CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Eric Whittaker
Hearing dates:	14 to 18 October 2019
Date of findings:	28 February 2020
Place of findings:	State Coroner's Court, Lidcombe
Findings of:	**State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – Cause and manner of death Death in custody – Parklea Correctional Centre – Ruptured Cerebral Artery Aneurysm – Subarachnoid Haemorrhage – Failure by correctional officers to respond to emergency "knock up" calls
File number:	2017/020885

Representation:	Ms P Dwyer, Counsel Assisting, instructed by Mr J Loosley, Crown Solicitor's Office J Blackshield and T Takavarasha, Levitt Robinson Solicitors, for the Whittaker family Mr A Jobe, Office of the General Counsel, Department of Communities and Justice, for the Commissioner of Corrective Services NSW Ms T Berberian, instructed by Mr J McGrath, Sparke Helmore Lawyers, for GEO Group Australia Pty Ltd Mr S Russell, instructed by Mr D Longhurst, McNally Jones Staff Lawyers, for Paul Hanson Mr P Rooney, instructed by Ms S Idowu, Makinson d'Apice Lawyers, for the Justice Health and Forensic Mental Health Network Ms P Robertson, NSW Nurses and Midwives' Association, for Registered Nurse Keith Cayanan and Endorsed Enrolled Nurse Elizabeth Vucetic
Findings:	**Identity of deceased**: The deceased person was Eric Whittaker **Date of death**: Eric died on 4 July 2017 **Place of death**: Eric died at Westmead Hospital, Westmead NSW 2145 **Cause of death:** The direct cause of Eric's death was a subarachnoid haemorrhage with an antecedent cause of ruptured cerebral artery aneurysm. **Manner of death:** Eric died while detained as an inmate on remand at Parklea Correctional Centre after he suffered a ruptured cerebral artery aneurysm that went untreated for several hours in the morning of 2 July 2017.

Non-publication orders:	Pursuant to s. 74(1)(b) of the *Coroners Act 2009*, there is to be no publication of the following material: 1. The names, addresses, phone numbers and other personal information that might identify: a. Any member of Eric Whittaker's family; and b. Any person who visited Mr Whittaker while in custody (other than legal representatives or visitors acting in a professional capacity). 2. The names, personal information and Master Index Numbers (MIN) of any persons in the custody of Corrective Services NSW (**CSNSW**), other than Mr Whittaker. 3. Floor Plan of Area 3 at Parklea Correctional Centre. 4. Parklea Correctional Centre daily rosters for 30 June 2017 to 4 July 2017 (inclusive). 5. The following sections of the Parklea Correctional Centre Operating Manual: a. 065 – Stenofon (Cell Alarms) Procedure; b. PCC/OP006 – Upper Control Area (Base); and c. OP019 – Escorts. 6. Parklea Correctional Centre Post Order – Hospital Escort dated 1 September 2017 (Post Order Number POAR701) 7. General Manager Instructions regarding escort procedure dated 30 November 2010. 8. The following sections of the CSNSW Operations Procedure Manual: a. Section 6 – Escorts; b. Section 12.1 – General Matters Affecting the Safety, Security, Good Order and Discipline of the Correctional Centre. 9. CSNSW Custodial Operations Policy and Procedures – Section 19.6 Medical Escorts. 10. Images and footage taken from CCTV.

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The Coroners Act 2009 (NSW) *in s. 81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the findings of an inquest into the death of Eric Whittaker.

Introduction

1. This is an inquest into the death of Eric Whittaker (**Eric**), a proud Kamilaroi man who was only 35 years of age when he passed away at Westmead Hospital on 4 July 2017. Eric was part of a large and loving family, many of whom attended the inquest so that they could patiently hear the evidence about the tragic circumstances of his death.

2. Eric was rightly proud of his Aboriginality and of his family. I was humbled to have them in Court for the entirety of the inquest and in particular to hear about Eric as a loving partner, son, grandson, nephew, sibling, cousin and father. I extend my deepest sympathies to Eric's family, who will always grieve their great loss.

3. Eric was the father of four beautiful, bright children and they are a great credit to him, to their devoted mother and to Eric's extended family.

4. At the time of his death, Eric was an inmate who had been held on remand at Parklea Correctional Centre (**Parklea CC**) until he became seriously unwell in the early hours of 2 July 2017 and was subsequently transferred to Blacktown, and then Westmead Hospital. The pathologist at autopsy, Dr Sairita Maistry, has confirmed the cause of Eric's death was a subarachnoid haemorrhage, which occurred as a consequence of Eric suffering a ruptured cerebral artery aneurysm.[1]

5. In the hours preceding his transfer to Blacktown Hospital, Eric was placed in a cell on his own in Unit 3A of Parklea CC. During this period, he likely experienced great confusion, as well as physical pain. Eric first came to the attention of night rovers at around 4:50am when those two correctional officers heard Eric shouting in a distressed and panicky tone. One of those officers then attended the cell and spoke to Eric, who was pleading for help, saying that he was claustrophobic and asking to be let out. The officer asked Eric what symptoms he had, and since Eric was not able to describe any medical condition, the officer did not believe that there was any medical issue that needed attending to. Rather, like his fellow officers after him, he thought Eric was distressed but not physically unwell in any way that warranted medical intervention.

[1] Exhibit 1: Vol 1, Tab 3.

6. Between 5:24am and 7:59am on 2 July 2017, Eric used the emergency intercom system, known as a "stenofon" call or "knock up" call, on 20 occasions[2] seeking the assistance of correctional officers and often pleading for help. Despite his distress, the correctional officers who responded to the knock up calls failed to recognise the signs of a medical emergency and failed to make the effort required to get Eric seen by clinic staff. This resulted in a delay of care to Eric that is disgraceful in the circumstances of this case.

7. True it is that Eric could not clearly articulate what was wrong with him, but by the time he had made several knock up calls, it should have been obvious to any correctional officer who was adequately trained and exercising due diligence, that Eric needed to be assessed by medical staff at the Parklea CC Clinic (**Clinic**). Instead, he was not taken to the Clinic until the commencement of the morning shift at around 8:00am on 2 July 2017, with the result that vital hours to treat Eric's condition were lost.

8. The knock up calls Eric made from his cell on 2 July 2017 were recorded and admitted into evidence. It was both necessary and heartbreaking to hear them played during the inquest. I can only imagine how difficult it must have been for Eric's family to have heard the content of those calls and to appreciate his obvious distress in the immediate period before his death. It compounds their grief to know that he suffered alone before he passed away.

9. It is not possible to know for certain that earlier medical intervention would have saved Eric's life; but it may have done. Certainly, any intervention would have saved him hours of physical and emotional torment and spared his family this additional distress.

10. The number of Aboriginal people dying in custody continues to be a national shame and a great concern to this Court. From 1987 to 1991, the Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**) was appointed by the Commonwealth Government to study and report on the underlying social, cultural and legal issues behind the disproportionate numbers of Aboriginal deaths in custody. The final report, published in 1991, made 333 recommendations aimed at reducing the numbers. Yet by 2017, when Eric tragically died, and still today, indigenous Australians continue to be massively overrepresented in the numbers of persons dying in custody.[3]

[2] Exhibit 1: Vol 3, Tab 53.

[3] See for example: the Statistical Report of the Australian Institute of Criminology, L Doherty and S Bricknell, *Deaths in Custody 2017-2018*. The National Deaths in Custody Program (NDICP) is responsible for monitoring the extent and nature of deaths occurring in prison, police custody and youth detention in Australia since 1980.

11. Although the action and inaction of several correctional officers came under scrutiny in this inquest, the aim is not to attribute blame to any individuals involved in the circumstances of Eric's death. Rather, the inquest sought to understand how, in a wealthy country like Australia, and almost 30 years following the release of the final report of the RCIADIC, a prisoner in Eric's situation did not receive urgent medical care and treatment.

12. Another important objective of the inquest is to identify any recommendations that are necessary and desirable to make so as to minimise the risk that another inmate with an acute medical condition would die in similar circumstances. I was pleased to note the changes in policy that have been introduced by the GEO Group Australia Pty Ltd (**GEO Group**), and Corrective Services NSW (**CSNSW**), in order to address the shortcomings that existed at the time of Eric's death. Had those changes not been made before and during the inquest, I would have made recommendations aimed at bringing them into effect. An inquest often sharpens the minds of interested parties and encourages them to implement reforms before findings are bought down, and that appears to be the case here.

13. To their credit, from the outset of the inquest, Eric's family have expressed a desire for lessons to be learnt from his death, in order to ensure that another family might be spared the type of pain and loss that they have experienced. I thank them for their enormous contribution to this inquest, and for their courage and grace.

The Inquest

14. The *Coroners Act 2009* (**the Act**) provides that where a person dies in lawful custody, an inquest into their death is mandatory and must be presided over by a senior Coroner (ss. 23 and 27).

15. Section 81 of the Act requires me to make a finding as to the identity of the individual who has died, the date, and place of death and the cause, and manner of death. "Cause of death" refers to the physical cause and "manner" refers to the circumstances leading up to and surrounding the death.

16. A secondary, but equally important function is governed by s. 82 of the Act, which empowers me to make any recommendations that are considered "necessary or desirable" in relation to Eric's death.

17. Having a public inquest is particularly important when a person dies while in the custody because prisoners are a vulnerable group within our community. Their vulnerability is three-fold. First, it is well accepted that many prisoners suffer from some form of physical or mental illness, including those related to illicit drug use. Second, the loneliness and distress of custody may well exacerbate

any mental distress. Third, prisoners do not have the agency to make their own decisions about the type of medical care that they can access, and are away from family and friends who might otherwise care for them. They are completely dependent on the authorities who detain them; in this case, the employees of a correctional centre which was privately operated, and contracted by the State to provide correctional services.

18. A hearing for the inquest into Eric's death was held before me at the State Coroner's Court in Lidcombe from 14 to 18 October 2019. The inquest heard oral evidence from 17 witnesses, including expert evidence from a neurologist, Dr David Rosen; a toxicologist, Professor Alison Jones; and an emergency physician, Professor Anna Holdgate.

The Evidence

Eric's Background

19. Eric James Whittaker was born 10 December 1981 into a large and loving family. The Court had the privilege of hearing stories of Eric, or Ek as he was sometimes called by his siblings, as he grew up. A persistent theme from the stories of his family is of a young man who was fun loving, kind and protective of those he loved.

20. Eric's sister Kayla told the Court that as children they played, shared, laughed, were brutally honest and protected one another. As they grew up, they shared stories, and she knew that Eric was a kind, gentle, curious and somewhat cheeky young man who never stopped being her big brother. He loved music and dancing, and it is not hard to imagine him stealing the show at the break dance competition at Lethbridge Park.

21. Eric's sister Shandelle told the Court stories of her brother that showed what a fun loving prankster he was and how much he made his family laugh. Those stories were tempered by other memories of him being gentle and wise, and able to comfort his younger sister in times of distress. Anyone hearing Shandelle speak about Eric can understand why he was "the best, most kind, loving big brother" a sister could ever want and need.

22. From his cousin Steve, the Court heard about Eric growing up with a very loving family. Eric was a man of good qualities that were instilled in him from an early age by his parents and grandparents. He was well mannered, polite, courteous and considerate. Eric treated people the way he wanted to be treated, with respect, compassion, empathy and understanding. He was non-judgmental and well-liked by family friends, his peers and all who met him.

23. Eric's extraordinary children gave the Court a great insight into the man Eric was. They spoke of their memories of him teaching them how to ride bikes, going to the zoo, watching TV, playing handball, going to the shops and the park. They miss him dearly and he will always be in their hearts.

24. In May 2004, Eric met and fell in love with his partner, Jessica Holmes, the mother of their four children. Jessica told the Court that it was love at first sight and described some of their happier family memories. They went on holidays, fished on weekends and spent hours at the park. They took the kids to the movies, played footy on the oval and went out for dinner, making precious memories as a family that they will always treasure. I heard from Jessica that Eric adored his kids, and would have done absolutely anything for them because, in her words, he was a great dad.[4]

25. Sadly, Eric suffered throughout his life with depression and that may help to explain his struggles with an addiction to illicit drugs. Eric tried hard to battle his addiction, sometimes moving away from family so that he would not subject them to it. In 2015, Eric and Jessica separated, although Eric continued to play a very big part in their lives and maintained regular contact with his children.

26. As a consequence of his addiction to illicit drugs, Eric came into contact with the criminal justice system and had a significant criminal history within New South Wales, mostly relating to theft offences and drug possession.[5] As a result, he spent periods in and out of correctional centres in New South Wales. That did not stop him loving or being loved by his family, who never lost contact with him for any lengthy period.

Arrest and Entry into Police Custody

27. On 27 June 2017, Eric was arrested by police on Bourke Street, Woolloomooloo and charged with two outstanding warrants for a failure to appear in Court. The warrants were for relatively minor charges of having goods in custody suspected of being stolen and possession of a knife in a public place. These offences were alleged to have been committed on 13 April 2017 and 30 May 2017, respectively.[6]

28. Eric was taken to the Kings Cross Police Station where he was entered into custody. According to a pro-forma questionnaire filled out by police, Eric reported that at the time of his arrest he was not using prohibited drugs. That electronic form recorded that Eric had a mental illness – "anxiety, depression" –

[4] 18/10/19 at T24.47.
[5] Exhibit 1: Vol 1, Tab 9, pp. 49-96.
[6] Exhibit 1: Vol 1, Tab 8, p. 28.

but that he otherwise appeared "calm and compliant" and was not agitated, aggressive or intoxicated.[7]

29. Eric was refused bail by police and transported to the Surry Hills Cells during the afternoon of 27 June 2017. A "prisoners transfer note" recorded that Eric was found with an uncapped syringe in his pocket, and was a self-confessed ice and heroin user.[8] On his arrival, Eric was subject to a further reception questionnaire entitled: New Inmate Lodgement and Special Instruction Sheet.[9] That document recorded that he had no medical problems requiring review on his reception at a correctional centre.

30. Police records indicate that Eric had reported no general medical conditions. It was further noted that Eric had answered no to the question: "do you use any non-prescribed drugs?"[10] Eric was described as "calm and cooperative". He was not thought to be agitated or mentally disturbed and there were no apparent signs of being under the influence of drugs or alcohol.[11]

31. Eric subsequently appeared at Central Local Court on 27 June 2017 where he was formally refused bail by the presiding Magistrate.

Admission at Parklea Correctional Centre

32. On 30 June 2017, Eric was transferred from Surry Hills Cells to Parklea CC. Parklea CC is one of only two privately operated correctional centres in NSW, the other one being Junee Correctional Centre. At the time of Eric's admission, Parklea CC housed prisoners on remand (such as Eric) as well as minimum and maximum security inmates.

33. At the time of Eric's death and until 31 March 2019, Parklea CC was managed by the GEO Group. Since 1 April 2019, the Parklea CC has been operated by a joint-venture known as MTC-Broadspectrum. GEO Group continues to operate the privately operated prison at Junee.

34. Eric arrived at Parklea CC by truck at around 6:10pm, along with several other inmates.[12] Correctional Supervisor Anthony Mott interviewed Eric in order to complete the Reception, Screening and Induction Checklist,[13] which variously includes the Reception Accommodation Checklist, the Gang ID form (not

[7] Exhibit 1: Vol 1, Tab 12, pp. 167-171.
[8] Exhibit 1: Vol 1, Tab 12, p. 172.
[9] Exhibit 1: Vol 1, Tab 12, p. 159.
[10] Exhibit 1: Vol 1, Tab 12, p. 164.
[11] Exhibit 1: Vol 1, Tab 12, p 165.
[12] Exhibit 1: Vol 2, Tab 29, p. 507.1.
[13] Exhibit 1: Vol 2, Tab 29, p. 507.2.

relevant to Eric), Information about Correctional Centre Discipline and Indemnity for Lost Property, which are all apparently explained to newly arrived inmates.

35. Eric was provided with prison attire and dinner while he was placed in the holding cell waiting to be screened by Justice Health and Forensic Mental Health Network (**Justice Health**) nursing staff. A Registered Nurse (**RN**) employed by Justice Health, Jeremy Nuevo, completed a Reception Screening Assessment. The Drug and Alcohol Screening Tool specifically lists the questions asked of Eric relating to his use of drugs. It appears that Eric denied using any drugs or alcohol in the four weeks prior to his incarceration and RN Nuevo assessed Eric as neither intoxicated nor withdrawing from drugs or alcohol. As part of the assessment, Eric was asked if he had anything causing concern and he answered: “no”. In responding to the question: "How do you think you will cope in prison?, Eric’s answer is recorded as: "Wonderful". In accordance with the assessment by RN Nuevo, Eric was housed in the general inmate accommodation (Area 3A) as a “Normal cell placement”.[14]

36. On 1 July 2017, Eric participated in a Questionnaire with an Operational Services Officer employed by the GEO Group, Ms Tanya Kearney. The purported purpose of the screening is not medical, but rather to assist in the transition to Parklea CC.[15] Ms Kearney completed the questionnaire by hand and later entered the information into the system. There were no specific concerns or fears recorded. In addressing Question 53 asking whether the inmate had been treated or medicated for a mental health issue, it is recorded: “depression/anxiety/not medicated”. In responding to Question 56 asking: “At home what do you do when stressed?”, Eric apparently answered: “Pot, Ice, Heroin”.[16]

37. Ms Kearney noted that Eric "presented well", "maintained eye contact" and "answered questions appropriately". She found Eric to be very polite and respectful, and to have answered all questions clearly and in a manner that corresponded with the questions asked. Eric showed no signs of intoxication or other matters that were of concern to her.[17]

38. Question 73 on the Intake Screening Questionnaire asked whether the inmate would have custody of their children following their release. In response to this question, it would appear that Eric indicated that he had no children. This response is in direct conflict with the Inmate Identification and Observation Form completed at Eric’s reception at the Surry Hills Cells. On this form, Eric stated

[14] Exhibit 1: Vol 1, Tab 15, pp. 255-271.
[15] Exhibit 1: Vol 2, Tab 25, p. 414.
[16] Exhibit 1: Vol 1, Tab 12, pp. 140-142.
[17] Exhibit 1: Vol 2, Tab 25, p. 414

that he had four children – aged 10, 11, 14 and 18 – and that they were in the care of their mother, Jessica Holman.[18]

39. CCTV footage of Area 3A at Parklea CC was made available to the inquest.[19] Footage from 1 July 2017 shows Eric walking around the common area, apparently communicating with other inmates and walking with full motor control. He appeared calm and showed no signs of agitation. There are no reports of any unusual or erratic behaviour exhibited by Eric on that date.

40. At 3:08pm on 1 July 2017, Eric walked up the stairs that led to the first level tier of cells in Area 3A at Parklea CC towards cell 17, which he had been assigned. Prior to entering his cell, Eric can be seen on CCTV footage stopping at cell 18 and communicating with the occupant of this cell. The vision of this interaction is obscured by a grate and the bars of the upper tier. The entire interaction lasted less than 30 seconds. Police investigators spoke with the inmates who were the occupants of cell 18 – John Boyd and Richard Van Gaalen – some months after Eric's death. Neither was able to recall this discussion with any certainty.

41. Eric then entered his cell for a short time before exiting and walking down the stairs once more, carrying a red cup. He disappears from camera view at 3:09pm and returned moments later carrying the cup. Eric again walked up the stairs to the first tier and re-entered cell 17, which he occupied as "one-out". At 3:10pm, the door to cell 17 was closed and secured by correctional officers. There were no further movements in or out of cell 17 until the following day on the 2 July 2017.

Welfare Check

42. At around 4:50am on 2 July 2017, two correctional officers who were rostered on as night rovers, David Stankovski and Sukhvir Gill, attended Unit 3A as part of a routine security check.[20] Shortly after attending, Mr Stankovski attended cell 17 to conduct a welfare check after hearing Eric shouting in what he perceived as a distressed and panicky tone.[21]

43. Mr Stankovski gave evidence that he could hear an inmate who he now knows to be Eric shouting in a distressed and panicky tone words to the effect of: "*Help me, let me out of here. I don't fucking belong in here. I don't belong in prison. I can't handle being in here. Please let me out I have to call Mum. No one knows where I am*".[22]

[18] Exhibit 1: Vol 1, Tab 12, p. 132.
[19] Exhibit 1.
[20] Exhibit 1: Vol 2, Tab 27, p. 464.
[21] T15/10/19 at T8.22.
[22] Exhibit 1: Vol 2, Tab 27, p. 464.

44. Mr Stankovski approached Eric and asked him what the problem was. His memory was that Eric said: '*Let me out, I'm claustrophobic, I have been fucking wrongly accused, I'm not meant to be locked up. No one knows where I am. I don't deserve to be here'. Eric kept repeating: 'Let me out, I don't like being locked up*.' Mr Stankovski then asked Eric if he wanted to be seen by the nurse, to which he replied: '*Open the door - let me out'*. Mr Stankovski's evidence was that he tried asking the same question in a number of ways, such as: '*Is there anything bothering you? Do you have any symptoms*?', however Eric kept repeating his earlier responses.[23] Mr Stankovski thought that Eric "might be coming down off something".[24]

45. Mr Stankovski returned downstairs and reported some of what he had observed to the night shift supervisor, Correctional Manager Operations (**CMO**) Peter Toulson. He explained to Mr Toulson that Eric was pacing backwards and forwards and shouting in his cell. When asked by Mr Toulson about the condition of Eric's cell, Mr Stankovski replied with words to the effect of: "*no cell mate, no self-inflicted wounds, no marks, cell neat and tidy".* Mr Toulson then directed Mr Stankovski to finish the security check and informed him that he would do a handover with the day shift.[25] Mr Stankovski said that no further calls were receiving during his shift to attend Eric's cell.[26]

46. In closing written submissions received on behalf of Eric's family on 24 December 2019, it was submitted that a referral should be made by me to the Director of Public Prosecutions, pursuant to s. 78(4) of the Act, with respect to the conduct of Mr Stankovski. While not expressly stated, I have proceeded on the basis that Eric's family submit that the evidence in the inquest has enlivened s. 78(1)(b) of the Act. That provision allows for certain procedural steps to be taken in relation to the conduct of an inquest in circumstances where a coroner forms an opinion as to the likelihood of a known person being convicted of an indictable offence that is causally related to the death of the person who the inquest is concerned with.

47. As is the case in every inquest over which I preside, I have considered the possible application of s. 78 of the Act in relation to the circumstances of Eric's death. However, in view of the evidence given during the course of the inquest, I have not formed any opinion that would result in the enlivenment of s. 78(1)(b) of the Act, including and in particular as it extends to the conduct of Mr Stankovski. For that reason, the legal representatives were advised on 23 January 2020 that I did not require any submissions from any interested party, or counsel assisting, addressing this issue.

[23] Exhibit 1: Vol 2, Tab 27, p. 465; 15/10/19 at T11.17.
[24] Exhibit 1: Vol 2, Tab 32 at [11.16].
[25] 15/19/19 at T15.8
[26] 15/10/19 at T17.42.

The Knock-Up Calls

48. During the night shift on 2 July 2017, Correctional Officers James Dobry and Tevita Fa'ao were rostered on to perform the role of the Upper Control Room (**UCR**) operators. Part of the UCR operators' responsibility involved responding to knock up calls made by inmates in their cells. Inmates are directed that use of the stenofon is reserved for medical emergencies.

49. At 5:09am, Mr Dobry responded to a knock up call from cell 31 in Unit 3A to advise that an inmate was screaming for help.[27] As a result, Mr Dobry contacted Mr Stankovski by radio and instructed the night rovers to conduct a welfare check in Unit 3A. Mr Dobry was subsequently advised that a welfare check had already been conducted, that the inmate was alright but just wanted to go home and the shift manager had been notified.[28]

50. At 5:24am, Eric contacted the UCR for the first time using the stenofon located in his cell. All of the knock ups were recorded and I have extracted a number of them below so that there is an adequate understanding of the nature and scope of the calls made by Eric. However, it must also be said that reading the transcripts of the knock up calls in isolation does not provide a complete picture of the obvious distress and suffering felt by Eric on 2 July 2017. The tone of Eric's voice, as well as the tone of correctional officers who responded to the knock up calls, was critical to my understanding of the manner of Eric's death.

51. The first knock up call was answered by Mr Dobry. He would ultimately respond to three further knock up calls made by Eric at 5:29am, 6:06am and 6:25am. Mr Dobry gave evidence that it did not occur to him that Eric might be having a medical emergency, but rather, he thought he was experiencing an "emotional reaction".[29]

52. In the first knock up call at 5:24am, Eric stated:

    "Open my door I'm stuck inside, please unlock my door"[30]

53. In the second knock up call at 5:29am, the following exchange took place:

    Control: "State your medical emergency."

    Whittaker: "Someone unlock my door, please"

    Control: "What's your problem?"

    Whittaker: "I'm stuck in the room please help me."

[27] 15/10/19 at T34.46; Exhibit 1: Vol 3, Tab 55, p. 925.
[28] 15/1019 at T35.43.
[29] 15/10/19 at T37.50.
[30] Exhibit 1: Vol 3, Tab 55, p. 926.

Control: "Yes it's called a cell and you've been seen by the rovers just two minutes ago so what's the problem?"

Whittaker: "The room please someone come and unlock."

Control: "What's your medical emergency?"

Whittaker: "In the room I need to go some..."

Control: "Yes your locked in a cell that is called a cell you're in gaol okay, you've just been seen by the night rovers, what is your problem?

Whittaker: "I need to get out please."

Control, "Where do you want to go?"

Whittaker: "To go somewhere please help me, help me."

Control: "Okay, well you've been seen by the rovers, shift manager's been notified so you stay there until day staff comes."[31]

54. Eric's tone can be described as distressed and panicked and he was pleading for assistance. Mr Dobry's tone was brisk and direct, without any obvious sympathy or concern. Mr Dobry gave evidence that when he is working and communicating on the radio he speaks in the same official tone of voice and he did not mean any disrespect to Eric.[32] He agreed that his voice might be heard as being robotic and he said that coming from New York, he is a fast speaker.[33] Having heard Mr Dobry give evidence, I accept that his natural tone is brisk and unemotional and can come across as clinical or harsh. I accept that he did not mean any disrespect to Eric, but because of his lack of understanding and inquiry, he failed to respond appropriately to an inmate who was so obviously exhibiting distress.

55. A third knock up call made at 5:35am was answered by a different Correctional Officer, this time Mr Tevita Fa'ao, who went on to respond to two further knock up calls made at 5:49am and 5:54am. The first knock up call at 5.35am proceeded as follows:

Control: "????(Indecipherable) State your emergency."

Whittaker: "Unlock my door, please unlock my door please."

Control: "Where do you want to go mate?"

Whittaker: "Please help me baby, help me get out of this room please."

[31] Exhibit 1: Vol 3, Tab 55, pp. 927-928.
[32] 15/10/19 at T51.5.
[33] 15/10/19 at T51.12.

Control: "What are you doing here?"

Whittaker: "The toilet, that's all and the door shut on me."

Control: "Eight o'clock staff will be on site and they can open your door for you mate"

Whittaker: "Help me please help me. Unlock my door, please unlock my door"

Control: "What's your name?

Whittaker: "Eric, my name's Eric.

Control: "What's your last name?"

Whittaker: "Whittaker."

Control: "What's wrong?"

Whittaker: "What happened?"

Control: "What's wrong with you?"

Whittaker: "I come in to use the toilet and the door shut on me, please unlock my door, help me please".

Control: "What do you mean you went to use the toilet and the door shut on you?"

Whittaker: "Yes it did, the door shut on me, help, now I'm stuck in the room, I can't get out."

Control: "Well you're in prison mate, that's what you've got to understand, well you're in prison, the door is secure you can't get out till eight o'clock."

Whittaker: "What, I'm stuck in this room till eight? No let me out, please"

Control: "We can't mate you're in prison okay. I'll let the staff know that when they come in they can check you to see what your issues are yeah."

Whittaker: "(Crying)"[34]

56. Eric was again distressed and both his intonation and his words reflected confusion. Mr Fa'ao did attempt to be gentle in his response and there is some care reflected in his tone. Mr Fa'ao gave evidence that he thought Eric was "just sad from being in gaol".[35] It is clear that Mr Fa'ao recognised that Eric was emotionally distressed and tried to be compassionate and provide some reassurance to him. As with Mr Dobry, it did not occur to him that Eric may have been experiencing a medical emergency and that was the reason for his knock

[34] Exhibit 1: Vol 3, Tab 55, pp. 929-930.
[35] 15/10/19 at T67.13.

up calls. Mr Fa'ao gave evidence that "a lot of people cry in gaol"[36] and he had not had any training to recognise if Eric had a mental health issue.

57. Having had the opportunity to reflect, Mr Fa'ao accepted that it should have been evident to him that Eric was suffering from some sort of physical or mental health issue that warranted intervention.[37] He agreed that this case demonstrated that correctional officers like him needed better training about how to recognise when there is a prisoner in need of medical care.

58. At 6:00am, Correctional Officer Paul Hanson commenced his shift in the UCR, taking over from Mr Dobry. Mr Hanson gave evidence that Mr Dobry told him not to worry about requesting a welfare check for Eric because he had been checked by the Night Rovers during the night.[38] Mr Hanson also claimed that Mr Dobry had referred to Eric as a "spinner"[39] (a derogatory term used to refer to inmates with mental health issues) who had been knocking up all throughout the night; approximately 20-30 times.[40] Mr Dobry strongly denied this claim. He said that he remembered doing a handover with Mr Hanson where he said we have an inmate in the cell who was in need of help, rovers had been notified and the shift manager had been notified.

59. Mr Hanson made no complaint at the time about Mr Dobry having used a derogatory term and, in light of the vehement denials by Mr Dobry, it is not possible for me to be satisfied that it happened.[41] Regardless of the words that were used, the conversation Mr Dobry had with Mr Hanson conveyed to him that there was no significant medical condition or need for urgent medical care of Eric, with the result that none was arranged.

60. At 6:18am, Mr Hanson responded to a knock up call made by Eric, who reported his emergency as being stuck in his cell. Eric could be heard begging the UCR for help, saying: "*Please come and let me out please, unlock my door please, I'm stuck in here please help me out. Help please, help me*". Mr Hanson told Eric to give him a couple of hours and then he would come down.[42]

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[36] 15/10/19 at T67.17.
[37] 15/10/19 at T66.44.
[38] 16/10/19 at T16.4.
[39] 16/10/19 at T52.40.
[40] Exhibit 1: Vol 3, Tab 45, p. 763.
[41] In his internal investigation report, Mr Lang stated that "[d]uring interviews with some of the employees (not all) they referred to some inmates as '*spinners'*. This included one Manager. When questioned this term appears to be applied colloquially to those inmates who exhibit behaviours consistent with mental illness and/or intoxication. The use of the term is demeaning, crass and disrespectful. The manner in which the employees used the expression lead this investigator to conclude it is in common usage at the PCC (and possibly wider in corrections). Its use should be discouraged": see Exhibit 1: Vol 2, Tab 32 at [11.76].
[42] Exhibit 1: Vol 3, Tab 55, p. 935.

61. At 6:25am, a further knock up call made by Eric was answered by Mr Dobry. The exchange was as follows:

> *Control: "State your medical emergency."*
>
> *Whittaker: "Please unlock my door, get me out of here please,"*
>
> *Control: "What's your medical emergency?"*
>
> *Whittaker: "I need to get out of here..."*
>
> *Control: "Rovers have been notified, shift manager notified, they'll be there shortly, till then you'll have to wait."*[43]

62. Eric made subsequent knock up calls to the UCR at 6:29am, 6:31am, 6:38am, 6:42am, 6:44am, 6:49am, 6:53am and 6:56am. Each of these was answered by Mr Hanson, who told Eric that he would have to wait and to stop using the knock up button.[44] Subsequent calls were made at 6:57am and 7:10am that went unanswered, or at least there is no record that they were answered.[45]

63. During the 6:57am knock up, Eric stated: "*Please I'm getting claustrophobic right now and I've got an appointment with Centrelink can you please get me out of here (Sounding tired and out of breath)".*

64. During the 7:10am knock up, Eric can be heard sobbing and said: "*(Sobbing) Let me out, please, (sobbing) bloody hell (sobbing and sounds of items being moved)"*.

65. Eric attempted a final knock up call at 7:51am. This was answered by Correctional Officer Mathew Riley. During this final knock up call, which lasted approximately nine minutes, Eric was extremely distressed and can be heard panting and sobbing. Despite its distressing content, it is important that I set out the contents of this call in full:

> *Whittaker: "Emergency. Please come and release me I'm getting claustrophobic right now. Please help me [hyperventilating]. Help. Please, somebody open my door. Please [hyperventilating] Release me please. Come and help me please [hyperventilating]. Come and vjgit me please. Get me out of here. Please help me. Help me [sobbing] Help me. [hyperventilating/sobbing] Please release me. Help [sobbing]. Whoo. Help me now. Help. I'm getting claustrophobic [hyperventilating]. Ah, release me [laughing], whoo-hoo. whoo. [hyperventilating] [sobbing]. What would I do? Please. I'm starting to get claustrophobic right now. Someone please release me [sobbing]. Please [hyperventilating]. Release me. Fuck."*

[43] Exhibit 1: Vol 3, Tab 55, p. 936.
[44] Exhibit 1: Vol 2, Tab 55.
[45] Exhibit 1: Vol 3, Tab 53.

Control: "Yeah."

Whittaker: "Open my door please."

Control: "What's up?"

Whittaker: I need to be released."

Control: "Huh?"

Whittaker: "I need to be helped. Please open my door. Please."

Control: "What is it?"

Whittaker: "I've got nowhere to go in here"

Control: "Can you breathe?"

Whittaker: "Hardly."

Control: "Are you asthmatic?"

Whittaker: "Yes."

Control: "You are asthmatic."

Whittaker: "Yes. Please open my door. Please open my door [long pause] Please open my door too."

66. GEO Group's procedures at Parklea CC required all knock up calls to be recorded in the emergency call system register.[46] Despite Eric knocking up on 20 separate occasions on 2 July 2017, only one entry was made with respect to cell 17 in Area 3A. That entry was recorded at 5:23am and noted that Eric had stated he wanted out of his cell.[47] Mr Fa'ao gave evidence that his understanding at the time was that knock up calls should only be recorded in emergency situations.[48]

67. Mr Hanson gave evidence that he was concerned about Eric because of the tone of his voice, because of his distress, his confusion and his persistent calls. As a result, he made mention of his concern to Mr Riley, and he requested through the shift manager, Derrick Brown, to get the morning staff to check on Eric as soon as possible.[49] There was, however, no recognition of the possibility of a medical emergency that required immediate attention.

[46] 15/10/19 at T32.5.
[47] Exhibit 1: Vol 3, Tab 54, p. 922.
[48] 15/10/19 at T64.9.
[49] 16/10/19 at T31.49.

68. Derrick Brown was the CMO who came on shift at 6:00am on 2 July 2017. He was aware of the stenofon policy in place at the time of Eric's death which stated that: "If the call alerts them to a serious incident or potential serious incident, the officer must immediately arrange for staff to attend the cell and investigate the situation and take any responsive actions required. The CMO and/or area manager are to be informed immediately of the situation".[50] It was Mr Brown's expectation that, as the CMO on at a night shift, he would be told of a potential serious incident, in which case he would assess it himself or speak to the attending officers.

69. Mr Brown gave evidence that he was at no time during the morning shift told anything about Eric's situation.[51] He had an expectation that staff in the UCR would have told him about an inmate who was in that much distress, and was extremely disappointed when he found out, after Eric's death, that he had not been informed.[52] In an interview with the GEO Group investigator, Mr Brown said that had he been informed, he would have gone and assessed the situation himself. He said: "Look in that call you can hear it in him, that he's sick, he's so delirious and he's frightened. That is not normal actually". When asked his view on the action or inaction of staff in the UCR, Mr Brown said:

> "I don't even know how to say this, right. They should've acted on it, bottom line. Yeah, we do deal with a lot of mental health issues here, especially the clinic. They deal with those sorts of issues every minute of the day. But, yeah, it should've been dealt with".[53]

70. On no occasion did any of the correctional officers who answered the knock up calls arrange for a welfare check or review by Justice Health medical staff. Each of the correctional officers gave evidence that if they had perceived a medical emergency, they would have placed a "CERT" call – that is a Centre Emergency Response Team – which would have triggered an immediate clinical review by Justice Health medical staff.[54] The thrust of the evidence given by the correctional officers was that because Eric did not complain of an acute episode – such as self-harm, chest pain, assault or some other medical emergency – they did not perceive that he had legitimately used the stenofon and therefore did not consider the need to active a CERT.

71. I had the benefit of reviewing two investigation reports, one prepared by Mr Robert Lang of GEO Group's Office of Professional Integrity and another by Senior Investigation Officer employed by CSNSW, Mr Kenneth Johnston. Mr

[50] 16/10/19 at T67.45.
[51] 16/10/19 at T68.30.
[52] 16/10/19 at 69.30/
[53] Exhibit 1: Vol 3, Tab 47, pp. 809-827.
[54] 15/10/19 at T44.23 and T57.30.

Lang listened to the 20 calls and found that on each occasion, Eric was in a distressed state.[55] Mr Lang made findings that there were 186 minutes (over three hours) during which it "should reasonably have been known by a large number of PCC correctional employees that inmate Whitaker was emotionally and mentally distressed"[56]. He recommended disciplinary action against a number of officers. He was particularly concerned that Mr Stankovski thought that Eric "might be coming down off something"[57] and found that "the suspicion that the inmate was drug affected alone should surely have prompted an intervention causing the inmate to be medically examined with the objective of determining whether or not he was drug affected and if so the most appropriate means of managing any associated risks"[58]. I respectfully agree with that conclusion.

72. After listening to the stenofon calls, Mr Johnston concluded:

> "The investigation has highlighted a number of issues in relation to the actions and inactions of officers charged with the duty of care for Eric.
>
> It could be argued that it should have been clear to all officers who dealt with Eric whether in person or by the Stentofon system that he was clearly delirious and completely unaware of his surroundings. He could not be reasoned with nor conduct a rational conversation.
>
> Clearly Eric was suffering from a health issue whether it would be drug induced or a psychotic or medical episode is not the issue, what is apparent is that some type of medical intervention should have occurred." [59]

73. I agree entirely with that those findings. I accept that where a prisoner cannot clearly articulate their medical issue, it may be difficult to distinguish between the emotional distresses many prisoners experience and something more medically significant. I accept that there will be prisoners who use the stenofon inappropriately to express frustration. However, I do not accept that the majority of inmates exhibit signs like the sobbing, confusion and distress that Eric was demonstrating on 2 July 2017 and I do not accept that those symptoms can be ignored over a three hour period, where 20 calls were made. Correctional officers must be trained to recognise that the symptoms Eric exhibited might be signs of mental illness, drug withdrawal or clinical distress, and the way to determine that is to seek medical attention.

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[55] Exhibit 1: Vol 2, Tab 32 at [6.18].
[56] Mr Lang stated that "[i]t is not known what the actual impact, if any, of the 186 minutes (over three hours) during which it should reasonably have been known by a large number of PCC correctional employees Inmate Whitaker was emotionally and mentally distressed may have had on the effective treatment of whatever medical condition he had experienced": Exhibit 1: Vol 2, Tab 32 at [11.74].
[57] Exhibit 1: Vol 2, Tab 32 at [11.16].
[58] Exhibit 1: Vol 2, Tab 32 at [11.17].
[59] Exhibit 1: Vol 1, Tab 11 at [191]-[193].

74. I have given thought to what training could be given to correctional officers to help them recognise that the signs of distress exhibited by Eric warrant clinical review, but the stark reality is that it should already have been evident to them, based on their fundamental understanding of human distress and the duty of care they owed, that Eric needed to followed up for a welfare check, which should in turn have led to medical intervention. I endorse the evidence given by Dr Rosen, who gave expert evidence but spoke also of basic humane responses. When asked by counsel assisting how correctional officers could be trained on what to look out for when a prisoner appears "extremely distressed, fearful and confused", he said:

> "Yeah, no I thought about that and in one sense the, the answer is very simple and intuitive. Most of us in this room would recognise the distress in a baby that isn't telling us what is wrong. Most of us would recognise the distress in an Italian tourist who was critically ill, without actually understanding what we were being told. So, you know, can one give any more of a lesson or instruction, than simply to be observant and to understand what distress is?
>
> ….
>
> In fact, how do you instruct somebody or teach someone to, to understand and respond to distress, I don't know where to start really. I mean it's just, there can't be anybody in this room that wouldn't fully appreciate distress when they saw it, without a lesson.
>
> …
>
> Look, I don't want to sound facetious but it goes without saying that if there is sign of distress, if there is somebody who clearly is in need or seems to be asking for help and you can't provide that help, then the next step is to find someone who can provide that help." [60]

Release from Cell 17

75. At 8:05am, two correctional officers, Michael Tago and Jesse Peteru, attended cell 17 in Area 3A to conduct a welfare check on Eric at the request of Correctional Supervisor Gregory Beencke.[61] Mr Tago and Mr Peteru can be seen on CCTV footage and appeared to communicate with Eric without opening the cell door. Both gave evidence that Eric told them he was claustrophobic and couldn't breathe.[62] They requested their supervisor, Correctional Supervisor Christine Walsh, to attend Eric's cell.[63]

[60] 17/10/19 at T21-22.
[61] 14/10/19 at T68.14.
[62] 16/10/19 at T58.48.
[63] 14/10/19 at T68.47.

76. At 8:08am, Ms Walsh was granted authorisation to open the door to cell 17. Mr Tago gave evidence that at the time the cell door opened, Eric appeared to have urinated, vomited and defecated on himself.[64]

77. At 8:16am, CCTV footage captured Eric walking out of cell 17. He appeared to be very unsteady on his foot. He was holding on to nearby railings to maintain balance and ultimate required assistance from Mr Peteru and Mr Tago to get down to the ground level of Unit 3A.[65] Once there, Eric remained on the ground floor, awaiting the arrival of nursing staff. He can be seen on CCTV to initially sit on the floor at the foot of the stairs. However, he appeared at that stage to have considerable difficulty sitting still. He alternately leaned forward, moved his legs and flailed his arms. At one point, Eric lay face down on the floor next to the railing, alternating between a face-down lying position and a semi-kneeling position. He also used the railing to pull himself along the floor whilst lying on his back.

78. At 8:28am, a Justice Health nurse attended Eric on the ground floor of Area 3A. Eric's erratic movements continued while the nurse attempted to conduct a physical assessment. At 8:33am, Eric was assisted into a wheelchair and almost immediately taken from Area 3A.

Transfer to Parklea Correctional Centre Clinic

79. At 8:38am, CCTV footage captured Eric arriving at the Parklea CC Clinic. Endorsed Enrolled Nurse (**EEN**) Elizabeth Vucetic was on shift at the time of Eric's arrival. EEN Vucetic was the only nurse in the Clinic as her supervisor, RN Teresita Lee, was attending a medication round and welfare checks in the segregation unit.[66]

80. EEN Vucetic noted that Eric was incontinent of urine and faeces. She also noted that correctional officers had informed her that he had vomited during his transfer to the Clinic. EEN Vucetic attempted to perform a set of general observations while Eric was in the wheelchair.[67] Nursing and correctional staff were unable to transfer Eric into a bed because he was so agitated; moving up and down, kicking his legs, talking and screaming. Eric was subsequently secured by correctional staff in the Clinic's holding cell. He was treated with oxygen therapy on a non-rebreather mask, although it is clear from the CCTV footage that he could not or would not keep the mask in place.

[64] 16/10/19 at T60.5.
[65] 16/10/19 at T60.29.
[66] 16/10/19 at T88.22.
[67] Exhibit 4.

81. Because RN Lee was absent from the Clinic, EEN Vucetic contacted the After Hours Nurse Unit Manager, Valerie Bailey.[68] At approximately 9:00am, while EEN Vucetic was on the phone, RN Keith Cayanan came into the Clinic and received a handover of Eric's medical status. RN Cayanan entered the holding cell and took another set of observations.[69] Clinical notes indicate that Eric was disoriented and complaining of being unable to breathe. He was shaking and not able to sit still. His pupils were observed to be dilating from 7mm-3mm.[70] Eric also admitted to nursing staff that he had consumed heroin and ice two days prior.[71]

82. At around 9:25am, EEN Vucetic contacted the Remote Offsite Afterhours Medical Service (**ROAMS**) by telephone and spoke with the on-call Drug and Alcohol Doctor, Dr Sergiu Grama. EEN Vucetic relayed to Dr Grama Eric's symptoms, observations and the fact that he was distressed and screaming out for help.[72] Dr Grama asked for a further set of observations, following which he gave a phone order for a 5mg dose of Haloperidol (an anti-psychotic medication) and 10 mg dose of Maxolon (anti-vomiting medication). Those drugs were administered.[73]

83. At 9:35am, EEN Vucetic made notes about Eric's presentation in the Justice Health clinical file.[74]

84. At 9:50am, Dr Grama telephoned the Clinic back with advice to send Eric to hospital. In the intervening period, Dr Grama had spoken to the Drug and Alcohol Medical Director, Dr Jill Roberts, who had confirmed that Eric needed to be transferred to hospital. [75] At 9.55am, NSW Ambulance was contacted on Triple 0 and the Hospital transfer documentation completed by RN Cayanan. The transfer notes indicate that Eric had not been diagnosed with anything prior to transfer but there was a record to "query substance withdrawal, disorientation, agitation, elevated heart rate and elevated blood pressure".[76]

Transfer to Blacktown Hospital

85. At 10:04am, CCTV footage captured NSW Ambulance personnel arriving at the Clinic. They subsequently departed for Blacktown Hospital at 10:25am.

[68] 16/10/19 at T90.37.
[69] 16/10/19 at T81.6.
[70] Exhibit 1: Vol 1, Tab 22, pp. 300-308.
[71] Exhibit 1: Vol 1, Tab 22, p. 304.
[72] 16/10/19 at T91.25.
[73] 16/10/19 at T93.49.
[74] 16/10/19 at T95.12.
[75] 16/10/19 at T9.19.
[76] Exhibit 1: Vol 1, Tab 16, pp. 272-274.

86. The ability for Eric to be absent from a correctional centre for the purposes of medical treatment was authorised under s. 24(1) of the *Crimes (Administration of Sentences) Act 1999*.

87. At the time of Eric's transfer to hospital, GEO Group had operating procedures in place that determined when and how restraints should be used on inmates during medical escorts.[77] The hospital escort journals completed by correctional officers contained clear instructions that the inmate was to be handcuffed and ankle cuffed at all times.[78]

88. Eric arrived at Blacktown Hospital at 11:00 am on 2 July 2017 and was immediately admitted at 11:01am. Admission notes indicate that Eric was agitated and restless.[79] It is also apparent that ambulance officers administered 10 milligrams of Droperidol, an anti-psychotic and sedative medication, during Eric's transfer to hospital. Further sedative medication was administered at Blacktown Hospital due to Eric's non-compliant behaviour and agitated state.

89. At 11:45am, a chest x-ray was conducted which identified no issues with Eric's lungs or heart. At 2:25pm, a CT scan was conducted upon Eric's brain, abdomen and pelvis. It was noted that the appearance of his brain were highly suggestive of global hypoxic ischaemic injury. A CT angiogram showed a ruptured anterior communicating cerebral artery aneurysm. It is apparent from the medical records that treating doctors suspected, but were unable to confirm, that Eric had a subarachnoid haemorrhage. Medical staff noted there were no obvious signs of external head injury, no bruising, no contusion and no blood in the ears.[80] Following the CT scan, Eric was transferred to the Intensive Care Unit (**ICU**) and intubated.

90. At 5:30pm, an analysis of Eric's blood and urine was conducted. The urine screen was positive for stimulants and benzodiazepines. This was a screening test and therefore did not indicate the levels at which these drugs were present.[81] Professor Jones stated that those toxicology results indicated that the most likely scenario was that Eric had ingested amphetamines on the evening of 1 July 2017 while he was in custody at the Parklea CC.[82]

91. At around 5:40pm, Eric's condition deteriorated significantly. His blood pressure was noted to be extremely high. He was administered 3mL of Propofol and his blood pressure reduced. Approximately 10-15 minutes later, his blood pressure plummeted so that he became hypotensive and resuscitation attempts had to be

[77] Exhibit 1: Vol 3, Tab 70.
[78] Exhibit 1: Vol 3, Tab 53.
[79] Exhibit 1: Vol 4, Tab 77, p. 1134.
[80] Exhibit 1: Vol 4, Tab 77, pp. 1122-1123.
[81] Exhibit 1: Vol 4, Tab 78, p. 1265.
[82] 17/10/19 at T55.15.

commenced. Eric was administered adrenaline and a defibrillation machine used while a central venous catheter was inserted. Once his condition stabilised, it was noted that Eric's pupils were dilated and non-reactive.[83]

92. At 9:36pm, a further angiogram CT scan (using contrast dye) of Eric was conducted as a matter of urgency. This contrast scan identified a 5.5mm aneurysm related to the anterior communicating artery. The scan did not exclude the possibility of a subarachnoid haemorrhage. Extensive brain oedema (fluid and swelling) was noted as being present.

93. At 11:30pm, Eric was transferred to Westmead Hospital for urgent neuro-critical care and neurosurgical opinion.

Transfer to Westmead Hospital

94. At around 12:20am on 3 July 2017, Eric arrived at the Westmead Hospital ICU and his care was continued by medical staff there. Medical records indicate that Eric was reviewed by medical officers during the morning ward round on 3 July 2017. During this round, it was noted by the treating doctors that Eric's eyes were fixed and dilated at 5mm and there was an absence of several other reflexes. Eric's limbs were also noted as indeterminately twitching, consistent with brain injury. This led the attending doctor to suggest brain death testing be conducted.[84]

95. An entry in the medical records at 11:38am indicates that the ankle restraints on Eric were removed for medical purposes and then re-applied shortly after at 11:46am.

96. At 4:05pm on 3 July 2017, the existence of a severe subarachnoid haemorrhage and absent brain-stem reflexes was confirmed. It was noted that Eric's brain death was imminent.[85] It was subsequently noted by medical staff that restraints were removed by a correctional officer at 3:41 pm.

97. On 4 July 2017, further testing was conducted and Eric was formally declared brain dead at 12.55pm.[86] At 4:55pm, Eric's family were advised of his brain death and advised that his life support apparatus would need to be removed.[87]

Cause of death

98. On 6 July 2017, an autopsy of Eric was performed at Glebe Morgue by Dr Sairita Maistry.[88] Dr Maistry concluded that the direct cause of Eric's death was

[83] Exhibit 1: Vol 4, Tab 77, p. 1157.
[84] Exhibit 1: Vol 4, Tab 82, p. 1304.
[85] Exhibit 1: Vol 4, Tab 82, p. 1304.
[86] Exhibit 1: Vol 4, Tab 82, p. 1301.
[87] Exhibit 1: Vol 4, Tab 82, p. 1305.

a subarachnoid haemorrhage with an antecedent cause of ruptured cerebral artery aneurysm.[89]

99. An additional CT scan of Eric's brain was conducted by a radiologist, Mohammed Nasreddine, at the request of Dr Maistry on 5 July 2017. Mr Nasreddine's report dated 4 December 2017 confirmed evidence of an extensive subarachnoid haemorrhage.[90]

100. The Court heard evidence from three experts who touched on the causes of Eric's aneurysm and his cause of death. Dr David Rosen is a neurologist at Prince of Wales Private Hospital, with a private practice, Sydney Neurology, located in Camperdown. Professor Anna Holdgate is a senior staff specialist in emergency medicine working at Liverpool and Sutherland Hospitals, with 23 years of clinical experience as a specialist in emergency medicine. Professor Alison Jones is a specialist physician and clinical toxicologist and is a staff specialist toxicologist at Western Sydney Local Health District.

101. Dr Rosen explained that a brain aneurysm is like a little bubble, or swelling, or an outpouching of the wall of the artery. In some cases, the artery, or the aneurysm, will rupture and because of the high pressure within the artery, a jet of blood is emitted from the artery. Dr Rosen said that the outpouching in the artery may sit there for a long period of time and may never rupture; effectively meaning that many people may have an aneurysm their entire life without knowing or being affected by it.[91]

102. Dr Rosen gave evidence that it was "most likely" that Eric had the brain aneurysm when he came into custody on 27 June 2017, but it is not possible to say how long he had that underlying condition for.[92]

103. Professor Holdgate explained that an aneurysm might form because of a hereditary predisposition, or a history of high blood pressure, smoking or other cardiovascular risk factors. Some particular illnesses that affect the development of blood vessel walls can also increase the risk of developing an aneurysm.[93]

104. Professor Holdgate said that the majority of people living with an aneurysm don't actually realise that they have one, but in a small number of cases, the aneurysm can burst.[94] Once someone has an aneurysm, anything that

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[88] Exhibit 1, Vol 1, Tab 4, pp. 9-16.
[89] Exhibit 1: Vol 1, Tab 4, p. 10.
[90] Exhibit 1: Vol 1, Tab 5, p. 17.
[91] 17/10/19 at T17-18.
[92] 17/10/19 at T16.45.
[93] 18/10/19 at T4.12
[94] 18/10/19 at T4.7.

increases the pressure within the blood vessel, increases the risk of rupture. That means that anything that increases blood pressure, such as the use of illicit drugs, can increase the risk of rupture of an aneurysm.[95]

105. Dr Rosen told the Court that we will never know what caused Eric's aneurysm to rupture, although he considered possibilities included the fact that he had used amphetamines in custody, as had been revealed by the urine screening taken at 5:30pm on 2 July 2017 at Blacktown Hospital.[96] Professor Jones gave evidence that the tests suggested that Eric had consumed amphetamines on either the afternoon, evening or night of 1 July 2017.[97] Professor Jones said that the known effects of amphetamines on the vascular system include heightened blood pressure, which could have easily been the most proximal event, prior to the rupture. In other words, Professor Jones continued, the rupture may have been caused by the acute effects of intoxication with amphetamine or amphetamine-like drugs. Further, agitation and stress may provoke high blood pressure and cause re-bleeding.[98]

106. According to Dr Rosen, when an aneurysm does rupture, blood pours out of the artery into the subarachnoid space of the brain that contains cerebral spinal fluid. The immediate effect of blood entering that space under high pressure is that the pressure inside the skull rises to a point where the perfusion of the brain is compromised.[99]

107. Approximately two-thirds of persons survive a burst aneurysm and they may present with a very wide spectrum of symptoms. The most common symptom for presentation would be the most severe headache someone has ever experienced, commonly described as like being hit on the back of the head or the head with a baseball bat. There are also a range of other symptoms that can accompany this primary symptom, depending on the location of the aneurysm. This includes: loss of function, confusion as a result of damage to certain structures within the brain, paralysis, agitation, emotional distress and even coma.[100]

108. Dr Rosen explained that to diagnose effectively, it is important to have a high index of suspicion about the symptoms being exhibited.[101] He said that the definitive treatment for a ruptured cerebral aneurysm is to locate the aneurysm. The initial CT scan will simply look at the whole brain and get a picture of the brain, but not necessarily showing any of the blood vessels. The second test is

[95] 18/10/19 at T4.19.
[96] 17/10/19 at T23.11.
[97] 17/10/19 at T54.44.
[98] 17/10/19 at T23.21.
[99] 17/10/19 at T17.43.
[100] 17/10/19 at T18.9.
[101] 17/10/19 at T18.44.

an angiogram which involves injecting dye into a blood vessel so that the dye goes to the arteries in the vein and outlines the arteries, making it relatively easy to see whether or not there's a swelling of an artery, indicative of a ruptured aneurysm.[102]

109. Dr Rosen continued that the next step is to clip or seal the aneurysm to prevent it from ever bleeding again. In the meantime, the presence of blood within the subarachnoid space is damaging to the surface of the brain and that means that there are a series of events unfolding within the brain that need to be managed.[103] In Eric's case, by the time the diagnosis was made at Blacktown Hospital, "his level of consciousness was deteriorating and a number of events outside the brain were unfolding, effecting his circulation and his lungs and probably also there was a degree of swelling within the brain that was compromising the blood flow to the brain".[104] Tragically, it was too late to save him.

110. Although Dr Rosen could not be certain that earlier intervention would have saved Eric, he was adamant that about three vital hours were lost during which time Eric's chances for survival could only have been improved by timely interventions.[105]

Standard of Medical Care and Treatment

111. Professor Holdgate was not critical of the care that Eric received by nursing staff at the Clinic.[106] Eric entered the clinic at 8:35am on 2 July 2017. Although he was recognised as being distressed and unwell, he had a range of symptoms that could have represented a range of conditions. His initial vital signs, apart from one errant reading, were normal, but he continued to deteriorate. Professor Holdgate thought it was reasonable in the first instance to try a small dose of sedation to see if that helped Eric improve, and then once it didn't, nursing staff consulted the doctor again, who recommended they call an ambulance. Professor Holdgate considered the period of time Eric spent in the Clinic before an ambulance was called, approximately one hour, was reasonable.

112. Professor Holdgate also gave evidence that once Eric got to Blacktown Hospital, the medical treatment he received in the Emergency Department and ICU was appropriate.[107]

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[102] 17/10/19 at T19.28.
[103] 17/10/19 at T19.43.
[104] 17/10/19 at T20.10.
[105] 17/10/19 at T41.26.
[106] 18/10/19 at T4.45.
[107] Professor Holdgate was critical of the standard of record keeping in the Emergency Department at Blacktown Hospital. A response to that criticism was sought from the Director of Medical Services at Blacktown and Mount Druitt Hospitals, who agreed that the records from Eric's admission at the

Consideration of Proposed Recommendations

Use of Restraints

113. An issue of great concern to Eric's family and to this Court was the continued use of restraints on Eric while he was in hospital, even after Eric had been completely sedated. The sight of Eric with shackles in his hospital bed was deeply distressing to his family who, understandably, thought of it as disrespectful, degrading and unnecessary. Any family would be distressed by that sight, but it is likely more damaging for Aboriginal families, given the historical context in this country.

114. Professor Holdgate explained that hospital staff use restraints firstly as a last resort, and secondly for the briefest period of time possible, as a bridge to achieving control of agitation through other means such as administration of medications.[108] Within an hour of entering the ICU at Blacktown Hospital, Eric would have been unconscious from the medications he had been given. He was also placed on a breathing support apparatus. There could have been no possible justification for continuing to shackle Eric after that time.

115. Eric remained unconscious when transferred to Westmead Hospital. For the entire time he was admitted there, he would have been completely incapable of moving. When asked whether she could understand the family's distress at seeing Eric shackled at Westmead Hospital, Professor Holdgate replied: "[t]hat photograph is horrific for a clinician, yeah".[109] As the State Coroner, I share the views of Professor Holdgate and Eric's family that the shackling of an unconscious man in hospital is horrific.

116. I accept that there are some prisoners in need of medical care who do present a security risk and will require some form of restraint for some period of time. But that was not the case for Eric; who was receiving treatment for a catastrophic brain injury and organ failure. Although there is no suggestion that the restraints on Eric contributed to his death, this inquest provided an opportunity for CSNSW to reflect on how to improve its policies to ensure that correctional officers take greater responsibility for removing shackles where there is no security risk.

117. It was gratifying to see the new policies introduced by CSNSW relevant to Guarding Inmate Patients.[110] In summary, they require that:

Emergency Department were below the standard of care expected and confirmed that steps had been taken to investigate the issue (see Exhibit 8).

[108] 18/10/19 at T6.21.

[109] 18/10/19 at T7.11.

[110] 18/10/19 at T12-T13; Exhibits 5 and 6.

a. All handcuffs are to be removed at the request of health professionals while the inmate is undergoing consultation, examination or treatment.
b. Handcuffs may be removed from inmates who are severely incapacitated.
c. Where circumstances change during a medical escort, for example where the inmate's condition deteriorates or they become severely incapacitated, a review of initial escort assessment must be completed.
d. Under the topic of “risk assessment”, staff are advised that a risk level may decrease due to deterioration in the inmate's health and the requirements for restraint should be reviewed.
e. Under the heading, “End of Life Care" it notes that for "an inmate receiving end of life care, security arrangements can be reviewed to assess supervision requirements and visiting arrangements by family and friends”.

118. Those policies will still require that correctional officers are adequately trained in the exercise of their discretion and in being sensitive to the emotional distress of families faced with the possible death of a loved one.

Changes to Stenofon Policies and Procedures

119. At the time of Eric’s death, GEO Group had a number of relevant policies and procedures in place at Parklea CC that governed the roles and responsibilities of the UCR, including in relation to the use of the stenofon system. These policies included as follows:

a. Parklea Correctional Centre Operating Manual: Stenofon (Cell Alarms Procedures) 6.6.16;[111]
b. Parklea Correctional Centre Operating Manual: Upper Control Area (Base) 14.11.16;[112] and
c. Parklea Correctional Centre General Manager’s Instruction 117, 4.8.16.[113]

120. The Stenofon Policy relevantly provided that correctional officers who receive a knock up call alerting them to “a serious incident or potential serious incident” must immediately inform the Officer in Charge (**OIC**) or CMO (in circumstances where a knock up call is received after-hours). The General Manager’s Instruction 117 also directed that the UCR operator was not to decide which knock up calls may or may not require attention at their discretion.

121. The investigation report prepared by Mr Lang found multiple breaches of these policies and initiated disciplinary action against Mr Dobry, Mr Fa’ao, Mr Hanson, Mr Stankovski and Mr Gill. Mr Lang concluded that it should reasonably have

[111] Exhibit 1: Vol 3, Tab 67.
[112] Exhibit 1, Vol 3, Tab 68.
[113] Exhibit 2.

been known to those correctional officers that Eric was in significant distress during the early hours of 2 July 2017 when he was repeatedly calling for help.

122. Mr Lang also made the following recommendations by way of amendments to GEO Group policies and procedures:

> "12.1.6 The PCC Policy No. OP065 - Stenofon (Cell Alarms) Procedure is amended to include a requirement for PCC Control Room Operators to immediately initiate a Welfare Check following the receipt of any stenofon cell alarm call where an inmate is presenting in a clearly emotional and/or distressed and/or disoriented state.
>
> 12.1.7 The PCC Policy No. OP065 - Stenofon (Cell Alarms) Procedure is amended to include a requirement for PCC Control Room Operators to immediately advise their manager/supervisor following the receipt of any stenofon cell alarm call where an inmate is presenting in clearly emotional and/or distressed and/or disoriented state.
>
> 12.1.8 The CMO is required to attend at the PCC Upper Control at least twice during the night shift period, consult with Control Room Operators and review the Logs/Journals.
>
> 12.1.9 The Control Room Operator training package is further reviewed to ensure that it will provide adequate instruction and guidance on how to respond as well as to whom and when to report cell alarm calls from inmates who are clearly distressed, disoriented and/or apparently intoxicated."[114]

123. In written closing submissions dated 28 November 2019, counsel assisting submits that I should endorse these recommendations and make formal recommendations, pursuant to s. 82 of the Act, to that effect.

124. In written closing submissions dated 16 December 2019, GEO Group has confirmed that the recommendations made by Mr Lang have already been implemented. In particular, the Stenofon Policy was amended on 1 September 2017 and now directs, relevantly, that a correctional officer who receives a knock up call from an inmate who is presenting in a clearly emotional/distressed and/or disoriented state must immediately inform the OIC or CMO of the location where the call was made.

125. In those circumstances, I am satisfied that no recommendations should be directed to GEO Group.

[114] Exhibit 1: Vol 3, Tab 32, p. 664.

126. As GEO Group is no longer the operator at Parklea CC, counsel assisting also submits that these recommendations should be extended to the Commissioner of CSNSW, so as to ensure that the new operator of Parklea CC, MTC-Broadspectrum, has similar policies and procedures in place.

127. In written closing submissions dated 13 December 2019, the Commissioner of CSNSW submits that existing policies for responding to knock up calls would require correctional officers to immediately attend the cell to check on the welfare of an inmate who is presenting with a similar condition to that of Eric in the early morning of 2 July 2017.

128. The current CSNSW policy – Custodial Operations Policy and Procedures (**COPP**) Section 5.5: Cell security and alarm calls – was admitted into evidence.[115] This policy provides that correctional officers must immediately go to a cell in circumstances where an inmate knocks up in physical or mental distress. The policy also relevantly requires correctional officers to escalate calls raising concerns by immediately notifying the Centre's OIC.

129. Although the current Parklea local operating procedure for MTC-Broadspectrum has not been made available to this inquest, I accept the submission of the Commissioner of CSNSW that any MTC-Broadspectrum local policies cannot be inconsistent with overarching CSNSW policies.

130. Accordingly, I do not propose to extend any of the recommendations proposed by counsel assisting to the Commissioner of CSNSW or MTC-Broadspectrum.

Findings required by s81 of the *Coroners Act 2009*

131. The findings I make under s. 81(1) of the Act are as follows:

The identity of the deceased

The deceased person was Eric Whittaker.

Date of death

Eric died on 4 July 2017.

Place of death

Eric died at Westmead Hospital, Westmead NSW 2145

Cause of death

The direct cause of Eric's death was a subarachnoid haemorrhage with an antecedent cause of ruptured cerebral artery aneurysm.

[115] Exhibit 3.

Manner of death

Eric died while detained as an inmate on remand at Parklea Correctional Centre after he suffered a ruptured cerebral artery aneurysm that went untreated for several hours in the morning of 2 July 2017.

Closing Remarks

132. Eric's death is a tragedy that has caused great hardship to his family and is an immeasurable loss, particularly for his four children. That was so eloquently put by Steve, Eric's cousin, when he said: "the last two years have been just this constant perpetual state of grief that we'd be in as a family and stuff, because you know, we've had, you know, numerous deaths and stuff, and as an Aboriginal person you live with this constant state of, you know, being traumatised and in a constant state of grief".

133. Eric's parents, Margaret and James, and his Aunt, Dianne, gave the Court a statement that summed up so much heartbreak on hearing of Eric's death. They said:

> "The family are at a loss for words and they demand answers. We feel that the correctional protocols have been ignored and his basic human rights have been violated. The family wish only to have this young man's dignity back. We, the family, are here today to show you that Eric is loved and missed, and that a great injustice has occurred while he's in custody."

134. So many indigenous families have felt a similar crushing pain on learning of the death of their loved one while they were in custody. I am reminded of the words of the *Uluru Statement from the Heart*, which urges us as a country to do better. It includes the following passage:

> "Proportionally, we are the most incarcerated people on the planet. We are not an innately criminal people. Our children are alienated from their families at unprecedented rates. This cannot be because we have no love for them. And our youth languish in detention in obscene numbers. They should be our hope for the future. These dimensions of our crisis tell plainly the structural nature of our problem. This is *the torment of our powerlessness."*

135. I am encouraged that the GEO Group and Commissioner of CSNSW have made policy changes in response to Eric's death. It shows a willingness to learn from this tragedy and to improve the standard of care provided to vulnerable inmates. There is, of course, so much more that needs to be done to tackle inherent disadvantage and incarceration rates. Sadly, much of that is beyond the power of this Court, but I hope that Eric's passing has contributed in some way to improving the system for others.

136. It is fitting to share again the words of Eric's sister, Kayla, who I am sure was speaking on behalf of all the family when she said:

> "He endured many struggles, hardships and pain throughout his short life. He was a kind, loving and giving person. Always gentle and putting others before himself. Walking away from those he loved most so that his actions didn't impact them, I think that shows true courage and selflessness.
>
> My big brother Eric. A true warrior."

I close this inquest.

Magistrate Teresa O'Sullivan
State Coroner
28 February 2020
State Coroner's Court, Lidcombe