CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 27th day of May, the 1st, 2nd, 3rd, 6th, 17th, 21st, 24th and 28th days of June 2022 and the 10th day of November 2023 , by the Coroner's Court of the said State, constituted of Ian Lansell White, Deputy State Coroner, into the death of Giovanni Trotta.

The said Court finds that Giovanni Trotta aged 58 years, late of the Yatala Labour Prison, 1 Peter Brown Drive, Northfield, South Australia died at Northfield, South Australia on the 5th day of July 2018 as a result of acute bronchopneumonia. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. Giovanni Trotta[1] died in his cell[2] within E Division of Yatala Labour Prison[3] on Thursday, 5 July 2018. He was 58 years of age.

1.2. Mr Trotta had been in custody on remand since his arrest by South Australia Police[4] on 14 February 2018 for the charge of arson. This charge related to a mental health episode he suffered on 23 November 2017 at his home address.

1.3. Mr Trotta had been acutely unwell in the days preceding his death with a persistent cough and extreme fatigue.

[1] Also known as John Trotta
[2] Cell 305
[3] YLP
[4] SAPOL

1.4. His cellmate, Guy Stubing, stated that from Monday, 2 July 2018 Mr Trotta had been '*complaining about a chest infection*' and said he:

> 'was coughing a lot and was sleeping for most of the day and night. In the last couple of days he hadn't been waking up in the mornings. This morning[5] I woke him up to go to breakfast … John got up and we received breakfast in our cell. John hadn't been eating for the past 2 days and complaining a lot about having a chest infection.' [6]

1.5. Mr Stubing further described that Mr Trotta did not eat his breakfast but went back to sleep having taken his usual medications, including sodium valproate liquid which is prescribed for mood stabilisation and for epilepsy. Mr Stubing left soon after breakfast and returned at about 11:30am where he found Mr Trotta asleep and '*snoring heavily*'.

1.6. Mr Trotta slept on the floor of the cell on his mattress due to his bad back.

1.7. When lunch was provided at 11:30am Mr Trotta did not eat his, but merely had some milk and refused to have his daily coffee.

1.8. Mr Stubing left the cell to go to the YLP gym at 1:30pm. When he returned at 2:30pm Mr Trotta was still asleep until dinner was served at 3:30pm, which he did not eat.

1.9. In the evening medication rounds Mr Trotta was provided with some more sodium valproate liquid. He then deteriorated badly with body shakes and a fall. His eyes rolled back.

1.10. Mr Stubing pressed the intercom within the cell. He reported that Mr Trotta was '*unconscious and ... starting to have fits*'.[7] He put Mr Trotta into a basic recovery position and was aware of YLP prison staff standing outside the cell. Mr Trotta looked like he was deteriorating further with his face turning a '*purple/blue colour*' with no signs of breathing.

1.11. Mr Stubing correctly thought that Mr Trotta was dying and '*about 1 or 2 minutes later the guards came into our cell*'.[8]

1.12. Mr Stubing was removed from the cell as prison staff, including YLP nurses, administered emergency first aid to Mr Trotta. They were unable to save his life.

[5] 5 July 2018
[6] Exhibit C4, Affidavit of Guy Everard Stubing dated 5 July 2018, paragraph 3
[7] Exhibit C4, paragraph 9
[8] Exhibit C5, paragraph 10

2. Legal reasons for Inquest

2.1. Mr Trotta was a remandee prisoner, therefore was being legally detained by the Department for Correctional Services.[9] As he died in the legal custody of DCS, his death must be subject to a mandatory Inquest pursuant to section 21(1)(a) of the Coroners Act 2003.[10] This Inquest must examine the cause and circumstances of Mr Trotta's death.[11]

3. Mr Trotta's cause of death

3.1. Mr Trotta was subject to a post-mortem examination at Forensic Science South Australia.[12] Dr Karen Heath, an experienced forensic pathologist employed by FSSA, conducted this examination on 6 July 2018.

3.2. Dr Heath noted that Mr Trotta weighed 96kg and was 172cm tall.[13] A specimen of his blood was taken and analysed. It showed the presence of clozapine, valproic acid, paracetamol and aripiprazole.

3.3. An examination of his lungs revealed '*patchy but widespread acute bronchopneumonia*',[14] together with mild to moderate pulmonary emphysema.

3.4. Dr Heath concluded that the cause of Mr Trotta's death was acute bronchopneumonia. I accept her opinion and make a finding concerning his cause of death accordingly.

3.5. Before leaving this topic, I note that Dr Heath identified that Mr Trotta also had hypertensive heart disease and chronic obstructive airways disease.[15] On top of these physical afflictions Mr Trotta was profoundly deaf and had difficulty communicating. Therefore, it is easy to conclude that at the time of his death he was struggling generally with his physical health before becoming much worse in the days preceding his death. There is support for this in Mr Stubing's description of his time sharing a cell with Mr Trotta since 24 June 2018, a period of 11 days.

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[9] DCS
[10] The Act
[11] Section 21(1) of the Act
[12] FSSA
[13] 5 feet 8 inches
[14] Exhibit C2a, post-mortem report of Dr Heath dated 14 August 2019, page 6
[15] COPD

3.6. The Inquest examined the reasons for Mr Trotta not receiving treatment for his medical condition that caused his death in the preceding days. This involved an examination of the reliability of his records in YLP concerning his medical history, as well as whether any opportunities to escalate medical care were missed to prevent his death.

4. Hindsight and outcome bias

4.1. I warn myself concerning these two vital considerations in the assessment of the evidence and any potential criticisms of witnesses in this Inquest, namely hindsight bias and outcome bias.

4.2. A description of '*hindsight bias*' is given in the Australasian Coroners Manual, namely as:

> 'The tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact. If it were, there would be far fewer mistakes made. It is an obvious point, but one that nonetheless bears repeating, particularly when Coroners are considering assigning blame or making adverse comments that might damage a person's reputation…
>
> Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. The distinction needs to be understood and rigorously applied.' [16]

4.3. I am very mindful of this warning when considering evidence of what efforts were made by YLP staff, in particular medical staff, in looking after Mr Trotta.

4.4. I also am very mindful of outcome bias. That is, the terrible outcome of Mr Trotta's death should not lead me to more harshly assess the evidence concerning his medical care and care in general by YLP. In other words, the outcome of Mr Trotta's death must not overwhelm or unduly influence my task of assessing the evidence about the issues in this Inquest.

5. Circumstances of Mr Trotta's death

5.1. Section 25(1) of the Act demands that this Finding must set out '*the cause and circumstances*' of Mr Trotta's death. I have already found his cause of death as acute bronchopneumonia. The circumstances of his death are more complex. It involved

[16] The Australasian Coroners Manual, page 10

examination of his care and treatment at YLP and briefly at the Adelaide Remand Centre[17] for two days[18] from his remand in custody on 13 February 2018.

5.2. In addition to his physical health problems, Mr Trotta had '*an extensive psychiatric history with a diagnosis of schizoaffective disorder*'.[19] On 23 November 2017 Mr Trotta was detained at the Queen Elizabeth Hospital[20] on an Inpatient Treatment Order[21] until his transfer into DCS custody.

5.3. His medical care in custody was a significant issue and circumstance to be considered in this Inquest. In particular, substantial evidence and opinion concentrated on whether Mr Trotta's very poor medical condition from about 2 July 2018 should have been subject to better and more intense treatment from the South Australian Prison Health Service.[22] In particular, the failure to identify and intensely treat his chest infection was argued to be a major missed opportunity to prevent his death on 5 July 2018.

5.4. Further, the Inquest examined whether his collapse on the evening of 5 July 2018 was appropriately handled by DCS officers, in particular with respect to calling the SA Ambulance Service[23] at the earliest opportunity once his collapse was known by them.

5.5. These above identified issues caused the Inquest to have a close examination of the procedures and records of the SAPHS and of the YLP.

5.6. The easiest way to begin to deal with these issues of care was to examine what information and/or records were possessed by SAPHS and YLP concerning Mr Trotta's health.

5.7. 14 February 2018 – Mr Trotta's transfer from QEH Cramond Clinic

5.8. As is usual, when Mr Trotta was discharged from the QEH a discharge summary was created outlining the treatment he had received, his medical history and all other relevant information for future treatment by SAPHS, which included schizoaffective disorder, deafness, hypolipidemia and COPD.[24]

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[17] ARC
[18] 21-22 June 2018
[19] Exhibit C27, Reference in the treatment notes of the Queen Elizabeth Hospital as quoted in the report of SAPOL into Mr Trotta's death authored by Detective Brevet Sergeant Michaela Tiss
[20] QEH
[21] ITO
[22] SAPHS
[23] SAAS
[24] See Exhibit C31, pages 134-136

5.9. Unfortunately, this information was not copied into SAPHS records in full upon admission to YLP.[25] These omissions of important medical conditions resulted in Mr Trotta not being treated or assessed at YLP in a background of a person who suffers COPD.

5.10. There was no challenge to the proposition that when his physical health is considered in conjunction with his mental health, deafness and limited ability to communicate, he could be rightly considered a '*vulnerable member of YLP*'.[26]

5.11. 5 March 2018

5.12. On this date a blood test result from 28 February 2018 showed that Mr Trotta had a very high blood sugar level. This was noted to need a follow up of an urgent medical officer review as he was not a known diabetic.[27]

5.13. No follow up occurred which was described by expert witness, Professor Kelly, as '*astounding*'.[28] This left him coping with untreated diabetes. As a consequence, this made him more prone to suffer infections, which he ultimately did get in July 2018.

5.14. This was admitted by SAPHS to be an omission.[29] It was a very significant one given its seriousness.

5.15. 20 February – 3 April 2018

5.16. Mr Trotta recorded two low oxygen saturation readings during this time period. Professor Kelly expressed an opinion that those readings alone should have caused an escalation of care into a medical review or intervention.[30] The escalation could have involved a chest X-ray, consideration of his medication regime, or even a hospital admission.[31]

5.17. 21-22 June 2018

5.18. Mr Trotta briefly transferred to the ARC due to overall accommodation difficulties for YLP. During this brief stay it was reported he had difficulty coping[32] in the ARC with

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[25] Exhibit C31, pages 42-48
[26] Transcript, page 586
[27] Exhibit C31, page 63 nursing note, page 116 result
[28] Transcript, page 273
[29] See evidence of Dr Thomas Turnbull, Medical Director of SAPHS since 2021
[30] Transcript, page 278
[31] It was admitted by Dr Turnbull on behalf of SAPHS that no medical action did occur following these readings as should have been the case; Transcript, page 547
[32] Known also as acopia

stairs. This indicated his general poor health. In the absence of any complaints concerning legs and/or arthritis, it tended to suggest problems consistent with COPD in the opinion of Professor Kelly.[33]

5.19. 2 July – 5 July 2018

5.20. This three-day period up to his death was an extremely important issue at the Inquest. This timeframe was carefully considered in review by expert Professor Anne-Maree Kelly and Dr Turnbull from SAPHS. It involved numerous important observations from other relevant witnesses, including cellmate Guy Stubing and Mr Trotta's lawyer, Ms Trish Johnson who saw him on the morning of 5 July 2018.

5.21. Professor Anne-Maree Kelly AM

5.22. Professor Kelly is the Director of the Joseph Epstein Centre for Emergency Medicine Research at Western Health Victoria, based at Sunshine Hospital. She has held this position since 2000. She was also Director of Emergency Medicine at Footscray Hospital for 10 years, initially from 1998 to 2006 and then again in 2016 to 2017. Her curriculum vitae[34] outlines her distinguished career in emergency medicine where she has held numerous important positions in that field. She has been involved in, or solely authored, an extensive number of articles and discussion papers concerning emergency medicine. At the time of giving evidence at the Inquest she was the Senior Emergency Physician at the Western Health Hospital in Footscray, Victoria.

5.23. Professor Kelly has engaged in extensive research in the topic of respiratory medicine, in particular concerning asthma and COPD. This included being the *'lead of a very large international study involving more than 3,000 patients on the management of shortness of breath in emergency departments of which COPD was a significant sub-group*'.[35]

5.24. She explained that COPD as:

> '… basically chronic damage to the lungs which is associated with scarring and breakdown of the little air sacs in the lungs, so that effectively it gives an obstructive effect to airflow through the lungs and oxygen exchange.' [36]

[33] Transcript, pages 278, 285
[34] Exhibit C47
[35] Transcript, pages 254-255
[36] Transcript, page 255

A common cause of COPD is cigarette smoking. Mr Trotta was a smoker. Professor Kelly also noted that COPD develops from being asymptomatic when mild to causing shortness of breath and intolerance to exercise in its moderate form. When acute it can be '*completely disabling*'.[37] COPD is also often associated with infection which causes '*quite significant drops in oxygen and threat to life in fact*'. COPD can be exacerbated by infections, usually viral.[38]

5.25. Professor Kelly's report and evidence

5.26. Professor Kelly's report concerning Mr Trotta's death was tendered at the Inquest.[39] She was provided with key documents as she set out clearly in her report.[40] These became exhibits in the Inquest. Therefore, her opinions were based on the evidence at the Inquest, most of which was not contested.

5.27. Professor Kelly focussed on the long-term treatment of Mr Trotta up to his collapse on the evening of 5 July 2018.

5.28. She also considered the response of SAPHS and YLP in their attempts to save Mr Trotta prior to the arrival of the SAAS ambulance officers at his cell on the evening of 5 July 2018.

5.29. As will be seen in detail later, it appears that it takes approximately 10 minutes from the arrival of a YLP correctional officer[41] to him in distress until SAAS is contacted. That will be the subject of separate consideration later in this Finding. This delay was an important issue in the Inquest, separate from Mr Trotta's care by YLP.

5.30. I am satisfied that Professor Kelly's oral evidence was based on all relevant information and exhibits in the Inquest. Professor Kelly's evidence supplemented her report in considering five major issues identified, namely:

1. The management of Mr Trotta's health whilst at YLP, in particular whether his bronchopneumonia, heart disease and COPD should have been identified prior to his collapse on the evening of 5 July 2018.

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[37] Transcript, page 255
[38] Transcript, page 256
[39] Exhibit C47a, dated 8 October 2020
[40] Exhibit C47a, page 2
[41] CO

2. The significance of the time gap between a Code Black being called by COs and the attendance of SAPHS to Mr Trotta's cell.
3. Whether the delay of the calling of the Code Black and the attendance of SAAS to Mr Trotta's cell contributed to his death.
4. The procedures of YLP concerning who was entitled to call SAAS in an emergency situation.
5. Was Mr Trotta's death preventable?

5.31. General issues concerning Professor Kelly's evidence

5.32. Professor Kelly acknowledged that her role in providing an expert review differed from that of Mr Trotta's medical health providers. She especially acknowledged the difference between her own work as an emergency physician in a hospital compared with providing care in a prison environment. She addressed the issues of hindsight and outcome bias that I have set out earlier on in this finding. I am grateful to her for that acknowledgement.[42]

5.33. I have already set out her extensive clinical work and research, the specifics of which are detailed within her curriculum vitae.[43] She was extremely well qualified to assist this Inquest.

5.34. *Issue 1 – management of Mr Trotta's medical condition at YLP*
Overall Professor Kelly's perusal of the SAPHS records for Mr Trotta showed that his mental health disorder was subject to evaluation. He received treatment from psychiatrist, Dr Furst, in March 2018. He also underwent regular blood testing for his white cell count and levels of clozapine and aripiprazole. The side effects of clozapine include lowering the level of white blood cells together with cardiac side effects of myocarditis[44] and cardiomyopathy[45].[46] The lowering of the white blood cell levels puts a person at risk of '*serious infection*'.[47]

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[42] See Exhibit C47a, pages 3-4
[43] Exhibit C47
[44] Inflammation of the heart
[45] Impairment of the function of cardiac muscle
[46] Transcript, page 265
[47] Transcript, page 264

5.35. I have already outlined the many physical difficulties suffered by Mr Trotta as well as his physical health conditions.

5.36. Professor Kelly's evidence reviewed and at times criticised the handling of his physical health at YLP, in particular his final few days from 2 July 2018 until his death. She also found fault in some key records of the SAPHS, including his initial assessment upon admission on 14 February 2018 that was in error on crucial matters. This included a lack of acknowledgement of his COPD that was clearly mentioned in his discharge summary from the QEH.[48]

5.37. *Issue 2 – Lack of treatment of chest infection*

It was clear to Professor Kelly that the identification of the chest infection in Mr Trotta was a key matter, particularly in gauging whether his death was preventable. In short, her report and evidence made it clear that a much more comprehensive examination and assessment should have occurred when he requested a salbutamol inhaler,[49] commonly used for short term relief for COPD and other associated lung problems that cause airflow limitation.

5.38. The SAPHS notes indicate[50] that Mr Trotta was '*thankful*' when the puffer was provided to him and instantly took two puffs. This was an indicator to Professor Kelly that he felt he needed it urgently. This is supported by the time of night at which the request was made and provided in her opinion.

5.39. Professor Kelly clearly classified this request and the provision of the inhaler as a:

> '… missed opportunity to identify that he had a chest infection and to explore whether there was any problem with his white cell count and the severity of that chest infection to see whether he needed additional treatment and/or transfer to hospital.' [51]

She was strongly of the opinion that had he received the treatment he needed for this chest infection that his death was '*potentially preventable*'.[52]

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[48] Exhibit C31, page 44
[49] Commonly known as a Ventolin inhaler
[50] Exhibit C31, page 74
[51] Transcript, page 282
[52] Exhibit C47a

5.40. In addition, she considered the observations of what he did, and more importantly, did not do in the following days up to his collapse on the evening of 5 July 2018. As she said:

> '… if Mr Trotta's normal behaviour had changed such that he was sleeping more, unable to eat, unable to do his normal activities in the prison, that is another indication that he might be unwell and that he might need clinical review...'

This was rather than what she regarded was an '*automatic assumption that he was just being difficult*'.[53] She believed that was the only logical alternative explanation available in the circumstances. I note his cellmate Mr Stubing seemed to have excluded that Mr Trotta was being difficult and came to the opinion he was struggling badly with his health.

5.41. 2 July – 5 July 2018

5.42. Professor Kelly's comments lead to a more detailed examination of what happened in that crucial three-day period.

5.43. As was obvious from the evidence, Mr Trotta did not comply with the daily prison routine. That is clear by reference to his cellmate, Mr Stubing's affidavit[54] as already set out in this Finding. Based on this uncontested evidence it is clear that Mr Trotta did not get up to eat breakfast. Mr Stubing was told that if Mr Trotta did not get up on 5 July 2018 there would be problems. Mr Stubing remembered this demand as it was coupled with a threatened loss of privileges for him to use the gym and be outside in the yard.

5.44. Consistent with the previous days, Mr Trotta did not eat the provided daily breakfast. He had not eaten '*for the past two days*'.[55] At an initial level of analysis the fact that Mr Trotta had not been eating, was sleeping all the time and coughing seemed to suggest that he was not suitable to continue to live in that cell.

5.45. At the very least, a visit to the YLP medical centre for assessment was more than warranted on that description, especially given his physical and mental health conditions.

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[53] Transcript, page 284
[54] Exhibit C4
[55] Exhibit C4, paragraph 3

5.46. This led to the issue of which YLP staff were was involved with Mr Trotta in the period 2 July to 5 July 2018.

5.47. <u>2 July 2018 - Barbara Doyle - YLP night nurse</u>

5.48. Barbara Doyle is an experienced nurse having obtained her qualifications in 1979. She has worked in her position at YLP as a night nurse since 1999.

5.49. She delivered Mr Trotta his Ventolin inhaler at about midnight on 2 July 2018 at Cell 305. She noted these events as follows in the SAPHS notes:

> 'm/night DCS in unit rang. Client requesting an inhaler. Ventolin inhaler issued. Did not have an old inhaler to return. Thankful for inhaler. Took two puffs when it was issued.' [56]

5.50. In her evidence at the Inquest she described Mr Trotta sitting at the front of the cell near the small trapdoor, similar to the size of a tissue box attached on the cell door.[57] Mr Trotta was sitting '*at the chair next to the trap*'.[58] All of her communication was through that trap. She noticed that he '*wasn't breathless*',[59] was speaking without being laboured and without '*wheezing*'.[60] According to her there was nothing unusual about the time of the callout, being midnight. She went further to say that if Mr Trotta had '*shortness of breath and having difficulty I would have requested he being brought over to the health centre so I could have done a better assessment on him*'.[61]

Cell door to Cell 305
'Trap Door' indicated

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[56] Exhibit C33d, page 74
[57] Exhibit C26a
[58] Transcript, page 504
[59] Transcript, page 505
[60] Transcript, page 505
[61] Transcript, pages 508-509

5.51. No history was taken from Mr Trotta's cellmate. No additional information was given about his health in the initial request for the inhaler via the CO to the SAPHS.

5.52. Ms Doyle further admitted that his temperature was not taken, nor an oximeter used on his finger for his oxygen saturation levels. She was unaware of his COPD but did know that he was a smoker. His midnight request for a Ventolin inhaler was the first such request by him for 4½ months.[62] She denied that the midnight request necessarily meant that there was some urgency associated with it, even allowing for the fact that he took two immediate puffs when she gave it to him through the trap.

5.53. Ms Doyle was only asked to recall this matter in detail about a month prior to giving evidence.[63]

5.54. She did not take any other medical equipment with her that night. She had no other medical complaint other than Mr Trotta wished to have his puffer. She was adamant in assessing that nothing further needed to be done, and that she could:

> '… only go by what I see at the time and when he used his Ventolin inhaler, which was two breaths, he used it correctly, he wasn't coughing afterwards, he wasn't struggling for breath when he used the inhaler.' [64]

5.55. No follow up appointment was scheduled. She noted that Mr Trotta was regularly tested with '*clozapine bloods*'.[65]

5.56. She denied there was anything unusual by a midnight request for a puffer, despite the fact that he had not asked for one in 4½ months.[66]

5.57. <u>3 July - 4 July 2018</u>

5.58. Given Mr Stubing's statement, there is essentially little to report for this time period other than Mr Trotta did not leave his cell or participate in any meaningful activity. He simply lay on the floor on his mattress with his health deteriorating.

5.59. At first examination it seems extraordinary that no intervening action was attempted or forced by anyone in charge of him to have him assessed by SAPHS during this time.

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[62] Transcript, page 523
[63] Transcript, page 517
[64] Transcript, page 521
[65] Transcript, page 522
[66] Transcript, page 523

5.60. The SAPHS notes are effectively silent[67] in that no-one, including Mr Trotta himself, has sought their service. I do not blame him for this given he was unwell, deaf and with mental health afflictions. Nor do I blame Mr Stubing. As his cellmate he has no supervising role or duty concerning Mr Trotta.

5.61. Therefore, attention must be drawn to what observations and/or actions were done by COs. If, as seemed to be the case here, Mr Trotta was physically unable to leave his cell, common sense would suggest a medical investigation into why should be conducted. It would clarify whether he was sick or was deliberately defying the prisoners' routine and/or feigning illness.

5.62. A note on the YLP prisoner information system at 1:56pm on 5 July 2018 seems to be the only official reference to 3 and 4 July 2018. This was made by CO Darren Shillabeer who gave evidence but did not supply a statement prior to the Inquest. This note read as follows:

> 'YLP Echo division unit 3 prisoner Trotta has <u>failed to be ready for unlock for the past two days now</u>[68] and continues to be asleep on his mattress on the cell floor. Oweing (sic) to his deafness, his communication is limited and for the most part doesn't answer officers therefore making communication between the two parties difficult. Prisoner Trotta's cellmate has tried to explain that he has a chest infection and has been seen by nursing staff.' [69]

5.63. <u>CO Darren Shillabeer</u>

5.64. Mr Shillabeer has been a CO for over 13 years. On 5 July 2018 he was a Level 2 CO.[70] At the time of the Inquest was Level 3.[71]

5.65. He began working in YLP from November 2013. On 5 July 2018 he was working in E Division[72] on the day shift from 7:30am to 4:30pm.[73]

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[67] Exhibit C31, page 74
[68] My emphasis
[69] Exhibit C33d, page 1 (after title page)
[70] CO2
[71] CO3
[72] aka Echo Division
[73] Transcript, pages 357-358

5.66. Prior to giving evidence he had not provided any statement to DCS or SAPOL about Mr Trotta's death. He outlined the routine for unlocking cells within the Division, namely:

- 8am - unlocking for breakfast
- 11:20am – locking prisoners in their cells for lunch[74]
- 3:40pm – prisoners locked down in their cells for the end of the day

5.67. Mr Shillabeer admitted that he had no awareness of Mr Trotta's '*health needs*',[75] but was aware of his deafness and his consequential limitations on communication.

5.68. He was referred back to the '*general casenote*'.[76] He wrote it for the purpose of future rostered COs in E Division and assessment of possible '*future punishment*'.[77]

5.69. By reference to the information provided by Mr Stubing about the chest infection he rang the '*nursing staff*'.[78] He referred to the daily list of prisoners that go to SAPHS that is distributed at the morning medication rounds. He also outlined that SAPHS can assess a prisoner within the Division if he was '*in need of medical attention*'.

5.70. His observations of Mr Trotta on 5 July 2018 were that he was '*laying in bed or on his mattress on the floor*'.[79] He remarked that it was not unusual for prisoners to place their mattresses on the floor '*every now and then*'.[80] His evidence was that Mr Trotta did not make any comment about his health that day.

5.71. In cross-examination Mr Shillabeer clarified that he had no memory of making the phone call to SAPHS, but assumed he followed the procedure.[81] He classified the information from Mr Stubing about the chest infection as an excuse.

5.72. If that was so, then it tended to undermine his evidence that he did call SAPHS.[82] I accept that Mr Shillabeer cannot blindly accept everything said to him by a prisoner as being truthful or accurate. However, given that there was no challenge to Mr Stubing's

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[74] Although no timeframe was disclosed, COs have lunch during this time as the swing shift commences See Transcript, page 206
[75] Transcript, page 358
[76] Transcript, page 360 (his words)
[77] Transcript, page 360
[78] Transcript, page 361
[79] Transcript, page 364
[80] Transcript, page 364
[81] Transcript, page 366
[82] Transcript, pages 360-362 and 370-371

evidence, it is hard to reconcile the extent of symptoms shown by Mr Trotta as being convincing evidence for Mr Shillabeer to conclude he was making an excuse for not being ready when required, rather than being ill.

5.73. Certainly, one could argue that a medical assessment, even a brief one, either within E Division or at SAPHS, could have been an independent indicator as to whether Mr Trotta should remain within Cell 305, or should be somehow treated differently and/or even moved to the infirmary.

5.74. I found Mr Shillabeer's evidence to be contradictory and illogical on this topic.

5.75. His evidence was hampered by the fact he had no contemporaneous notes of these events save and except for the casenote he entered on 5 July 2018. He denied that he had ever threatened prisoners with losses of privileges.

5.76. He also did '*not recall*' threatening Mr Stubing about loss of privileges.[83]

5.77. I note he stated that it was common for prisoners to lie in their cells even after '*unlock*'.

5.78. I accept the fact that he took the time to make the casenote and his core duties are not to make crude medical assessments of a prisoner's health. However, he did not seek to bring this matter to a head by seeking a medical expert's intervention.

5.79. Being absolutely neutral, it was a pity this issue was not brought to a head on the morning of 5 July 2018. There is no record or memory of Mr Shillabeer calling the SAPHS. I therefore do not contemplate or find that SAPHS ignored a message about Mr Trotta having a chest infection on the morning of 5 July 2018. Further, Mr Shillabeer did accept that a person not being ready for '*unlocks*'[84] had in the past been punished by a loss of association privileges '*in circumstances of not following the divisional regimes, not being ready for unlocks*'.[85]

5.80. I therefore find that Mr Trotta's failures to be ready for the morning unlock on 5 July 2018 and the previous two mornings is such a situation that Mr Shillabeer finds was potentially liable to be punished.[86]

[83] Transcript, pages 373-374
[84] Transcript, pages 374-375
[85] Transcript, page 374
[86] Transcript, pages 374-375

5.81. 5 July 2018

5.82. I turn to the traumatic events immediately prior to Mr Trotta's death on the evening of 5 July 2018. These are all extensively and correctly summarised in the 32-page report of the SAPOL investigating officer into Mr Trotta's death, Detective Brevet Sergeant Michaela Tiss.[87]

5.83. The circumstances of Mr Trotta's last hours and his resuscitation attempts on the evening of 5 July 2018 occupied a significant part of the Inquest. His situation was not helped by a number of factors including the time taken to call SAAS by YLP. I quickly acknowledge that his state of health was such that even a rapid response and attendance by SAAS would have been unlikely to save his life. Professor Kelly made that abundantly clear.

5.84. However, the implementation of the Code Black alert and its procedures fell into difficulty after the arrival of YLP SAPHS at Cell 305 at 7:27pm. By this time Mr Trotta had a non-shockable rhythm which made resuscitation attempts most unlikely to succeed as ultimately eventuated.

5.85. The evidence of CCTV footage outside of Cell 305 supported the contention that SAAS was not called until about 11 minutes later at 7:38pm. This delay was due to a lack of assessment and practicality being applied to this emergency as well as false assumptions being made by COs in the pressure of the moment. I accept that policies and procedures of DCS and YLP must be the guide to behaviour in the reaction and duties of COs as a starting point for the assessment of behaviour of those involved in this emergency.

5.86. An assessment of the resuscitation attempts being performed by SAPHS nurses by those COs standing outside Cell 305 would have led most people to react that SAAS needed to be called urgently. Indeed, that was the request of the SAPHS nurses as almost immediately they began resuscitation attempts on Mr Trotta.

5.87. It is unfortunate that the Inquest had to delve into the minute detail about who was responsible for calling SAAS, rather than it being simply an issue of narrative fact that it was called immediately resuscitation commenced. In such a situation it is preferable that someone with a phone calls '000' immediately as would happen and does happen outside of prison in an emergency situation. Most civilians who are witnessing

[87] Exhibit C27, Report of Detective Tiss

resuscitation attempts on an obviously seriously unwell person would call SAAS immediately.

5.88. I also understand the pressure of Mr Trotta's collapse and the sight of him from that point could cause errors, misunderstandings and assumptions by COs that create a less than perfect response.

5.89. Unfortunately, it is necessary to delve into this evidence in some detail as conflicting accounts have emerged about the delay in calling SAAS. The simplest way to analyse this evidence is to refer to the CCTV from its first relevant point.

5.90. Detective Tiss concluded her entire report into his death concentrating on this topic as follows:

> 'Confusion as to whose responsibility it was to contact SAAS most certainly delayed the attendance of paramedics. SAPHS staff acted appropriately by immediately rendering first aid and were in attendance at the cell within minutes of the call of code black. The most appropriate action would have been for any DCS member observing the deceased being apparently unconscious on the floor of the cell, regardless of if the cell was locked or not, to immediately ring SAAS. It is my opinion that SAAS could have been cancelled should they not be required, but delaying the request for their attendance could have seriously jeopardised the chances of resuscitating the deceased. The defibrillators used by SAPHS and SAAS advised that deceased was in a non-shockable rhythm, however there should not have been a delay in requesting SAAS.' [88]

5.91. The issue has another consequence. As clearly set out by Detective Tiss, the confusion about the responsibility to call SAAS affected SAPHS. The three nurses had an obvious focus on Mr Trotta in attempting to save his life. Their role was clear, and they were the best placed people to do it at the time.

5.92. In short, they should not have been distracted from that role in these circumstances. Any one of the COs outside the cell could have described the frantic situation to SAAS. It was highly regrettable that the issue of who should make the telephone call to SAAS involved them at all once that request was made by them.

5.93. I give an example of how the consequences of this confusion has had a long-lasting[89] effect on the nursing staff. In the report of Detective Tiss, she noted Nurse Chen was '*visibly upset ... when she recalled asking DCS to again ring an ambulance and stated that she started to panic when she realised no one had called one*'.

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[88] Exhibit C27, Report of Detective Tiss

[89] Exhibit C27, page 31

5.94. Pre-emergency events of the evening of 5 July 2018

5.95. As already described, Mr Trotta had not left his cell for days and was obviously unwell as observed by his cellmate, Mr Stubing. At about 6pm nurses Dunn and Chen performed the afternoon medication rounds in E-Division of YLP. When they arrived at Cell 305, they called Mr Trotta's name to come to the trap door. He did this and was observed by them to take clozapine and the sodium valproate, as prescribed. He refused to take medication for constipation and did not make any complaint to either nurse.[90]

5.96. The evidence was that in general no acute nursing observations are made during the medication round. I accept this is inevitable given the number of prisoners to service with medication and the very limited interaction between the nurses and the prisoners during such an occasion.[91]

5.97. Morning medication round

5.98. This is a much quicker procedure. There are more limitations for the nurses than the afternoon round, including the important factor of time[92] and the prison day has begun, including release of prisoners from their cells at 8am for breakfast. There is a controversial aspect of this morning that involved a threat to Mr Stubing that his and Mr Trotta's privileges would be lost if Mr Trotta did not leave the cell and take part in the usual daily routine.

5.99. A second important matter occurred that morning, namely Mr Trotta's appointment with his solicitor from the Legal Services Commission, Ms Trish Johnson. She quickly realised that he was unwell. Just prior to the appointment she was told by a CO that Mr Trotta was feeling unwell and had been to the infirmary. In her words:

> 'The main thing that stood out was his loud cough …. he had a number of coughing fits during our appointment … I was concerned that talking was aggravating his cough, so after I received these essential instructions from him, I left the prison.' [93]

5.100. Her visit was for approximately half an hour. The information given to her about his time in the prison infirmary on 4 July 2018 was clearly incorrect. Her observations

[90] Exhibit C17 Statement of Ms Dunn; Transcript, page 56
[91] Transcript, page 58
[92] Transcript, page 55
[93] Exhibit C19, Affidavit of Ms Johnson drafted by her 8 July 2018 and sworn 10 August 2018

clearly support those of Mr Stubing. They show that Mr Trotta needed an examination of his chest as Professor Kelly outlined in her report and evidence.

5.101. He was obviously not in a healthy state above and beyond his chronic medical difficulties.

6. Summary of the actions of YLP staff in the emergency attempts to save Mr Trotta's life

6.1. In light of the summary by Detective Tiss and the extensive viewing of the CCTV footage I have decided only to give a summary of the actions of the YLP officers, in particular the CO staff concerning this segment. The SAPHS staff and SAAS acted with professionalism in attempting to preserve Mr Trotta's life which, by that stage according to Professor Kelly, had deteriorated to the situation where:

> '… his chance of a good outcome was already terrible by the time CPR was started. We were already in the 1% chance of survival, less than half a percent chance of neurologically good survival at that stage'.[94]

6.2. She continued that the documented delay between the alert and SAAS being called did not make a '*big difference. I think things were already terrible before that delay*'.[95]

6.3. As she observed in a common sense manner such a delay in another situation:

> '… could be critical to the outcome and therefore my firm belief is that a collaborative approach is needed to calling an ambulance especially when the clinicians on site are trying to save somebody's life. Whoever can make the call should .. make it if at all possible.' [96]

6.4. Therefore, the following analysis of this situation should be properly understood in the context of Professor Kelly's comments and advice.

6.5. I shall briefly refer to most of the YLP staff involved in these frantic minutes in or around Cell 305 about the delay in calling SAAS.

6.6. Ms Chen – SAPHS nurse

6.7. In essence, she wanted the 000 call to be made by someone taking the responsibility to dial the number.

[94] Transcript, page 289
[95] Transcript, pages 289-290
[96] Transcript, page 290

6.8. As this was refused by CO Cattanach, who brought the phone down to them, her fellow nurse, Joseph Penaflorida, had to '*stand up and try to make a phone call*'. He never did as another senior CO, Mr Hills, had called just before him.

6.9. Ms Chen contrasted this situation to an emergency involving a severe neck wound to a prisoner that she assisted in 2019 where she attended on a Code Black call. As soon as she arrived to the prisoner, she told the CO present to '*call the ambulance*'. Unlike this situation, there was no debate or delay. The ambulance arrived very quickly, only moments after other SAPHS staff had arrived at the relevant cell.[97]

6.10. Ms Chen generally accepted that medical staff will call SAAS because '*we can provide more details in the medical handover*'.[98] She agreed that it is a '*common sense decision on who's to call*'.[99]

6.11. <u>CO Irish</u>

6.12. Ms Irish was a CO4. She had worked for 14 years with the DCS and solely at YLP. As at 5 July 2018 she held the position of Operations Supervisor with high level duties that varied slightly in content depending on the shift she was working on.

6.13. One of these roles was as an officer in charge[100] which makes her effectively responsible for the whole of YLP operations whilst on shift.

6.14. This was her role on 5 July 2018.

6.15. It followed logically that should she give an order or direction, as OIC, the expectation is that it would be obeyed by COs.

6.16. As OIC, Ms Irish made her way to Cell 305 as soon as alerted. She confirmed the cell door could not be opened until she arrived. This was for operational and safety considerations and policy, in particular for the safety of COs in case the situation was not a genuine one.

6.17. I have viewed the CCTV footage of her arriving and dealing with Mr Stubing after the cell door was opened, including leaving with him and gathering information at the

[97] Transcript, pages 90-91
[98] Transcript, page 93
[99] Transcript, page 93
[100] OIC

nearest CO area controlling the Division.[101] Ms Irish was communicating via walkie-talkie with the control room of the YLP. She gave her cordless phone to CO Cattanach for him to take down to the cell.[102] This was after she was informed by him that the nurses were asking about an ambulance. Having done that, she advised the control room that an ambulance had been called so that they could coordinate SAAS' swift entry into YLP and to E Division.[103]

6.18. Her instructions to CO Cattanach were to get SAPHS staff to call the ambulance.[104]

6.19. When she returned to the area outside of Cell 305, about a minute after giving CO Cattanach the phone, she had assumed SAAS had been called.[105] Part of that assumption was that there was no active call at that time. This falsely indicated to her that the nursing staff had made the arrangements with SAAS to attend. No one told her otherwise at that time.

6.20. If she believed that was not the case, then she would have at that point instructed '*one of my staff to call*'.[106]

6.21. When she was handed back the phone by CO Cattanach just on 7:33pm she remained at the cell door with him. At this time she was giving continual brief updates via her walkie talkie for about 90 seconds. She then left with the phone and returns to the '*fishbowl*'.

6.22. Meanwhile, CO Cattanach remained at the cell door looking in until just before 7:37pm. He returned to inform Ms Irish that SAAS had not been called by the nurses.[107] Her reaction was, as she put it in evidence, that she was '*shocked*'.[108] She had made all the arrangements for YLP to receive the ambulance. She admitted swearing and candidly told the Inquest that she had never been involved with a Code Black situation where an ambulance had not been called promptly.[109]

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[101] Known in slang at the YLP as the 'fishbowl'
[102] Transcript, page 140
[103] Transcript, page 142
[104] Transcript, page 141
[105] Transcript, page 145
[106] Transcript, page 145
[107] Transcript, page 415 – CO Cattanach
[108] Transcript, page 148
[109] Transcript, page 148

6.23. The CCTV footage shows CO Cattanach returning to Cell 305 with her phone which he seemed to present to the cell before being summoned back by CO Hills a few seconds later. He gave the phone to CO Hills who leaves and calls the ambulance.[110]

6.24. The delay in calling the ambulance upset Ms Irish.[111]

6.25. Ms Irish gave an interview to DCS on 9 August 2018.[112] She outlined in brief what she did during this emergency situation, including describing that Mr Darren Hills, a fellow CO4 officer, had come down to assist her in the coordination of this matter.

6.26. Ms Irish was an experienced a dedicated CO with a wide range of experience of duties within YLP admission of prisoners through to her position as OIC. She ensured that the YLP control room logbook[113] accurately reflected the time the ambulance was called at the time. This was noted by a junior officer, Ms Dobbin. Ms Irish insisted the YLP logbook note be done, even if it might be to her detriment.[114] Finally, she commented on the fact that it was against YLP policy and procedures for a prisoner to take his mattress off the bunk and put it on the floor to sleep. She believed, unlike Mr Shillabeer, it was not common practice for that to happen.[115]

6.27. <u>CO Martin Crowe</u>

6.28. Mr Crowe had 20 years of working experience at YLP. He was a CO2. On 5 July 2018 he was working in E Division and knew Mr Trotta well as a prisoner. He described him as '*Quiet, easy to get along with. A good prisoner*'.[116]

6.29. He was one of the first officers at Cell 305. He was there when Mr Trotta's cell door was opened and he described seeing Mr Trotta being assisted by the nurses, including the connection of '*a defib machine*' to him.[117]

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[110] Transcript, page 149
[111] Transcript, pages 149-150
[112] Exhibit C9a, Transcript of Interview
[113] Exhibit C41
[114] Transcript, pages 191-193
[115] Transcript, pages 169-170
[116] Transcript, page 201
[117] Transcript, page 209

6.30. He played an active role in the attempted resuscitation by supporting Mr Trotta's head and making sure his airway was clear. As the nurses tired, Mr Crowe assisted them by performing chest compressions.[118]

6.31. He did not hear anyone talk about calling an ambulance, other than whilst doing compressions hearing Mr Cattanach if the nurses could make that call.[119] He was unsure as to what happened about that after the request was made.

6.32. He agreed that usually for an emergency medical situation outside of the YLP Health Centre, the OIC would make a call or delegate it to another CO.[120]

6.33. In further evidence, he accepted the proposition that nursing staff were busy from the time they entered the cell, basically being '*flat out*'.[121] Based on that he easily concluded that the nursing staff were too busy to ring SAAS themselves. He responded to CO Cattanach's request that they call SAAS by saying words like '*the nurses are busy, can't you do it?*'.[122]

6.34. He was not aware of the situation of a delay in calling SAAS until 6 July 2018 and therefore did not mention it in his statement made on the night to SAPOL at about 10:20pm. I accept his evidence. He was reliable and credible. He also did everything he could to help Mr Trotta.

6.35. <u>CO Darren Hills</u>

6.36. Mr Hills is an experienced CO with a rank of CO4 as at July 2018. He has been employed by DCS since 2008 and worked predominantly at YLP. He is now a CO7.

6.37. On 5 July 2018 he was working as a supervisor in the holding cells. These are used for admitting new prisoners and transferring of prisoners to court and or other DCS institutions. He had a good working relationship with Ms Irish.

6.38. In his experience, for a Code Black, SAPHS would usually initiate contact with SAAS. He noted that most Code Blacks result in the prisoner ending up in the SAPHS and that a situation such as Mr Trotta's was '*rare*'.[123]

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[118] Transcript, page 210
[119] Transcript, page 211
[120] Transcript, pages 215-216
[121] Transcript, page 217
[122] Transcript, page 218
[123] Transcript, page 233

6.39. He had a good opinion of Mr Trotta who he found to be a '*friendly prisoner*'[124] with significant deafness. He understood the need to communicate slowly with him to allow lip reading. Mr Hills accepted that Mr Trotta relied on his cellmates to assist with communication. He was not aware of Mr Trotta's long standing physical health problems.

6.40. On the night of 5 July 2018, Mr Hills became aware of the Code Black being called for Mr Trotta. He also heard information from Ms Irish over the radio system that an ambulance had been called. In his experience that required a lot of organisation and appropriate documentation to be completed so he offered to assist her, in particular with the paperwork.[125]

6.41. Once the necessary paperwork was completed he left the holding cell area and went to E Division in the area of Cell 305. Ms Irish was on the office landline phone when he arrived. He handed her the paperwork.

6.42. Mr Hills went down to Cell 305 and soon established, in less than a minute, that SAAS had not been called. He immediately went back to the '*fishbowl*' to let Ms Irish know. At that point he noticed '*panic on her face*'.[126] She handed her portable phone to CO Cattanach and told him to ring an ambulance.

6.43. CO Cattanach declined to call SAAS and walked towards the cell where he attempted to pass the phone to the nurses. Mr Hills gestured CO Cattanach to return, took the portable phone and called SAAS himself.

6.44. Mr Hills believed CO Cattanach should have called SAAS once told to by OIC Ms Irish. Once he believed her order was not being carried out by CO Cattanach, he took control and made the call himself.[127] The conclusion he made is consistent with that of Detective Tiss in her report, namely that someone from DCS needed to make the call in these circumstances.[128]

6.45. Mr Hills was referred to the Standard Operation Procedure[129] for DCS Code Black situations which dictate that the control room should generally contact SAAS.[130]

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[124] Transcript, page 236
[125] Transcript, page 238
[126] Transcript, page 241
[127] Transcript, pages 241-242
[128] Exhibit C27, page 31
[129] SOP
[130] Transcript, page 312

6.46. This procedure is recognised in what is known as the Local Interpretation Statement[131] for YLP. LIS' are allowed to be developed within each prison so as to reflect the best system within that prison to achieve the outcomes necessary for situations such as a Code Black.

6.47. YLP responded to Code Black situations in accordance with its LIS.[132] Mr Hills was referred to a note he made hours after Mr Trotta's death on a standard DCS form called the employee report form.[133] Part of his reason for making an extensive note was due to what had happened that evening with the call being delayed to SAAS.

6.48. I set out part of that note as follows:

> 'Whilst standing at the top of the barrier I observed a nurse pop her head out of Cell 305 and ask towards the top of the wing for an ETA for SAAS, to which I heard from an officer say I thought you'd called the Ambulance. At this point the OIC had thought SAPHS had called the Ambulance and after realising it hadn't she gave the phone to the officer who then declined to ring and proceeded to Cell 305 and told SAPHS to ring it. At this point I was walking down the wing towards Cell 305 and heard SAPHS state can you please ring them as we are currently under CPR. Again nothing happened so I took the phone from the officer and called 000 myself, this was approximately 1940 hours. I was then on the phone to the operator providing updates on the prisoner until SAAS had arrived in the Unit at 1947 hours.'

6.49. I believe this note basically encapsulated Mr Hills' evidence and obvious endeavours that night to end the impasse that had been created about calling SAAS.

6.50. Although he later accepted that Ms Irish had made a '*request*' to CO Cattanach rather than a direction,[134] he pointed out that a direction was a '*last resort when a request had been refused*'.

6.51. He did accept the proposition that if Ms Irish had said to CO Cattanach to take the phone down for the nurses to call the ambulance before he arrived on the scene his opinion of the situation concerning the cause of the delay would change.[135] Even so, I will still need to analyse the reactions of CO Cattanach to what he saw of the CPR and chest compressions in Cell 305 and why he did not react to call SAAS himself, especially as the nursing staff were still busy trying to save Mr Trotta.

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[131] LIS
[132] Exhibit C44c; Transcript, pages 313-315
[133] Exhibit C1c
[134] Transcript, page 352
[135] Transcript, pages 353-354

6.52. Mr Hills noted that he had never had the experience of a CO2 being reprimanded for calling an ambulance.[136]

6.53. CO Simon Cattanach

6.54. Mr Cattanach began his career as a CO in 2009 at Port August Prison. In 2014 he transferred to YLP. In 2019 he was promoted from CO2 to CO3.

6.55. To his credit, he cooperated with SAPOL on the night of 5 July 2018 by providing a statement to SAPOL[137] and completing an employee report form.[138] Further, he took part in a record of interview with DCS Investigations on 9 August 2018.[139]

6.56. Later, on 17 September 2018 he supplied a further statement to SAPOL concentrating on the issue of the phone call and his possession of the portable phone.[140] In this statement he confirmed that he took the phone from Ms Irish in an area near the fishbowl and returned to Cell 305. He believed his instructions were to hand the phone to the nurses for them to call SAAS.

6.57. When SAPHS understandably refused given that they were performing emergency first aid, he returned to Ms Irish with the phone and told her '*they're not making the phone call*'.[141] He explained that he was ordered to go back to them as Ms Irish told him '*they needed to make the phone call*'.[142]

6.58. He handed the phone to the male nurse[143] and told him that he needed '*to make the phone call*'. The '*male medic*' took the phone off him and put it to his ear.

6.59. His evidence was about '*10 minutes later or thereabouts*'[144] the nurses asked what time the ambulance was arriving. Mr Cattanach replied that they had made the call to which they confirmed that they did not. Mr Cattanach asked where the phone was to which they said they did not know. He went into the cell and found it on the bottom bunk. He took the phone back to Ms Irish and told her that an ambulance had not been called.

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136 Transcript, page 354
137 Exhibit C6
138 Exhibit C6b
139 Exhibit C6c
140 Exhibit C6a
141 Exhibit C6a, paragraph 10
142 Exhibit C6a, paragraph 10
143 Which must be Joseph Penaflorida
144 Exhibit C6a, paragraph 12

Consistent with her evidence he said that she swore. CO Hills then took charge of the phone.

6.60. When examining this evidence and comparing it with the CCTV footage, it becomes apparent that his involvement is as follows. At 7:30:05pm Mr Cattanach arrives at Cell 305 with the phone. He is seen to go into the cell briefly and then remain outside looking in until 7:32:46 when he leans in and grabs the phone and gives it to Ms Irish. She had arrived at the cell at 7:31:06. At that time there were a total of six COs outside the cell door with Mr Cattanach being the closest to the cell.

6.61. Once she had arrived Ms Irish was continually talking into her walkie talkie and directing the other COs. She did not talk to Mr Cattanach who was spending his time staring into the cell.

6.62. At 7:34:24pm Ms Irish left the Cell 305 area. At 7:36:52 Mr Cattanach left before returning at 7:37:15. At 7:37:35 he left the Cell 305 area and as he was walking towards the fishbowl he caught the cordless phone that had been thrown to him at 7:37:42. He returned to Cell 305 before being summoned by CO Hills to give him the phone, which he did at 7:38:05.

6.63. The CCTV footage showed that Mr Cattanach spent a long time watching the resuscitation attempts.

6.64. It was submitted that if Mr Cattanach did not know if SAAS had been called, he must have been not paying attention or absorbing anything that was happening directly in front of him. That was a fair submission.

6.65. Indeed, at 7:37:52pm it appeared that the issue of the failure to call SAAS came to a flashpoint between SAPHS nurses and Mr Cattanach when it was fully realised by all there that SAAS had not been called.

6.66. Mr Cattanach gave extensive evidence about these minutes in front of Cell 305, together with his perception of what Ms Irish had directed him to do. He maintained he was to take the phone to the medics for them to call the ambulance.[145]

[145] Transcript, page 440

6.67. As earlier described, he was also firm in his view that the ambulance had been called by the medics. He maintained that nurse Joseph Penaflorida had '*put the phone up to his ear*'.[146] He was referred to his interview with DCS on 9 August 2018 where he described that the medics were '*quite flustered and um, sort of half remember that 2 of them were working on Trotta*'.[147] He described the third medic as '*getting machines ready and writing down stuff, which he refused to make the phone call*'.[148] This evidence about Mr Penaflorida putting the phone to his ear was the first mention of this event by him. Mr Penaflorida did call SAAS from the '*officers' station*', but this was after CO Hills called. He discontinued the call when CO Hills indicated that he was on a call with them.[149]

6.68. He admitted that despite his concern about the delay in calling SAAS, he did not make any reference to this issue in his employee report form,[150] nor in his statement to SAPOL. He denied this was a deliberate omission.[151] He believed that effectively Mr Trotta had died once he saw him stop breathing prior to the arrival of SAPHS.[152] Further, in his opinion his task was complete once he took the cordless phone to the cell.[153]

6.69. He failed to inform Ms Irish that the nurses were very busy after he arrived with the phone for them to call SAAS as he said he was ordered. He admitted not taking any proactive steps to allow him or another CO to ring SAAS because he was '*just following what the OIC's instructions was to get them to make the phone call; she was quite assertive over that, you know, "Make them make the phone call"*'.[154]

6.70. In response to a question concerning hindsight and whether he would have done anything differently to tell Ms Irish about the difficulties of the medical staff with Mr Trotta, he said it was '*quite possible*'.[155] If this emergency happened outside of the prison walls, he would not have hesitated to call SAAS.

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[146] Transcript, page 447
[147] Exhibit C6c; Transcript, page 453
[148] Exhibit C6c; Transcript, page 453
[149] Exhibit C14, Affidavit of Joseph Penaflorida sworn 24 October 2018
[150] Exhibit C6b
[151] Transcript, page 459
[152] Transcript, page 461
[153] Transcript, pages 465-466
[154] Transcript, page 493
[155] Transcript, page 493

7. Findings

7.1. I now come to the findings that I believe are warranted based on the evidence. I refer again to hindsight and outcome bias as earlier expressed in this Finding. I also refer to the general concession by Dr Turnbull about the deficiency in the care of Mr Trotta and the inadequacy of the SAPHS records, in particular concerning Mr Trotta's discharge from the QEH into DCS custody. I refer to the important omissions of significant medical conditions suffered by Mr Trotta, in particular COPD.

7.2. Late into the Inquest I received a form developed by SAPHS after Mr Trotta's death.[156] This form was explained by SAPHS through Mr Andrew Wiley, Director of SAPHS since May 2021. This form simplified the task of accurately recording a prisoner's health profile compared with the forms relevant in 2018. As explained by him:

> 'The form, which can be issued any time a SAPHS medical or nursing staff member becomes aware of any significant medical/health issue or a change in status with respect to a medical/health issue, alerts DCS to a prisoner's health status and highlights what DCS and its staff need to be aware of and what steps ought to be taken to ensure a prisoner's wellbeing.' [157]

7.3. I am satisfied that this form will likely reduce the type of error that followed Mr Trotta's admission in February 2018 to YLP. It is a standard form for any change in health status that may occur for a prisoner whilst in custody. The error concerning recording Mr Trotta's medical conditions would have been less likely with this simplified form.

7.4. Personal circumstances of Mr Trotta

7.5. Mr Trotta was one of four children born to his parents who emigrated to Australia from Italy in 1962. He began, but did not complete, Year 11 at Campbelltown High School where unfortunately his deafness was not diagnosed. Upon leaving school he worked briefly as a packer and forklift driver and later for his brother who was a builder.

7.6. However, unfortunately since he was 22 he suffered a '*psychotic mental episode*' which caused him to be placed on the disability pension.[158] As earlier stated, he was on remand for the charge of arson and was taken into DCS custody on 14 February 2018.

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[156] Exhibit C50
[157] Exhibit C51, paragraph 5
[158] Exhibit C27, pages 14-15

7.7. Physical health

7.8. I have already outlined his physical ailments, including COPD. During his time in custody, and in particular once housed in E Division at YLP with Mr Stubing from 24 June 2018, Mr Trotta's physical health was poor. I accept the accuracy of Mr Stubing's description of Mr Trotta's health during the time he was sharing the cell with him, namely suffering a sore back, and from on or about 2 July 2018, persistent coughing, fatigue and complaining of a chest infection. From this date until his death, save for meeting his solicitor, Mr Trotta did not leave his cell and was not eating.

7.9. Mr Trotta's last days 2 July - 5 July 2018

7.10. On the night of 2 July 2018, at about midnight, Mr Trotta requested an inhaler which was supplied. Upon receipt of that at that time he immediately took two puffs, but no further assessment of his health was undertaken or considered. That was a missed opportunity to assess him further, despite no complaints about his state of health having been made.

7.11. The last time Mr Trotta was at a SAPHS health centre was in the ARC on 21 June 2018 during a two-day stay. The opportunity for medical intervention prior to his death in this period was missed from the night of 2 July 2018 when he obviously needed his puffer, as well as CO Shillabeer taking control of the situation that Mr Trotta was not ready as required in the mornings when the cell door was unlocked. CO Shillabeer, was not expected to make any medical assessment. This issue could have been solved by asking him whether he was sick. A referral to SAPHS in order to gauge whether Mr Trotta was simply being defiant or malingering rather than being markedly unwell was also warranted. At the very least, his coughing was a prima facie indicator that he needed some treatment.

7.12. I do not accept CO Shillabeer's evidence that he made contact with SAPHS as he suggested in evidence. He had no positive memory of doing so which he only admitted in follow-up questioning on this topic. Mr Trotta remained in his cell on 3 and 4 July 2018. He basically was not eating and was coughing continually. He complained to his cellmate of a chest infection.

7.13. At 9am on 5 July 2018 Mr Trotta saw his solicitor, Ms Johnson, in an interview room. She noticed he was distinctly unwell with a bad cough. She was under the misapprehension that he had been seen the previous day by SAPHS. He was coughing

up phlegm that was visible to Ms Johnson. On the contrary, Mr Trotta had not sought medical nor had received any attention concerning his medical condition.

7.14. During this time period he had received his usual medications twice daily from SAPHS, but due to such limited and brief contact through the trap door of his cell, no meaningful assessment could be made about his physical condition.

7.15. I agree with the description of him made at the Inquest that overall he was a very vulnerable member of the YLP prison population. The was due to his mental health problems and physical problems including his chronic deafness which affected his communication skills.

7.16. During this three-day period no proactive actions were taken by YLP COs to have him medically assessed. This was despite the fact that he did not leave his cell during that time period before his death other than to see Ms Johnson as already described.

7.17. There is only one official note concerning his medical condition in the YLP records during that time, which was an entry placed in the Prison Information System by CO Shillabeer. Having regard to all the evidence I find that this note was made, not as an indicator to be concerned about Mr Trotta's health, but for the purpose of recording that he had failed to be ready for unlock as required on 3 and 4 July 2018.

7.18. The inaction at the YLP in this critical time period dramatically reduced Mr Trotta's chances of preventing death.

7.19. I make this finding based on my total acceptance of Professor Kelly's assessment and opinion of this time period with respect to possible medical interventions that were not done.

7.20. I accept Dr Turnbull's evidence that even a simple escalation in care on the night of 2 July 2018, when the puffer was provided, may have changed the course of events for Mr Trotta. He stated that an assessment could have been undertaken by the use of a simple saturation probe that neatly sits at the end of the finger to measure oxygen saturation rates and pulse rates.[159]

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[159] Transcript, page 552

7.21. This would have been even more desirable had the prison records accurately reflected Mr Trotta's COPD condition as it should have done.

7.22. As he put it, '*the most logical and practical step would be review the next day at the health centre*'.[160] As Professor Kelly clearly said, a consultation at the health centre of YLP would have changed the course of events for Mr Trotta.

7.23. <u>Evening of 5 July 2018</u>

7.24. In essence, I agree with the findings and conclusions set out in Detective Tiss' report, and particularly the quotes already set out in this Finding.

7.25. I accept Professor Kelly's opinion that by that stage, despite the delay in calling SAAS, Mr Trotta's chances of survival were extremely poor. This does not excuse the delay. This was accentuated by CO Cattanach's lack of willingness to simply call SAAS as he would have in such a situation had it been outside of prison walls.

7.26. Sometimes, the best thing is to just act and then deal with any consequences that may have followed. I doubt that any consequences would have followed had CO Cattanach simply rung the ambulance as instructed by both the nurses. Similarly he should have followed Ms Irish's revised instructions after refusing the direction of the nurses. It would have been seen by any reasonable person as a proactive and justified reaction to what he was seeing in Cell 305.

7.27. Unfortunately, I do not accept his evidence as being accurate in the exchanges he said occurred between him and Ms Irish. Where their evidence differed, I preferred the evidence of Ms Irish. She made records about the delay promptly compared with CO Cattanach who did not refer to this issue in his initial statement to SAPOL, his employee report form or DCS interview. This issue was not mentioned by him until his second statement to SAPOL on 17 September 2018.

7.28. Had he followed the example set by CO Hills of simply making a decision to call, then this segment of the Inquest would have barely required evidence about what happened in those minutes.

[160] Transcript, page 565

7.29. I make those findings and comments understanding CO Cattanach was a subordinate officer whose work routine follows a strict set of rules, guidelines and respect for hierarchy.

7.30. CO Cattanach's involvement outside Cell 305 was passive despite the fact he did realise it was an emergency. Perhaps this passive response was also influenced by his assessment that Mr Trotta's life was not retrievable after he believed he stopped breathing. The contrast between his actions and those of CO Crowe is enormous. CO Crowe did almost everything he could to save Mr Trotta. The best that can be said on the evidence for CO Cattanach is that he doggedly followed what he thought were his instructions and did not react to what was in front of him. In the end, this issue did not affect Mr Trotta's fate that night.

8. Summary

8.1. Overall, Mr Trotta's treatment and care by YLP was deficient to him regarding the need for accurate medical information to be recorded and easily accessible to those that needed to know it. This is particularly so given his vulnerability. His death was not a sudden, unexpected decline in health from a fully fit state, but rather as a result of a lingering untreated condition on a background of serious medical and mental health ailments. I accept Professor Kelly's observations that the deficiencies in his care were not acceptable for the reasons she expressed and as set out in this Finding. In line with her evidence, I find his death was at least potentially preventable.

9. Recommendations

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

9.2. It is a difficult task to contemplate and then make recommendations to cover situations such as a medical emergency. The basic principle is to try to do the best one can to ensure everything has been done that needs to be done. For Mr Trotta on the evening of 5 July 2018, this was to provide the best possible immediate first aid response and to ensure SAAS were notified to attend as soon as possible.

9.3. Likewise, for the previous days it is also difficult to make recommendations that rely on basic principles of observation and care for a vulnerable, unfit 58-year-old man that should have resulted in Mr Trotta having a considered medical assessment.

9.4. For long-term matters, such as the vital need for accurate medical information to be stored and available with relative ease when required, this is a more tangible task.

9.5. I am told and accept that DCS are fundamentally upgrading their electronic data storage system including for medical services for people in custody.[161] In particular, a system called '*iSAFE*' will replace the system that had the unfortunate capacity to produce a '*buried screen of medical history*'.[162]

9.6. In the end, I am satisfied that the DCS has been undertaking a substantial upgrade to its system of electronic records and notes. Their system needs to allow DCS staff to be able to have authorised access to these records that are relevant to a prisoner's day to day care and welfare within proper boundaries of confidentiality.

9.7. Code Black policy

9.8. I have referred to the SOP and LIS for this emergency situation. In my view the SOP and LIS have set out procedures that strictly read are inflexible about what should be done. In dynamic situations that inevitably exist in Code Black calls, flexibility of instructions needs to be acknowledged and sanctioned by operating procedures.

9.9. Therefore, I make the following recommendation directed to the Minister for Correctional Services and the Chief Executive of the Department for Correctional Services:

1. The Standard Operating Procedure for DCS regarding Code Black calls in correctional institutions be reviewed to consider including terms of reference for direction of orders and requests by SAPHS medical staff to COs during a Code Black emergency.

[161] Transcript, page 653
[162] Transcript, page 653

2. This recommendation assumes that the Minister will invite submissions and consultation with SAPHS and authorised representatives of the Correctional Services Officers.

9.10. Ms Gina Barozzi

9.11. Finally, I would like to acknowledge the presence throughout the Inquest of Mr Trotta's sister, Ms Gina Barozzi, who also provided important personal details about him to Detective Tiss in her investigation.[163]

Key Words: Death in Custody; Prison; Delayed Medical Assistance; Natural Causes

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 10th day of November, 2023.

Deputy State Coroner

Inquest Number 54/2020 (1242/2018)

[163] Exhibit C20, Statement of Ms Barozzi