STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest	**Inquest into the death of Paigh Bartholomew**
Hearing dates:	26 -29 June 2017
Date of findings:	25 July 2017
Place of findings:	NSW State Coroner Court - Glebe
Findings of:	**Deputy State Coroner H Barry**
File number:	2012/189678
Representation:	Ms J Davidson, Counsel Assisting, instructed by Ms C Skinner (Crown Solicitor's Office) Mr R Reitano, instructed by Mr M Burns for Correctional Officers Walker and Duggan Ms D Ward, instructed by Mr A Jobe for Corrective Services NSW Mr S Rees, instructed by Aboriginal Legal Service, for Ms K Bartholomew

Findings:	**I find that Paigh Bartholomew died on 16 June 2012 at House 3 Emu Plains Correctional Centre, Old Bathurst Road, Emu Plains. The cause of her death was mixed heroin and alprazolam toxicity. The manner of death was the consumption of drugs illegally delivered to the Correctional Centre.**

Introduction:

On 16 June 2012, Paigh Bartholomew was found unresponsive by Corrective Services staff, supine on a mattress in the house she shared with nine other inmates of the minimum security complex at Emu Plains Correctional Centre (EPCC). She had received a quantity of drugs the previous evening, after she had exited her bedroom window. She took the drugs via injection and later manifested decreasing consciousness. She was found by staff at approximately 7.30am. She was only 21 years old.

Paigh Bartholomew:

Counsel representing Paigh's family read a statement to the Court from Ms Kerrie Bartholomew, Paigh's aunt.

In that statement Kerrie described how she had raised Paigh from the age of 13 months to 18 years. Paigh was described as a happy child and full of energy, who had a loving relationship with Kerrie and her other daughters.

Regrettably Paigh's father died whilst he was in custody and her mother exhibited scant interest in her. For the rest of her life Paigh struggled to come to terms with the fact that her parents were not part of her life.

Paigh loved drama, music and art and was described as a "social butterfly". She was thoughtful and compassionate, baked for the local Sunday School and attended church regularly.

As she entered into her teens Paigh found it more difficult to reconcile the fact that her mother had no involvement with her. In her statement, Kerrie described Paigh as going "off the rails"

By the age of 18 Paigh was pregnant and already addicted to drugs.

Her baby was taken from her and this exacerbated her deteriorating behaviour.

Kerrie loved her very much as did a large number of the Glebe community where Paigh had grown up. She is very much missed by Kerrie and her daughters and by the members of the Glebe community.

The Inquest:

The role of the Coroner as set out in s.81 of the *Coroner's Act 2009* (the Act") is to make findings as to:

(a) the identity of the deceased

(b) the date and place of the person's death;

(c) the physical or medical cause of death; and

(d) the manner of death, in other words , the circumstances surrounding the death.

The focus of this inquest is the manner of Paigh Bartholomew's death and the actions of those persons whose duty it was to supervise her at Silverwater Women's Correctional Centre (Silverwater) and Emu Plains Correctional Centre (EPCC).

Paigh's death was reported to the Coroner because it occurred whilst she was an inmate at EPCC. In these circumstances an inquest is mandatory pursuant to the combination of ss.23 and 27 of the *Coroner's Act 2009.*

"The purpose of a s.23 inquest is to fully examine the circumstances of a death…in order that the public, relatives and the relevant agencies can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post death investigation. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82."(Waller, Coronial Law and Practice in New South Wales,p.106).

The Evidence:

The Autopsy

An Autopsy Report was prepared by forensic pathologist Dr Rebecca Irvine.

Dr Irvine reported that the cause of death was mixed heroin and alprazolam toxicity.

Paigh was found to have a 0.4cm area of red ecchymoses on her right arm, containing an apparent recent puncture site. Toxicology detected a therapeutic concentration of alprazolam and a therapeutic concentration of morphine, as well as a sub-therapeutic concentration of paracetamol.

Morphine is the immediate metabolite of heroin in the body, and urine tests indicated heroin was the parent drug of morphine in this case.

The Autopsy Reports records that "*Although the morphine and alprazolam are both in the therapeutic or non– toxic range, their combined depressive effects on the central nervous system would be expected to be greater than the simple addition of*

their effects. Further, examination of the suspected injection site shows an early inflammatory response and the lungs had developing pneumonia; these changes would take a few hours to become apparent. The pneumonia suggests a period of several hours of decreased responsiveness."

The events at Silverwater Women's Correctional Centre

Between 26 March 2012 and 12 April 2012, Paigh was in custody, on remand at Silverwater. She had been charged with breach of bond, supplying a prohibited drug and possession of a prohibited drug. She was released to bail on 12 April 2012 and readmitted to custody on 27 April 2012, for breaching her bail conditions and further offences. On 27 April 2012 she had been travelling (with two men) in a vehicle that was stopped by NSW Police and when searched, it was found that she had over 9 grams of brown powder (which, when tested was found to contain heroin) in her possession. She remained in custody, on remand, until her death.

On 2 May 2012,at Silverwater, a random search of inmates was conducted by the State Emergency Unit (a unit within Corrective Services NSW) and Silverwater staff in the induction area. Paigh was observed to drop a package to the ground by Silverwater staff. As a result, she was strip searched and admitted to dropping the package and to possessing another smaller package in her underpants.

Paigh claimed to have picked up the packages in her cell, where they had been hidden behind the television. She claimed not to know what was in the packages.

During the search, Senior Correctional Officer (SCO) Renee Craft, an officer with the K9 Unit (part of the State Emergency Unit), opened the packages and found them to contain a brown" dough-like" substance. From her work with the K9 unit, SCO Craft had had some experience in identifying drugs.

In her oral evidence, she described the substance as looking like" cookie dough". She broke the "dough ball" apart and found it to be a 'wet type of texture'. It did not have any smell.

The larger package was wrapped in CSI (Corrective Service Industries) type wrapping with black plastic around it and bound by sticky tape.

Despite requesting the dog handler to 'run' past the drugs again, the dog gave no indication that the package contained drugs.

SCO Craft gave evidence that she had completed a 13 week canine course where she had been shown pictures and actual samples of drugs. She had been shown various types of heroin and knew that there were a number of different types and colours of heroin. On training days, the K9 Unit was kept informed of any new type of heroin in circulation.

Her evidence was that she had" not seen any drug like this".

The relevant Corrective Services policy at the time (part of the Corrective services Operations Procedures Manual) stated:

"Drugs are unknown substances until analysed. Correctional centre staff must operate on the premise that the suspected substance is a prohibited drug"

SCO Craft sealed the substance in an exhibit bag and in compliance with the policy, treated it as though it was a drug. She entered the packages in the exhibit safe at Silverwater.

SCO Craft spoke with Acting Manager of Security (MOS),at the time SAS Diane O'Donoghoe, and told her that she did not know what was contained in the packages. SCO Craft gave evidence that she formed the view, after discussion with SAS O' Donoghoe that she could not charge Paigh because she did not know what she would be able to charge her with.

SCO Craft then prepared a synopsis report and an Incident Reporting Module (I RM). Those reports were emailed to the General Managers at Silverwater and for the State Emergency Unit and the Acting MOS at Silverwater. SCO Craft understood that her synopsis report would be read by the General Manager at Silverwater who would see that the packages had been seized and entered into the exhibit safe. Within that report it was recorded that the two packages weighed 17.8g for the larger package and 1.6g for the smaller one. SCO Craft recorded in that document that the packages contained a "brown unknown substance".

It was not until after Paigh died that those packages were, in fact analysed. It was revealed that the substance in the larger package was 14.7g of heroin(at 15.5% purity) and a further 1.1 g of heroin(purity not tested) in the smaller package.

SAS O'Donoghoe was the Acting MOS at Silverwater on 2 May2012.After the packages were located, she attended the induction unit and spoke with SCO Craft. She recalls being told by SCO Craft that some"stuff" had been found on an inmate but that it was not known what it was.

At that time SAS O' Donoghoe dismissed the incident. She stated that this was because SCO Craft had told her that she didn't think the item was anything in particular and it was not known what the substance was.

SAS O' Donoghoe stated that she recalled seeing the substance which she described as being" like a balled up piece of bread". She had not seen any substance like that before and she told the Court that she had little knowledge in relation to the identification of drugs. She stated that if SCO Craft couldn't identify the substance, as a member of the K9 Unit with experience handling drugs, the she did not feel she would be able to either.

She did not think to check the exhibit safe to see if in fact the item had been deposited there.

In her oral evidence SAS O Donoghoe stated that she did not recall seeing the report that SCO Craft had emailed to her nor did she recall seeing the incident details

contained within the IRM. However, she did not dispute that it was likely that SCO Craft sent her the report via email and stated, “if she (SCO Craft) said that she did, then she did”

When the relevant Corrective Services policy was drawn to SAS O’Donaghoe’s attention, she agreed that the policy indicated that any unknown substance must be treated as a drug until the unknown substance is analysed.

A report by Officer Wayne Taylor, MOS of Silverwater from 2012,dated 25 June 2012 states:

“*I have formed the opinion that procedures relating to the discovery of drugs and other contraband were not followed by staff after the search of inmate Bartholomew and regardless of personal opinions the seized items should have been treated as a drug and comprehensive reports should have been submitted by all staff involved in the search and appropriate actions should have been implemented to have the matter investigated and dealt with internally or handed over to New South Wales Police which I believe would have been the more prudent option.”*

In her oral evidence, SAS O’Donoghoe accepted those conclusions and agreed that she ”should have alerted police to the presence of the package”. She further stated. ”It was reported to me so I should have called the police” She agreed that she did not follow policy in relation to the packages.

Regrettably, SAS O’Donaghoe’s late concessions as to her failure to follow policyin relation to the discovery of the packages on 2 May 2012 did not assist SCO Craft, who faced disciplinary action for her role in the matter, notwithstanding the fact that SCO Craft had indeed followed procedure by preparing an IRM and placing the unknown substance in an exhibit bag and depositing it in the exhibit safe.

As a result of the failure of staff at Silverwaterto properly follow procedure in relation to the discovery of the two packages in Paigh’s possession, there was no assessment or review of her classification prior to her transfer to the minimum security facility EPCC.

SAS O’ Donoghoe stated that, given the amount of drugs located in the two packages had there been a police investigation then that may well have had an impact on Paigh’s classification and subsequent movement between correctional centres. She was unable to say that it certainly “would” have had an impact, but she said those factors would have been taken into consideration in a review of Paigh’s classification and /or placement and Paigh may not have been sent to a minimum security centre. Silverwater is a maximum security centre, but if Paigh had retained a minimum security classification after a review of her classification, it was possible she would not have been moved to EPCC.

The Events at Emu Plains Correctional Centre.

(EPCC) is a minimum security correctional centre for females. It is a working dairy farm utilising the services of inmates to perform dairy farm duties. The centre has 11 accommodation houses in the main centre and a further 9 accommodation houses in what is known as the Jacaranda Centre which is an area outside the main confines of the gaol.

Each residential house in the main centre has up to 10 inmates at any one time. Each house has its own bathroom, kitchen and laundry with each bedroom positioned around a central lounge room of the house.

All accommodation houses are positioned in the north eastern corner of the facility. The corner in which these accommodation houses are located is bounded on the northern side by a paddock. The eastern side is also bounded by a paddock and orchard, both of which form part of the EPCC external grounds.

The boundary fence of the Centre consists of a tall barrel roll fence which is unable to be scaled due to the barrel roll being positioned on the top of the fence. The area between the barrel roll fence and the internal fence surrounding the accommodation houses is what is known as the “sterile zone”. The sterile zone is an area where inmates are prohibited from entering unless under supervision. This zone is designed to maintain a secure area between the accommodation houses and the other areas of the Centre. The zone is approximately five metres wide being measured from the barrel roll fence to the rear of the accommodation houses. The rear of each accommodation house backs onto the sterile zone and each bedroom has an external window which can be partially opened .These windows are secured by security mesh grille on the outer side of the window.

On 18 May 2012, Paigh was transferred to EPCC. She was accommodated in house 3, in a room with a window facing towards the external sterile zone.

The Anonymous Note

On 9 June 2012, Paigh received a visit from Nicholos Vossos. He was her only visitor on that day.

On 11 June 2012, Senior Assistant Superintendent (SAS) Angelika Sassenberg received an” anonymous” handwritten note initially given by an inmate to another officer. The information contained in that note suggested that Paigh had received heroin during the visit on 9 June 2012 and had been using drugs with other inmates in house 3. All inmates in House 3 had been “target” urine tested on 10 June 2012. The urine test results did not become available until after Paigh’s death (Paigh did not test positive for any illicit drug in the sample taken on 10 June 2012).

As at 11 June 2012 SAS Sassenberg was acting as the Intelligence (Intel) Officer at EPCC.

Following receipt of the anonymous note, SAS Sassenberg put in place the following management plan:

- She listened to telephone calls received by Paigh the previous week. It was clear to her that the substance of those telephone calls were to the effect that Mark Younis (who was listed as a "friend" on Paigh's list of permitted contact telephone numbers, and was listed in Corrective Services records as Paigh's next of kin) was arranging a delivery of an illicit drug to Paigh.

- SAS Sassenberg interviewed Paigh about the allegation contained in the anonymous note. Paigh denied the receipt of heroin, but when asked if her urine would come back clean she replied: "I don't know." SAS Sassenberg viewed this as an admission by Paigh in relation to the use of heroin.

- Paigh was told by SAS Sassenberg that she would be watched closely. Arrangements were made for Paigh to be monitored during any forthcoming weekend visit.

- SAS Sassenberg advised Paigh to make an appointment with the drug and alcohol counsellor regarding her addictions.

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Following her discussion with Paigh, SAS Sassenberg spoke with another inmate, T, from House 3. Inmate T confirmed that Paigh had received "a drop of heroin and pot". SAS Sassenberg spoke to inmate T about any concerns with Paigh and the other residents in the house. Inmate T stated that there were concerns that some of the other residents might expect Paigh to try and collect more drugs, and that she, inmateT, would monitor this and look after Paigh. SAS Sassenberg gave evidence that she had known inmate T for a length of time and felt that she could relate to her and that T would tell her what was going on.

At that time, SAS Sassenberg did not believe she had sufficient evidence to consider an alteration to Paigh's housing arrangement.

Regrettably, SAS Sassenberg was not rostered to work on 14 and 15 June 2012 and there was no replacement for her as Intel Officer. Essentially, any intelligence that could have been gathered in those two days and any monitoring of Paigh, especially her telephone calls, could not be pursued..

On 17 June 2012,(the day aftyer Paigh's death) SAS Sassenberg listened to telephone calls made by Paigh on the afternoon of 15 June 2012.Paigh had again contacted Mark Younis and, Nicholas Vossos. Another inmate from the house, inmate A, can be heard speaking in one of those conversations. Five telephone calls were made by Paigh to the drug syndicate responsible for the delivery of drugs to Paigh. It was arranged that Mr Vossos and a female were to pass the heroin and syringes to Paigh that night. It was apparent to SAS Sassenberg, from the content of those telephone calls, that the drugs were to be transported to the jail on the evening of 15 June 2012 and to be delivered at around 10:30 PM.

14 June 2012

There was evidence from several of the inmates in House 3 that Paigh had attempted to exit the house via a window on 14 June 2012; that is the night before the drug delivery. The evidence was that Paigh had kicked at the grille attached to the outside of the window and had dislodged it from the bottom of the frame. She was able to exit through that opening.

Inmate T initially told police in a record of interview that this occurred on 14 June 2012. However in her oral evidence inmate T insisted that this activity had taken place on 15 June 2012 only.

Other inmates, inmates P and L stated that an attempt had been made by Paigh on 14 June 2012 to escape by climbing through the window into the sterile zone.

That attempted escape cannot be confirmed one way or the other. Officer Angela West who was the Manager of Security at the centre at that time, gave evidence that the relevant records indicated that perimeter checks by officers, which included the sterile zone, had been completed as per the standard protocols on the 14 June 2012 and until the evening of 15 June 2012.. In fact the records indicated that on 15 June 2012 there were two sterile zone checks during the course of one shift. All those officers involved (with the exception of Officers Duggan and Walker, whose evidence is considered below)) attested to the fact that they had correctly completed the checks of the sterile zone on that day.

In her oral evidence, MOS West expressed doubt that the attempt by Paigh to exit the house via the window, had been made on 14 June 2012, as it would be expected that any damage to the window would have been discovered during those checks.

On the one hand it would be surprising that the inmates would manufacture the information concerning 14 June 2012. These inmates did not give evidence and their statements could not therefore be tested.

On the other hand, if the officers, as they attest in their statements, performed their duty according to protocol and successfully completed the checks of the sterile zone, then over those five occasions between the evening of 14 and 15 June 2012, it is unlikely that the breach would have remained undiscovered. These officers did not give oral evidence and as such their written statements cannot be tested.

On the material before me, there is no evidence that the checks on the sterile zone on 14 June 2012 or on 15 June 2012 (until the night shift) were defective.

In the circumstances I am unable to make a finding as to the events relating to the possible escape attempt by Paigh on 14 June 2012.

The Window Grilles

The windows of the houses facing the sterile zone are covered in a light alloy mesh grille. There is in place an EPCC standard operating procedure pertaining to the inspection of those grilles. At the time of thess events that procedure entailed a requirement for the grilles to be visually and physically inspected on a daily basis at the commencement of each shift using either a hammer or another tool.

There was evidence that because of the nature of the material of the grille, the use of a hammer was considered to be inappropriate. Instead, it was generally the accepted practice that officers inspected the integrity of the grilles by physically grabbing the mesh and shaking it.

At the commencement of each shift two officers were directed by the Officer in charge to complete a perimeter check of the Centre which includes the inspection of the grilles. Once the officers had completed the inspection they were to return to the main office and report any findings to the senior officer of the day.

From time to time random checks(including the sterile zone) were conducted throughout the shift. As with the routine checks, these are recorded in the Security Compliance Journal by the senior officer on duty.

Correctional Officer (CO) Robert Hanigan, in his oral evidence, agreed that a check of the window grilles was usually completed by grabbing the mesh and shaking it. He also gave evidence that whilst there was always a check at the beginning of each shift, from time to time there was a second random check conducted on the night shift.

Corrections Officers West and Felstead also gave evidence of second random checks being carried out during a single shift from time to time. They confirmed that the usual practice of ensuring the grilles were secure was to physically grab the grille by hand and shake it.

I find that the accepted procedure for checking the window grilles was the physical grabbing of the mesh. The evidence suggests that this practice was sufficient to ensure the security of the grilles notwithstanding the written procedure.

MOS West conducted ‘validation’ checks to ensure compliance with Corrective Services and EPCC policy and procedure. This included validation checks of the perimeter checks(including the sterile zone) and the results were entered into the MOS Journal.

Prior to Paigh's death, the last time a validation check of perimeter checks had been performed by MOS West was 10 June 2012. On that day, MOS West physically attended the inspection of the sterile zone being undertaken by correctional officers and observed them to ensure that the checks were being correctly conducted. All windows facing the sterile zone were found to be secure on that day.

15 June 2012

On the evening of 15 June 2012, Mr Vossos and a female travelled to EPCC. At about 10pm they delivered an unknown quantity of heroin and syringes to Paigh through the boundary fence. Mr Vossos has been convicted of an offence of supplying a prohibited drug relating specifically to the supply of heroin at EPCC on 15 June 2012.

There are varying accounts from the inmates in House 3 in their statements (given on 16 June 2012) as to the events of the evening of 15 June 2012.

Inmate A heard a man's voice yelling from the outside fence.

Inmate C heard a loud bang from Paigh's room at about 10pm. She entered Paigh's room and helped her climb back in through the window. The mesh screen had been bent out.

Inmate M stated that at about 10pm inmate A said "my baby is getting a drop" .About 10 minutes later, Paigh emerged from her room and appeared white in colour and blue around the mouth.

Inmate D saw Paigh and inmates T and A emerge from Paigh's room at about 10pm. They were all affected by drugs.

Inmate T was in Paigh's room with Paigh and inmate A. All three took heroin. There are conflicting accounts of the amount of heroin consumed.

Inmate A claimed in her recorded interview with police, to have consumed only a small amount orally, after which she claims she left the room and fell asleep on the couch.

Inmate T stated to police that she observed Paigh holding a syringe full of dark brown liquid. She told Paigh there was too much in the syringe and that she should not inject that much. She saw Paigh inject about 40 lines on the syringe. According to inmate T's account, she injected about 10 lines on the syringe and inmate A consumed about the same amount as Paigh.

Following the consumption of the drugs, there are a number of accounts as to Paigh's appearance and demeanour.

Inmate J saw Paigh emerge from her room about 10.30pm. Her lips were blue, she could not open her eyes properly nor walk in a straight line. Inmate J said that Paigh looked like she was "ODing" and did not appear to be breathing properly.

Inmate C saw Paigh come out from her room and heard her chest making a rattling sound, which this inmate recognised from experience as being the sound of a person overdosing.

Inmate M stated she and a few other inmates walked Paigh around the house until about 1am. She further stated that inmate T obtained a mattress from Paigh's room and placed it on the living room floor.

Some inmates laid Paigh down on the mattress, and rubbed her legs trying to keep her awake until about 1 or 2am. Inmate D stated that she was the inmate who laid Paigh on the mattress and that Paigh remained in the same position for about 40 minutes.

Inmate D stated that Paigh was still alive and breathing but "gasping" for air. Inmate D laid on the lounge and fell asleep, finally going to bed between 1 and 1:30am. She stated that Paigh was still breathing when she left the room.

Inmate C said she tried to help Paigh until about 2:30am. Initially Paigh had been sitting beside her on the lounge and she tried to keep Paigh's head propped up because she kept falling forward and backward.

The evidence from all the inmates is that they all eventually fell asleep.

Buzz Up - Knock up

The "buzz up" or "knock up" is a duress alarm system whereby inmates at EPCC can depress a button which alerts staff to a problem in the house.

A number of inmates in their statements spoke of wanting to" buzz up" when they observed Paigh's poor condition.

Inmate C stated that she wanted to 'buzz up' because to her it was obvious that Paigh was "going and she was overdosing and not in a good way". In her statement, she spoke of a number of other inmates who wanted to 'buzz up.'

She states that they were told not to ”buzz up” by inmates A and T, because inmates A and T did not want staff to ”ruin their stone”

In her oral evidence, inmate T denied she had said this. InmateT claimed that she told Paigh she was worried about her and wanted to ‘buzz up’ but it was Paigh who rejected that idea.Inmate T splashed water on Paigh’s face and claimed to have stayed with her until about 2:30 am.

In response to the suggestion by several of the inmates that they ‘buzz up’, inmate T stated in her oral evidence that it was inmate A who” went crazy” saying “if anyone buzzes up, I’ll swear….”. Inmate T claims this was said in a threatening manner and she also claims that Paigh was also insistent that there be no’ buzz up’

Inmate T agreed that she knew that if there had been a ‘buzz up’ then medical help would have been forthcoming.

What is clear is that none of the inmates ‘buzzed up’

16 June 2012

On the morning of 16 June 2012, an officer conducting a check of the sterile zone shortly after 7am observed the grille on the window of room number 7,Paigh’s window. The grille was not secured and appeared to have been kicked out from the inside.

SAS Sassenberg was notified. SAS Sassenberg attended the house and opened the door to Paigh’s room, observing the room to be empty with no mattress on the bed. She then saw the mattress on the floor in the lounge room and observed Paigh lying on the mattress.

In her evidence, SAS Sassenberg stated Paigh’s arm was blue, her eyes were open like slits and her face was blue around the mouth and eyes. Paigh was not breathing and SAS Sassenberg commenced CPR. CO Hanigan relieved SAS Sassenberg and continued CPR. An ambulance arrived at 7:27 am and CPR was discontinued at 7:30am.

Officers Duggan and Walker

Corrective Services Officers Kerry Walker and Kieran Duggan were on duty on the night shift of 15-16 June 2012 at EPCC. They were instructed to complete a perimeter check of the centre which included checking all doors, grilles, locks and gates, in between the houses and the sterile zone.

On this evening Cos Walker and Duggan only checked the doors of the houses and the windows of the houses that did not face the sterile zone. They did not enter the sterile zone or check any of the windows facing the sterile zone.

Their evidence was that perimeter checks were to be conducted at the commencement of each shift. CO Walker stated he had never been on night shift when 2 checks were conducted in the sterile zone.

CO Duggan acknowledged that sometimes there had been a second random check.

The shift commenced at 10 pm.Each officer gave similar evidence to the effect that had they had conducted the check as required, the check would have commenced at about 10:05pm.

By the time they had completed checking the internal areas it was usually 20 to 25 minutes before they would have entered the sterile zone; thus they would have been in the sterile zone at approximately 10:30pm.

In relation to the mode of checking the windows, CO Walker stated that each officer had their own method. His method was to grab hold of the mesh on the windows and shake it, although this was not done by him on every window.

Officer Duggan stated it was not his normal practice to physically check every window but to inspect them visually and only physically check them if he noticed something unusual. He told police in August 2012 that he would have seen the damage to Paigh's window on 15 June 2012 if he had done a visual check. His oral evidence was that he could have missed seeing the damage when performing a visual check of Paigh's window.

Officer Walker stated:

"If I had done the check at 10pm and done a physical I would have discovered the breach"

By a remarkable coincidence, CO Walker said that this night shift, being 15 June 2012, was the only night he had failed to perform the check as ordered.

CO Duggan acknowledged that there had been one prior occasion when he had not performed this duty as directed.

CO Duggan in response to a question as to why he did not complete the checks on this occasion stated:

“Complacency. Made an error. That’s all I can think of. We just didn’t do it.”

Had the officers completed the check and observed the breach, that would have triggered an examination of the inside of the house and Paigh and her deteriorating condition would have been discovered.

Changes Made

SAS Felstead gave evidence of changes made at EPCC, following the death of Paigh.
A device called a Digi–tool has been installed. This is an electronic recording system that records proof positive movements of officers conducting security checks.

Following oral evidence given by SAS Felstead in camera, a number of improvements to this system have been suggested and I have included these as recommendations.

In addition, changes have been made to the duress alarm. Earlier evidence from MOS West indicated that if a duress alarm had been pressed in the house then a red flashing light outside the house(visible from the inside) would have signalled that the alarm had in fact been activated. That duress alarm is now a silent alarm, so that any inmate who in the future may feel intimidated and reluctant to ‘buzz up’ will be able to do so without alerting others in the house to that action.

I have also made a recommendation that involves better information for new inmates at EPCC about the duress alarm or ‘knock up’ system.

Conclusion

The last few months of Paigh’s life can be characterised as a series of system failures and missed opportunities.

First,there was the failure to follow procedure on 2 May 2012, when Paigh was found in possession of contraband at Silverwater.

Had procedures been followed, and the police been notified and Paigh’s classification or placement reviewed as a result of a police investigation, there is a possibility that Paigh would not have been moved to EPCC.

Apart from the failure by Corrective Services staff to follow correct procedures, one of the issues arising in this inquest is the paucity of training available to Corrective Services staff concerning the identification of prohibited drugs.

It is acknowledged by staff that drugs in correctional centres are a major issue. SAS Sassenberg, in her written statement said “it is a common occurrence for illegal drugs to be inside gaols”

For this reason I propose to make a recommendation which should enable Corrective Services staff to receive update briefings on the identification and current concealment methods of heroin and other drugs

Second,there was the missed opportunity to follow up the information contained in the anonymous note received by SAS Sassenberg on 11 June 2012.

Whilst SAS Sassenberg put in place a management plan for the purpose of monitoring Paigh, her position as Intel Officer was not filled on 14 and 15 June 2012 when she was rostered off work. There was no procedure in place for staff to follow up that management plan and significantly there was no one available to listen to the telephone call made by Paigh on 15 June 2012 which disclosed information concerning a drug drop. Had there been an Intel Officer available to listen to that telephone call on 15 June 2012 there was a very real potential to interrupt the drug drop.

Third, the failure by Cos Duggan and Walker to conduct the sterile zone check on the evening of 15 June 2012 was a significant failure of their duty and a missed opportunity to discover the security breach by physically checking the grille on Paigh’s window.

Both officers agreed that had they completed the check as directed, they would have likely discovered the breach if it had occurred before 10.00pm. On CO Walker’s own evidence they would probably have discovered the breach if it had occurred at 10.15pm or 10.30pm.As set out above, the officers’ evidence was that they normally commenced the perimeter checks at about 10.05pm and on their evidence it was about 20 to 25 minutes before they entered the sterile zone.

Although there is some contest as to the frequency of a second random check of the sterile zone, the real possibility remains that had these officers conducted a second random check during their night shift on 15-16 June 2012 then the breach would have been discovered and Paigh’s condition discovered.

Of course the eventuality of discovering the security breach is connected to the timing of the exit by Paigh from the window. There are varying accounts as to when Paigh exited the window.

Inmates K and J stated that they observed Paigh about 10.30pm and her lips were blue which would infer that Paigh had already consumed the drugs.

Inmate M saw Paigh emerge from her room at about 10.10pm – following inmate A's claim that Paigh was getting a drop.

Inmate C saw Paigh's legs and body outside the window about 10.00pm.

Inmate D saw Paigh and inmatesT and A emerge from Paigh's room about at 10.00pm and they all seemed affected.

Inmate T told police in 2012 that she saw Paigh and inmate A coming out of Paigh's room to get water at about 5 minutes to 10.00pm,and they then went back to Paigh's room and called inmate T in to take drugs 10 to 15 minutes later.

Therefore, there would appear to be ample evidence to suggest that Paigh exited the window sometime between 10.00pm and 10.15pm, well before it would have been expected that Cos Duggan and Walker would have entered the sterile zone.

That leaves the real possibility that had the perimeter check been properly done, the damaged window would have been detected and an opportunity for Paigh to receive medical assistance would have arisen.

Fourth, there was available to inmates in the house the option of depressing the duress alarm, which would have activated a flashing light outside the house, or of using an intercom button to seek assistance for Paigh on the night.

It is possible that some inmates may have felt intimidated by inmates A or T and for this reason did not 'buzz up'. Inmate T denied that she intimidated anyone and nominated inmate A as being the one who went "crazy" and acted in an intimidating fashion. It was not possible to examine inmate A as she could not be located.

I am unable to make a finding as to why there was no 'buzz up' on this night, but to avoid the future possibility that inmates may feel intimidated into not using the duress alarm in similar circumstances I have included recommendations to address this issue.

Paigh Bartholomew

Paigh Bartholomew was a vibrant young woman, who was struggling to manage her addiction to drugs. Notwithstanding a childhood in which she was very much loved by her aunt and cousins, Paigh was unable to reconcile herself to the fact that her parents were not in her life and, in relation to her mother, that she had been virtually abandoned.

At the time of her death she was only 21 years old. The tragedy of this matter is that, apart from the failings by Corrective Services staff on the night of her death, had any of the other inmates in House 3 chosen to “buzz up” there seems little doubt that Paigh could have been saved.

I find that Paigh Bartholomew died 16 June 2012 at House 3 Emu Plains Correctional Centre, Old Bathurst Road, Emu Plains. The cause of death was mixed heroin and alprazolam toxicity. The manner of her death was the consumption of drugs illegally delivered to the Correctional Centre.

Recommendations

Recommendation to the Commissioner of Corrective Services

1. That the induction process for any new inmate to the Emu Plains Correctional Centre and any information provided (in writing and orally) during that process should specifically note:

    a) The presence of the duress alarm within each house.
    b) If the alarm is pressed it will sound in the Administration Centre to alert Corrective Services staff who will attend the house.
    c) Pressing the alarm will not cause an alarm to sound nor a light to flash within or around the house.
2. That the Commissioner of Corrective Services give consideration to approaching the Commissioner of the New South Wales Police Force to request update briefings on current concealment methods and packaging for heroin, so as to assist in detecting contraband within New South Wales Correctional facilities and training Corrective Services staff.

Not For Publication

Recommendations 3 and 4 removed.