IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2006 / 1090

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: DARREN JOHN PARKES

Delivered On:	17 April 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne
Hearing Dates:	8 August 2013, 12 August 2013, 23 August 2013, 9 September 2013
Findings of:	JUDGE IAN L GRAY, STATE CORONER
Representation:	Mr A Murphy on behalf of Mr Brian Parkes Ms D Foy on behalf of Ms Jodie Arthur Mr J Goetz on behalf of St Vincent's Correctional Health Ms C Harris on behalf of G4S Ms D Coombs on behalf of Corrections Victoria
Police Coronial Support Unit	Leading Senior Constable Tania Cristano

I, JUDGE IAN L GRAY State Coroner, having investigated the death of DARREN JOHN PARKES

AND having held an inquest in relation to this death on 8, 12, 23 August 2013 and 9 September 2013

at MELBOURNE

find that the identity of the deceased was DARREN JOHN PARKES

born on 23 June 1976

and the death occurred on 23 March 2006

at Port Phillip Prison

from:

1 (a) STAB WOUND TO THE CHEST

in the following circumstances:

Background

1. Darren John Parkes was born in Lake Taueo, New Zealand on 23 June 1976 to Brian and Sandra Parkes.

2. Mr Parkes migrated to Australia with his mother at the age of 10 years and grew up primarily in the Dandenong area.

3. In 1990 at the age of 14, Mr Parkes met Jodie Maree Arthur who then was 17-years-old and a relationship commenced.

4. In 1993 Ms Arthur gave birth to their first child. In 1995 Ms Arthur gave birth to their second child, and in 1998 a third child.

5. On 20 June 2005 Mr Parkes was arrested by police in relation to matters which resulted in him being remanded in custody.

6. Mr Parkes was undergoing a period of remand at Scarborough North Unit, Port Phillip Prison and, at the time of his death was housed in Cell 406.

7. Scarborough North Unit of Port Phillip Prison contains approximately 64 male prisoners both undergoing sentence and on remand awaiting trial. The unit is primarily a management unit housing difficult inmates. No security cameras or other form of video recording operate within the unit complex.

8. Mr Parkes had been an occupant of Cell 406, Scarborough North Unit, Port Phillip Prison since 12 January 2006. His incarceration related to remand for offences of armed robbery and attempted murder against fruiterer, Benedetto Riccardi on 22 May 2005. Cell 406 was a single cell occupied by Mr Parkes alone.

9. At approximately 4.30pm on Thursday 23 March 2006 corrections staff noticed a commotion, in the form of loud voices coming from the vicinity of Cell 406.

10. At the time, staff became aware of an incident near cell 406, Rosario Guiseppe Giammona was observed by prison staff to exit Cell 406 and enter Cell 407.

11. Immediately after Mr Giammona left Cell 406, Mr Parkes emerged from that cell with visible bleeding injuries to his upper body. Prison staff immediately called an emergency code pink lock down. This resulted in attendance of additional staff for the lock down of the unit.

12. Only Mr Parkes and Mr Giammona were observed to leave Cell 406 from the time of the yelling to the time of the lockdown.

13. Mr Parkes was immediately conveyed to the Prison Hospital (approximately 100 metres from the unit) where he received emergency intervention supervised by Dr T. Mr Parkes was found to be suffering multiple serious penetrating wounds to the upper body which were bleeding heavily. Efforts to arrest the loss of blood were unsuccessful. Within 10 minutes of arriving at the medical unit Mr Parkes lost consciousness and died.

14. Medical staffs' effort to revive Mr Parkes continued, however chest compressions during CPR were found to induce the pumping of blood from his chest wounds.

15. Mr Parkes gave no verbal indication to prison staff as to the causes of his injuries.

16. Prison staff acted quickly to remove Mr Giammona from Cell 407, seize his clothing and to detain him in an isolation cell prior to police arrival. This action would appear to have secured evidence from destruction or loss.

17. Examination of Cell 407 located a hand made stabbing weapon (shiv) within the toilet bowl of Cell 407. Blood within Cell 406 suggest that it was contained within that location.

18. A port mortem examination was conducted at the Victorian Institute of Forensic Medicine by Professor David Ranson on Friday 24 March 2006.

19. Preliminary examination of the body by Dr Ranson revealed a number of wounds to both his front and rear upper body and limbs.

20. Dr Ranson gave evidence on the issue of how far Mr Parkes was allowed to walk after he had been stabbed and before he was required to lie down to be treated. In his opinion walking made no ultimate difference to the timing of Mr Parkes' death and cannot be said to have contributed to it. I accept his evidence on the point.

21. On 26 September 2008, Mr Rosario Giammona pleaded guilty to one count of defensive homicide in the Supreme Court.

Scope of Inquest

22. The two issues identified as the focus of the evidence at inquest were:-

    1. Communication between medical/nursing staff and prison staff.

    2. How communication coming into the Port Phillip Prison (PPP) was, and is, managed.

23. Extensive evidence was called on these issues from thirteen witnesses and written submissions were received from:-

    - Department of Justice (on behalf of Corrections Victoria)
    - G4S Custodial Services Pty Ltd
    - St Vincent's Hospital
    - Mr Brian Parkes (father of the deceased)
    - Ms Jodie Arthur (partner of the deceased).

24. Mr Brian Parkes, represented by Mr Murphy (briefed by Corrs Chambers Westgarth) put forward six proposed recommendations relevant to the two issues. He sought specific findings and recommendations for two reasons:

    " (a) to establish that Darren's treatment was unacceptable; and

    (b) to help prevent other prisoners and their families suffering from similar, tragic circumstances."[1]

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[1] Submission of Brian Parkes, pg 1

25. He submitted that the evidence revealed "serious systemic shortcomings in the operation, management and oversight of Port Phillip Prison (PPP) with respect to:

    (a) the treatment of information or warnings within PPP relating to risks to the wellbeing or safety of prisoners; and

    (b) the treatment of PPP of eternal information or warnings relating to risks to wellbeing or safety of prisoner; and

    (c) the intelligence system which operates at PPP."[2]

26. Ms Jodie Arthur, represented at the inquest by Ms Foy of Counsel, submitted that it was open for me to find, on the balance of probabilities, that there was:

    "a. a failure by St Vincent's Health Service and G4S, the prison operator, to ensure proper communication between them; and

    b. a failure of G4S to have a proper system of recording external callers, such as Ms Arthur, contributed to the circumstances of Mr Parkes' death."[3]

27. The Department of Justice did not seek any recommendations. It submitted "The Minister of Corrections, and the Secretary of the Department of Justice have acted upon the Corrections Inspectorate's investigation into the death of Mr Parkes, and the required improvements were implemented by G4S."[4]

28. St Vincent's Hospital, on behalf of St Vincent's Hospital Correctional Health Service (a business unit of St Vincent's Hospital that provides the medical and psycho-social healthcare to all PPP prisoners), submitted that actions taken in August 2006 in response to the death of Mr Parkes in reference to the relevant Manual meant that there was no need for me to make recommendations that it review its policy and procedures relating to communication between hospital staff and G4S staff when the life or well being of a prisoner might be at risk. It was submitted "This has already been done."[5]

[2] Ibid

[3] Submission on behalf of Jodie Arthur pg 62

[4] Closing Submissions on Behalf of the Department of Justice pg 3.

[5] Submissions of behalf of St Vincent's Hospital pg 15

29. G4S submitted that the investigation into the death has not revealed any matters that ought to be addressed by G4S to improve operations at PPP."[6]

30. G4S and the Department of Justice contended as follows: - It is clear that Mr Parkes was stabbed to death by Mr Giammona. The issues relating how it was that Mr Giammona was able to fashion a shiv and stab Mr Parkes with it were comprehensively examined and reported on by the Corrections Inspectorate and the Department of Justice to which reports G4S responded. In that context the Corrections Inspectorate identified a number of matters which needed to be addressed by G4S. Those issues were addressed by G4S to the apparent satisfaction of the relevant authority by early 2007 with the majority of issues having been addressed within weeks of Mr Parkes' death. Ultimately the Secretary to the Department of Justice issued a Certificate under the Prisons Services Agreement identifying non compliance issues based on the review by the Corrections Inspectorate. The Corrections Inspectorate conducted a Post Audit of the implementation of the Port Phillip Prisons actions in response to the Secretary's Certificate, noting most recommendations for improvement were completed and a subsequent commitment from G4S to complete the implementation. The Minister for Corrections issued a Default Notice to G4S. The improvements were made and no further action was proposed to be taken by the Minister or the Secretary to the Department of Justice against G4S. I accept that this is an accurate summary of the history of responses to Mr Parkes' death.

31. As a result, and consistent with s.7 of the *Coroners Act 2008* (cautioning against "unnecessary duplication of inquiries and reviews"), it was not necessary in this inquest to traverse any of the ground covered by the Corrections Inspectorate Review. However the two issues identified for focus in this inquest, were not the subject of analysis in that review, nor the subject of recommendations or changes to practice.

32. I will firstly consider the issue of communications into the Port Phillip Prison and secondly the issue of communications between medical/nursing staff and prison staff.

Communications into the Port Phillip Prison

33. Both Ms Maya Pinkster and Ms Jodie Arthur gave evidence that they sought to inform the Port Phillip Prison (PPP) that Mr Parkes feared for his life at the prison and that he believed there was a plan to kill him at the prison as a result of an allegation of murder (a reference to

[6] Submissions on behalf of G4S Custodial Services Pty Ltd pg 58-59

a contract to kill him, and a reference to mafia involvement). Each referred in their statements and in their oral evidence to the telephone calls they made.

34. The telephone records maintained by the PPP revealed that Mr Parkes called Ms Arthur on most days, and on some days more than once. He also telephoned Ms Pinkster who was a close family friend.

35. It is clear from the evidence (in particular the notes of the attendances of Mr Parkes made by the Prison Health Service staff) that during the eight months that he was in the prison, he was anxious about Ms Arthur and his children. He was clearly aware that if convicted on the charge of attempted murder he was likely to receive a lengthy sentence.

36. Ms Arthur gave evidence that he told her of his fears on a number of occasions and that she attempted to pass on those concerns to staff at the prison. Ms Pinkster also gave evidence that she contacted the prison on one occasion at Mr Parkes' request to tell them of his fears about retribution. Each was adamant that they made the calls to the PPP but each had difficulty being specific about certain key details. Their evidence of the nature of the complaints, concerns and fears he spoke of to them, is consistent with the evidence about what he was telling St Vincent's staff at the PPP.

37. In my view Ms Arthur and Ms Pinkster were honest witnesses, and the essence of their evidence (Mr Parkes saying that he was worried about his safety and security in the prison and about being attacked/killed as retribution) is consistent with the nature of what he was saying to various members of the St Vincent's clinical staff. As Ms Foy submitted:

"The notes of consultation with Dr L, Nurse C and Dr O each refer to Mr Parkes telling them in words to the effect that he believed that:

a. there was to be retribution or a contract out on him[7];

b. that the retribution or contract arose as a result of the alleged attempted murder of a person at the South Melbourne Market by Mr Parkes [8];

and

c. he was at risk of being stabbed[9].

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[7] Exhibit 5, medical notes Dr O, pg 11, medical notes Nurse C p32, medical notes Dr L p 40; Exhibit 4, Statement of Nurse C at paragraph 3

[8] Exhibit 9, Statement of Dr O p 276 at paragraph 3

[9] Exhibit 5, medical notes of Dr L p 40

The first of these consultations occurred the day after Mr Parkes was told that he would be moved from the Charlotte Unit to a mainstream unit, which was not the back units,..."[10]

In the consultations with Dr L, Dr O and Nurse C, there is a note to the effect that those staff believed that Mr Parkes's fears were "realistic" or "reality based"[11].

Each of the medical practitioners and the mental health nurses gave evidence in Court that they did not consider Mr Parkes to be thought disordered or suffering from delusions or hallucinations[12].

Recording incoming phone calls

38. The evidence was that there is no recording system for calls going into the prison. Ms AH, who worked in the control room in the prison where all telephone calls are taken after hours and on weekends, gave evidence that there was no logbook or formal system to record calls about prisoner welfare.[13] I accept that that was the case.

39. Ms ML, the only female switchboard operator in the control room during the period of December 2005 to March 2006 gave evidence of the "absence of any formal logging system for incoming phone calls to the prison[14]"[15]. She accepted that it was possible that external calls may have been made about Mr Parkes' concerns but she could not recall receiving any. Ms DL the Executive Assistant to the Director at the time also could not recall receiving a call about Mr Parkes and his welfare before his death. She had a personal system in place for recording calls that she took, but she told me that this is entirely her own system and in any event would have been deleted when she stopped working in that role.

40. The evidence is clear that none of the staff who routinely took calls remembered receiving any relevant calls. However I agree with Ms Foy when she submitted, "Any failure by staff to recall such a call does not mean that the calls were not made."[16]

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[10] Submissions on behalf of Jodie Arthur paragraphs 18-21

[11] Exhibit 5, medical notes Nurse C p 3; medical notes Dr L p 39; medical notes Dr O p 11; Evidence of Nurse C, T p 163; Exhibit 23 Statement of Dr L.

[12] Evidence f Nurse C, T p 178 at 1-13; Exhibit 9, Statement of Dr O at paragraph 2.2, Exhibit 5, medical notes Dr L p 39; Evidence of Dr O, T p 271 at lines 2-4

[13] Evidence of Ms AH, Tp 140 at lines 9-11

[14] Evidence of Ms ML, T p 423 at line 31

[15] Submissions on behalf of Jodie Arthurs paragraph 47

[16] Submissions on behalf of Jodie Arthurs paragraph 50

41. In submissions made on behalf of G4S Custodial Services Pty Ltd (G4S) there was an extensive analysis of the evidence of Ms Arthur and Ms Pinkster and a critique of their reliability. The submissions states: "The situation created by the totality of Ms Pinkster's evidence on the issue remains unsatisfactory, as the timing most consistent with the records and the more specific aspects of her evidence as to the subsequent regular phone calls, made by Mr Parkes is inconsistent with both her initial recollections of when the call was made, and the content of the call itself (having referred to being "transferred to mainstream" at a time when he was already in a mainstream unit). The purpose of Mr Parkes asking Ms Pinkster to contact the prison, without stipulating any person, nor requesting that he not be identified as the source of the information, also remains entirely unclear given the opportunities he had to convey the same information himself, directly to corrections staff including senior corrections officers, which he did not take."[17]

42. In dealing with the critique, which goes to the reliability of Ms Pinkster's evidence, I have concluded that the evidence of Ms ML, Ms AH and Ms DM does not, individually or in combination, contradict the evidence of Ms Arthur and Ms Pinkster. Each of the G4S staff just identified were honest witnesses and I accept their evidence. I also accept their experience and expertise and what they stated to be their practices. However, it does not necessarily follow that Ms Pinkster and Ms Arthur did not make the calls they gave evidence of making. There are some unsatisfactory aspects of Ms Arthur's explanation for inconsistencies in her evidence, but as G4S conceded, there where reasons why her personal circumstances could have influenced the accuracy of her memory.

43. Ultimately I accept that Mr Parkes made phone calls to Ms Arthur and Ms Pinkster about his worries in the prison, and I conclude on the balance of probabilities that Ms Pinkster and Ms Arthur tried to communicate the essence of Mr Parkes concerns to PPP by telephone. I do not criticise staff at the PPP for any action, or non action, taken in response to the calls being made or for any failure of precise memory which might of corroborated the making of the calls. The system in place (the non logging of relative incoming calls) was the problem, not the actions or memories of individuals.

44. It was submitted on behalf of G4S that Ms ML and Ms DM were reliable and "relevantly unchallenged" as witnesses. I accept that they were broadly reliable and certainly honest. It may be that it "is inherently unlikely that they would receive such a phone call and say that

[17] Submissions on behalf G4S Custodial Services Pty Ltd paragraph 110

there was nothing they could do, or fail to ensure that the call was dealt with by an appropriate person."[18] However taking that at its highest, and accepting their honesty and broad reliability, the fact is there was no logging system for incoming calls; however conscientious the persons taking calls were, and with the best will in the world there is the possibility that those in the positions held by Ms ML and Ms DM and others may themselves have flawed memories - certainly after a lengthy period of time.

45. I accept Ms Foy's contention: "On the basis of the evidence before the Court, it is clear that Mr Parkes did have fears, regarded by health professionals as reality-based fears that ultimately came to fruition as he died in prison by way of stabbing by another prisoner."[19] Ultimately the fact of and nature of the murder of Mr Parkes tends to support the inherent likelihood that Ms Pinkster and Ms Arthur made the calls they said they did. I note that it is clear that he was killed by Mr Giammona in a defensive homicide and that he, Mr Parkes, had attacked Mr Giammona and was the instigator of the assault which ultimately ended with his own death. However this does not contradict the proposition that Mr Parkes had his own fears, regarded by health professionals as "reality based fears" for his own safety.

46. Whether the failure of G4S to have a proper system of recording external callers contributed to Mr Parkes' death is another matter. As a matter of system it would appear to be deficient, or at least sub-optimal. Even though the key communication is the communication between the receiver of a call and a person in authority who could act to protect a prisoner in the position of Mr Parkes, nonetheless the system deficiency is of note.

47. I accept the submissions made on behalf of Mr Brian Parkes (paragraphs 79 – 91 of his submissions). I accept that in relation to Ms ML, she made a note of incoming calls but "discarded her notes once the required action had been taken". I note, and accept the submission, that "Ms (ML) had no recollection of receiving a call of the nature described by Ms Pinkster, but stated that such a call was possible."[20] I note the submissions made by Mr Brian Parkes in relation to Ms AH. Again accepting entirely the honesty of each of those witnesses, the system permitted calls to "fall through the cracks" and the non logging/recording of all incoming telephone traffic (particularly traffic relating to concerns about safety and security) was unsatisfactory.

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[18] Ibid paragraph 132

[19] Submissions on behalf of Jodie Arthurs paragraph 57

[20] Submission of behalf of Mr Brian Parkes paragraph 94

48. I agree with the submission made by Mr Parkes Senior under the heading "Policy Failures":

"It is submitted that Ms (AH), Ms (DM) and Ms (ML)'s evidence supports a finding by the Coroner that PPP's record keeping system for the recording and identification of telephone calls was unsatisfactory.

As evidenced by the informal practices put in place by Ms ML, Ms AH and Ms DM, a formal system was required for the recording of calls of the nature described by Ms Pinkster and Ms Arthur. The evidentiary uncertainty that was explored in the course of the inquest and the prejudice to Sergeant Forehan's investigation would have been avoided."[21]

49. I also agree with the proposed recommendations put forward by Mr Parkes Senior:

"All telephone calls to Port Phillip Prison reception should be recorded, with the option to cease recording upon transfer to particular extensions within the prison.

Reception and Control Room (when operating as reception) staff keep an electronic note of telephone calls, time stamped so as to be reconcilable with recordings".[22]

50. I will recommend accordingly.

Communication between Medical/Nursing Staff of St Vincent's and Prison Staff at PPP

51. It is necessary to put this issue in to a brief historical setting.

52. On or about 15 December 2005 Mr Parkes was informed that the Sentence Management Unit had decided to return him to a mainstream unit at the prison. He had been in a management unit (Charlotte) and subsequently a less restrictive unit (Swallow).

53. On 25 December 2005 Mr Parkes lacerated his chest and was removed to the medical unit at the prison, St Johns. He saw nurses C and W. On 5 February he saw Dr T and psychiatrist Dr O. It is clear for the notes of the attendances on Mr Parkes by the prison health service staff, during the 8 months that Mr Parkes was in the prison, that he was anxious about Ms Arthur and his children, and if convicted of the charges of attempted murder, he was likely to receive a lengthy sentence.

54. The real issue here is whether the polices, practices and procedures in place at PPP at the time required that medical/nursing staff inform to prison staff a prisoner's expressed fears/concerns about his safety/security.

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[21] Ibid paragraphs 107 and 108.

[22] Ibid page 17

55. What follows is a chronology of Mr Parkes; contact with St Vincent's staff at PPP.[23]

- On 16 October 2005 Mr Parkes was reviewed by Dr L, psychiatric registrar at the St Thomas' outpatient clinic. Mr Parkes was "worried he was going to get stabbed" and said that someone had "put a contract on me". He told Dr L that he was "lagging if saying something". He referred to stressors on himself and his family. On the evidence Dr L discussed some alternatives regarding the ways in which Mr Parkes could deal with his problems. Dr L's evidence was that if he had found Mr Parkes' safety concerns credible and specific, which he said he couldn't recall, he would have informed the G4S staff of the safety concerns and done so verbally.

- On 25 October 2005 Registered Nurse SW working in the St Paul's psychiatric facility was notified by telephone of a referral from St John's by Nurse CH. The notes of the telephone conversation record that "has contract out on him –reality based fears". Nurse W conducted a psychiatric assessment. She noted that Mr Parkes was depressed with self harm ideation and he was admitted to St John's ward for review by a psychiatric nurse. Nurse W also said that had she received any information that Mr Parkes had realistic fears for his own safety she would have told the G4S staff member and documented it in the hospital record and that she had an obligation to pass information on. She said in evidence that if Mr Parkes had told there was a contract out on his life or that he had a fear of retribution (she could not recall being told that) she would have told G4S. She went onto say that it was her normal practice to alert G4S if a prisoner had specific fears about harm to himself by another person or group. Nurse W was a credible witness; and I accept her evidence.

- Registered Nurse O saw Mr Parkes at 1.35pm on the same day and noted that he had "fears for own safety". Unfortunately Nurse O could not be found for the purposes of giving evidence at the inquest.

- At 5.45pm on the same day, psychiatric nurse, Nurse C, reviewed Mr Parkes. He told her that "a contract for his health" (to "either cripple him or kill him") had been made by the "mafia". Nurse C believed that Mr Parkes' safety fears to be "reality based". There was a discussion about being placed in protection but her evidence

[23] Derived from the submission made by St Vincent's and including quotations made from that submission.

was he was “adamant that he will not go on protection – but also expressing reluctance to return to CH – alleging officer harassment”.

Importantly Nurse C’s evidence was that she told Mr Parkes that he would have to speak to G4S about placement in the prison system because hospital staff have no control over placement of prisoners. After her review of Mr Parkes she said she spoke to a G4S member and told him that he was to remain on intensive watch and needed to speak to a supervisor before discharge from St John’s. Nurse C was an impressive and credible witness. She had a high reputation at the prison and was described by Dr T as “the gold standard”.

- On 28 December 2005, Mr Parkes was reviewed by Nurse W. He said that his impression was that Mr Parkes was generally concerned about his safety and wellbeing. He described the concerns as being quite non-specific and that there was no direct evidence of imminent threat. He said that it was his practice that if he became aware of any risk to a prisoner’s safety and/or wellbeing he would inform G4S of the threat. He says that he noted, “wants to speak to G4S manager.” He said that because his notes record the name of the G4S operations manager then he would have contacted that manager. However he had no specific recollection of doing so. He said it was his usual practice to record the name of the person that he contacted or intended to contact. There is no proof in fact that he did so in this case, although he was a generally credible witness.
- On 6 February 2006 Mr Parkes saw Dr T, medical practitioner and then Director of Medical Services at St Vincent’s Correctional Health Service. She said that Mr Parkes had the opportunity to raise issues with her but didn’t mention any concern about his welfare or that a contract was out on his life.
- On 8 February 2006 Mr Parkes saw Dr O. His notes stated that Mr Parkes had “realistic fears of retribution from his other inmates for his crimes.” Dr O assessed him as “anxious ++”. He said also that by noting “realistic fears re retribution” he meant that the fears were not delusional. His evidence was that because the fear was “general and not specific and no references made to fears about being placed in Scarborough” Dr O did not consider it necessary to pass this information on to G4S. His evidence was that if he had had specific concerns he would have communicated those to G4S. Dr O was not a convincing witness. To make an assessment that a

prisoner has "realistic fears re retribution" but to conclude that it was not specific enough to justify a reference to G4S staff is completely unsatisfactory. Dr O's evidence was that the threat to Mr Parkes' personal safety was not his principle concern at the time of the review. His evidence that if there were concerns about risk he would assess whether the risk was specific, genuine and imminent and make a judgement call about whether passing on the information to G4S. In my view he clearly should have done so as soon as he had formed the professional assessment about the fears re "retribution" were "realistic".

- On 6 March 2006 Dr T saw Mr Parkes again and reviewed him. He expressed "sadness for his situation" but didn't mention a contract being out on him or concerns for his well being.
- On 20 March 2006 he was seen at St Thomas' by Nurse T. Her notes state that he was "crying and extremely distressed. Worrying about his own safety and not being able to guarantee his own safety". Her evidence was that the plan was for him to be reviewed by a psychiatric nurse the same day and placed in a holding cell and observed. Nurse T was not able to be contacted to give evidence.
- 15 minutes after Nurse T's consultation Mr Parkes saw psychiatric Nurse F. Nurse F, who was also unable to be located and therefore not called to give evidence, made notes which stated "Remains tearful and distressed. Explained there were numerous situational factors involving relationships, family and his forthcoming court case that were distressing him. Denies he said he couldn't guarantee his own safety but was threatening to harm himself if he didn't receive any help.....When informed he would be on random watch he left the room stating his safety."[24]
- Mr Parkes was admitted to St Johns' ward overnight that night, again on the following night and on 22 March 2006 his status was downgraded from "random watch" to "alert". He returned to Scarborough Unit (general prisoner unit) on either the evening of 22 March 2006 or the following day.

56. In summary, the notes of the St Vincent's Health Service and the evidence given at the inquest by staff reveal that Mr Parkes did raise specific concerns about his physical safety to

[24] Submission of behalf of Mr Brian Parkes paragraph 43

clinical staff on at least four occasions –in December 2005 to Dr L; on 24 December 2005 to Nurse W; on 25 December 2005 to Nurse C and on 8 February 2006 to Dr O.

57. As the submissions made on behalf of Ms Arthur state " The notes of the consultations with Dr L, Nurse C and Dr O each refer to Mr Parkes telling them in words to the effect that he believed that:

a. there was to be retribution or a contract out on him;[25]

b. that the retribution or contract arose as a result of the alleged attempted murder of a person at the South Melbourne Market by Mr Parkes[26]; and

c. he was at risk of being stabbed[27].

In the consultations with Dr L, Dr O and Nurse C, there is a note to the effect that those staff believed that Mr Parkes' fears were "realistic" or "reality based"[28].

Each of the medical practitioners and the mental health nurses gave evidence in Court that they did not consider Mr Parkes to be thought disordered or suffering from delusions or hallucinations[29].

58. I am satisfied that Mr Parkes' beliefs about the risks to his safety were realistic and not fanciful, and find that Mr Parkes did indicate to St Vincent's staff his concerns about his safety within the prison. Mr Parkes' concerns about his safety should have been passed on to PPP. Dr L should have passed them on. He should have done so on the day they were conveyed to him. He agreed that he had previous experience with persons divulging safety concerns to him. He said that what he had done in respond to this previously was to contact G4S or another relevant person in authority. Dr L's explanation for not passing on Mr Parkes' concerns to PPP staff was unconvincing.

59. I note the following submission made on behalf of St Vincent's: "An Inquiry into the death of the deceased was carried out by the Corrections Inspectorate which found that there was

[25] Exhibit 5, medical notes Dr O p11, medical notes Nurse C p32, medical notes Dr L pg 40; Exhibit 4, Statement of Nurse C at paragraph 3.

[26] Exhibit 9, Statement of Dr O p 276 at paragraph 3.

[27] Exhibit 5, medical notes of Dr L p 40.

[28] Exhibit 5, medical notes nurse C p3; medical notes Dr L p 39; medical notes Dr O p11; Evidence of Nurse C, Transcript p 163; Exhibit 23 Statement of Dr L.

[29] Evidence of Nurse C transcript 178 at 1-13; Exhibit 9, Statement of Dr O at paragraph 2.2, Exhibit 5, medical notes Dr L p 39; Evidence of Dr O transcript p271 at lines 2-4.

"*no indication that the deceased was particularly at risk of serious assault by other prisoners*"[30]. Based on a summary of the deceased's medical history prepared by the DHS[31] the Inquiry found that the deceased's reported concerns about his person safety were "*apparently not communicated to corrections staff*". *However at no time did Mr Parkes ask to be placed on protection*[32]".[33]

60. I accept that the evidence supports the assertion that "at no time did Mr Parkes ask to be placed on protection"; there was never an *explicit* specific request to this effect ever noted. However the question is whether Mr Parkes' expressed concerns about his personal safety were communicated to prison staff or not.

61. In her submissions, Ms Foy for Ms Arthur referred to the evidence of Nurse C to the effect that she gave evidence that she asked G4S to arrange for Mr Parkes to speak to a supervisor. Nurse C however did not make a note of making that request and G4S staff gave evidence that they did not recall the request and made no note of it. Nurse C, whose evidence I accept, gave evidence that she believed she was unable to disclose his concerns without his consent. She was of that belief because she understood that the section on release of patient information of the St Vincent's Correctional Health Service policy on 20 February 2003 prevented disclosure to correctional staff without the consent of the prisoner.

62. Ms K and Mr N, the two correctional officers who were on duty at the relevant time on 25 December 2005, gave evidence that there was no formal system put in place at the prison between health staff and G4S if a clinician told them that a prisoner needed to speak to a supervisor.

63. I accept the proposition, argued by Ms Foy, that it is more likely than not that Nurse C did make the request on 25 December 2005 after seeing Mr Parkes, giving the extent of her notes about his concerns and her general conduct. I accept also that the evidence suggests, as Ms Foy puts it, "that it is more likely that Ms (Nurse) C's request was never communicated to a supervisor"[34]. This assertion is made in the context of the evidence that it was, to quote Ms Foy's submission regarding Ms DW, the supervisor on 25 December

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[30] Exhibit 41 page 18

[31] Ibid pages 15-17 and appendix 2

[32] Ibid page 17

[33] Submissions of behalf of St Vincent's Hospital paragraph 50

[34] Submission on behalf of Ms Jodie Arthur paragraph 38

2005 that it is: "unlikely that she would have returned to St John's unit after 6.00pm that day as she had already attended at the unit twice during the day, unless she had been expressly called[35]".[36] There is no evidence that she was expressly called that evening and no evidence that any request from Mr Parkes to see a supervisor was in fact logged

64. Neither Dr L nor Dr O alerted the prison staff or the Director of Medical Services about Mr Parkes' concerns.

65. It is reasonable for St Vincent's to assert, that it was a reasonable expectation of hospital staff, when they inform G4S staff on receipt of information which they assess as representing a genuine risk, that steps would be taken by G4S staff to speak with Mr Parkes to assess his concerns.

66. It is also reasonable to assert that Mr Parkes had opportunities to seek protection from or inform G4S staff of his concerns about his safety and welfare.

67. In relation as to whether there was or was not a "contract" out on Mr Parkes, I accept that nothing that hospital staff did do, or omitted to do, was causally connected to the killing of Mr Parkes by Mr Giammona which appears to be have been "unpredictable" and an act done in self defence. (In the words of Justice Lasry "whatever occurred, the incident was initiated by Parkes [the deceased]"[37].

68. On a review of the evidence, and the submissions, I am not satisfied that there was in fact a clear report to G4S staff of any of the complaints\concerns\fears raised by or on behalf of Mr Parkes, apart from the evidence of Nurse C that she spoke with a G4S member about Mr Parkes remaining on intensive watch. I accept that it was a limited follow up, made dependant in part on him speaking with a supervisor before being discharged from St John's. It was dependant also on her expectations about follow up being met; on the evidence they were not.

69. Ultimately the problem was a lack of a clear guidelines, giving direction to St Vincent's staff who were told by Mr Parkes, (or who might be told by any other prisoner) about concerns for safety as to the obligations of those staff to report them to G4S. That was the problem.

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[35] Evidence of Ms DW, Transcript page 246 at lines 4-23.

[36] Submissions on behalf of Ms Jodie Arthur paragraph 38.

[37] R v Giuseppe Giammona [2008] VSC 376.

70. Dr T gave evidence of her preparation of an advice to staff titled "Responsibility of St Vincent Correctional Health Service staff – Re the sharing of information with the correctional provider and the situation in which the life of a patient or another may be at risk.[38],[39] She did this in light of Mr Parkes' death and the fact that he had disclosed concerns about his safety which were either not relayed to or not noted by corrections staff. I accept that evidence. She took this action to make the situation clear, to remove doubt and confusion about the obligations of St Vincent's staff (this is the 2006 Protocol).

71. I am satisfied that if there had been a clear policy applied to Mr Parkes' complaints there would have been no need for the preparation of the advice and direction contained in Exhibit 2B.

72. I accept the following submission made by Ms Foy:- "It is submitted that Mr Parkes' expressed legitimate and rational fears about his safety at the prison which were relayed to clinical staff and to Ms Arthur, other members of his family and Ms Pinkster. It is clear that had the system, subsequently put in place by the St Vincent's Health Service, been operational at the time, it is more likely than not that those fears insofar as they were disclosed to clinical staff, would have been relayed to correctional staff.[40] And the further submission "Had either St Vincent's Health Service or Ms Arthur successfully relayed Mr Parkes concerns to the prison, it is more than likely that steps may have been taken by the prison which may have prevented the death of Mr Parkes.[41]

73. As the submission made by St Vincent's conceded there was a Policy and Procedure Manual in place at the time of Mr Parkes' death. The Manual made no specific reference to a procedure for informing G4S of a risk to a prisoner by another prisoner. It was submitted that "Notwithstanding any lack of specifications in the Manual, it was well understood by hospital staff that should they have a genuine concern about risk to a prisoner by another prisoner, that they should inform G4S staff of that concern."[42] I do not agree. It is not at all clear that this was understood by all, some believing that they had to obtain the consent of the prisoner before they could pass information on, whatever it's level of specificity,

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[38] Exhibit 2B Statement Dr T, Annexure EMT 2.

[39] Submission on behalf of Ms Jodie Arthur paragraph 44.

[40] Ibid paragraph 59.

[41] Ibid paragraph 61.

[42] Submission on behalf of St Vincent's Hospital paragraph 72.

genuineness or seriousness and it was also bedevilled by the need for a subjective assessment about whether the risk was "a genuine concern or not".

74. It was submitted by St Vincent's that the policies and procedures in place at the time regarding informing G4S when a hospital staff member had a genuine concern about risk were appropriate. I do not accept that submission. The need for Dr T to propagate a clarifying memorandum (August 2006) contradicts the assertion that the policies and procedures in place were adequate.

75. The publication of the August 2006 memo addressing "the lack of specificity in the Manual" and the review of the Manual were appropriate and necessary actions. I fully accept the evidence given by Dr T as to this issue, her assessment of the adequacy or otherwise of the original manual and her assessment of the need to clarify the obligation and basis and purpose of the August 2006 document.

76. It is significant that Nurse C, an excellent witness, did not regard the 2003 policy as requiring or permitting her to disclose confidential information about patients. She regarded all patient information as confidential and therefore "not to be released without the clients consent". Her evidence was that the 2003 policy did not tell her how to report or record Mr Parkes' concerns and that there was no form in which she could have complete to ensure that a supervisor from G4S would see Mr Parkes.

77. I accept and agree with the submission made by Mr Brian Parkes as follows: "If a practitioner of Nurse C's years of experience, held in the highest regard by Dr T, did not appreciate that there were circumstances where confidentially was overridden by safety, then the Court can be satisfied that the 2003 Policy was manifestly inadequate."[43]

78. I agree with the submission made by Mr Brian Parkes: "Dr T issued the 2006 memo after a review of the circumstances surrounding Darren's death from SVCHS' perspective. She did so because she thought the guidance provided to SVCHS staff in the 2003 Policy about when they should communicate a risk about a prisoner to corrections staff and how to document that communication, required improvement.

[43] Submission on behalf of Mr Brian Parkes paragraph 22.

Dr T agreed that it is vital in health care generally, and within PPP, to have policies that are accessible to all staff. She also agreed that it was important for health care professionals to take accurate records and maintain accurate documentation."[44]

79. In relation to the "Overriding obligations" referred to in the submission of behalf of Mr Brian Parkes, I accept that the import of the Code of Ethics for Nurses (2008) – Exhibit 10 clearly supports the notion of an "overriding obligation". However the matter was not the subject of any other submissions or any broader body of evidence or commentary and I make no recommendation about it.

80. Mr Brian Parkes sought the following recommendations:-

"SVCHS should regularly revise its policies and procedures in relation to communications with G4S. It should assess the implementation of those procedures as part of such a review.

SVCHS should train each new staff member on commencement, and all staff on a six monthly basis, on the importance of the policy.

SVCHS should retain records demonstrating that this training has occurred, including signed attendance sheets."[45]

81. I will make recommendations along these lines but in a less prescriptive fashion.

82. Mr Brian Parkes also put forward a recommendation relating to the recording of information, warnings or requests passed onto them by SVCHS staff. As he put it "Their practice was to telephone a supervisor, or to hope that they remembered to inform a supervisor when a supervisor attended at some point in their shift. They would not take notes."[46]

83. Mr Brian Parkes proposed the following recommendation to deal with this issue:-

"G4S and SVCHS should jointly prepare a short, easy to use pro forma to record the transfer of critical information regarding a prisoner's wellbeing or prisoner requests which could not be immediately be attended to (such as a request to speak to a supervisor).

The pro forma should be prepared in duplicate. One copy should be retained by SVCHS on a prisoner's medical file. G4S should enter a copy onto a prisoner's IMP file. If the

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[44] Ibid paragraph 43 and 44.

[45] Ibid page 11

[46] Ibid paragraph 78.

conversation is verbal, the pro forma should be signed by all participants. The date and time of the notification should be recorded.

If the conversation is electronic, the person conveying the information should require an acknowledgment by the recipient, and append both their initial communication and the acknowledgement to the form."[47]

84. Again I will recommend along these lines but without the prescriptive detail put forward by Mr Brian Parkes. The management of the proposed pro-forma, its retention and filing should be a matter for the discretion of the two organisations.

FINDINGS

I am satisfied on the balance of probabilities that there was:-

(a) a failure by St Vincent's Correctional Health Service (SVCHS) and G4S to ensure proper communication between them;

(b) there was a failure of G4S to have a proper system of recording external callers.

It is not possible to be satisfied on the balance of probabilities that the failure to have a proper system for recording external callers "contributed to Mr Parkes' death", in a causal sense given the immediate circumstances of his death and the Supreme Court finding that Mr Giammona was guilty of defensive homicide.

RECOMMENDATIONS

Pursuant to section 72(2) of the ***Coroners Act 2008***, I make the following recommendation(s) connected with the death:

1. All telephone calls to Port Phillip Prison reception should be recorded, with the option to cease recording upon transfer to particular extensions within the prison. The method used for recording and noting phone calls should be a matter for the PPP.

2. SVCHS should regularly review its policies and procedures in relation to communications with G4S. It should assess the implementation of those procedures as part of such a review. SVCHS should train each new staff member on commencement, and all staff on a regular basis.

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[47] Ibid page 12.

3. G4S and SVCHS should jointly prepare a short, easy to use pro forma or similar to record the transfer of critical information regarding a prisoner's wellbeing or prisoner requests which could not be immediately be attended to (such as a request to speak to a supervisor).

I apologise for the lengthy delay in bringing this case to conclusion and I extend my condolences to the family of Mr Darren Parkes.

I direct that a copy of this finding be provided to the following:

Mr Brian Parkes, Senior Next of Kin
Leading Senior Constable Tania Cristiano
Mr A. Murphy
Ms D Foy on behalf of Ms Jodie Arthur
Mr J Goetz on behalf of StVincent's Correctional Health
Ms C Harris on behalf of G4S
Ms D Coombs on behalf of Corrections Victoria

Signature:

JUDGE IAN L GRAY
STATE CORONER
Date: 17 April 2014