is recorded as having made further claims of unwellness and complaints of strokes, chest pain and vertigo. The room was noted to smell of urine. There were claims of rape and of police corruption made by Ms Parker. It was noted that Ms Parker was 'fixated on convincing staff that she is unwell'[13].

5.4. Ms Parker was again admitted to AWP on 26 February 2008. In the meantime she had experienced the episodes of seizure that I have described. Dr Nawana saw Ms Parker on 28 February 2008. This was the only occasion Ms Parker was to see a doctor during this period of custody, but she continued to be seen by nursing staff on an almost daily basis. The notations within the PHS notes and the evidence of correctional officers and nurses who came into contact with Ms Parker in this period

[13] Exhibit C22, page 20

very much suggest that Ms Parker's behaviour and frame of mind deteriorated to the point where any reasonable person would have taken appropriate remedial action at the first available opportunity. There were notations of persecutory ideas[14], claims of multiple rape, grandiose ideas with claims of a connection with ASIO and that she was working as an under cover police officer. The assessment on 1 March 2008 was that Ms Parker had poor insight in regards to her circumstances and legal issues, was grandiose and deluded. There are other notations over the next few days that suggested that Ms Parker was at times coherent, composed and cooperative[15] but that she was still preoccupied with accusations of rape, kidnapping and hostage situations and that she made continuing claims of being a psychic police officer and Zen master[16]. By 8 March 2008 Ms Parker had developed a preoccupation with the notion that she was pregnant which was not the case[17]. On 10 March 2008 she was noted to have been 'up all night talking to God'. Monday 10 March 2008 was a public holiday and but for that fact, Ms Parker would have been psychiatrically assessed on that day. It was anticipated that she would be psychiatrically assessed the following Monday 17 March, but she died in the meantime.

5.5. In the next two days Ms Parker attended Court on two occasions and it was in respect of these attendances that she failed to acknowledge the bond and was therefore not released. One matter of concern is that the Court expressed the view that Ms Parker required urgent psychiatric assessment. This assessment did not take place, and certainly did not occur urgently. There was no expectation that Ms Parker would be psychiatrically evaluated other than by way of the visit that would in any event take place on Monday 17 March. There is no notation of any other expectation or plan in this regard, and so it appears that nobody did anything to expedite the psychiatric review that the magistrate believed was desirable.

5.6. Much of Ms Parker's acute behavioural difficulties occurred and escalated from that point in time onwards. It was reported that Ms Parker did not sleep for 72 hours as observed by correctional officers[18]. There was much singing and dancing exhibited by Ms Parker in her cell, and on 13 March 2008 she was talking to herself and pretending to ride a motorbike in her underwear. On that day, in the afternoon, it was

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[14] Exhibit C22, page 27
[15] Exhibit C22, page 28, 3 March 2008
[16] Exhibit C22, page 29, 3 March 2008
[17] Exhibit C22, page 31
[18] Exhibit C22, page 61

noted that she had been voiding in her cell and throwing food, urine and what was thought to be faeces around the walls and onto the door. She was yelling and was threatening towards DCS and medical staff. The correctional officers were unable to enter her cell and offer her a shower and she was refusing to speak to medical staff. There was a notation on this day that she was still to be seen by the psychiatrist on the Monday. There does not appear to be any evidence that any effort was made for Ms Parker to be seen any earlier and for reasons that appear to involve poor communication within the correctional system, the court ordered psychiatric review did not occur.

5.7. On 14 March 2008 there was a note to the effect that in the morning she was uncooperative with DCS regimes. The cell was squalid and filthy. Ms Parker was smearing faeces on the wall. She threw water at an officer and her severe sleep disturbances were noted. The plan at that point was for her to undergo DCS management, daily nursing review, for the DCS to monitor her food and fluid intake and for the psychiatric examination to take place on the Monday. It was that afternoon that the incident involving the hosing out of Ms Parker's cell took place. I return to that particular incident in a moment.

5.8. The only medical assessment that Ms Parker had during this period of custody was the one that was conducted by Dr Nawana on 28 February 2008. Dr Nawana formed a conclusion that Ms Parker's presentation had been very similar to that in December 2007[19]. Dr Nawana did not regard Ms Parker's psychiatric review as urgent, the plan in the meantime being for Ms Parker to be seen by the nursing staff on a daily basis and for Ms Parker again to be seen by a doctor in a fortnight[20]. The medication of Sabril at 500mg twice per day was again noted, as was the absence of a Lithium medication regime.

5.9. Dr Nawana was not made aware of any recent seizures in respect of Ms Parker. That set of circumstances owes itself to the fact that no information from SAPOL made its way to the PHS. Dr Nawana was naturally asked in her evidence as to whether she had questioned Ms Parker about seizures since Dr Nawana had last seen her. Some of Dr Nawana's answers in this regard were unhelpful[21]. In the event, I was not at all confident that Dr Nawana had asked Ms Parker whether she had suffered any seizures

[19] Transcript, page 525
[20] Transcript, page 528

since she had last seen her. Nor does it appear from her evidence as a whole that Dr Nawana gave any further consideration as to whether or not Ms Parker had experienced epileptic seizures and whether Ms Parker's current regime of anticonvulsant medication was working. Dr Nawana conceded that information about recent seizures would have been relevant in any medical assessment and it is not difficult to see why that would be the case. She conceded that she would have wanted to know that three days prior to her examination on 28 February Ms Parker had experienced a seizure in police custody[22]. Again, this would have been an obviously relevant piece of information. Dr Nawana said that if she had known this she may have considered a neurological review, but she indicated that this might have taken some weeks to organise. In addition, Dr Nawana said that she would have needed to obtain further history from Ms Parker's general practitioners, and perhaps from Ms Parker herself, in order to determine whether it was necessary for Ms Parker's medication to be altered. Dr Nawana seems to have held the belief that while Ms Parker was being observed in a camera cell, she was in a safe environment in the context of possible seizures[23]. This statement by Dr Nawana is somewhat ironic having regard to the fact that when Ms Parker did experience a seizure on 15 March 2008, camera observation within her cell was to count for little in terms of the response to Ms Parker's seizure.

5.10. Dr Nawana had to concede that the recent epileptic episodes would have been of relevance to Ms Parker's ongoing care. If it became obvious that Ms Parker had not been sleeping and it had also been appreciated that she was not taking her anticonvulsant medication, there was in Dr Nawana's opinion reason to consider Ms Parker as being at potentially higher risk of seizure and that for that reason she should be monitored more closely[24]. In her view such would include ensuring that the correctional officers were equipped to identify a seizure that was being experienced by a patient[25].

5.11. The level of sleep deprivation experienced by Ms Parker appears to have been quite widely known amongst correctional staff. One is reminded that on the morning of 14 March 2008 it was noted that DCS staff had spoken of severe sleep disturbances in

[21] Transcript, page 534, line 36 and following, Transcript, pages 535, 548, 549, 563 lines 7-10
[22] Transcript, page 529
[23] Transcript, page 531
[24] Transcript, page 572
[25] Transcript, page 572

Ms Parker. As far as medication is concerned, it was known by nursing staff that she did not take her Sabril dosage either on the night of 14 March 2008 or during the morning of 15 March 2008, dosages which in any case were virtually the bare minimum. Thus, by 15 March 2008 Ms Parker was at an enhanced risk of seizure. Although that risk may not have been clearly understood by those whose responsibility it was to care for Ms Parker, there was certainly information available from which a conclusion of enhanced risk of seizure could be drawn. The notion that Ms Parker's risk could be managed by CCTV observation was proved to be incorrect. There was an element of naiveté about the notion that it could. What Ms Parker required was professional medical evaluation at this point.

5.12. To my mind Ms Parker's risk of an epileptic episode was neither properly assessed nor effectively managed.

5.13. As far as Ms Parker's psychiatric health was concerned, Dr Nawana did not believe that Ms Parker required an urgent psychiatric review as of 28 February 2008. Her expectation was that it would take place within the next few weeks depending on other urgent matters that may be brought to the attention of the psychiatrist[26]. Dr Nawana regarded the FMC management plan that had been compiled by Professor Kalucy as a plan that she could use, together with her own assessment, in order to formulate a plan for Ms Parker in the AWP[27]. Dr Nawana knew that Ms Parker had not taken Lithium for some weeks but did not feel that this medication could be enforced; thus the focus was essentially on observation of the patient and maintaining her safety, considering that it was not possible in her opinion for her to be detained. Dr Nawana was of the view that Ms Parker could only be detained under the MHA if she had a treatable psychiatric diagnosis which she did not believe she had. She did not believe that there was evidence that would sufficiently warrant detention of Ms Parker. Dr Nawana was challenged as to that view in the light of Ms Parker's subsequent behaviour. Certain features of Ms Parker's ongoing presentation were drawn to Dr Nawana's attention, such as Ms Parker's talking to God all night, her pretending to ride a motorbike in her underwear and naturally her habits concerning bodily secretions. Dr Nawana expressed the view that the reason underlying that behaviour could have been her severe personality disorder, but indicated that it would not be unreasonable for a medical practitioner to see a patient in those circumstances

[26] Transcript, page 526

and to make a decision about whether the patient required assessment. Behaviour that Ms Parker exhibited on 14 March 2008 that included pretending that she was shooting at people, yelling profanities and throwing a bowl of urine at the door, ideally should have attracted the attention of a medical practitioner in Dr Nawana's view. This appears to be an understatement. However, she believed that the most likely diagnosis was that as previously established and that such behaviour was perfectly consistent with her diagnosed 'personality disorder'[28]. Dr Nawana expressed the view that MHA detention required a treatable condition and that Ms Parker's current diagnosis would not in its own right have enabled the patient to be detained. This is a very debatable proposition having regard to the broad definition of mental illness in the MHA[29].

6. The events of Friday 14 March 2008

6.1. I have already referred to some of Ms Parker's behaviour on Friday 14 March 2008. By that morning it appears that Ms Parker's intransigence and lack of cooperation with DCS regimes was well established. As well, her cell was squalid and filthy and it was noted by one of the nurses, Mr Trevor Aylett, that she was now smearing faeces on the walls. It was during the morning of that day that Mr Aylett was made aware of the fact that DCS staff had observed severe sleep disturbances. Mr Aylett was later that day to converse with a member of the corrections staff, Mr Mark Humphreys, about what should be done regarding the situation that had developed. It was following these discussions that the incident in which Ms Parker's cell was hosed out occurred.

6.2. Earlier that day DCS staff had approached one of the other members of the nursing staff, Ms Cheryl Hyland, about Ms Parker and her behaviour. It was said that DCS officers could no longer handle the odour emanating from Ms Parker's cell. Ms Hyland went to D Wing and observed what appeared to be faeces present on the window in the door to Ms Parker's cell and that there was liquid coming out from under the door. It was on this occasion that Ms Parker gesticulated in a shooting motion and yelled profanities. By this time Ms Parker had been reduced to wearing a bra and nothing else and this was to remain her state of dress until her collapse the following day. At one point Ms Parker picked up a bowl of what appeared to be urine

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[27] Transcript, page 528
[28] Transcript, page 559

and threw it at the door. Ms Hyland gave evidence in the Inquest and described these events. In a note that she made of these events, Ms Hyland recorded:

> 'Liaised ċ DCS to arrange client to be cleaned up & brought to medical for MSE, ċ plans for further evaluation. ? Refer to RAH or manage here' [30]

Ms Hyland told me that she was concerned about Ms Parker to the point that she wanted her to be brought to the medical centre so that an appropriate environment could be established in which she could be assessed by a mental health nurse[31]. Ms Hyland believed that for this purpose Ms Parker should have been cleaned up, but Ms Hyland made it plain in her evidence to me that she would still have been prepared to see her in the medical centre even if she remained unclean[32]. Before Ms Hyland left for the day she raised the entire issue with a more experienced nurse, Mr Aylett. Ms Hyland recalled that Mr Aylett contacted DCS staff and suggested that they cleanse Ms Parker and bring her to the medical centre for assessment[33]. Ms Hyland explained what had been in her mind when she recorded the last two sentences of her note. She had in mind the possibility that the on-call doctor be called, or that Ms Parker be sent away to hospital for possible detention under the MHA. As I understood Ms Hyland's evidence she did not in terms necessarily raise that as a viable strategy with her more senior colleague, Mr Aylett[34]. In the event, she became aware of correctional staff's inability or unwillingness to bring Ms Parker to the medical centre, but at the time she left for the day she was still of the belief that they might have cleaned her up and brought her over.

6.3. Mr Aylett also gave evidence in the Inquest. Mr Aylett had seen Ms Parker earlier in the morning and he explains in a statement that he made to police[35] that his impression was that whether or not a psychosis accounted for Ms Parker's presentation, she was in any case starting to deteriorate and was becoming 'hypomanic', similar to deteriorations that he had understood had happened to her in the community. Mr Aylett did not formulate any specific plan at that point but later that day other nursing staff, and that would be Ms Hyland, expressed concern about Ms Parker. Mr Aylett told me that he had his own concerns about Ms Parker by then. He knew nothing of

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[29] Mental Illness means any illness or disorder of the mind
[30] Exhibit C22, page 35
[31] Transcript, page 196
[32] Transcript, page 197
[33] Transcript, page 197
[34] Transcript, page 220
[35] Exhibit C8a

any Court ordered psychiatric assessment which he told me he would have welcomed in the circumstances. He believed that Ms Parker required psychiatric evaluation at the earliest opportunity[36]. That afternoon Mr Aylett contacted Mr Mark Humphreys, a corrections officer, about the matter. Mr Aylett had decided that he would ask DCS to bring Ms Parker to the medical centre for a proper physical and psychological examination because:

> 'I felt that it was appropriate to get her out of that environment and actually have a good look at her.' [37]

Mr Aylett's own note in the PHS records, records that he had a 'long discussion' with Mr Humphreys and he noted that the upshot of their discussion was that Ms Parker would be cleaned up that day[38]. Mr Aylett noted the following:

> 'I am happy to re-assess but DCS feel that Ms Parker is too aggressive to unlock.' [39]

In the event, sometime during that afternoon Mr Humphreys told him that although his officers had put on biohazard suits to go into the cell, they had changed their minds due to Ms Parker's aggression. At the same time, Mr Aylett claims that Mr Humphreys told him that they had hosed Ms Parker down. He believed that the expression that Mr Humphreys had used was '*I hosed her down*'[40], but later conceded in evidence that Mr Humphreys may have said that he had hosed the cell down. Mr Aylett told me that he then spoke to his nurse manager who expressed shock at this development[41], an emotion that he says he felt himself. Mr Aylett, however, did not make any record in his note of that afternoon's events about the hosing down incident. Nor is there anything mentioned about that in Mr Aylett's witness statement.

6.4. Mr Aylett told me that he did not see the need to go over Mr Humphreys' head because he did not perceive or believe that Ms Parker was in imminent danger[42]. He also told me that there was difficulty for medical staff to assert themselves. He said that at that time there was a very strong tendency for operations, as opposed to medical, to exert more control over the prison environment[43].

[36] Transcript, page 398
[37] Transcript, page 409
[38] Exhibit C22, pages 35-36
[39] Exhibit C22, page 36
[40] Transcript, page 410
[41] Transcript, page 411
[42] Transcript, page 502
[43] Transcript, page 507

6.5. Mr Aylett told me that when he spoke to his manager, Ms Eckert, there was no suggestion made about calling a doctor. His own belief was that he should possibly call a medical officer on that day, but he decided against it because his priority was to keep Ms Parker safe and that this would be facilitated by keeping her cell under camera observation. This was unfortunate missed opportunity. If Mr Aylett had brought a medical practitioner in that day, it may well be the case that the outcome could have been altered by having Ms Parker removed from that terrible environment.

6.6. Mr Aylett rejected the suggestion put to him by Ms Kereru in cross-examination that he had the power to have Ms Parker removed from the cell notwithstanding the attitude of correctional services. He said:

> 'I don't have the power to tell correctional staff what to do.' [44]

He did accept that he had a right to call a doctor.

6.7. Mr Mark Humphreys gave evidence in the Inquest. He offered a differing version of these events. During the afternoon of Friday 14 March 2008 Mr Humphreys was the supervisor of the Women's Centre. He was not the officer in charge of the whole institution that afternoon. At about 3pm Mr Humphreys inspected Ms Parker's cell through the door. He observed faeces spread over the cell, all over the walls and all over the viewing glass in the door. He took the view that the cell needed to be cleaned up quickly. Prisoners and staff were complaining about the condition of the cell. At that time the management team within the prison were in a meeting and, as far as Mr Humphreys was concerned, they were unavailable[45]. So he took the initiative.

6.8. Mr Humphreys believed that the staff who were selected or had volunteered to clean the cell needed to put on protective clothing. His intention was that the cell would be cleaned while Ms Parker was placed in the shower. When they approached the cell for this purpose, Ms Parker was requested to leave the cell and have a shower. This request was greeted with violent yelling and screaming. At that point she threw what appeared to be faeces and urine towards the door. There was an attempt to grab one of the officers. Mr Humphreys decided that it was unsafe for any of the staff to enter the cell. He informed Ms Parker that he would hose down the cell with Ms Parker in it if she refused to leave. Ms Parker was non-compliant and continued to yell abuse at

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[44] Transcript, page 501

the officers. Mr Humphreys then commenced to hose down the cell through the trap door in the door. While he did this Ms Parker jumped in and out of the stream of water and changed in demeanour from one of violence to giggling and laughter. Mr Humphreys believed that the hosing of the cell was effective in cleaning it. No attempt was made to dry the cell off. He denied that he was punishing Ms Parker and believed that there was no other way of dealing with the situation at that time.

6.9. In his evidence Mr Humphreys denied that Mr Aylett had requested him to have Ms Parker cleaned up and brought over to the clinic for assessment[46]. He said that he had conversed with Mr Aylett about what could be done with respect to Ms Parker, but he denied that he was ever asked to bring her over to the medical centre. Mr Humphreys elaborated on his communication with nursing staff. After seeing the condition of Ms Parker's cell, he said that he had gone to the medical centre and had enquired as to what corrections officers could do about the situation. They had basically indicated to him that detention under the MHA was futile, that her presentation was deemed 'behavioural' and that if she was detained she would be released from detention and sent straight back to prison. In essence, he was told that nothing that could be done about it[47]. Mr Humphreys maintained that he had that conversation with Mr Aylett. He denied that Mr Aylett had made the approach to him. Mr Humphreys said that the approach was made to medical staff by himself.

6.10. Mr Humphreys asserted in evidence that he had no recollection of ever telling Mr Aylett that he had hosed down the cell or had used words to that effect.

6.11. Mr Humphreys believed that he told both Mr Cornell, a senior corrections officer, and Mr Richards, the Unit Manager, about the hosing out exercise. The only reaction that he obtained had come from Mr Cornell who had said that when Ms Parker calmed down she should be given dry clothes, which in her case would be dry canvas.

6.12. In essence, the purpose of Mr Humphreys' actions that afternoon was to sanitise the squalid environment in which Ms Parker was being housed and also to see that Ms Parker was herself cleansed. He said that he did not have any information about any desire on the part of PHS to have Ms Parker brought to the medical centre for assessment. If that is true, it is a curious feature of Mr Humphreys' evidence that he

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[45] Transcript, page 593
[46] Transcript, page 604
[47] Transcript, page 605

himself had initiated the communication with Mr Aylett at the medical centre. If Mr Humphreys' sole purpose was to cleanse Ms Parker and her environment, it would not have been necessary to involve medical in that exercise. The fact that Mr Humphreys and Mr Aylett conversed at all strongly suggests that there was discussion about what should happen to Ms Parker in terms of her medical assessment that afternoon. Mr Humphreys did not need Mr Aylett's permission to cleanse Ms Parker or her cell. It was certainly in Ms Hyland's mind, as evidenced by her note at 1pm, that DCS be asked to arrange for Ms Parker to be cleaned up and be brought to medical for a mental state examination that day. On the other hand, in Mr Aylett's note of his 'long discussion' with Mr Humphreys, all that Mr Aylett has recorded was that there was a consensus that Ms Parker would be cleaned up that day and that he was 'happy' to reassess her, but that DCS had felt that Ms Parker was too aggressive to be unlocked. Mr Aylett has not recorded anything by way of protest about that. Rather, the note suggests that Mr Aylett had neither entertained nor expressed any strong desire that Ms Parker be brought to the medical centre and had acquiesced in the DCS position that Ms Parker was too aggressive for her cell to be unlocked. Furthermore, Mr Aylett mentioned nothing of the hosing incident either in his note or in his witness statement, notwithstanding the indignation that he claims he felt upon receiving that piece of information and then discussing it with his superior.

6.13. While I am satisfied on the balance of probabilities that there was some discussion between Mr Aylett and Mr Humphreys to the effect that an assessment in the medical centre would be desirable, in my view Mr Aylett was not especially insistent about that when speaking to Mr Humphreys and was content in the knowledge that the problem would be dealt with by Ms Parker remaining in her cell under CCTV observation until the psychiatric assessment scheduled for the Monday could be carried out. To my mind, Mr Aylett should have been more insistent if he genuinely believed that Ms Parker needed to be medically assessed that afternoon, as she manifestly should have been.

6.14. The actions of hosing Ms Parker's cell with her inside it was a lamentable, ham fisted and unintelligent response to a difficulty that required subtlety and professional intervention at that point in time. No person senior to Mr Humphreys was made aware of the difficulty that afternoon. The exercise achieved nothing other than a temporary sanitation of Ms Parker's environment if that. It probably did little to

improve her own personal hygiene and, in any case, the exercise was hardly conducted for her benefit. Mr Richards, the unit manager, told me in evidence that he thought the hosing out exercise was:

> 'Very poor, I didn't agree with it at all.' [48]

This of course is easy for Mr Richards to say. The fact of the matter was that he was not on hand to prevent it. His own evidence reveals that essentially he himself had done nothing to alleviate the situation regarding Ms Parker. The then acting General Manager of the AWP, Mr Kevin Baohm, told me in evidence that he was horrified when he learnt of the incident. He testified that he would not have approved of any such measure, but he had offered little in the way of any alternative as far as dealing with Ms Parker was concerned.

7. <u>The events of Saturday 15 March 2008 prior to Ms Parker's collapse</u>

7.1. Ms Parker was reviewed by Ms Hyland on the morning of Saturday 15 March 2008. Ms Hyland made a note of her examination and it was Ms Hyland who was to instigate a medical review that day. When Ms Hyland went to the cell she observed that the window to the door was covered in faeces. Ms Parker was muttering to herself. Ms Parker was naked except for her bra which was hanging around her neck like a necklace. When Ms Hyland offered Ms Parker her medication, Ms Parker spat at her through the trap. She did not take her medication. She put her arm through the trap in an attempt to grab one of the accompanying officers. The DCS report that morning was that Ms Parker stayed up all night and talked to her husband for hours on end, arguing with him, even though he was not there. She continued to throw faeces and urine around the room and was very aggressive.

7.2. By that point it is said that Ms Parker had not slept for something like 72 hours and she had declined her previous two doses of anticonvulsant medication.

7.3. Ms Hyland spoke to Mr Aylett on the telephone that morning. It was agreed that the on-call doctor should be contacted.

7.4. Ms Hyland contacted Dr Gregory Dayman who was the on-call doctor. Dr Dayman was at home. Dr Dayman gave evidence to the Inquest. Dr Dayman had not been previously aware of Ms Parker at the AWP. During the telephone conversation with

Ms Hyland, Dr Dayman was informed about Ms Parker's ongoing behavioural issues and about her previous diagnoses. Dr Dayman formed the belief, on the basis of what he was told about Ms Parker, that she required detention under the MHA. As a medical practitioner, Dr Dayman would have been legally empowered to do that by virtue of Section 12(1) of the Mental Health Act 1993 as it then was. That ought to have required Dr Dayman to have personally examined the patient. It also would have necessitated Ms Parker's transfer to an approved treatment centre which the RAH was. Dr Dayman ideally would have preferred a direct admission to James Nash House which is the psychiatric facility for DCS. When he contacted James Nash House, Dr O'Brien, the forensic psychiatrist on call that weekend, explained that there was no bed available, which is very often the case. In any event an admission to James Nash House would have had to have been facilitated through the RAH Emergency Department. Dr Dayman told me that he told medical staff at the AWP should that they should try to give Ms Parker 10mg of Diazepam in tablet form in order to sedate her so that Dr Dayman could interview her.

7.5. Dr Dayman went to the prison at about 12:30pm. He was told that the Diazepam had not been given and that the trap for Ms Parker's cell had not been opened because of safety concerns.

7.6. Dr Dayman had access to Professor Kalucy's document which he noted had advocated against detention. However, Dr Dayman believed that Ms Parker had recently presented with bizarre delusional ideation and agitated and grossly abnormal behaviour and was noted to have not slept for 72 hours. He made a diagnosis of mania based on this information and he believed that she was at risk of harm to herself and the staff at the prison. This information in his opinion satisfied the criteria for detention under the MHA. He wrote a referral letter to the assessing doctor at the RAH and then contacted the psychiatric registrar there to inform her of his plan to detain Ms Parker. He never actually interviewed Ms Parker at the prison because he believed it was unsafe to do so. Dr Dayman explained the basis of his decision to detain Ms Parker as follows:

> 'I mean my basis for that was that she had in the past a diagnosis of bipolar affective disorder and although more recently from reading her case notes that had been called into question and her mental illness was thought more to be personality based, nonetheless she had exhibited very severely distressed behaviour. She most importantly

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[48] Transcript, page 860

> had been noted to really not be sleeping for the last 72 hours, which I feel is much more strongly related to a medical illness than that behavioural problem and that she was a risk to herself by the fact that her cell was soiled and unclean and she was unable to be sort of kept hygienic and she was a risk to others by - through assault, so I thought she satisfied the criteria for detention under the Mental Health Act.' [49]

It is difficult to see why others could not earlier have come to that same lucidly expressed conclusion. Dr Dayman decided to detain Ms Parker notwithstanding Professor Kalucy's written views about her. In that regard he was reinforced by his discussions with Dr O'Brien. Dr Dayman did not have any reservations about detaining Ms Parker, notwithstanding that he was not going to be able to examine her himself. Strictly speaking, Section 12(1) of the MHA would have required Dr Dayman to examine Ms Parker. However, to pass comment that Dr Dayman's detention may not have been entirely in accordance with the letter of the law would be churlish and idle when regard is had to the fact that he could in any event probably have satisfied the requirement of examination by observing Ms Parker on CCTV. In addition, it is not as if a personal examination of Ms Parker would in any way have altered Dr Dayman's decision when Ms Parker's presentation that day is considered. My view is that Dr Dayman is to be commended for the decisive position he took in respect of Ms Parker.

7.7. Dr Dayman told me that as it transpired there was some resistance by corrections officers to facilitate Ms Parker's transfer to the RAH. He said that at one point there was a suggestion made by a corrections officer that he would not have enough staff to facilitate the transfer and that the staff that he did have were too junior for the job. Dr Dayman also states that he was told that there would not be enough staff available until the Monday to facilitate the transfer safely.

7.8. In the event, Dr Dayman had to prepare a letter in order to persuade correctional staff to facilitate Ms Parker's transfer out of the prison. Dr Dayman supplied that letter as well as the Form 1 detention order. Mr Frank Edwards, who was the officer in charge of the prison during the day shift, told me in his evidence that he was contacted in the first instance by the nurse, Mr Tony Reynolds, who told him that Ms Parker would be moved to James Nash House which was inaccurate insofar as she had to go the RAH. Mr Edwards told me that his reaction was that all of this was totally unexpected on a

[49] Transcript, pages 124-125

Saturday and that the transfer had come '*out of the blue*'[50]. Mr Edwards established for himself through James Nash House that Ms Parker would first have to go to the RAH for assessment. Mr Edwards told me that Mr Reynolds, the nurse, told him that Ms Parker needed to be out of the prison and needed to be looked after. He said that he asked Mr Reynolds on a number of occasions if it was an emergency. When told that it was not an emergency at that stage, Mr Edwards said that he needed written authority in order for him to facilitate a transfer. Mr Edwards himself spoke by phone to Dr Dayman who by then had left the prison and as a result Dr Dayman had to fax the letter to which I have referred. Mr Edwards told me about his efforts to organise staff to conduct an escort to the RAH in a DCS van. A van was organised as were additional staff, but the fact of the matter was that others had it in mind that Ms Parker would more appropriately be transferred by ambulance which seems to be more logical having regard to the fact that she may have required involuntary sedation. An ambulance was never at any time organised for this purpose. Some DCS staff had formed the belief that a van would be the preferred method of transport.

7.9. It seems an odd thing for Mr Edwards to have stood on ceremony about paperwork when it was universally understood that it was in everybody's interests for Ms Parker finally, and as swiftly as possible, to be removed from her cell and taken somewhere where she could receive meaningful assistance and have some dignity restored.

7.10. It was while preparations were being made to have Ms Parker removed from her cell and then to be transferred in whatever vehicular arrangement was to be preferred that Ms Parker experienced the fatal epileptic seizure. It was not clear to me as to why Dr Dayman's detention and desire to have Ms Parker removed from the cell for that purpose, a desire expressed several hours earlier, took so long to be actioned such that she was still in the cell at 1638.

8. Laura Parker's collapse

8.1. Ms Parker's collapse was first observed by way of CCTV that was being monitored in the AWP control room. The control room operator that afternoon was Ms Karyn Jarman who at that time was a corrections officer. Ms Jarman is now a serving police officer. At the time she made her observations Mr Wayne Cornell, also a corrections officer, was present. Mr Cornell was in fact the oncoming officer in charge of the

[50] Transcript, page 727

prison that afternoon, having taken over from Mr Frank Edwards whose shift had concluded at 4pm but who had stayed on to supervise Ms Parker's transfer to the RAH.

8.2. Ms Jarman provided two statements to the investigating police[51]. She also gave oral evidence in the Inquest.

8.3. Part of Ms Jarman's responsibilities included monitoring activity in cells to which CCTV cameras had been installed. This included Ms Parker's cell in D Wing. The CCTV monitors bore a time that was depicted in hours, minutes and seconds utilising the 24 hour clock. At the beginning of her shift Ms Jarman checked the accuracy of the time depicted on the CCTV monitors by calling Telstra. There was only a very small discrepancy of a few seconds which required no adjustment. There was another clock in the control room that was not checked for accuracy. It may well be that there is a discrepancy between the time depicted on the CCTV monitors and the clock on this occasion.

8.4. There was a recording facility associated with the CCTV monitoring. Recording was only activated at the instigation of the control room operator and was not constant. The evidence is not entirely clear as to when exactly the recording within Ms Parker's cell commenced and what prompted it. Ms Jarman was of the belief at one point that she activated the recording because of Ms Parker's observed collapse. On the other hand, a copy of the recording which was produced at the Inquest suggests that the recording was commenced some minutes prior to the collapse because Ms Parker is seen standing and is conscious. In any event, by 1638 hours Ms Parker is lying on the bed within the cell and is motionless apart from the rising and falling of her abdomen through apparent breathing. In addition, there are movements of her mouth that suggest that breathing is still taking place, but it is evident that Ms Parker was experiencing some kind of episode. Ms Jarman told me that she interpreted this as a fit. Dr Martin Robinson, a neurologist who gave expert evidence, has interpreted it in the same way. I have no doubt that Ms Parker was experiencing an epileptic fit. Over the next 2 minutes or so the movement of Ms Parker's abdomen appears to continue but it gradually slows. It is difficult to see any movement of the abdomen or other evidence of breathing from 1641 hours onwards.

[51] Exhibits C36 and C36a

8.5. Ms Jarman gave evidence that when she observed what she believed to be a fit being experienced by Ms Parker, she spun around in her chair and said to Mr Cornell that she thought Ms Parker was having a fit. At that point she hit the alert button which sends out a tone and she then called a Code Black. In this case this consisted of her broadcasting over the AWP radio system that could be monitored by each correctional officer with a handheld radio the words 'Alert, Alert, Code Black'. At about this point Ms Jarman also commenced an incident log that then recorded various events connected with this incident as they occurred. The times of each facet of the incident were recorded by Ms Jarman. I am not at all certain whether Ms Jarman utilised the time on the CCTV monitor, the time on the clock or a mixture of the two to record the times of various facets of the incident. I say this because in some cases there are discrepancies between the times of incidents as shown on the CCTV footage and the times recorded in Ms Jarman's written incident log in respect of the same incidents. In any event, Ms Jarman recorded the time of 1639 as the time at which Ms Parker appeared to have fitted and when the Code Black was called. This recorded time does accord with the CCTV footage. I here set out Ms Jarman's incident log in respect of relevant occurrences noted by her[52].

ITEM NO	DATE	TIME	NAME/ORGANISATION	EVENT/ACTIVITY/PURPOSE
	15/03/08	1639		Pr Parker #155817 appears to have fitted, code black called. CO Marshall attends Control Room
		1642		Prisoner lying on bed, breathing noted
		1647		Prisoner appears to have stopped breathing. Staff informed - CO Rowan
		1649	CO's in biohazard suits	Staff attended rm 1, commenced CPR, Ambo called
		1654	Nurse Tony	Medical attended commenced CPR
		1656		CPR still being conducted, PR Rohde placed in holding cells
		1658		Further call to Ambulance
		1701		On call Manager contacted to come in ASAP
		1703		Ambulance x 2 arrive
		1705		Ambulance officers enter Rm 1 x 3 officers
		1706		Ambulance officers commencing CPR

8.6. It will be noted from the above table that Ms Jarman noted against a time of 1647 that Ms Parker appeared to have stopped breathing. In my view there is a case for saying that there was little evidence of breathing beyond about 1641. It appears that what caused Ms Jarman to believe that Ms Parker had stopped breathing was her

[52] Exhibit C36f

observation that Ms Parker's hand had turned blue. This is in fact evident on the video at 1647. In any case, at whatever time Ms Parker visibly stopped breathing, it is clear that Ms Jarman did not inform any correctional staff member about that until she made her entry timed at 1647. Ms Jarman told me that at that time she telephoned the movements' officer, Mr Peter Rowan who was in the movements office adjacent to D Wing, that Ms Parker appeared to have stopped breathing.

8.7. According to the time on the CCTV footage, Ms Jarman zoomed in on Ms Parker's cyanosed right hand at 16:47:40. Ms Jarman then for a few seconds scans what can be seen of Ms Parker's face and upper body. A reasonable conclusion is available that the incident log is accurate insofar as it records that at 1647 Ms Jarman observed that Ms Parker had appeared to have stopped breathing and that she informed Mr Rowan of that fact that same minute.

8.8. It will be seen from Ms Jarman's incident log that she has noted against the time of 1649 that staff attended Ms Parker's cell. This does not accord with the time seen on the CCTV footage. Staff are not seen to enter the cell or attend to Ms Parker until 16:50:54 as shown on the screen.

8.9. What is shown on the CCTV footage are the two corrections officers, Messrs Cornell and Edwards, attending to Ms Parker. Both are wearing blue biohazard suits with hoods, light blue gloves and white rubber boots. There is a third officer present, a Mr Feo, who is wearing what appears to be a full-face perspex mask as well as the biohazard suit and other protective clothing. Mr Feo does not appear to take any significant part in what is transpiring which in the main appears to be an examination by Cornell and Edwards of an unresponsive Ms Parker.

8.10. It can be seen from Ms Jarman's incident log that against the time of 1654, Nurse Tony, who is Mr Tony Reynolds, attended and commenced CPR. In fact, according to the CCTV footage time, Mr Reynolds entered the cell at 16:52:15. However, glimpses of a person, apparently Mr Reynolds, can be seen in the vicinity of the doorway at a time prior to that. Mr Reynolds' evidence was that he had only just been notified of the incident and that he immediately made his way to the wing. I accept that evidence.

8.11. Ms Jarman's incident log is demonstrably inaccurate insofar as it records that at 1649 correctional staff attended Room 1 when in fact they did not attend until 16:50:54. It

is also inaccurate insofar as it records that Mr Reynolds did not attend until 1654 when he in fact entered the room at 16:52:15. A third inaccuracy is the assertion in the incident log that correctional staff commenced CPR at a time prior to the arrival of Mr Reynolds. This is not correct. The CCTV footage reveals quite clearly that no chest compressions were administered until after Mr Reynolds entered the cell.

8.12. Mr Reynolds is not in any way protected by any suit, surgical apparel, head gear, footwear or gloves. He is seen to commence an examination of Ms Parker without any hesitation and then to begin resuscitative efforts at close quarters.

8.13. As seen in the video footage SAAS personnel enter the cell for the first time at 17:03:40. Ms Jarman has recorded in the incident log against a time of 1649 that the ambulance service was called. It will be noted that this forms part of the same entry that records the first attendance of correctional officers in the cell. I have already commented on the fact that this time appears to be inaccurate. In any event, as will be seen, it is clear that SAAS were not called until such time as it was obvious that Ms Parker was in extremis. Equally clear is that SAAS were not called at any time prior to correctional staff entering the cell.

8.14. All this means is that the failure of corrections officers to enter the cell as soon as the Code Black was called resulted in a significant delay in calling an ambulance.

8.15. SAAS personnel do not don protective clothing except for gloves.

8.16. It is clear that from 1639 when the Code Black was called until 16:50:54 Ms Parker was not attended to. It was highly appropriate that Ms Jarman call the Code Black. The Department for Correctional Services Standard Operating Procedure (SOP)[53], while confusing in some respects, governs the procedure in respect of the calling of a Code Black. This document makes it plain that a Code Black is by definition a medical emergency[54]. Another document that was drawn to my attention, which is entitled STANDARD OPERATING PROCEDURE SOP 020A – CODE BLACK – MEDICAL EMERGENCY with an approval date of 22 October 2007, in effect stipulated that a person who was unconscious or was observed to suffer a seizure was to be regarded as the subject of a medical emergency. Equally clear is that this incident was properly identified as a medical emergency by Ms Jarman and Mr

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[53] Exhibit C18k
[54] Exhibit C18k, page 9

Cornell who were both present in the control room when Ms Parker's collapse was observed. The SOPs mandated a number of actions. Firstly, they mandate the officer who discovered the incident immediately to initiate the Code Black. Secondly, the officer must administer first aid and attempt resuscitation of the prisoner. This case was slightly unusual in that the officer discovering the incident was the control room officer whose responsibilities were confined to the control room. However, it will be remembered that Mr Cornell was present in the control room at the time. He attended D Wing immediately after the Code Black was called. He was there in what must have been less than a minute. There was in reality no responsibility upon Ms Jarman to administer first aid or to commence resuscitation having regard to her particular responsibilities. However, there was clearly an obligation on Mr Cornell to do so. A third mandated requirement, and in my view a fundamental requirement of paramount importance, was that the control room officer, Ms Jarman, had to notify prison medical personnel of the incident particulars. The documents state that the obligation upon the control room officer was to notify medical staff 'immediately' and to do so via telephone and to seek their assistance. There was also a concurrent obligation to contact the ambulance service and inform them of a Priority 1 status.

8.17. A further document issued in November 2006 entitled EMERGENCY PROCEDURES MEDICAL EMERGENCY - (CODE BLACK)[55] and which purports to be in effect a local operating procedure for the AWP, describes the same obligations identified within the SOPs, including the duty on the part of the control room officer to notify prison medical staff to attend the location. The document goes on to obligate the control room officer to notify the relevant emergency service - for example, SAAS, when directed by the OIC. The obligation upon correctional staff to assist with medical assistance (first aid) is also identified in this document. I pause to observe that a complication exists insofar as it is said that as of 15 March 2008 the version of the local AWP document entitled EMERGENCY PROCEDURES MEDICAL EMERGENCY - (CODE BLACK) that was actually housed within the control room, was an outdated February 2004 version[56]. The 2004 version differed from the 2006 version insofar as the former did not mandate the immediate notification of prison medical staff to attend the location of the incident.

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[55] Exhibit C18j
[56] Exhibit C36h

8.18. All of the documents to which I have referred state that in administering first aid, officers should wear protective clothing. Reference is made to latex gloves and protective biohazard suits as necessary. One would have thought, however, that the need to use protective clothing would depend upon the nature of the emergency and the environment in which it was taking place and that it would not, of necessity, mean that resuscitation of a person who had experienced a known cardiac arrest could be delayed solely on the basis that the patient or the patient's environment was unclean. One would think that common sense and the natural inclination to preserve life would prevail over concerns of cleanliness.

8.19. An examination of these procedural documents reveals that standard procedures were simply not followed in this case. There was no immediate administration of first aid or attempted resuscitation of Ms Parker. Nor was there any immediate notification of prison medical personnel of the incident, in the sense that nothing of this nature took place immediately upon the initiation of the Code Black by Ms Jarman. Ms Jarman endeavoured to explain her failure to notify prison medical staff on the basis that the emergency procedures document that was actually situated in the control room was the version that did not contain the obligation to notify prison medical staff. None of this alters the fact that the operative Code Black obligations at the time included notification of prison medical staff without delay in accordance with both the SOP as well as the then current 2006 version of the medical emergency procedure document. Mr Cornell himself knew of the Code Black because he was present in the control room when it was called and as a senior correctional officer and officer in charge of the prison at that time, he clearly should have known what the obligation was as far as notifying prison medical staff was concerned. In any event, common sense dictated that a medical emergency as obvious as this one was, or was becoming, clearly required the attendance of medical staff at the earliest opportunity and without delay. The excuse that a superseded version of the relevant document was the one situated in the control room was a lame excuse in my view.

8.20. I add here that the AWP medical staff did not have access to the institution's radio system over which Code Blacks are called. They would therefore be oblivious to the calling of a Code Black unless notified either personally or by telephone of the incident involved. This was in fact the case here.

8.21. It will be noted that Ms Jarman's evidence is to the effect that she indicated to Mr Cornell, who was present in the control room at the time, that Ms Parker was apparently experiencing a 'fit'. She put it in those terms within the employee report form that she compiled prior to completing her shift. In her first witness statement made to police the day after, she described what she had said to Cornell in these terms:

> 'Fuck, I think Parker is fitting.' [57]

Ms Jarman explained to me in evidence that she had believed that Ms Parker was having a fit because her son had once experienced something similar. Ms Jarman has at all times been consistent in her assertion that she told Mr Cornell that Ms Parker was fitting.

8.22. Mr Cornell provided a statement to police on Thursday 3 April 2008[58]. He also gave evidence at the Inquest. Mr Cornell had also compiled an employee report form[59]. The report form in Mr Cornell's own writing is dated 15 March 2008. In his evidence before me Mr Cornell testified on oath that the contents of that document was true and correct, that it accurately set out a description of what had occurred and that he wished to adopt it as part of his evidence in the Inquest. A typed version of the report form was also similarly adopted. As well, Mr Cornell swore that his statement to the police was also to be adopted as part of his evidence in the proceedings. In both the handwritten and typed version of Mr Cornell's employee report form he states that Ms Jarman had said to him that it appeared that Ms Parker was 'having a fit'. In his police statement he describes what he was told in much blander terms, namely that Ms Jarman indicated to him that 'she wasn't happy … about the appearance of Ms Parker on camera'[60]. In his evidence in the Inquest Mr Cornell assiduously avoided any acknowledgment of the suggestion that at the beginning of the incident he had been told or had any understanding that Ms Parker was experiencing a fit.

8.23. Mr Cornell's evidence was that he hurried to D Wing from the control room, which only took him a very short period of time. The site visit of the AWP that took place during the Inquest would suggest that Mr Cornell must have been at D Wing within less than a minute. He proceeded to the D Wing office which was next to Ms Parker's

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[57] Exhibit C36, page 6
[58] Exhibit C40b
[59] Exhibit C40
[60] Exhibit C40b, page 2

cell. Mr Cornell states that Mr Edwards was in the office and was in the process of putting a protective suit on. Mr Cornell himself went to the door to Ms Parker's cell, pulled back the black plastic cover that was covering the viewing panel and yelled through the door and kicked the bottom of the door. He did this in order to draw a response from Ms Parker. He observed her '*flinch*'[61] in response, and in his statement he suggested that her 'whole body just jolted'. This alleged movement on Ms Parker's part does not appear on the CCTV footage, although to begin with the regular movement of Ms Parker's abdomen can be seen for a minute or two. Whatever Mr Cornell observed, it certainly could not have in any way reassured him that Ms Parker was not in need of assistance.

8.24. Mr Cornell then returned to the D Wing office and started to put on protective clothing. Mr Cornell suggested that it is standard procedure to 'suit up' before entering the cells and in this case he did so due to the fact that her cell was covered in faeces, urine, vomit and other bodily fluids and was 'putrid'[62]. He says that the equipment was already in the D Wing office when he arrived. Mr Cornell maintains that as he went into the D Wing office to don the protective clothing, Mr Edwards was leaving the office as the latter was by then already kitted up. He heard Mr Edwards yelling to Ms Parker and kicking the door of the cell. Another officer, Mr Feo, then entered the D Wing office and began to get dressed in protective clothing. When Mr Cornell completed putting on the protective clothing, he states that he returned to Cell 1 where he again banged and kicked on the door. Mr Cornell says in his statement that at that time he believed Ms Parker's left arm moved. He then went to the movements office to locate Mr Edwards. At that point a communication was received by the movements officer from Ms Jarman that they should go into the cell because it appeared that Ms Parker had stopped breathing. Mr Cornell and Mr Edwards then went to the cell and entered it straight away. They found Ms Parker laying prone and unresponsive. It was at that point that medical staff were called. Mr Cornell believed that it was the responsibility of the control room officer to have already done that. He suggested elsewhere in his evidence that the movements officer was under an obligation to do that[63].

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[61] Transcript, page 651
[62] Exhibit C40b, page 3
[63] Transcript, page 658

8.25. In due course the nurse, Mr Reynolds, arrived in the cell. Mr Cornell maintained that in the meantime he and Mr Edwards were both giving chest compressions to Ms Parker, switching over. As I say, the CCTV footage reveals nothing of the sort prior to the arrival of Mr Reynolds.

8.26. Mr Cornell maintained that he had no idea that Ms Parker had suffered from epilepsy. This, notwithstanding the fact that the police PD 331 from her arrest on 26 February 2008, which stated that she suffered from epilepsy, was on Ms Parker's case management file. Mr Cornell also stated that he was totally unaware of any recent fits that Ms Parker had experienced in police custody.

8.27. In cross-examination Mr Cornell said that he did not know that Ms Jarman had formed or expressed a belief that Ms Parker was having a fit. He did not recall her saying anything when he was in the control room about Ms Parker fitting[64]. When asked whether he thought there had been a medical emergency before he left the control room to go to D Wing he said:

> 'We called a Code Black. It is better to call a code than to not call the code.'

This to my mind was an evasive answer in keeping with Mr Cornell's avoidance of any acknowledgement that Ms Jarman had told him that she believed Ms Parker was fitting. Mr Cornell's own employee report form, in both its handwritten and typed versions, clearly states that that is what Ms Jarman had told him. I find that Mr Cornell was told by Ms Jarman that she believed Ms Parker was fitting. I also believe that in his evidence before me Mr Cornell was deliberately avoiding any acknowledgement of the same.

8.28. Mr Cornell reiterated that he would have expected Ms Jarman, an experienced officer, to call medical in accordance with her duty. However, when strategising with his colleagues as to how they should enter the cell prior to going in, he said it did not occur to him that medical may not have been called[65].

8.29. Ms Kereru, counsel assisting the Court, asked Mr Cornell to view some of the CCTV footage. Mr Cornell acknowledged, as he had to, that a period of nearly 12 minutes elapsed prior to correctional officers entering the cell. Mr Cornell believed that he had arrived at the door to Ms Parker's cell within a minute of the Code Black being

[64] Transcript, page 678

called and because of Ms Parker's response to his kicking the door, he did not believe that she was in any medical trouble at that time because of her signs of life and movement. When considering what is revealed in the CCTV footage at about that point in time, he agreed that it appeared she was not doing very well. When asked specifically whether she had appeared to be conscious at that stage, he said:

> 'In all honesty, I can't say whether she was or she wasn't. You couldn't see her eyes because of her arm over her head. You couldn't see through the viewing panel 100% clear because it was smeared with all sorts of bodily fluids and faeces and bits and pieces.' [66]

He agreed that nothing on the footage that was consistent with Ms Parker making a jolting movement could be seen[67]. In any event he agreed that Ms Parker at no point, from what he saw with his own eyes that afternoon, had appeared to make any voluntary act at all[68].

8.30. Mr Cornell could not really explain why it took several minutes to don the protective equipment other than to say that there were difficulties occasioned by the nature of the clothing, and that he was anxious that there was a code going on and that his adrenaline was pumping[69].

8.31. Mr Cornell could not account for the apparent time lapse between the movements officer, Mr Rowan, being advised of Ms Parker not breathing and their entering the cell, notwithstanding that they were only a matter of seconds away from the door.

8.32. Mr Cornell deflected the failure for medical to be summoned immediately after the Code Black had been called by suggesting that he would have expected officers to contact medical staff as per their duty statements, but he acknowledged that it was his responsibility to see that correctional officers for that shift were performing their duties in accordance with SOPs[70]. When specifically asked as to why he did not ensure that medical were notified and obtained straight away when he had arrived at the wing and discovered that they were not in attendance, he said:

> 'It is a question I can't answer. I was in the zone of getting in, checking for signs of life, getting myself kitted up, making sure I was - in all honesty I wasn't physically aware of

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[65] Transcript, page 680
[66] Transcript, page 696
[67] Transcript, page 697
[68] Transcript, page 698
[69] Transcript, page 698
[70] Transcript, page 710

> looking for every nitty-gritty. You get to a point at that stage you have to have some sort of trust in your officers to do their job.' [71]

The fact that Mr Cornell said that it was a question he could not answer suggests very much that there was no sensible answer to that question. One would have thought that irrespective of any written requirement that may have existed regarding the obtaining of medical assistance, the absence of such a resource, a resource that was on the premises and ready to be utilised, would instinctively have been noticed.

8.33. Mr Cornell acknowledged that there were Departmental expectations that correctional services officers would administer first aid such as CPR to prisoners in cases of emergency but he said that there was no way he would go into a cell in that state unprotected[72]. He said:

> 'The hesitation was I was not going to go into that cell without personal protective equipment on to protect myself and possibly to protect my family of anything that could be in that cell that I could carry home to my family, as well as myself.' [73]

Mr Cornell went so far as to say that even in a case where someone was positively understood to be suffering from a cardiac arrest he would still suit up in those circumstances but would try to do it as quickly as possible. It goes without saying that in any medical emergency in which one perceived a need to don protective clothing, one would do so as quickly as possible, but the notion that rescuers would hesitate to assist in a situation of known cardiac arrest in my view is patently wrong. In any event, it is even more difficult to justify the delay in entering Ms Parker’s cell when it is remembered that the fundamental requirement of obtaining immediate medical assistance was not in any case met. In my view, in his evidence Mr Cornell down played the seriousness of Ms Parker’s medical emergency and endeavoured to deflect responsibility for the failure to seek medical assistance by assigning it to another staff member when he was in fact the person in charge of the prison and was the person on hand in D Wing to make appropriate decisions. Even accepting that there was no means by which it could be established that Ms Parker had experienced a cardiac arrest until the cell was actually entered, it must have at least been clear to Mr Cornell that Ms Parker was unconscious and unresponsive and that it was believed

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[71] Transcript, pages 710-711
[72] Transcript, page 703
[73] Transcript, page 704

that she had experienced a fit. All of this meant that it was imperative that Ms Parker receive immediate assistance.

8.34. Mr Frank Edwards also gave evidence. He gave a statement to the police on 3 April 2008[74]. Mr Edwards' own employee report form was also tendered to the Inquest[75].

8.35. It will be remembered that Mr Edwards had been the officer in charge of the prison until the shift changeover and was intending to take charge of the transfer of Ms Parker from the AWP to the RAH. Mr Edwards' version of events was that he was putting on protective equipment in preparation for the transfer of the prisoner when he was alerted by Mr Rowan, the movements officer, that Rowan had received information that Ms Parker in cell 1 was 'fitting'. The word fitting is used in his witness statement that was made within only a few weeks following these events. Mr Edwards' employee report form does not use that expression. Rather, he describes the beginning of his involvement in the incident in terms of initially discovering merely that a Code Black medical emergency had been broadcast.

8.36. In his employee report form of 15 March 2008 Mr Edwards refers to the Code Black medical emergency being broadcast by telephone to the D Wing area. He then looked through the window of Ms Parker's cell and observed her to be lying on the bed and that he saw what appeared to be movement of her chest and left arm. He then went to the adjacent office and donned protective clothes and footwear. Mr Cornell and Mr Feo also suited up following which they entered the cell.

8.37. Mr Edwards' statement to the police made in April 2008 describes the matter somewhat differently insofar as he states that he had already placed his bio suit on in preparation for the transfer of Ms Parker to the RAH when Mr Rowan, the movements officer, told him that he had received a call that Ms Parker was 'fitting'[76]. He states that he had taken his radio off and left it in the D Wing office adjacent to Ms Parker's cell at the time he had put his bio suit on. Thus, when he went to the cell door and viewed the interior through the viewing panel, it was then that he, according to this statement, saw her lying on the bed and that she did not appear to be fitting at that time. He kicked the door several times but she did not move. He called out to her as well but there was no verbal or physical response. It was then that Mr Cornell

[74] Exhibit C41
[75] Exhibit C41a
[76] Exhibit C41, page 5

made his attempt to seek a response from her by kicking the door and yelling out to her. Then, Mr Cornell suited up as did Mr Feo. They then entered the cell. Mr Edwards' statement then asserts that Mr Cornell started giving Ms Parker chest compressions whereupon the nurse, Mr Reynolds, entered the cell. This assertion is inaccurate insofar as the CCTV footage demonstrates that no chest compressions were administered before Mr Reynolds' arrival. On the version of events as described in Mr Edwards' police statement, he was already clothed in the protective suit at the time he found out about the Code Black, save and except for gloves. On that version it is not clear as to when exactly he found out about the Code Black because he says he did not have his radio and would not have heard it broadcast at the time Ms Jarman first broadcast it. In any event, if he learnt of the Code Black at a time after he had put on the protective clothing, he would have been ready to enter the room, albeit on his own as Mr Cornell and Mr Feo had yet to put on their protective clothing. Mr Edwards' police statement mentions nothing about Mr Rowan's further information that Ms Parker had been observed to have stopped breathing.

8.38. Mr Edwards was interrogated about the matter on 12 February 2009 by Mr Darrell Smedley, the Investigations Manager with the Department for Correctional Services[77]. In that interrogation, as revealed by its transcript, Mr Edwards reiterated that he had not heard the original Code Black broadcast because he had taken off his radio. He stated in effect that he was not clear in respect of whom the Code Black had been called when he was told of its existence by Mr Rowan. In any case he went to Ms Parker's cell and saw her as he had earlier described to police. When Mr Cornell arrived he learnt that the Code Black related to Ms Parker and it was then that Mr Cornell kicked and banged her door. There was some discussion between him and Mr Cornell to the effect that she appeared to look 'alright'[78]. Mr Cornell and Mr Feo started putting on protective clothing and there was some difficulty about that in terms of the inappropriately sized Wellington boots. They then entered the cell. On examining Ms Parker, Mr Cornell caused medical to be summoned. In this interrogation Mr Edwards was asked whether he could explain why there had been a 10 minute delay between the calling of the Code Black and the entry of Ms Parker's cell. Mr Edwards could not explain that. In this interrogation Mr Edwards did say that when he first looked into Ms Parker's cell his impression of her was that she was

[77] Exhibit C41b
[78] Exhibit C41b, page 13

merely lying on the bed. He said it was not as if she had collapsed but was 'lying down as if she said, okay, kick back'[79]. He said that there were no signs of distress and he was not sure whether the Code Black had been directed to her. In this interrogation Mr Edwards appears to suggest that he had not donned his protective equipment at the time he learnt of the Code Black. When it was pointed out to him that his police statement had contained an assertion that when he learnt about Ms Parker's difficulty he was told that she was 'fitting', he suggested that that may have been based on something he had heard later.

8.39. Mr Edwards gave evidence in the Inquest. He there reiterated there that he had not heard the Code Black due to the fact that he had put his radio down in the D Wing office. He believed that Mr Rowan had shouted to him something about a phone call that he had received and then a number of officers came in through the wing including Mr Cornell and he then realised that a Code Black had been called. Mr Edwards said in evidence that he had had a phone call from the control room and that they had to '*get in there*'[80]. Later in his evidence he said that he was not sure whether Mr Cornell was there at that point. Mr Edwards said that he not only checked Ms Parker's cell but all of the other cell's occupants. It was after all of this that Mr Edwards said that he donned his protective clothing. The officers then entered the cell. He reiterated that Mr Cornell commenced CPR at a time before Mr Reynolds arrived. Again, this is incorrect.

8.40. In cross-examination Mr Edwards said he did not know about Ms Parker's epilepsy. He also stated that he could recall neither Mr Rowan nor Mr Cornell saying anything to him about Ms Parker fitting. He said in his evidence that when he was alerted to the emergency he did not know that Ms Parker was thought to be having a fit[81]. He said he had not put his bio suit on before the arrival of Mr Cornell[82].

8.41. In cross-examination Mr Edwards confirmed that the first he knew of a Code Black was through Mr Rowan. When shown the CCTV footage Mr Edwards appeared to accept that a period of about 12 minutes had elapsed from the time that he kicked on Ms Parker's cell door until the donning of his bio suit[83]. He also accepted that that was an extraordinary amount of time to respond to a Code Black. All that said, Mr

[79] Exhibit C41b, page 15
[80] Transcript, page 738
[81] Transcript, page 757
[82] Transcript, page 759

Edwards' knowledge about the Code Black did not come first hand from his radio and I am not entirely certain at what precise point in time he knew of the existence of the Code Black and to whom it related. Mr Cornell said in his evidence that Mr Edwards did not appear to know of the Code Black until Mr Cornell told him about that when he arrived at D Wing. Thus there is some support for Mr Edwards that he did not know of the Code Black as and when it had been called over the radio. However, if Mr Cornell arrived at the D Wing office very soon after the Code Black had been called and that he then informed Mr Edwards of the Code Black, then Mr Edwards must have known about the Code Black very early in the piece.

8.42. Mr Edwards accepted that there was an unacceptable response to the Code Black given the timeframe that has been identified[84]. In re-examination Mr Edwards said that he did not know anything about the suggestion that Ms Parker had been fitting and that the statement in his police statement that suggests that he did know something about that was incorrect[85].

8.43. The third officer who entered the cell, Mr Anthony Feo, also provided a statement to the police dated 3 April 2008[86]. Mr Feo was not at the wing when he heard the Code Black called over the radio. When he heard the Code Black he followed other officers to D Wing where Mr Cornell advised him to start putting on protective clothing. At first Mr Feo was uncertain in respect of whom the Code Black had been called but, at one point, Mr Cornell advised him that Ms Parker was not breathing so the cell was then entered. Prior to that, Mr Feo's impression had been that they were simply suiting up in preparation to transport Ms Parker to the RAH for assessment. Once in the cell, Mr Feo states that when it was established that Ms Parker was unresponsive, he was instructed to get an officer to call an ambulance and a medical officer immediately. Mr Feo states that he then went out into the corridor and yelled for somebody to call an ambulance and the medical officer and he was advised by officers in the movements area that they would take care of it.

8.44. Mr Feo told me in evidence that, although he was not certain, he thought that he had understood at the time that Ms Parker had suffered from epilepsy. However, he did not recall anything being said about Ms Parker apparently having experienced a fit

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[83] Transcript, page 809
[84] Transcript, page 816
[85] Transcript, page 820
[86] Exhibit C45

and that this had been the reason they were entering her cell. Interestingly Mr Feo suggests that when the officers were putting on their protective suits, he did not detect a sense of urgency[87], but that matters were treated urgently when it was understood that Ms Parker had stopped breathing[88]. When it was pointed out to Mr Feo in evidence that nearly 12 minutes had elapsed between the Code Black being called and the cell being entered, he said '*I thought we were doing it in good speed*'[89].

8.45. Mr Tony Reynolds, the nurse, provided a statement to the police[90] and gave evidence at the Inquest. Mr Reynolds said that he received a phone call at 1650, which we know is in excess of 10 minutes since the Code Black had been called, and was advised at that time that Ms Parker was turning blue. That was the first he knew of the matter. He would not have had access to the original Code Black because he was not equipped with a prison radio. Both in his statement and in his evidence before me he said that he treated the matter as an emergency in any event and went straight to the cell with his emergency trolley and was there within a matter of seconds. By then Ms Parker's cell had been entered and Messrs Cornell and Edwards were in the room in their bio suits. Mr Reynolds did not wear any protective clothing or gloves. Mr Reynolds called for an ambulance on his way into the cell. He directed that instruction to the officer who was in the movements office for that wing. The incident log compiled by Ms Jarman does not contain any reference to SAAS being called until a time after the cell had been entered by corrections staff. Thus it is clear that the SAAS were not called at any time prior to any person's entry of the cell.

8.46. Mr Reynolds acknowledged that it was a requirement at that time that a nurse attend when a Code Black is called. He also made the observation that this would be the case regardless of the precise reason for the calling of a Code Black. He said that an apparent epileptic fit should automatically trigger a Code Black because a person's airway might be compromised in such a situation[91].

8.47. Mr Reynolds' evidence about the timing of the phone call to him and his virtual immediate attendance at Ms Parker's cell was not challenged. What he said about that accorded with what Mr Cornell said, namely that medical staff were not fetched

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[87] Transcript, page 905
[88] Transcript, page 907
[89] Transcript, page 908
[90] Exhibit C35
[91] Transcript, page 254

until after he and Edwards had entered the cell and not before Ms Parker's cardiac arrest was detected.

8.48. Mr Reynolds' evidence confirms that the clear requirement that medical staff attend the location of a Code Black was breached in this case insofar as he was not notified immediately of the Code Black.

8.49. The failure to enter Ms Parker's cell and to summon the assistance of the nursing staff as soon as the Code Black was called was an egregious and costly error.

9. The evidence of Dr Martin Robinson

9.1. Dr Robinson is the Director of the Department of Neurology at The Queen Elizabeth Hospital (TQEH). As well, he is a consultant neurologist in private practice and has been so since 1991. Dr Robinson was asked to provide an expert opinion in relation to Ms Parker's collapse, resuscitation and death[92]. Dr Robinson possesses an expertise in epilepsy and its treatment. Dr Robinson also gave oral evidence in the Inquest.

9.2. Dr Robinson had access to the post-mortem reports as well as to the case management file and prison dossier relating to Ms Parker's period of remand in custody at the AWP. He also had access to relevant witness statements. Importantly, he also viewed the video footage from Ms Parker's cell that depicted her collapse and the subsequent resuscitation efforts[93].

9.3. Before dealing with Dr Robinson's opinions concerning Ms Parker specifically, it is as well to mention some of the general evidence about epilepsy and its treatment that was given by Dr Robinson. I should say at the outset that Dr Robinson's evidence about the appropriateness and efficacy or otherwise of Ms Parker's anticonvulsant medication regime was not something that I found especially germane to the issues that I had to inquire into. It is apparent from the evidence that Ms Parker had been tried on a number of different anticonvulsant medications over the years with varying success and also with differing side effects. In the event, she was placed on Sabril by a psychiatrist in 2007 and it was this medication that Ms Parker was still taking, or at least meant to be taking, in December 2007 and January, February and March 2008.

[92] Exhibit C37a
[93] Exhibit C18aaaq

Dr Robinson told me in evidence, and also stated in his report, that it was recognised that some antiepileptic drugs may potentiate psychiatric conditions. In particular it is known that Sabril may worsen mood disturbances such as depression and, in some patients, aggravate psychosis, although Dr Robinson thought it was noteworthy that the prescription for Sabril had been made by the psychiatrist. It was also made in the context of other anticonvulsant medications causing physical side effects in Ms Parker. In the event while Dr Robinson had some misgivings about Ms Parker's anti-epileptic medication regime, he was not really in any position to criticise it and he refrained from doing so.

9.4. Dr Robinson explained in his evidence that Sabril tablets come in 500mg doses. The prescription for Ms Parker of 500mg twice per day, being one tablet in the morning and one tablet at night, was a therapeutic dose that might be varied in an upwards direction depending on side effects and its ability to prevent seizures[94]. The normal range of dosage would be between 1gm to 3gm per day. Within that range, the therapeutic dosage for an individual patient would depend on how well the epilepsy was being controlled. Ms Parker was on 1gm per day, although other evidence suggested that she was meant to have been on 1500mg per day[95]. It is sufficient for me to record that Dr Robinson would regard 1 gram per day as an appropriate dose if it was successful in preventing seizures. The complicating factor in Ms Parker's case when assessing this is that it cannot be certain that she was not at all times compliant.

9.5. However, what is germane to the issue is Dr Robinson's evidence concerning risk factors that existed in Ms Parker's case that rendered her liable to seizures. Dr Robinson explained that abrupt withdrawal of anticonvulsant medication was undesirable, especially if a patient was taking what was for him or her a sub-therapeutic dose in the first instance. For example, Dr Robinson suggested that if Ms Parker had been taking the bare minimum dose of 500mg twice per day morning and night, and had missed the night dosage on one day and the morning dosage on the following day as she did, it was not a desirable situation at all. Seizures can be invoked purely through withdrawal from the drug. How likely that was to happen in any given situation was difficult to assess, but if Ms Parker had experienced a number of seizures, and her epilepsy had been difficult to control, then a sudden stoppage of

[94] Transcript, page 441
[95] Transcript, page 90

medication could be '*a recipe for disaster*'[96]. On the other hand, if she had not experienced any seizures for years and had experienced periods where she had not been taking any medication, then stopping a dose or two might not in those circumstances have been too much of a variation from the norm for her and may not have had as much significance in terms of risk. In general, however, stoppage and missing of medication was not to be advocated. In fact, Dr Robinson was of the view that Ms Parker's recent history of seizures suggested that her epilepsy was not under control. Dr Robinson suggested that in the context of a person such as Ms Parker who when stopping her medication had experienced seizures, then the warning signs would be such that one would seek assistance for that person and that the person's presentation would require and warrant further observation. In other words, in someone like Ms Parker, who was on a low dosage in respect of which she exhibited poor or varying compliance and who was experiencing seizures regardless, there would be a strong case for close supervision in any institutional setting.

9.6. Dr Robinson was of the view that Ms Parker's mental disability would not per se have rendered her more likely to experience seizures, but that the resulting sleep deprivation or her refusal to take her medication would, in combination, render her liable to cause her epilepsy to flare[97]. In this regard the evidence that Ms Parker had not slept for approximately 72 hours was highly relevant. Clearly by any standard that would amount to prolonged sleep deprivation.

9.7. Likewise, Dr Robinson did not believe that the experience that Ms Parker endured in respect of her cell being hosed out would in itself have rendered her prone to seizure, but the uncomfortable nature of her environment would not have assisted in terms of her ability to get to sleep[98]. The constant light in the cell could be viewed in the same way. This would not in itself have rendered her prone to seizure, but its capacity to inhibit her ability to sleep would be a relevant factor in assessing risk of seizure. Her solitary confinement in and of itself also would not have rendered her prone to seizure, although it may have been relevant in terms of its acceleration of her level of psychiatric illness[99].

[96] Transcript, page 443
[97] Transcript, page 447
[98] Transcript, page 449
[99] Transcript, page 450

9.8. The evidence would suggest, and I so find, that Ms Parker was at risk of seizures by virtue of her erratic refusal of medication, particularly that of the night before and on the morning of her collapse, and by virtue of her sustained sleep deprivation. The fact that Ms Parker had experienced recent seizures was a matter that also needed to be taken into consideration when assessing her risk of seizure. That said, Dr Robinson made a point of observing in his report that *'it could not have been anticipated that, even if she had seizure, that this would lead to a cardio-respiratory arrest'*[100].

9.9. Dr Robinson also gave evidence about the progress of Ms Parker's collapse and cardiac arrest and provided some commentary upon the resuscitation efforts in terms of its timing and appropriateness having regard to what the CCTV footage reveals. Dr Robinson expressed the view that it was reasonable to conclude that what Ms Parker experienced was a generalised brief convulsive episode that ultimately led to cardio respiratory arrest. This conclusion in my view is unassailable having regard to Ms Parker's known history of seizures, the risk factors for seizures that existed in her case and the lack of any autopsy evidence of significant cardiovascular disease or anything else that would explain an unexpected cardiac arrest. Ms Parker's cardio respiratory arrest, in my view, was clearly the result of an epileptic seizure and I so find.

9.10. Dr Robinson noted that following Ms Parker's seizure several minutes had expired before her cell was entered by correctional staff and then the nurse. In his report Dr Robinson made an observation that effortful breathing attempts characterised by movements of the abdomen appear to have stopped at 1641 hours and that Ms Parker thereafter remained motionless until staff entered the room at 1650 hours. I observe here that the control room operator, Ms Jarman, noted that the prisoner appeared to have stopped breathing and that staff were informed all at 1647 hours as recorded on her incident log[101]. For my part, I see no overt evidence of breathing after 1641.

9.11. Nowhere in Dr Robinson's evidence does he postulate any particular point in time at which Ms Parker experienced her cardiac arrest. In this regard Dr Robinson said that it could not be certain as to whether the cessation of breathing preceded the cardiac arrest[102]. However, he said that predominantly in these sorts of cases the problem is mainly to do with the heart and its rhythm rather than with the mechanism of the

[100] Exhibit C37a, page 5
[101] Exhibit C36f
[102] Transcript, pages 460 and 468

lungs. It may very well be that the cardiac arrest occurred at about the time of her initial collapse at 1638.

9.12. Dr Robinson did say that although electrical defibrillation is usually a waste of time in cases of a complete asystolic cardiac arrest, there was a possibility that at some point in time following Ms Parker's collapse that she may have been in a shockable rhythm, namely ventricular arrhythmia. However, there is no means by which it can be determined whether or not Ms Parker may at some point during the course of her collapse had a cardiac rhythm that may have been amenable to defibrillation if the same had been delivered in a timely way. All that is known is that when the ambulance personnel arrived she was in a complete asystolic arrest that only responded to adrenaline and atropine. Whatever the nature of Ms Parker's cardiac arrest, by the time Nurse Reynolds arrived in the cell, it would not respond to any defibrillation measures administered by him.

9.13. I asked Dr Robinson whether there was a point, or were points, in time prior to the arrival of ambulance personnel at which Ms Parker may have been resuscitated successfully. Dr Robinson's answer was as follows:

> 'Well yes. I don't know. What literature there is on resuscitation attempts in people who've had seizures and have gone into a cardiac arrest under supervision, even under supervised circumstances is that often resuscitation is not successful. Now the reasons why it's not successful I don't know but it's not as successful as if someone's had myocardial ischaemia and then on the coronary care unit sort of gone into the same problem. The attempts to resuscitate people from cardiac arrhythmias due to seizures is distinctly poor.' [103]

He went on to explain that notwithstanding this, one always attempts resuscitation and it makes sense that the earlier one can get in and do it effectively, then the better. However, that has not proven to be the case with seizures where attempts at resuscitation have been poor, not due to ineffective resuscitation, but by the intrinsic lack of ability to restart the heart. He went on to say:

> 'So, in that sense you could possibly argue that her fate was sealed right from the word go. As soon as she had the seizure, hopeless scenario thereafter despite whatever attempts might have gone on by the officers.' [104]

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[103] Transcript, pages 460-461
[104] Transcript, page 462

Dr Robinson said that he could not say whether if the officers had arrived in the cell 5 minutes earlier that it would have made any difference, although I note that it would have been physically possible for the officers to have gone into the cell well before 5 minutes prior to the time at which they actually did so.

9.14. As observed earlier, there were no CPR efforts made by any of the officers at a time prior to the arrival of Nurse Reynolds when chest compressions were performed for the first time. So much is revealed by the CCTV footage.

9.15. It is difficult to say what the outcome would, or may, have been if the officers had entered Ms Parker's cell immediately after the Code Black was called. It is worthwhile observing that the resuscitative efforts performed by SAAS, as delayed as they were, were successful in starting Ms Parker's heart and restoring her circulation. It was the extended period of time during which Ms Parker was experiencing her cardiac arrest, and her brain therefore being starved of oxygen, that was the ultimate cause of her death. A 'downtime' that Dr Robinson identified of a possible 12 to 13 minutes in his view would be regarded as considerable. Without adequate perfusion of the brain Dr Robinson suggested that a lack of pulse for 2 or 3 minutes could result in a person being in '*major trouble*'[105] and experiencing irreparable damage to the brain.

9.16. If the corrections officers had entered Ms Parker's cell immediately after her collapse at 1638, and if her cardiac arrest had occurred by then, they would have been in attendance very shortly after the cardiac arrest and they would have detected it at a much earlier stage. Alternatively, if the arrest occurred at a later time they would have been there when it happened and hopefully would have detected it as and when it occurred. Nurse Reynolds would have been there as well. Moreover, it is also reasonably open to conclude that SAAS would have been present much earlier than they were. If Ms Parker's cell had been entered immediately after her collapse was detected at 1638 and appropriate first aid treatment had been administered, when regard is had to the fact that SAAS personnel did manage to restore her circulation even after a considerable delay, there is a case for saying that the hypoxic downtime could have been significantly reduced and that the resulting brain damage may have

been substantially ameliorated. On this issue the following exchange took place between myself and Dr Robinson:

> 'Q. Just one thing in relation to what you said to me earlier about the chances of their being a satisfactory outcome when somebody has a cardio-respiratory arrest following a seizure and I think you suggested that the chances of someone surviving that are not high.
>
> A. Yes.
>
> Q. But in this particular case eventually they did restore bradycardia and then presumably a normal heart beat before she was eventually declared brain dead and died. Is that the kind of outcome that is against the odds, as it were.
>
> A. Well, yes to some extent. I mean the team did well to get a rhythm back and because they got the rhythm back she didn't die there and then.
>
> Q. And if they had got the rhythm back earlier, say -
>
> A. Yes, she might have done better.
>
> Q. - then she might have done better because there may not have been that profound level of hypoxia to the brain.
>
> A. Yes, that's right.' [106]

9.17. However, whether earlier CPR and / or defibrillation and the more sophisticated resuscitative measures delivered by SAAS would have altered the outcome for Ms Parker cannot be known with complete certainty.

9.18. What chance of survival Ms Parker may have had cannot now be known. But it cannot be said that her chances of survival would have been nil had clear and routine procedures governing medical emergencies been followed. This state of uncertainty owes itself to the fact that she was denied immediate medical assistance, that her resuscitative measures were unduly delayed and that the ambulance service was not called at an appropriate time. What can be said with certainty is that by the time Ms Parker's cell was finally entered her fate was absolutely sealed and that she had no chance of survival.

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[105] Transcript, page 452

[106] Transcript, pages 478-479

10. Recommendations

10.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

10.2. I make the following recommendations:

1) That the Minister for Health and the Minister for Correctional Services cause a database to be established that contains the medical histories of all prisoners who have been held both in police custody and custody within correctional institutions and that the database be accessible by authorised personnel of SAPOL, the Department for Correctional Services and the Prison Health Service;

2) That the Department for Correctional Services and the Prison Health Service so far as is considered necessary for the proper management of a prisoner, develop protocols and procedures for the sharing of information between those entities regarding the medical histories and clinical presentations of individual prisoners in Department for Correctional Services custody;

3) That the Minister for Health and the Minister for Correctional Services introduce such legislation as may be necessary to overcome confidentiality considerations in respect of the implementation of Recommendations 1) and 2);

4) That the Prison Health Service develop a protocol for the clinical management of prisoners who are known to suffer from epilepsy;

5) That in respect of prisoners who have a diagnosed condition and history of epilepsy, that the Prison Health Service conduct a medical review of each such prisoner upon his or her induction into a Department for Correctional Services custodial facility. The review should include an assessment of the efficacy of their anticonvulsant medication, a review of recent history of seizures and an assessment of risk having regard to known risk factors for epileptic seizure including disturbed sleep patterns, failure to take prescribed medication and recent history of seizure;

6) That officers of the Department for Correctional Services be made aware of an individual prisoner's diagnosis of epilepsy and any adverse risk assessment regarding risk of seizure in respect of an individual prisoner;

7) That officers of the Department for Correctional Services be trained in relation to epilepsy and its possible fatal consequences, and in respect of the risk factors that may exist in relation to seizure;

8) That Department for Correctional Services Standard Operating Procedures be amended to include a separate and specific direction to correctional services officers that any episode of unconsciousness or unresponsiveness exhibited by an individual prisoner should be regarded as a medical emergency requiring immediate intervention and the provision of medical treatment without delay;

9) That Department for Correctional Services officers be reminded both verbally and in writing that the calling of any Code Black, or the identification of any medical emergency, requires the immediate notification of medical staff and an immediate assessment of the need to call emergency services;

10) That Department of Correctional Services officers be advised both verbally and in writing that they should not resist or otherwise question clinical decisions made by staff members of the Prison Health Service in respect of an individual prisoner and that they should facilitate without delay all such clinical decisions;

11) That medical staff, including medical practitioners and nurses, employed by the Prison Health Service in custodial institutions be equipped with Department for Correctional Services radios to enable them to be advised of a Code Black as and when it is called;

12) That the Minister for Correctional Services introduce such legislation that would amend section 36 of the Correctional Services Act be so as to prohibit the delegation of section 36 powers and responsibilities to officers of the Department for Correctional Services below the position of General Manager of a custodial institution or a person acting in that position or capacity;

13) That the Minister for Correctional Services introduce such legislation that would amend section 36 of the Correctional Services Act so as to require both the said

Minister and the Chief Executive Officer of the Department of Correctional Services to be regularly informed of the current circumstances of a prisoner in respect of whom an order has been made that the prisoner be kept separately and apart from all other prisoners;

14) That Department of Correctional Services Standard Operating Procedures be amended so as to contain a requirement that the General Manager of a correctional institution regularly review the circumstances of a prisoner to whom section 36 of the Correctional Services Act applies.

Key Words: Death in Custody, Monitoring/Observation of Prisoners; Epilepsy

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 19th day of November, 2010.

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Deputy State Coroner

Inquest Number 2/2010 (0352/2008)