STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Edward Haenga
Hearing dates:	23 to 27 October 2017
Date of findings:	6 November 2017
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, psychotropic medication, QT interval prolongation, metabolic monitoring, metabolic syndrome, Junee Correctional Centre, cardiac arrhythmia, medication chart, administration of medication
File number:	2013/177495
Representation:	Mr P Aitken, Counsel Assisting, instructed by Ms C Berry, Crown Solicitor's Office Mr R Weinstein SC instructed by Tresscox Lawyers (for Dr M Jones) Mr S Barnes instructed by Avant Law (for Dr S Roberts) Ms T Berberian instructed by Sparke Helmore (for The GEO Group Australia Pty Ltd) Ms Douglas-Baker instructed by the Office of General Counsel (for Corrective Services New South Wales) Ms R Mathur instructed by Hicksons Lawyers (for Justice Health and Forensic Mental Health Network) Ms M O'Halloran instructed by the NSW Nurses and Midwives Association (for Ms J Workman) Ms R Patterson of Marsdens Law Group (for Mr Pepe Haenga) Mr T Saunders instructed by Meridian Lawyers (for Dr T Chew)

Non-publication orders: Pursuant to section 74(1)(b) of the *Coroners Act 2009* I direct that the following material is not to be published:

1. Sections 12.4.16 to 12.4.16.4 inclusive of the September 2012 extract from the Corrective Services NSW (CSNSW) Operation Procedures Manual, tendered as Exhibit 2 in the inquest which commenced on 23 October 2017;

2. Sections 12.4.16 to 12.4.16.4 inclusive of the February 2016 extract from the CSNSW Operation Procedures Manual, tendered as Exhibit 2 in the inquest which commenced on 23 October 2017;

3. Sections 4.1.6 to 4.1.11 inclusive and Section 4.4 in its entirety of the Junee Correctional Centre Operating Manual – Medication Administration Policy, dated 29 June 2012, tendered as Exhibit 2 in the inquest which commenced on 23 October 2017.

4. Sections 4.1.6 to 4.1.13 inclusive and Section 4.4 in its entirety of the Junee Correctional Centre Operating Manual – Medication Administration Policy, dated 21 April 2017, tendered as Exhibit 15 in the inquest which commenced on 23 October 2017.

Findings: I find that Mr Edward Haenga died sometime between 10:00pm on 8 June 2013 and 7:15am on 9 June 2013. Mr Haenga died at the Metropolitan Special Programs Centre at Long Bay Correctional Complex in Matraville NSW where he was in lawful custody serving a custodial sentence. The cause of Mr Haenga's death was cardiac arrhythmia. Mr Haenga died from natural causes in circumstances where complications from his morbid obesity and his use of multiple, concurrent psychotropic medications which carried the risk of QT interval prolongation, contributed to him suffering a fatal cardiac arrhythmia.

Recommendations:

1. To the Chief Executive, The GEO Group Australia Pty Ltd (GEO):

I recommend that:

(a) Junee Correctional Centre (Junee), as part of its metabolic monitoring policy, adopt the Justice Health and Forensic Mental Health Network (Justice Health) guideline, *Psychotropic Medications – Guidelines for prescribing and monitoring use within custodial and forensic mental health settings 2017,* and the associated NSW Ministry of Health Information Bulletin, *Metabolic Monitoring, New Mental Health Clinical Documentation Module* (dated 27/7/2012, IB2012_024); and

(b) GEO review its current *Medication Administration Policy* dated 21 April 2017 (*MAP*) to ensure that it accurately reflects the equivalent provisions in the Justice Health Medication Guidelines 2017, including, but not limited to, clauses 4.7.1 and 4.14.8 of the *MAP*.

2. To the Director, Justice Health and Forensic Mental Health Network, NSW (Justice Health):

I recommend that the resource currently used by GEO and Justice Health titled, *Metabolic Syndrome, From Monitoring to Management, A Resource for Health Professionals (2011),* be revised to include:

(a) the provision of sufficient information and guidance to clinical staff regarding the use, and relevance, of baseline and ongoing electrocardiogram (ECG) testing as part of metabolic monitoring; and

(b) to cross-refer to the recommended clinical timeframes for ongoing ECG testing as set out in the Justice Health guideline, *Psychotropic Medications – Guidelines for Prescribing and Monitoring Use Within Custodial and Forensic Mental Health Settings 2017*, in particular in relation to additional monitoring recommended for specific antipsychotic medication.

Recommendations:

3. To the Director, Justice Health and the Chief Executive, GEO and the Commissioner for Corrective Services New South Wales (CSNSW):

I recommend that GEO, Justice Health and CSNSW work collaboratively to provide further targeted education and training, through the use of Justice Health nurse education consultants, to GEO clinical staff in relation to medication administration requirements pursuant to the *Justice Health Medication Guidelines 2017*, in particular in relation to clauses 6.2.9 and 6.7.2.

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1. Introduction

1. Mr Edward Haenga was serving a custodial sentence at the time of his death. He had been in custody for almost 16 years and was due to be released in December 2013. During the evening of Saturday 8 June 2013 Mr Haenga spoke to his father on the phone and told him that he was looking forward to starting a new work program on the following Monday. Tragically, Mr Haenga was never able to start that program or be released from custody. On the morning of Sunday, 9 June 2013 Mr Haenga was found in bed, unresponsive, inside his cell. Despite resuscitation attempts he could not be revived and was pronounced deceased.

2. Why was an inquest held?

2. A Coroner's function and the purpose of an inquest are provided for by law as set out in the *Coroners Act 2009* (the Act). All reportable deaths must be reported to a Coroner or to a police officer.

3. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. This is because when a person is imprisoned or held in lawful custody as a result of breaching a law, the State, by depriving that person of their liberty, assumes responsibility for the care of that person. It is necessary to ensure that the State discharges its responsibility appropriately by independently and transparently examining the circumstances surrounding that person's death.

4. Once a person's death is reported to a Coroner, the Coroner has an obligation to investigate matters surrounding the death. This is done so that evidence may be gathered to allow a Coroner to fulfil his or her functions. A Coroner's primary function is to answer questions about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances surrounding their death and the events leading up to it.

5. In Mr Haenga's[1] case, ample evidence was gathered during the investigation following his death to allow the questions about his identity and where and when he died to be answered. The inquest was primarily focused on the cause and manner of Mr Haenga's death. In other words, what happened in the months and days leading up to 9 June 2013, and how did events during this period of time impact upon Mr Haenga and his death?

6. In the course of investigating the cause and manner of Mr Haenga's death several issues were identified. Many of these issues concerned the care and treatment that Mr Haenga received whilst he was in custody. Specifically, the issues related to the last 3 years of Mr Haenga's life when he was housed at Junee Correctional Centre (**Junee**). Unlike most correctional centres in New South Wales, Junee is privately operated by the GEO Group Australia Pty Ltd (**GEO**) under a management agreement with Corrective Services New South Wales (**CSNSW**).[2]

[1] Mr Haenga's father, Mr Pepe Haenga, requested that his son be referred to as Mr Haenga, rather than by his first name, during the inquest. In accordance with Mr Pepe Haenga's request, I have respectfully done the same in these findings.
[2] Exhibit 1, tab 67.

7. As Mr Haenga suffered from a number of physical and mental health conditions he had contact with a number of health care practitioners who worked at Junee and who were employed by GEO. Mr Haenga also had contact with a number of visiting medical officers who worked at Junee. Although Junee was a privately operated facility it still had an obligation (pursuant to the management agreement between GEO and CSNSW) to provide health care facilities and services to inmate patients to the standards of the public health care system.[3]

8. Furthermore, in providing these facilities and services GEO was under an obligation to comply with relevant policy directives, guidelines and procedures established by both the NSW Ministry of Health and the Justice Health and Forensic Mental Health Network (**Justice Health**). Justice Health is ordinarily responsible for the provision of health care services and facilities to inmate patients in correctional centres operated by CSNSW. In the last days of Mr Haenga's life he was housed at one such centre, the Metropolitan Special Programs Centre (**MSPC**) at Long Bay Correctional Complex in Matraville. Whilst there Mr Haenga was under the care of clinical staff employed by Justice Health as well as visiting medical officers.

9. The coronial investigation gathered evidence about these issues from various health practitioners directly involved in Mr Haenga's care in order to consider whether the care provided to him was adequate and appropriate. The inquest carefully examined this evidence and heard evidence from a number of independent experts who were asked to provide opinions concerning a number of issues central to the inquest. The inquest also reviewed the systems, processes, and applicable documentary policies and guidelines which governed the care and treatment provided to Mr Haenga. This review was done to consider whether any aspect of the systems and policies was deficient and, if so, whether any aspect, or aspects, could be improved upon.

3. Mr Haenga's life

10. Before going on to discuss the evidence and issues which the inquest examined it is important at this point to say a few brief words about Mr Haenga's life. As mentioned above inquests are often concerned with systems and processes and how they may be improved for the community at large. With such far-reaching intentions that may impact positively upon the broader community it is, perhaps, sometimes easy to forget that there is a single person at the centre of the inquest.

11. Inquests are often concerned with the circumstances of a person's death. These circumstances usually occupy the last few weeks, days, hours, and, sometimes, minutes, of a person's life. Usually a great deal of documentary evidence is gathered about these circumstances. However, those documents very rarely tell us much about the person who died, or the, often years, of life which preceded their death.

12. That is why it is extremely important, at the beginning of these findings, to acknowledge Mr Haenga's life and to recognise the impact that his death has had on his family.

13. Mr Haenga was born in New Zealand to his father, Pepe, and mother, Charlotte. He had 2 younger siblings, William and Rachel. In 1988 Mr Haenga and his father moved to Australia and they were joined a short time later by the rest of Mr Haenga's family.

[3] Exhibit 1, tab 67.

14. Mr Haenga went to school at Bankstown Primary School and, later, Liverpool Public School. In the early 1990s he formed a relationship with Morena Aparicio and moved to south-west Sydney. Mr Haenga and Morena had 3 children together: Amelia, Manuel, and Diego.

15. Tragically, Mr Haenga was involved in house fire in 1993 and suffered third degree burns to 70% of his body. He spent about a year in hospital and, after being discharged, regularly returned to hospital for burns treatment in the following years. According to William, this incident changed Mr Haenga as he found it difficult to readjust to life after being discharged from hospital. Mr Haenga and Morena separated a short time later and Mr Haenga lost contact with his children.

16. Sadly, around the same time Mr Haenga's mental well-being began to decline. He had been taking pain relief medication for his burns and later began to abuse illicit drugs. Mr Haenga also became involved in criminal activity and, as a result, spent some time in custody.

17. Mr Haenga later formed another relationship. Sadly this relationship ended with the death of Mr Haenga's partner and he was charged in relation to the death.

18. Mr Haenga's father described his son as having a passion for playing rugby league, which he had started doing at an early age, and for music. Mr Pepe Haenga said that his son was soft-spoken and loved his mother enormously; at a young age Mr Haenga would constantly follow his mother around and watch her cook in the kitchen. Mr Haenga was devoted to, and loved his, 3 children. He missed them enormously following the breakdown of his relationship and whilst he was in custody.

19. Mr Pepe Haenga described his son as someone who was more like a best friend to him, than a son. It was abundantly clear during some moving and heartfelt words spoken by Mr Pepe Haenga at the end of the evidence in the inquest how much he misses Mr Haenga. This fact, and the love that Mr Haenga had for his children, makes Mr Haenga's death at the young age of 37 particularly distressing.

4. Mr Haenga's custodial history

20. In December 1997 Mr Haenga was taken into custody after being charged with offences of murder and assault. It was not his first time in custody. In July 1999, following the outcome of the criminal proceedings, Mr Haenga was convicted and sentenced. In June 2000 Mr Haenga was convicted and sentenced for a number of armed robbery offences. Ultimately, the overall effect of these sentences meant that Mr Haenga would not be eligible for release to parole until December 2013.

21. After being sentenced in 1999 Mr Haenga was housed at a number of different correctional centres at Goulburn, Lithgow, Parklea, Bathurst and the MSPC. The first 13 years of Mr Haenga's sentence are not relevant to the issues considered by the inquest. Instead, the inquest focused on the last 3 years of Mr Haenga's sentence after he was transferred to Junee on 8 September 2010. Mr Haenga remained at Junee until 26 May 2013 when he was transferred back to the MSPC (via Bathurst Correctional Centre) arriving there on 27 May 2013. Mr Haenga remained at the MSPC and was discovered to be in his cell, deceased, on the morning of 9 June 2013.

5. What happened on 8 and 9 June 2013?

22. On 8 June 2013 at about 5:45pm Mr Haenga was given his prescribed medication by a Justice Health Nurse and CSNSW correctional officer. This was the last time that Mr Haenga was seen alive.

23. At about 7:15am on 9 June 2013 a CSNSW correctional officer was performing a head check in the wing where Mr Haenga was housed. The officer noticed that Mr Haenga was in bed and not moving. The officer called out to Mr Haenga and, after not receiving a response, shook the bed mattress in an attempt to wake Mr Haenga, believing him to be still asleep. When Mr Haenga did not respond the officer noticed that Mr Haenga did not appear to be breathing and an emergency radio call was made for immediate assistance.

24. A number of Justice Health nurses and CSNSW officers responded to the call. Cardiopulmonary resuscitation was commenced in an attempt to revive Mr Haenga but he remained unresponsive. NSW Ambulance paramedics were called and they arrived at the scene at about 7:32am and continued the attempts to revive Mr Haenga. However this was also unsuccessful and Mr Haenga was pronounced deceased at 7:35am.

6. What was the cause of Mr Haenga's death?

25. After being discovered in his cell on the morning of 9 June 2013, Mr Haenga was later taken to the mortuary at the Department of Forensic Medicine in Glebe where an autopsy was performed by Dr Kendall Bailey on 12 June 2013. Following her examination Dr Bailey prepared a report dated 4 February 2014.[4]

6.1 Autopsy Findings

26. In her autopsy report Dr Bailey noted that Mr Haenga had an enlarged heart (cardiomegaly). That is, Mr Haenga's heart weighed more than would normally be expected for someone of his height. Dr Bailey explained that heart enlargement increases the risk that a person will develop cardiac failure (the failure to adequately move blood around the body) and sudden potentially fatal cardiac arrhythmias (abnormal heartbeats). Dr Bailey also explained that Mr Haenga was obese which increased his risk of developing cardiac disease, such as high blood pressure (hypertension), and metabolic disturbances, such as diabetes and increased cholesterol levels. Dr Bailey ultimately concluded in her report that the cause of Mr Haenga's death was cardiomegaly, with obesity being a significant condition which contributed to his death.

27. In evidence during the inquest Dr Bailey said that if she had written her autopsy report in 2017 she might have recorded the cause of death as being complications of morbid obesity. This is because what Dr Bailey could demonstrate from the clinical findings at autopsy was that Mr Haenga had a body mass index (**BMI**) of over 60[5] and that his heart weight was outside what would be expected for someone of his height. Dr Bailey also pointed to other significant findings such as the fact that Mr Haenga had a large fatty liver, Hepatitis C, and early cirrhosis (all of which pointed to some level of liver dysfunction), along with some respiratory dysfunction. All of these findings would have impacted upon Mr Haenga's metabolic processes. But Dr Bailey was

[4] Exhibit 1, tab 3.
[5] A healthy BMI for an adult is typically between 18 and 25.

unable to point to any clinical finding which confirmed what this impact was. This is because, as she explained, these physiological processes cannot be demonstrated at autopsy.

28. In her report Dr Bailey referred to the toxicological testing that was conducted on a blood sample taken from Mr Haenga. That testing revealed the presence of a number of prescription drugs such as escitalopram, amisulpride, codeine, quetiapine and methadone. The therapeutic effect of these drugs, their side effects, and the reasons why they had been prescribed to Mr Haenga will be discussed in more detail later in these findings. Dr Bailey found that the concentration levels of these drugs in Mr Haenga's blood sample were consistent with what Mr Haenga's medical records indicated he had been prescribed.

6.2 Toxicology results

29. As part of the police investigation a forensic toxicologist. Dr William Allender, was asked to provide an opinion on the concentration levels of the drugs detected in the postmortem toxicological testing. In a report Dr Allender concluded that the concentrations of both citalopram[6] and codeine were outside the therapeutic ranges expected for these drugs.[7]

30. Given Dr Allender's conclusions, Dr Bailey was asked in November 2016 to clarify a number of aspects of her report.[8] Dr Bailey explained[9] that cardiac failure or cardiac arrhythmia, or a combination of the two, might have been the mechanism of death. However, because both of these are physiological phenomena it was not possible to point to any clinical findings to demonstrate either of them at autopsy.

31. Dr Bailey was also asked a number of further questions in relation to the toxicology results from the autopsy. Dr Bailey explained that whilst the levels of some medication found in the blood tests indicated, according to academic literature, that they were within the reported non-toxic range, she would defer to the opinion of an expert in toxicology.

32. As a result, Associate Professor Naren Gunja, a specialist medical practitioner in clinical toxicology, was asked to consider the toxicology results and provide a report. Associate Professor Gunja noted that the blood concentrations of both amisulpride and escitalopram were elevated. That is, they were higher than therapeutic levels.[10] In Mr Haenga's case a amisulpride concentration of 0.85 mg/L was detected where, according to Associate Professor Gunja, the therapeutic range is usually well under 0.5 mg/L. Associate Professor Gunja also explained that a escitalopram concentration of 0.66 mg/L was detected in circumstances where the usual therapeutic level is under 0.1 mg/L.

33. Associate Professor Gunja explained that these concentration levels could have been due to 2 things. Firstly, they could have been the product of post mortem redistribution. Secondly, they could represent doses that were more than the ordinary expected dose for treatment of a medical condition (a supratherapeutic dose).

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[6] Although escitalopram and citalopram are two different types of drugs, the testing methods in the laboratory where Mr Haenga's blood sample was analysed was unable to differentiate between the two drugs. As the evidence established that Mr Haenga had not been prescribed citalopram, it is accepted that the entire concentration of citalopram in the toxicology results actually represented a concentration of escitalopram.
[7] Exhibit 1, tab 10, page 5.
[8] Exhibit 1, tab 5A.
[9] Exhibit 1, tab 5B.
[10] Exhibit 1, tab 10A, page 6.

34. Post mortem redistribution is the phenomenon where drugs may shift from their original tissue compartment to a different tissue compartment. This can have the effect of increasing drug concentrations in the blood leading to a result that does not accurately indicate the true blood concentration at the time of death.[11]

35. Associate Professor Gunja thought it was more likely that the elevated level of amisulpride was due to post mortem redistribution. This is because amisulpride is lipophilic, meaning that it is capable of being dissolved in, or of absorbing, lipids (fats). This in turn means that it has a large volume of distribution and is more susceptible to post mortem redistribution. On this basis, Associate Professor Gunja also thought that it was more likely that the elevated level of escitalopram could represent a supratherapeutic dose.

6.3 Prolongation of the QT interval

36. Associate Professor Gunja explained that Mr Haenga had been prescribed a number of medications that carry the risk of prolonging the QT interval. In order to understand the cause of Mr Haenga's death, and the other issues which the inquest examined, it is necessary to briefly explain what is meant by QT interval prolongation.

37. With each person's heartbeat an electrical signal travels from the top to the bottom of the heart. As the signal travels it causes the heart to contract and pump blood. An electrocardiogram (**ECG**) is a test that records the heart's electrical activity and these signals as they move through the heart. Data from an ECG is mapped on a graph in 5 distinct electrical waves identified with the letters: P, Q, R, S and T. The QT interval is the measure of electrical activity between the Q and T waves in the heart's electrical cycle and shows activity in the heart's lower chambers, the ventricles. Normally the QT interval is about a third of each heartbeat cycle.

38. When the QT interval is prolonged it can upset the timing of the heartbeat and cause dangerous arrhythmias (irregular heartbeats). An abnormally prolonged QT interval is associated with an increased risk of ventricular tachycardia, a fast heart rate caused by improper electrical activity in the ventricles, especially a condition known as Torsades de Pointes (**TdP**).[12] Drugs which carry the risk of prolonging the QT interval are therefore known as *torsadogenic* drugs.

39. Associate Professor Gunja identified that Mr Haenga was taking:

    (a) 3 drugs (amisulpride, escitalopram and methadone) that had a high risk of prolonging the QT interval;

    (b) 1 drug (quetiapine) that had a low to moderate risk of prolonging the QT interval; and

    (c) 1 drug (pericyazine) that had a low risk of prolonging the QT interval.[13]

40. Associate Professor Gunja explained that the risk of developing TdP is often multi-factorial and can depend on factors such as abnormal heart size and shape, the use of torsadogenic drugs, and electrolyte abnormalities such as low potassium or magnesium. In evidence during the inquest he described this as a "*Swiss cheese effect*". That is, if each of these risk factors coincided at a

[11] Exhibit 1, tab 10A, page 10.
[12] Exhibit 1, tab 10A, page 8.
[13] Exhibit 1, tab 10A, page 8.

particular point in time it could lead to the risk materialising. In other words, in Mr Haenga's case, it could result in him suffering a fatal cardiac arrhythmia.

41. Associate Professor Gunja said that, from a toxicological perspective, it is recommended that drugs which prolong the QT interval not be prescribed concurrently. During the inquest two independent psychiatrists gave evidence and expressed a similar view. This issue will be discussed in more detail below. Associate Professor Gunja also expressed concern that Mr Haenga had been prescribed 3 highly torsadogenic drugs where he was known to be obese.[14]

42. In evidence, both Dr Bailey and Associate Professor Gunja agreed that even if one were to ignore the evidence of what medication had been prescribed and the toxicology results, the clinical findings still showed that Mr Haenga was at risk of sudden cardiac death. There is no evidence that Mr Haenga was suffering from QT prolongation. This is because the last time he had an ECG performed on him was in 2011, well before he was placed on the medication regime that he was on at the time of his death. Further, as explained by Dr Bailey, a fatal arrhythmia could not be demonstrated by any clinical findings at autopsy.

43. Given the agreement amongst all the experts, in pathology, toxicology, and psychiatry, as to the increased risk of QT prolongation from torsadogenic drugs, particularly when taken concurrently, it is not possible to ignore this as a factor which probably contributed to Mr Haenga's death. Dr Bailey said in evidence that it was reasonable to consider this as a factor in causing Mr Haenga's death and was not one which she was able to exclude. Associate Professor Gunja explained that QT prolongation, morbid obesity, and heart enlargement were all risk factors and that they were additive.

44. **CONCLUSION:** Complications from Mr Haenga's morbid obesity, including cardiomegaly, could have led to a cardiac arrhythmia which caused his death. Equally prolongation of the QT interval from the concurrent use of 5 torsadogenic drugs could also have led to a cardiac arrhythmia. There is no other evidence to suggest any other possible cause of death. The expert evidence established that both morbid obesity and QT prolongation are additive risk factors. It is therefore more probable than not that both of these sets of risk factors contributed to Mr Haenga suffering a fatal cardiac arrhythmia which caused his death.

7. Was Mr Haenga hoarding medication?

45. The elevated levels of amisulpride and escitalopram identified by Associate Professor Gunja raised a further question. That is, could these elevated levels be due to the fact that Mr Haenga had been hoarding medication he had been prescribed, and consuming them in larger doses than were intended by the prescribers of this medication? In examining this question I will only concentrate on the level of escitalopram as Associate Professor Gunja thought that it was more likely that this, rather than the amisulpride, possibly represented a supratherapeutic dose.

46. Mr Haenga's medication charts reveal that he received doses of escitalopram 30mg each day between 5 June 2013 and 9 June 2013[15]. Mr Haenga was transferred from Junee to the MSPC (via Bathurst) arriving on 27 May 2013. After his transfer, in accordance with CSNSW guidelines[16] his cell was searched 3 times: on 30 May 2013, 2 June 2013 and 4 June 2013. Hoarded

[14] Exhibit 1, tab 10A, page 8.
[15] Exhibit 3, page 327.
[16] Exhibit 2.

prescription medication is deemed to be contraband. If found by CSNSW officers the medication is seized and reported to Justice Health. In Mr Haenga's case no hoarded medication was found during any of the 3 searches.[17]

47. It is theoretically possible for Mr Haenga to have been given his escitalopram on any day between 5 June 2013 and 9 June 2013 and to have not taken it, with the intention of hoarding it. As escitalopram is not a type of drug which requires Justice Health staff to supervise a patient taking it, Mr Haenga could have not taken it on one day and then taken it, along with another dose, on another day. However, there is no evidence to establish, or even suggest, that Mr Haenga had ever hoarded any medication he had been given, either at Junee or after he arrived at the MSPC in May 2013.

48. **CONCLUSION:** The elevated levels of escitalopram and amisulpride detected during postmortem toxicological testing were due to postmortem redistribution. There is no evidence that Mr Haenga hoarded either medication and took supratherapeutic doses of them to explain the elevated levels.

8. When did Mr Haenga die?

49. The medical evidence does not allow for a conclusive answer to this question. As Dr Bailey explained in evidence at the inquest, the onset of rigor mortis after a person's death is variable and very inexact. Dr Bailey said rigor mortis had been documented in ranges between minutes up to 24 hours. Due to this high degree of variation, Dr Bailey said that it is not possible to give an estimated time of death based on rigor mortis.

50. However, the toxicology results may shed some further light on this issue. Mr Haenga was given 2 tablets of Panadeine Forte, along with his other medication, at about 5:45pm on 8 June 2013. Panadeine Forte consists of both paracetamol and codeine. Associate Professor Gunja explained[18] that the toxicology testing did not detect any paracetamol, meaning that it had been metabolised by the time of Mr Haenga's death. What the toxicology testing did detect was peak concentrations of codeine and its metabolites. Associate Professor Gunja explained that he would expect it would take at least 4 hours for the paracetamol to have been metabolised after the Panadeine Forte was taken.

51. **CONCLUSION:** Mr Haenga died sometime between about 10:00pm on 8 June 2013 and 7:15am on 9 June 2013.

9. Issues examined by the inquest and a Coroner's power to make recommendations

52. The inquest primarily focused on examining the care and treatment that Mr Haenga was provided with whilst in custody between June 2011 and the time of his death. Because of the way in which Junee was operated, this care was provided by clinical staff employed by both GEO (at Junee) and Justice Health (at the MSPC), as well as visiting medical officers. This examination was done to identify any inadequacies or shortcomings in care so that they might be eliminated or improved upon for the future benefit of, in this case, other persons held in custody.

[17] Exhibit 2.
[18] Exhibit 1, tab 10A, page 9.

53. From a Coroner's perspective, the power to make recommendations which might lead to such improvement is an extremely important one. This power is provided for by section 82 of the Act. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

54. The coronial investigation into the death of a person is one that, by its very nature, involves much grief and anguish. The emotional toll that such an investigation, and any resulting inquest, places on families and friends of a deceased person is enormous. A coronial investigation seeks to identify whether there have been any inadequacies or shortcomings, whether by an individual or an organisation, with respect to any matter connected with a person's death. It seeks to identify them not to assign blame or fault but, rather, so that lessons can be learnt from mistakes and so that, hopefully, these mistakes are not repeated in the future. The mere assigning of blame or fault rarely produces a positive outcome and often only serves to add to the anguish that a family member may be experiencing. If families of deceased persons must re-live painful and distressing memories that an inquest brings with it then, where possible, there should be some hope for some positive outcome. The recommendations made by Coroners are made with the hope that they will lead to some positive outcome by improving general public health and safety.

55. In this inquest Dr Andrew Ellis, an independent consultant forensic psychiatrist, was engaged to examine a number of different aspects of the care and treatment provided to Mr Haenga, and to provide an expert report for the Court. The aspects of care which the inquest and Dr Ellis focused on related to the types of medication that Mr Haenga had been prescribed, how that medication was administered to Mr Haenga, the effects of that medication on him, and whether other medical investigations were performed. These issues can be summarised as follows:

    (a) Whether Mr Haenga's medication regime, particularly in the last 6 months of his life, was appropriate, particularly having regard to Mr Haenga's comorbidities;

    (b) Whether, during the period from June 2011 to May 2013, Mr Haenga was provided with adequate health care at Junee, and whether metabolic monitoring and cardiac monitoring was, or should have been, provided to him;

    (c) Whether the recording and monitoring of Mr Haenga's medication regime was adequate.

56. I will deal with each of the issues below. In some cases shortcomings have been identified. Where necessary or desirable, I have made recommendations in the hope that systems and procedures can be improved upon.

10. The general management of Mr Haenga's physical and mental health

57. The management of Mr Haenga's health by CSNSW and Justice Health prior to his arrival at Junee in September 2010 is largely not relevant to the issues which the inquest examined. It is therefore not necessary to recount this period of time in any great detail. What is important to note is that during his time in custody, both at Junee and at other centres operated by CSNSW, Mr Haenga received care and treatment from a number of different health services: general physical health care, drug and alcohol services, and mental health care. Mr Haenga's care by these various health providers was due largely to events in his life which occurred before he

entered, and whilst he was in, custody. The different types of health care provided to Mr Haenga were:

(a) **Mental health care:** When Mr Haenga first entered custody on 30 December 1997 (after being arrested and charged for the offences that he was later sentenced for in 1999) he was diagnosed with post-traumatic stress disorder (**PTSD**) as a result of the severe injuries he sustained in the 1993 house fire. Whilst in custody Mr Haenga also disclosed that he was dealing with unresolved grief issues and had previously attempted self-harm. At various times whilst in custody Mr Haenga was found to have symptoms of paranoia, low mood, anger, depression and poor sleep. He was also diagnosed with a number of conditions including PTSD (as referred to above), bipolar disorder and antisocial personality.

(b) **Drug and alcohol issues:** Mr Haenga had a history of alcohol and illicit drug use before entering custody in 1997. After reporting further illicit drug use whilst in custody, Mr Haenga was placed on the methadone program in March 1998. Apart from a brief period in 2009, Mr Haenga remained on the methadone program during his entire time in custody up until his death.

(c) **Primary, or general physical, health care:** During his time in custody Mr Haenga was noted to be overweight and obese. Much of this weight gain may have been due to medication that he was taking, which will be discussed in more detail later. Mr Haenga also suffered from a number of different health conditions including chronic back pain, osteoarthritis in his knees, oedema in his legs and, at one point, pneumonia (for which he required hospitalisation).

58. The period of time which the inquest focused on was between June 2011 and May 2013. This is because it was on 9 June 2011 that Mr Haenga first saw Dr Matthew Jones, a psychiatrist who worked at Junee as a Visiting Medical Officer (**VMO**). At that time, Mr Haenga was also under the care of Dr Richard Baguley, the General Practitioner (**GP**) at Junee, who had first started seeing Mr Haenga some 9 months earlier on 17 September 2010. Supporting Dr Jones and Dr Baguley were a number of mental health, drug and alcohol, and primary health care nurses.

59. Dr Jones' involvement in Mr Haenga's care was prompted by a consultation that Mr Haenga had with Dr Baguley on 2 June 2011. Dr Baguley saw Mr Haenga on that day for a review as Mr Haenga had recently been hospitalised for pneumonia. Dr Baguley noted that Mr Haenga's mood was down and so referred him for a psychiatric review by Dr Jones.

11. Complexities and challenges

60. All of the medical practitioners who gave evidence at the inquest who were either directly involved in Mr Haenga's care, or had been asked to review and comment on the adequacy of it, agreed on two facts. Firstly, Mr Haenga was a complex patient to care for, and was described by Dr Ellis as "*more complex than most*" other patients in custody.[19] Secondly, because of this complexity, and the environment that Mr Haenga was in, his health care management presented a number of particular challenges. These complexities and challenges are summarised below:

[19] Exhibit 1, tab 10B, page 6.

(a) In general, there are particular constraints to providing psychiatric care to a patient within a prison environment. Dr Ellis made the general observations[20] that drug use and exposure to violence is prevalent within gaols and that dislocation from community supports is common. He explained that security takes primacy over health care, which in turn limits time that medical practitioners can spend with patients. These time limitations are further constrained by the need to triage and prioritise the most urgent cases, leaving little time for patients that do not fall within this category.

(b) Dr Jones worked at Junee one day per week. This allowed for approximately 4 hours per week for patients to be clinically assessed.[21] Due to the fly in, fly out nature of Dr Jones' position, his available time was spent not only on reviewing existing patients, but also seeing new patients, checking medical test results, and writing prescriptions.[22] In evidence Dr Jones said that on average he saw 10 patients each day he was at Junee, spending between 10 to 15 minutes with them. Between June 2011 and May 2013 Dr Jones had 10 consultations[23] with Mr Haenga. It was not uncommon for there to be a period of several weeks between each of these consultations. The infrequency of these consultations, made it difficult for Dr Jones to develop a therapeutic alliance with Mr Haenga.[24]

(c) Dr Jones estimated that in 2013 there were between 200 to 300 patients on the mental health wait list at any given time, and that many of these patients have complex and chronic mental health issues.[25] Information provided by Justice Health from their Patient Administration System (**PAS**) establishes that in May 2013 between 309 and 329 patients were on the wait list.[26] However, it was acknowledged in evidence during the inquest that not all of these patients were waiting for psychiatric review by Dr Jones; some of them may have been entered on the PAS for future appointments or follow up with a mental health nurse.

(d) Mr Haenga had a history of violent behaviour. Because of his physical size and sometimes threatening demeanour Mr Haenga could be, at times, an intimidating person to deal with.[27] When he first started seeing Dr Jones, Mr Haenga was fixated on the medication regime that he had been on and was reluctant to change it. Indeed, Dr Jones reports that Mr Haenga threatened him with violence when it was suggested that it should be changed.[28] Mr Haenga may also have been seeking to secure sedating medication.

(e) Mr Haenga presented as someone with diagnostic complexity. Dr Ellis noted[29] that previous diagnoses of PTSD, substance abuse disorder, bipolar disorder, pain disorder and personality disorder had all been considered for Mr Haenga and that because these conditions have overlapping symptoms they could have been easily confused with each other. Dr Ellis also noted that Mr Haenga could well have had all of these conditions.

(f) Arriving at a certain diagnosis would have required a comprehensive review of Mr Haenga's clinical records and past history. Features such as Mr Haenga's mood symptoms, behavioural

[20] Exhibit 1, tab 10B, page 11.
[21] Exhibit 1, tab 9DA, para 2.
[22] Exhibit 1, tab 10C, para 133.
[23] Two additional consultations were scheduled but Mr Haenga did not attend them.
[24] Exhibit 1, tab 10C, para 139.
[25] Exhibit 1, tab 9D, para 6.
[26] Exhibit 9.
[27] Exhibit 1, tab 9D, para 11.
[28] Exhibit 1, tab 9D, para 19.
[29] Exhibit 1, tab 10B, page 6.

disturbances and how his changing medication regime affected these factors would have been required. In particular, there was limited access to potentially relevant medical investigations (such as cerebral imaging) and to collateral information from Mr Haenga's family about his background and past history.[30] Time and resource constraints also did not allow for this type of comprehensive review to be performed.

(g) Due to these constraints, management of Mr Haenga's condition or conditions was done primarily through pharmacology, that is, the prescribing of various types of medication. However, Dr Ellis pointed out this alone was unlikely to result in remission of Mr Haenga's symptoms or more stable behaviour.[31] Whilst medication could assist with things such as mood stabilisation and improved sleep and concentration, it was unlikely on its own to bring about improved insight, motivation and interpersonal skills. The added difficulty was that there was an absence of alternatives to pharmacological treatment, and that Mr Haenga had a number of presumed conditions which could have benefited from it.[32]

12. Was Mr Haenga's medication regime appropriate?

61. In order to examine whether Mr Haenga's medication regime was appropriate it is first necessary to provide some detail about that regime and the prescribing rationale behind it. Apart from its appropriateness, Mr Haenga's medication regime also raised other issues which are discussed below.

12.1 What psychotropic[33] medication was Mr Haenga taking?

62. During his first consultation on 9 June 2011 Mr Haenga told Dr Jones that he had previously been diagnosed with bipolar disorder and PTSD. As a result Mr Haenga was already taking medication that had been prescribed by another psychiatrist in the 9 months before he first met Dr Jones. The relevant medication that Mr Haenga was taking by 9 June 2011 is summarised below:

(a) ***Sodium valproate***[34] (also known as valproic acid), an anti-epilepsy drug used as a mood stabiliser for the treatment of bipolar disorder;

(b) ***Quetiapine***[35], an antipsychotic drug used for the treatment of psychotic disorders like schizophrenia. This had been prescribed to Mr Haenga to treat his diagnosed bipolar disorder and PTSD;

(c) ***Gabapentin***, an anticonvulsant that is also used to treat nerve pain which had been prescribed to Mr Haenga for his chronic back pain; and

(d) ***Methadone***, as part of the methadone program Mr Haenga had been on for several years.

[30] Exhibit 1, tab 10B, page 5.
[31] Exhibit 1, tab 10B, page 6.
[32] Exhibit 1, tab 10B, page 7.
[33] Medication that is used to treat the symptoms of mental illness and/or behavioural disorder.
[34] This is known by the brand name, Seroquel. In the evidence the actual names, and trade or brand names, of different types of medication were used interchangeably. For clarity and consistency in these findings I will refer to the various medications by their actual, rather than brand or trade, names.
[35] Brand name, Seroquel.

63. Following this initial meeting Mr Haenga continued to take each of the above medications. In addition Dr Jones prescribed a new medication for Mr Haenga, ***escitalopram***[36] at a dose of 10mg daily. Escitalopram is an anti-depressant drug of the selective serotonin reuptake inhibitor class and is used to treat depression and anxiety disorders.

64. Apart from the new prescription of escitalopram, over time both Dr Jones and Dr Baguley made a number of other significant changes to Mr Haenga's medication regime. These are detailed below:

(a) On **26 July 2012** Dr Baguley decreased Mr Haenga's dose of quetiapine from 900mg to 800mg to help with his weight loss, pending psychiatric review.[37] At the same time Dr Baguley replaced gabapentin with another type of analgesic medication, ***pregabalin***. This is a nerve-conduction blocking drug used to treat neuropathic pain syndromes.[38]

(b) On **4 December 2012**, Dr Baguley commenced Mr Haenga on 1 tablet of ***Panadeine Forte*** 3 times per day for pain relief.

(c) On **7 February 2013** Dr Jones increased Mr Haenga's dose of escitalopram to 20mg. Dr Jones noted that whilst Mr Haenga was thinking positively about his release at the end of the year, he was still reporting that he felt depressed.[39]

(d) Sometime between **14 February 2013 and 14 March 2013** Dr Baguley increased Mr Haenga's dose of Panadeine Forte to 2 tablets 3 times daily.[40]

(e) On **14 March 2013** Dr Jones increased Mr Haenga's dose of escitalopram to 30mg as Mr Haenga continued to report that he still felt depressed. Dr Jones reduced Mr Haenga's dose of quetiapine from 700mg to 400mg. Dr Jones also prescribed a new medication, ***amisulpride***[41] (200mg), as a trial. Amisulpride is also an antipsychotic drug like quetiapine. Dr Jones prescribed this for Mr Haenga's bipolar disorder, to help him with his agitation, thinking and in an attempt to motivate him.[42]

(f) On **11 April 2013** Dr Jones prescribed Mr Haenga with another new drug, ***pericyazine***[43] (20mg) at night. Like quetiapine and amisulpride, pericyazine is also an antipsychotic drug. It appears that the pericyazine was prescribed to offset the side effects that the reduction in quetiapine was having; it had been causing Mr Haenga to have trouble sleeping.

(g) On **2 May 2013** Dr Jones saw Mr Haenga for the final time. Dr Jones believed that the pericyazine was having a good effect and increased the dose to 30mg at night.

65. All of the above means that by **11 April 2013** Mr Haenga was taking 3 different types of antipsychotic medication: quetiapine, amisulpride, and pericyazine. He remained on this medication, and the others described above, up until 8 June 2013.

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[36] Brand name, Lexapro.
[37] Exhibit 1, tab 9E, para 1.16.
[38] Exhibit 1, tab 10A, page 5.
[39] Exhibit 1, tab 9D, para 24.
[40] Exhibit 1, tab 9E, para 1.20; Exhibit 1, tab 36C, page 143.
[41] Brand name, Solian.
[42] Exhibit 1, tab 9D, para 31.
[43] Brand name, Neulactil.

66. At this point it is important to point out that Mr Haenga should not have been taking quetiapine up until 8 June 2013. This occurred due to a series of events in late April and early May 2013. On 29 April 2013 Mr Haenga did not take his quetiapine, although he did take his other medication. Mr Haenga continued to not take his quetiapine for the next 2 days. The reason for this is unknown. However, what is known is that Mr Haenga had a consultation with Dr Jones on 2 May 2013 and told Dr Jones that he had stopped talking quetiapine. Despite being told this, Dr Jones did not stop Mr Haenga's prescription of quetiapine. After his consultation with Dr Jones, Mr Haenga continued to not take his quetiapine in the following days until 5 May 2013 when he took it again.

67. The effect of all this is that on 6 May 2013 Dr Baguley recharted (that is, re-prescribed) the quetiapine, after noting that Mr Haenga had not taken it for 6 days since 28 April 2013 but then resumed taking it on 5 May 2013. The recharting by Dr Baguley resulted in Mr Haenga being given quetiapine on 6 May 2013 which he then continued to take up until 8 June 2013. This sequence of events will be discussed in more detail below.

68. The appropriateness of the medication regime will be considered in this context. That is, whilst Mr Haenga was *actually* prescribed 3 different antipsychotics (amisulpride, pericyazine, and quetiapine) at the time of his death, the *intention* of Dr Jones was that he only should have been prescribed 2 antipsychotics (amisulpride and pericyazine). The prescription of quetiapine was due to inadvertent error. This error will also be discussed further below.

12.2 Mr Haenga's history on the methadone program

69. The fact that Mr Haenga was on the methadone program is relevant to the question of whether his medication regime was appropriate. This is because, as already noted above, methadone had a high risk of prolonging the QT interval.

70. When Mr Haenga arrived at Junee in September 2010 he was taking 120mg of methadone daily.[44] This remained consistent until January 2011 when there was a gradual increase of the dosage up to 150mg.[45] The dosage remained at this level until 12 January 2012 when a gradual reduction began.[46] By the end of August 2012 the dosage had been reduced to 50mg and it remained at this level until February 2013 when there was a further slight reduction to 45mg.[47] This reduction continued for the next few months reaching a lowest dose of 20mg on 30 April 2013.[48] The dose remained at this level until 24 May 2013 when it was increased to 25mg and then gradually increased to 50mg, this last dose being given on 8 June 2013.[49]

71. Dr Baguley saw Mr Haenga for the last time on 24 May 2013. At this time Dr Baguley began a gradual increase in Mr Haenga's methadone after noting that Mr Haenga had tried to reduce his dosage too quickly. Dr Baguley ordered the dose to increase from 25mg up to 80mg, but this increase was planned by Dr Baguley to occur incrementally over a period of time with a gradual series of 5 mg increases.[50] It was Dr Baguley's eventual plan to reduce Mr Haenga's dose of

[44] Exhibit 3, page 153.
[45] Exhibit 3, page 155.
[46] Exhibit 3, page 163.
[47] Exhibit 3, page 298.
[48] Exhibit 1, tab 36C, page 123.
[49] Exhibit 1, tab 36C, page 125.
[50] Exhibit 1, tab 9E, para 8.2.

Panadeine Forte as the methadone dose increased, but this plan never eventuated as Mr Haenga was transferred away from Junee two days later on 26 May 2013.[51]

12.3 Expert opinion

72. One of the matters which Dr Ellis was invited to consider was whether Mr Haenga's medication regime was appropriate. Another consultant forensic psychiatrist, Dr Anthony Samuels, was engaged by the legal representatives for Dr Jones to also consider this issue, and others.

73. In evidence during the inquest both Dr Ellis and Dr Samuels agreed that generally where it is not possible to be certain about a diagnosis for a patient, such as in Mr Haenga's case, it is acceptable to treat and manage that patient's symptoms with medication and attempt to refine a diagnosis over time. With this in mind, both experts also agreed that there was a clinical rationale for Dr Jones to have prescribed the medication which he did.

74. Dr Ellis thought that there was no indication that 3 antipsychotics were required, accepting, as described above, that the quetiapine was prescribed inadvertently. [52] Dr Ellis even queried whether a single, or even no, antipsychotic medication should have been prescribed as Mr Haenga had no obvious history of psychosis associated with mood disorder.[53] However, Dr Ellis acknowledged that it was difficult to arrive at a certain diagnosis for Mr Haenga, and that Mr Haenga himself had pressured clinical staff to not change his medication and asserted that it was helping him.

75. In evidence during the inquest Dr Ellis was asked whether there was any indication for the 2 intended antipsychotics (amisulpride and pericyazine) to have been prescribed. Dr Ellis agreed with Dr Jones' intention to rationalise Mr Haenga's medication regime, that is, reduce the number of different medications that Mr Haenga was taking. In this regard, Dr Ellis noted that it was Dr Jones' intention to eventually replace the quetiapine with amisulpride and that, by introducing pericyazine, Dr Jones was effectively cross-tapering it with the quetiapine (along with helping Mr Haenga's difficulties with sleeping). Whilst Dr Ellis indicated that it was not outside proper medical practice to engage in such cross-tapering he reiterated that polypharmacy[54] should generally be avoided. Dr Ellis did qualify this opinion by noting the complexities and challenges which Mr Haenga's management presented, as already described above[55], and that there are circumstances where polypharmacy is required.[56]

76. Dr Samuels agreed with Dr Ellis that, in general, polypharmacy (particularly using multiple antipsychotics) is "*not considered optimal practice*"[57]. Dr Samuels did note though that Dr Jones was working with Mr Haenga to rationalise his medication and that he had successfully convinced Mr Haenga to stop taking quetiapine temporarily (before it was inadvertently recharted). In evidence Dr Samuels noted that the doses of amisulpride and pericyazine were both low, meaning they would have been readily metabolised but agreed with Dr Ellis that, ideally, polypharmacy is not a good idea.

[51] Exhibit 1, tab 9E, para 1.23.
[52] Exhibit 1, tab 10B, pages 6, 7.
[53] Exhibit 1, tab 10B, page 7.
[54] The concurrent use of multiple medications by a patient
[55] Exhibit 1, tab 10B, page 7.
[56] Exhibit 1, tab 10B, page 10.
[57] Exhibit 1, tab10C, para 137.

77. Both Dr Ellis and Dr Samuels[58] agreed that it would have been unwise to suddenly stop Mr Haenga's antipsychotic medication. To do so may have placed Mr Haenga at risk of physical withdrawal, it may have caused him to act out against medical and correctional staff, and it may have adversely affected his mental state. Both experts therefore agreed with Dr Jones intention to rationalise Mr Haenga's medication.

78. Dr Jones himself in evidence during the inquest appeared to accept that polypharmacy was not ideal. When asked by his own counsel whether he could think of any recommendations of his own which he could make following Mr Haenga's death, Dr Jones referred to a need to be more aware and mindful of the use of polypharmacy in practice. Dr Jones went on to explain that he believed that vigilance was required in this regard and made the frank concession that, at times, such a situation may be due to complacency.

79. **CONCLUSION:** Mr Haenga's medication regime was, in general terms, not clinically optimal. This is because he was prescribed more than one type of psychotropic medication. Antipsychotic medications were part of this regime. The intended use of 2 antipsychotics, and the unintended use of a third antipsychotic, meant that Mr Haenga was placed at increased risk of adverse side effects. The most significant side effect was prolongation of the QT interval which carried the risk of causing a fatal cardiac arrhythmia. However it is acknowledged that Dr Jones was working therapeutically with Mr Haenga with the intention of rationalising Mr Haenga's medication regime over time.

12.4 Was the dose of escitalopram as at 8 June 2013 appropriate?

80. The second issue to consider in relation to Mr Haenga's medication regime is the dose of escitalopram. At the time of his death Mr Haenga's dose was 30mg. Dr Jones had increased it to this level on 14 March 2013. Associate Professor Gunja described the usual dose as being 10-20mg daily[59] and described 30mg as an "*uncommon dose used in intractable or severe cases*".[60] He also described it as "*particularly high*" in view of the other medication (pericyazine, methadone, amisulpride and quetiapine) that Mr Haenga was taking, all of which carried risks of QT prolongation.

81. Dr Ellis describes the increase in escitalopram to 30mg on 14 March 2013 as being "*above the usual maximum recommended dose*".[61] Somewhat in contrast, in his report Dr Samuels describes the 30mg dose as "*not an excessively high dose*" and referred to a prescribing manual which indicates that there are some instances where doses can go as high as 40mg.[62] However, even Dr Samuels acknowledged that caution would have to be exercised when prescribing a dose of 30mg given the multiple other medications that Mr Haenga was on.[63] Later in his report, Dr Samuels stated that the 30mg "*possibly was too high*" in combination with the other medications that Mr Haenga was on.

82. **CONCLUSION:** The dose of 30mg escitalopram was probably too high on its own, and too high in conjunction with the other medication that Mr Haenga was on. This is because it was one of 4

[58] Exhibit 1, tab 10C, para 146.
[59] Exhibit 1, tab 10A, page 5.
[60] Exhibit 1, tab 10A, page 7.
[61] Exhibit 1, tab 10B, page 4.
[62] Exhibit 1, tab 10C, para 140.
[63] Exhibit 1, tab 10C, para 140.

intended medications that Mr Haenga had been prescribed, all of which carried the risk of QT prolongation.

12.5 Was it appropriate for escitalopram to have been prescribed on 4 June 2013?

83. The third issue to consider is whether it was appropriate for the escitalopram to have been prescribed on 4 June 2013. In his report Dr Ellis indicated that doctors who gave phone orders for the continuation of Mr Haenga's medication should also have queried nurses who requested such orders about whether physical investigation had been performed because of Mr Haenga's unusual medication regime.[64]

84. Mr Haenga's transfer from Junee to the MSPC did not interrupt his administration of escitalopram. He continued to take it up until his departure from Junee and after his arrival at the MSPC up until 3 June 2013.[65] However on that day Justice Health nursing staff recognised that the medication chart for the escitalopram was reaching the end of the page which meant that it was required to be recharted. As Mr Haenga had not yet been reviewed, and was not due to be reviewed, by one of the psychiatrists who worked at the MSPC, it was recognised that a new chart would have to be re-written.[66]

85. This led to a request for an interim order for the prescription to be resumed. That request was made via phone call, by a Justice Health nurse at the MSPC, to Dr Samson Roberts the VMO psychiatrist at the MSPC at the time. At 2:00pm on 4 June 2013 Dr Roberts gave an order for the dose of escitalopram to be continued until Mr Haenga could be reviewed by him. This order resulted in Mr Haenga's prescription of escitalopram being continued each day from 5 June 2013 until 8 June 2013.

86. It should be made clear that the phone call on 4 June 2013 was the only occasion when Dr Roberts had any involvement in Mr Haenga's care. He had not seen Mr Haenga or reviewed his clinical file after Mr Haenga arrived at the MSPC, nor did he see Mr Haenga or review his file at any time between 4 June 2013 and 9 June 2013.

87. Dr Roberts explained that at the time it was his practice (and was still his practice at the time of the inquest) to continue an existing prescription for a patient for a limited time pending the writing of a new prescription.[67] Dr Roberts also explained that he considered it would be ethically and clinically inappropriate to prevent continuation of medication for a patient without undertaking a clinical assessment of the patient.[68] Dr Roberts did not have any recollection what information he was provided during the phone call about Mr Haenga's clinical history and, in particular, the nature of his medication regime. However, Dr Roberts explained that even if he had such information, and this information highlighted the challenges in Mr Haenga's pharmacological management, he still would have given the order. Dr Roberts said that the risk of any side effect from continuing the escitalopram (where no side effect had been identified previously) was outweighed by the greater risk that Mr Haenga would be adversely effected if his escitalopram was abruptly stopped, in circumstances where he had been taking it for a long time.[69]

[64] Exhibit 1, tab 10B, page 9.
[65] Exhibit 3, page 318.
[66] Exhibit 1, tab 9M.
[67] Exhibit 1, tab 9AA, para 4.2.
[68] Exhibit 1, tab 9AA, para 4.3.
[69] Exhibit 1, tab 9AA, para 4.4.

88. At the time there was a specific Justice Health guideline which addressed the prescribing of medication overt the phone. ***Clause 7.1.3.7*** of the Justice Health Medication Guidelines 2012 (**the 2012 Medication Guidelines**) allowed for a medical officer to prescribe medication by phone and stipulated how such an order is to be put into effect. Relevantly, it provided that "*as soon as practicable (and preferably within 24 hours of ordering medication but at least on the next working day)"* the prescriber must "*attempt to review the patient, or make arrangements to ensure that the patient is followed up by a local practitioner if [the prescriber] considers it appropriate in the circumstances of the case*".

89. Dr Roberts did not attempt to review Mr Haenga at any time after 4 June 2013. In a statement prepared before the inquest, and in evidence during the inquest, Dr Roberts said that he could not recall what information he was provided with by the nurse during the phone call. However Dr Roberts explained that when faced with a request for a prescription to be given over the phone he assumed that the patient receiving the medication had been reviewed, and that a determination had been made that the medication itself, and its dose, were appropriate. Dr Roberts went on to explain that at best he was receiving third-hand information (from the prescriber, to the medication chart or progress notes, to the nurse making the phone call) and that for him to second guess the judgment of another clinician who had had face-to-face contact with the patient would have been inappropriate.

90. Dr Roberts explained that in his experience he had encountered many inmate patients on multiple medications. Whilst, at face value, there may be a concern regarding the multiple medications, Dr Roberts indicated that the multiplicity might also indicate that the patient was a challenging one.

91. Ultimately, it is not known what information was conveyed to Dr Roberts on 4 June 2013. Neither Dr Roberts, not the nurse who phoned him[70], were able to recall what (if anything) might have been discussed during the phone call about what other medication Mr Haenga was on. In these circumstances and noting Dr Robert's very limited indirect involvement in Mr Haenga's care, there is no evidence to suggest that Dr Robert's should have reviewed Mr Haenga or arranged for follow up in accordance with clause 7.1.3.7 of the 2012 Medication Guidelines.

92. **CONCLUSION:** It was appropriate for Dr Roberts to give an interim order on 4 June 2013 to continue Mr Haenga's prescription of escitalopram. On the limited evidence of what information was available to Dr Roberts there was nothing to indicate that the prescription should not have been continued. There was also nothing to indicate, at that time, that Mr Haenga warranted review.

12.6 Was it appropriate for Panadeine Forte to have been prescribed on 6 June 2013?

93. On 6 June 2013 a different medication was prescribed for Mr Haenga by phone. On this occasion the medication was Panadeine Forte and it was prescribed by Dr Chong Kee (Tony) Chew, the staff specialist GP who was rostered on the Justice Health afterhours medical service at the time. This occurred at about 11:20am on 6 June 2013.[71] Dr Chew gave an order for 2 tablets of Panadeine Forte (500mg of paracetamol and 30mg of codeine) to be prescribed. Dr Chew explained that he ascertained that Mr Haenga had been on the same medication since February

[70] Exhibit 1, tab 9M.
[71] Exhibit 1, page 322.

2013 and that there were no apparent issues with continuing it.[72] On that basis, Dr Chew did so. Similar to Dr Roberts, Dr Chew explained in evidence that the nature of the phone order was not for him to query investigations performed by other clinicians. Dr Chew said that the sole purpose of the phone order was to rewrite or continue an order in circumstances where the order was interim in nature only, and to stop medication abruptly might have potentially dangerous consequences.

94. Neither Dr Bailey nor Associate Professor Gunja expressed any concern at the level of codeine (0.45 mg/L) in Mr Haenga's toxicology results. Associate Professor Gunja described it as a being consistent with therapeutic ingestion of Panadeine Forte[73] (2 tablets containing 60mg codeine in total).

95. **CONCLUSION:** It was appropriate for Dr Chew to give an interim order on 6 June 2013 to continue Mr Haenga's prescription of Panedeine Forte. On the information available to Dr Chew there was nothing to indicate that the prescription should not have been continued. There was also nothing to indicate, at that time, that Mr Haenga warranted review.

13. Was the recording of and monitoring of Mr Haenga's medication regime appropriate?

96. This question is largely concerned with the circumstances which led to Mr Haenga's quetiapine being inadvertently recharted by Dr Baguley on 6 May 2013. In order to answer this question it is necessary to look at what events preceded 6 May 2013 and whether appropriate systems were in place to prevent such inadvertence.

13.1 How did the quetiapine come to be recharted?

97. On 29 April 2013 Mr Haenga did not take his quetiapine. However, the medication administration charts indicate that Mr Haenga did take the other medication (sodium valproate, pericyazine, amisulpride, naproxen, pregabalin) that he was prescribed on that day.[74] Exactly why Mr Haenga did not take the quetiapine is not known. However, given that he had been concerned that the quetiapine had been contributing to his weight gain, and that he had discussed this with Dr Jones, it is likely that Mr Haenga made the decision himself to stop taking it.

98. This is supported by the fact that on 2 May 2013 Mr Haenga saw Dr Jones. During that consultation[75], Mr Haenga told Dr Jones that he had stopped taking quetiapine and that it did nothing for him apart from increasing his weight gain. In Mr Haenga's progress notes, Dr Jones wrote on 2 May 2013: "*Stopped taking Seroquel…Seroquel [increased] my [weight], didn't do nothing for me*". Dr Jones explained in both his statement[76], and during his evidence in the inquest, that whilst he *intended* to stop Mr Haenga's quetiapine prescription he did not *actually* do so.

99. The effect of this was that on 6 May 2013 Dr Baguley recharted the prescribed dose of quetiapine. Dr Baguley did so because he saw that Mr Haenga had not been taking his quetiapine between 29 April 2013 and 4 May 2013. At the time that he recharted the quetiapine Dr Baguley

[72] Exhibit 1, tab 9B, para 7.
[73] Exhibit 1, tab 10A, page 6.
[74] Exhibit 3, pages 319-320.
[75] Exhibit 3, page 337.
[76] Exhibit 1, tab 9DA, para 19.

was not aware of the notation which Dr Jones had made in the progress notes on 2 May 2013 regarding Mr Haenga ceasing to take quetiapine. [77] Dr Baguley explained that he would not put a stop on medication, such as quetiapine, as a matter of prudence without first discussing it with the prescribing physician, Dr Jones.[78]

100. Dr Jones acknowledged that whilst he had discussed the ceasing of quetiapine with Mr Haenga, he (Dr Jones) never formally ceased the order, or documented it in the progress notes.[79] In evidence Dr Jones was asked why he had not written about his intention to stop quetiapine in Mr Haenga's clinical progress notes. Dr Jones frankly acknowledged that it was an omission on his part which he regretted. Dr Jones explained that as Mr Haenga had told him that he had stopped taking the quetiapine that was, to Dr Jones, as good as if he had not prescribed it. Dr Jones believes that after Mr Haenga told him he had stopped, he (Dr Jones) became relieved and simply thought that it was good that he had done so.

101. In evidence Dr Baguley was asked a number of questions about the circumstances which led to him recharting the quetiapine on 6 May 2013. Dr Baguley was firstly asked whether he had noticed that Mr Haenga had not taken his quetiapine for 6 days. Dr Baguley said that he had noticed this but that he had also noticed that Mr Haenga had taken quetiapine on 5 May 2013. This led Dr Baguley to assume that Mr Haenga had simply started taking it again. Dr Baguley also said that he relied on there being a stop order on the medication chart to prevent the inadvertent recharting of medication.

102. Dr Baguley was also asked whether he would have been concerned by the fact that Mr Haenga had suddenly started taking the quetiapine after 6 days. Dr Baguley said that he would not have been concerned and thought it was a good thing that Mr Haenga had started taking the quetiapine again. Dr Baguley went on to explain that if Mr Haenga had continued to not take the quetiapine he (Dr Baguley) would probably have asked to see him in order to find out why.

103. Finally, Dr Baguley was asked whether it was policy at Junee for a GP to rechart medication which had been prescribed by a psychiatrist. Dr Baguley explained that whilst it was not policy it was a customary practice. Dr Baguley said that in his lunch hour he would rechart up to 50 or 60 medication charts where it was required (that is, where the medication charts were approaching their 6 week limit). As to this last point, there is no evidence to suggest that such a practice was inappropriate. Dr Jones said that he had no issue with it and was aware that Dr Baguley followed such a practice. Dr Ellis also said that he saw no issue with the practice adopted by Dr Baguley and indicated that in his own practice he (Dr Ellis) would often rechart medication prescribed by a GP.

104. **CONCLUSION:** I accept that Dr Jones, as part of his attempts to rationalise Mr Haenga's medication regime, intended to stop the prescription of quetiapine. However, this was neither documented on Mr Haenga's medication chart nor in his progress notes at any time. It should have occurred on 2 May 2013 when Mr Haenga told Dr Jones that he had stopped taking the quetiapine. If it had occurred Dr Baguley would not have recharted it. Dr Baguley only did so because the medication chart was approaching its 6 week limit. Although Dr Baguley was aware that Mr Haenga had resumed taking the quetiapine after a 6 day hiatus, there was nothing to indicate on the information available to Dr Baguley that it should not have been recharted. Dr

[77] Exhibit 1, tab 9E, para 10.1-10.3.
[78] Exhibit 1, tab 9E, para 11.2.
[79] Exhibit 1, tab 9DA, para 23.

Baguley was appropriately more concerned about the 6 day hiatus from taking quetiapine rather than the sudden recommencement of taking it; the former situation raised an appreciable risk that Mr Haenga may have decompensated and developed symptoms of psychosis. It was also appropriate for Dr Baguley, as a GP, to follow his usual practice of recharting medication which had been prescribed by the psychiatrist, Dr Jones.

13.2 Were any policies or guidelines in place to prevent the inadvertent recharting of the quetiapine?

105. In order to stop the quetiapine Dr Jones should have complied with ***clauses 7.1.12 and 7.1.3.6*** of the 2012 Medication Guidelines.[80] These clauses provide that if a medical officer wishes to cease a medication order that medical officer must draw a line after the last entry where the medication is recorded as being administered and then sign and date the medication chart. This obviously should have occurred, but did not. There is no reason to doubt Dr Jones' frank concession that it was due to omission on his part. On 2 May 2013 Dr Jones complied with clauses 7.1.12 and 7.1.3.6 when he increased Mr Haenga's dose of pericyazine. That is, Dr Jones crossed out the old prescription of 20mg[81] and recharted the new prescription of 30mg[82].

106. No reason was recorded why the quetiapine was not administered by nursing staff. The failure to do this was contrary to the 2012 Medication Guidelines. ***Clause 6.2.10*** of the 2012 Medication Guidelines stipulates that if medication is not, or cannot be, administered, the reason for this must be indicated on the medication chart and in the patient's notes. This means that for each of the 6 days between 29 April 2013 to 4 May 2013 there should have been a note on Mr Haenga's medication chart and in his progress notes as to why he did not take his quetiapine. However, for each of these 6 days no such notes were made.

107. As quetiapine is an antipsychotic medication, an additional requirement applied. ***Clause 6.6.1*** of the 2012 Medication Guidelines applied to antipsychotic and antidepressant medication and provided that if a patient does not attend to receive such medication then they must be followed up immediately. If the patient refuses to take their antipsychotic medication the patient must be seen by the treating psychiatrist "*at the earliest opportunity*" and there should be daily contact with the patient until the psychiatrist sees them.

108. A similar provision is contained in the Junee Correctional Centre Operating Manual, Medication Administration Policy dated 29 June 2012[83] (**the 2012 Junee Medication Policy**). This was in operation in May 2013. Clause 4.7.1 of the 2012 Junee Medication Policy stipulated that when a medication could not be administered details as to why it was not administered should be recorded in the progress notes. In a case where an inmate patient fails to collect his medication then a nurse should contact a medical officer for further advice.

109. **CONCLUSION:** There were appropriate Justice Health and GEO polices and guidelines in place in May 2013 to prevent the inadvertent recharting of quetiapine to Mr Haenga. The recharting only occurred due to non-compliance with specific requirements in these polices and guidelines. Dr Jones omitted to cease the prescription in accordance with clauses 7.1.12 and 7.1.3.6 of the 2012 Medication Guidelines. The reason why Mr Haenga did not take his quetiapine between 29 April

[80] Exhibit 1, tab 9FA, para 6.
[81] Exhibit 3, page 320.
[82] Exhibit 3, page 326.
[83] Exhibit 2.

2013 to 4 May 2013 was not documented on his medication chart and progress notes by nursing staff in accordance with clause 6.2.10 of the 2012 Medication Guidelines or clause 4.7.1 of the 2012 Junee Medication Policy. After Mr Haenga did not take his quetiapine on 29 April 2013, and the days after, there was no follow up to ensure that he was seen by Dr Jones in accordance with clause 6.6.1 of the 2012 Medication Guidelines.

13.3 Changes to policies and guidelines since 2013

110. The above clauses that I have referred to relate to the 2012 Medication Guidelines which applied at the time of Mr Haenga's death. Since then, there have been at least 2 revisions to the guidelines, once in December 2016[84] (**the 2016 Medication Guidelines**) and again in August 2017 (**the 2017 Medication Guidelines**).

111. Clause 6.2.10 of the 2012 Medication Guidelines is reproduced in identical terms in ***Clause 6.2.9*** of the 2017 Medication Guidelines. Clause 6.2.9 provides: "*In circumstances where a medication is not, or cannot be administered, the details as to why the medication is not administered* ***must*** *be indicated on the medication chart and in the patient's medical notes* [original emphasis]".[85]

112. In contrast the Junee Correctional Centre Operating Manual: Medication Administration Policy issued on 21 April 2017 (**the 2017 Junee Medication Policy**) provides at clause 4.7.1: "*In circumstances where a medication cannot be administered, details as to why the medication was not given* ***should*** *be indicated in the progress notes* [emphasis added]*".*[86]

113. It is obvious from a comparison of the two clauses that the one contained in the 2017 Medication Guidelines is mandatory whilst the one contained in the 2017 Junee Medication Policy is discretionary. As GEO, pursuant to its management agreement with CSNSW, is obliged to comply with policies established by Justice Health (and the NSW Ministry of Health), including the 2017 Medication Gudielines, this inconsistency is highly undesirable and has the potential to cause confusion amongst clinicians and lead to inconsistent clinical practice.

114. The inquest identified one further discrepancy in the 2017 Junee Medication Policy in clause 4.14.8. This clause is found within a section which deals with the supplying of medication by telephone orders. Clause 4.14.8 refers to the "*Justice Health and Forensic Mental Health Network medication guidelines* ***2015*** *for further guidance* [emphasis added]".[87] This is clearly a reference to a guideline which is no longer current, and should instead refer to 2017 Medication Guidelines.

115. **CONCLUSION:** There are fundamental inconsistencies and discrepancies between the 2017 Medication Guidelines established by Justice Health and the 2017 Junee Medication Policy. These inconsistences and discrepancies have the potential to lead to undesirable, and possibly unsafe, clinical outcomes and should, obviously, be corrected.

116. ***RECOMMENDATION:*** *I recommend that GEO review its current Medication Administration Policy to ensure that it accurately reflects the equivalent provisions contained within the 2017 Justice*

[84] Exhibit 1, tab 9FA, Annexure C.
[85] Exhibit 11, page 97.
[86] Exhibit 15, page 8.
[87] Exhibit 15, page 12.

Health Medication Guidelines including, but not limited to, clauses 4.7.1 and 4.14.8 of the 2017 Junee Medication Administration Policy.

117. The 2016 Medication Guidelines replaced clause 6.6.1 of the 2012 Medication Guidelines with a new clause 6.7.2[88]. Essentially clause 6.7.2 was in the same terms except that it applied to *all* supervised medication[89], and *not only* antipsychotic or antidepressant medication. This same clause is reflected in the 2017 Medication Guidelines.[90] Clause 6.7.2 provides that if supervised medication is not administered the reason why must be documented in the inmate patient's health record. Furthermore, any patient who does not attend for medication must be followed up and this must be communicated at handover. If a patient continues to refuse to take medication once follow up has occurred then this must be discussed with an appropriate clinician within 48 hours.

118. In evidence during the inquest, Ms Jan Te Maru, the Health Services Manager at Junee, was asked about these two discrepancies. Ms Te Maru said that she only became aware of the 2017 Medication Guidelines in the "*last few days*" prior to giving evidence at the inquest. When taken to the differences between clause 6.6.1 of the 2012 Medication Guidelines and clause 6.7.2 of the 2016 and 2017 Medication Guidelines Ms Te Maru was not aware that there had been any amendment.

119. Ms Te Maru accepted that so far as the overall circumstances which led to the recharting of the quetiapine to Mr Haenga there had been non-compliance with the 2012 Medication Guidelines in a number of respects. When asked to provide any reason why such non-compliance might not occur today, Ms Te Maru was unable to provide any. However, she agreed that further education of clinical staff at Junee about the need to comply with the 2017 Medication Guidelines would be beneficial.

120. Having regard to the lack of awareness by Ms Te Maru regarding the change to clause 6.7.2 of the 2016 and 2017 Medication Guidelines, and the inconsistencies between the 2017 Medication Guidelines and the 2017 Junee Medication Policy, it also appears that training of clinical staff to educate them about these changes is required.

121. During the inquest counsel for Justice Health asked Mr Gary Clark, the Operations Nurse Manager for Justice Health how changes in guidelines are communicated to clinical staff at the operational level. Mr Clark pointed to two methods: (a) accessing guidelines via the Justice Health intranet; and (b) the deployment of Justice Health nurse education consultants to provide training for clinical staff at different correctional centres. When asked about the second of these methods Ms Te Maru indicated that nurse education consultations are not available at Junee as a matter of course. It emerged from the evidence at inquest that in order for such education to be provided GEO would have to make a request to CSNSW (pursuant to its management agreement) for the necessary funding to be provided for Justice Health to, in turn, provide it.

122. In closing submissions Justice Health submitted that procedures are in existence for policies and guidelines to be disseminated and distributed at the operational level. However it became

[88] Exhibit 1, tab 9FA, Annexure C, page 104.
[89] This includes Restricted Substances (Schedule 4D) and Drugs of Addiction (Schedule 8) on the NSW Poisons List, along with anabolic steroids, and injectable medication (except insulin).
[90] Exhibit 11.

apparent during the inquest that a number of witnesses (Dr Jones, Dr Baguley, Dr Chew, Dr Roberts) had either never seen a guideline such as the 2012 Medication Guidelines, or were not familiar with some of its precise provisions. Of particular importance was the fact that Dr Katerina Lagios, the Clinical Director, Primary Care, for Justice Health, said in evidence that she was not aware of one Justice Health guideline[91] and had not read not read a policy directive[92] that was relevant to the issues considered by the inquest.

123. **CONCLUSION:** Clinical staff at Junee should be educated about current medication administration requirements. The available evidence suggests that reliance on existing procedural dissemination of relevant guidelines and policies is not as effective as specific targeted education. The lack of awareness amongst senior executive personnel within both Justice Health and Junee reinforces this ineffectiveness.

124. ***RECOMMENDATION:*** *I recommend that GEO, CSNSW and Justice Health work collaboratively to provide further targeted education and training, through the use of Justice Health nurse education consultants, to GEO clinical staff at Junee in relation to medication administration requirements pursuant to the 2017 Medication Guidelines, in particular in relation to clauses 6.2.9 and 6.7.2.*

13.4 Were any other systems in place in 2013 to prevent the inadvertent recharting of the quetiapine?

125. In answering this question there was focus on two issues during the inquest: clinical handover and multidisciplinary team meetings. It was suggested that either or both of these clinical practices might have been able to detect the fact that quetiapine had continued to be prescribed to Mr Haenga, and that he had not participated in metabolic monitoring (discussed further below). In May 2013 (and since) there were no formal policies or guidelines which governed either practice.

13.4.1 Clinical Handover

126. The issue of clinical handover arises in the context of Mr Haenga's transfer from Junee to the MSPC on 27 May 2013. When he arrived at the MSPC Mr Haenga was seen by a primary health care nurse as part of an intake screening process. However, because he was being transferred from another correctional centre, and was not a person newly entering custody, Mr Haenga was not seen by a mental health nurse for a mental health assessment. In the period between 27 May 2013 and 7 June 2013 the PAS indicates that Mr Haenga had a number of other appointments with primary health nurses[93], but none with any mental health nurse. Mr Haenga was also not reviewed by a psychiatrist, nor did he have an appointment on the PAS to see one.

127. In evidence, Dr Lagios said that she would have expected Mr Haenga to have been placed on waitlist to see a mental health nurse and that his mental health issues would have been identified at that presentation. According to Dr Lagios this process would have occurred within approximately 2 weeks of Mr Haenga's arrival at the MSPC on 27 May 2013.

128. As Dr Roberts was the VMO psychiatrist at the MSPC at the time of Mr Haenga's transfer he was asked about the handover process in evidence. Dr Roberts said that there is no formal handover

[91] Exhibit 13.
[92] Exhibit 12.
[93] Exhibit 8.

process and the majority of transfers initiated by CSNSW occur with little or no notice. Due to security reasons, inmates are often not provided with much notice prior to being transferred between correctional centres. This in turn means that no notice is often provided to an inmate's treating clinicians, as occurred in Mr Haenga's case.

129. Dr Roberts explained that in an ideal system CSNSW would notify a patient's treating psychiatrist of any prospective transfer and that treating psychiatrist could then contact the receiving psychiatrist at the correctional centre that the inmate is being transferred to so that there can be continuity of the therapeutic process. Dr Robert was asked about the ability to effectively perform a handover after the event, that is, for a current treating clinician to contact a previous one. Dr Roberts explained that this was not practical because it would mean contacting a previous clinician who had not seen a patient for weeks (meaning that the patient's clinical status could have changed significantly during that time) and who did not have access to the patient's file.

130. Dr Baguley said that in the period from 2011 to 2013 there was no formal handover process when a patient either arrived at, or was transferred away from, Junee. Dr Baguley said that in his experience he might have only received 2 or 3 calls per year from a GP at another correctional centre with respect to a new inmate who had arrived at Junee.

131. Dr Jones said in evidence that due to inflexibilities within the custodial setting they have the bare minimum of processes in relation to patient handover. He said that a clinician-to-clinician handover was not as common as in other medical care settings due to the difficulty in communicating between clinicians.

13.4.2 Multidisciplinary team meetings

132. Dr Baguley explained that in the period from 2011 to 2013 there were no team meetings between clinicians because there was neither the time, nor the facility, to hold such meetings. Instead, Dr Baguley described the process as much more informal in the sense that "*everyone did their job*". This meant, according to Dr Baguley, that if a nurse had a concern he or she would approach Dr Baguley and that, similarly, if Dr Baguley had a concern about a mental health issue he would approach Dr Jones. Dr Baguley also referred to the fact that there would often be "*corridor conversations*" regarding a patient. That is, there would be informal discussions in passing between clinicians regarding any issue relating to a patient which may require further action or increased observation.

133. In evidence Dr Jones said that he thought Dr Baguley had underestimated how communication took place between clinicians regarding patients. Dr Jones said that, in his experience, after reviewing patients he would spend about 20 to 30 minutes discussing the patients (usually those patients who had more significant management needs) with Dr Baguley and the nursing staff.

134. **CONCLUSION:** Best practice medicine indicates that there should be multidisciplinary team meetings to discuss the care and management of patients, and a formal clinician-to-clinician handover process when the care of a patient is transferred. However, the limitations of the correctional setting means that such ideal practices can rarely be implemented which in turn means that pragmatic and informal processes are adopted.

13.5 Have any changes or improvements been made since 2013?

135. Dr Huong Van Nguyen, the Director of Medical Programs for Justice Health was invited to indicate whether any systems are in place to detect a situation such as occurred in May 2013 when Dr Jones inadvertently failed to stop the order for quetiapine. In her statement[94] and in evidence Dr Nguyen referred to a number of changes to address this issue.

136. Firstly she referred to the fact that medication chart reviews are routinely conducted by clinical pharmacists at a number of correctional centres where Justice Health provides health care. Such reviews were likely to detect omissions in the prescribing and administration of medication, and the reasons for such omissions. She was asked to elaborate about this in evidence and indicated that the sample size for such reviews was 10 medication charts at each correctional centre. As this sample size seemed disproportionately low compared to the number of inmate patients, Dr Nguyen went on to explain that other methods current exist to detect the error in Mr Haenga's medication prescription: 3-monthly checks performed by drug and alcohol services, and the fact that Mr Haenga was on the methadone program and positive for Hepatitis C would have registered a chronic disease notification.

137. Secondly Dr Nguyen referred to a new Long Stay Medication Chart (**LSMC**) introduced in 2016. The back page of the LSMC contains a section containing a number of codes for nursing staff to enter on the chart to indicate the reason why a medication has not been administered.[95] For some of the codes there is an additional prompt for the nurses to notify the medication prescriber that the medication has not been administered.

138. Thirdly Dr Nguyen referred to the fact that Justice Health is in the initial stages of moving to an electronic medication management system. According to Dr Nguyen this system will, amongst other things, "*improve accuracy and visibility of medication information being communicated between health care providers*".[96]

139. Dr Jones was also asked about improvements at Junee since 2013 and explained that there is now a non-compliance register in which a nurse records the names of patients who have not collected their medication for 3 days. Dr Jones also pointed to informal daily handover meetings where if it was identified that a patient had not collected their medication they might be placed on supervised administration.

140. **CONCLUSION:** Appropriate changes and improvements have been put in place by Justice Health, and at Junee, since 2013 to reduce the likelihood that the non-compliance with guidelines that led to the inadvertent recharting of quetiapine will be repeated.

14. Was Mr Haenga provided with adequate health care?

141. When Mr Haenga first saw Dr Jones in June 2011 he weighed approximately 150 kilograms.[97] At the time of his death Mr Haenga weighed 199 kilograms. It has already been established that because of Mr Haenga's morbid obesity he was at risk of sudden cardiac death. Further, Dr Ellis explained that because Mr Haenga was on a complex medication regime, his overall

[94] Exhibit 1, tab 9FA, pages 6-7.
[95] Exhibit 4 and Exhibit 1, tab 9FA, Annexure F.
[96] Exhibit 1, tab 9FA, page 7.
[97] Exhibit 1, tab 9D, para 20.

management should have included regular physical examinations, regular testing for the QT interval, and regular blood monitoring. The evidence established that these risk factors could have been assessed through the use of metabolic monitoring and ECG testing.

14.1 Metabolic monitoring

142. Metabolic Syndrome refers to a cluster of cardiovascular risk factors including insulin resistance, hypertension, central obesity and dyslipidaemia.[98] These factors result in significantly increased risk of cardiovascular disease and mortality. Persons with mental health issues, particularly those with diagnoses of bipolar disorder, have up to four times greater risk of developing metabolic syndrome than the general population as a result of lifestyle factors and the side effects of medication regimes.

143. In order to reduce the risk of cardiovascular disease and mortality, persons at risk of metabolic syndrome are monitored under a system known as metabolic monitoring. This monitoring involves regular tests being conducted to measure a person's weight, girth, blood pressure, cholesterol level, calculate their body mass index, and screen them for type 2 diabetes and insulin resistance.

144. Prior to September 2012, metabolic monitoring at Junee was conducted on an informal basis. In Mr Haenga's case, the monitoring was performed by Ms Janice Workman RN who first met Mr Haenga on 13 September 2010 in her capacity as the mental health nurse at Junee. The metabolic monitoring was initiated by Ms Workman because of Mr Haenga's cardiac risk factors and because he was on the methadone program, as methadone use carried a known risk of QT interval prolongation. Ms Workman conducted metabolic monitoring which included measurement of Mr Haenga's girth, weight, blood sugar level, blood pressure, pulse and she also made arrangements for ECG testing. Ms Workman explained that she used the metabolic monitoring appointments with Mr Haenga to promote healthy lifestyle choices and spoke to Mr Haenga about weight loss, exercise, developing metabolic syndrome, the potential side effects of antipsychotic and mood-stabilising medication, and the importance of ECG testing.[99]

145. The clinical progress notes reveal that although Ms Workman made a number of metabolic monitoring appointments for Mr Haenga he, unfortunately, did not attend most of them. Between October 2010 and July 2012 Mr Haenga did not attend 8 scheduled metabolic monitoring appointments and declined a suggestion from Ms Workman on 10 July 2012 that he attend a 9th appointment. However during this period Mr Haenga did attend 3 metabolic monitoring appointments with Ms Workman on 15 November 2010, 21 June 2011 and 5 April 2012.

146. In September 2012 Junee received funding from CSNSW to employ a full-time metabolic monitoring nurse.[100] From 15 October 2012 to the time of Mr Haenga's death this was Samantha Byrne RN.[101] However it appears that Ms Byrne never performed any monitoring on Mr Haenga because Mr Haenga declined to attend the only 2 scheduled appointments that Ms Byrne made for him on 30 October 2012 and 4 March 2013.

[98] Exhibit 14.
[99] Exhibit 1, tab 9T, page 4.
[100] Exhibit 1, tab 9V.
[101] Exhibit 1, tab 9U.

147. Apart from metabolic monitoring to address Mr Haenga's weight gain and cardiac risk factors, another measure was available. On 5 April 2012 Dr Baguley referred Mr Haenga to the Junee Health Promotions Officer. At the time this was Matthew Canny RN. Mr Canny's role was to provide health education and healthy eating advice to inmates. This was incorporated into a 12 week program run by Mr Canny. The program involved the taking of metabolic measurements at the start of the program, an exercise component, a classroom education component which focused on health eating options, a healthy cooking class, and metabolic measurements at the end of the program to monitor any changes.[102] Mr Canny recalls that Mr Haenga often attended both the classroom education component and the healthy cooking class. It was hoped that the education provided by Mr Canny and Ms Workman would influence the food that Mr Haenga purchased during his "buy ups".

148. Apart from the metabolic monitoring conducted by Ms Workman and the program run by Mr Canny, the evidence established that Dr Baguley often spoke to Mr Haenga about his weight gain. However, Dr Baguley said that Mr Haenga was resistant to making necessary lifestyle changes, such as improving his diet and exercising, despite being told about the risks to his health.[103]

149. Although Mr Haenga's failures to attend metabolic monitoring appointments with Ms Workman and Ms Byrne were documented in his progress notes, Dr Baguley was never directly informed of Mr Haenga's non-attendances. Dr Baguley explained that had he been made unaware of these non-attendances he would have attempted to persuade Mr Haenga to attend. It is clear that Dr Baguley, and Ms Workman and Ms Byrne, had limited options available to them to manage Mr Haenga's reluctance to participate. As they could not compel Mr Haenga to participate the only alternative left to them was continual advice and reminders about the benefits of participation, leaving it to Mr Haenga to decide whether he would act upon their advice.

150. **CONCLUSION:** Measures were put in place for Mr Haenga to participate in metabolic monitoring both on a formal and informal basis. Unfortunately, Mr Haenga declined to attend 8 out of the 11 metabolic monitoring sessions that were scheduled for him. Although these non-attendances were noted in Mr Haenga's progress notes, it appears that neither Ms Workman nor Ms Byrne advised Dr Baguley when Mr Haenga declined to attend. Even if Dr Baguley had known about Mr Haenga's non-attendance from reading the progress notes there was no means to compel Mr Haenga to attend. The evidence indicates that Mr Haenga was provided with ongoing education by Ms Workman, Mr Canny, Dr Jones and Dr Baguley about the potential health risks involved with metabolic syndrome and how metabolic monitoring could be of benefit to him. It was unfortunate that Mr Haenga declined to act on this advice. I therefore conclude that the general health care provided to Mr Haenga, specifically in relation to the attempts to engage him in metabolic monitoring, was appropriate.

14.2 ECG monitoring

151. Given that Mr Haenga was taking medication known to prolong the QT interval Dr Ellis said that it would have been helpful for ECG testing to have been performed before Mr Haenga was started on new psychotropic medication and whilst he was on it. In evidence Dr Ellis elaborated by explaining that it was important to ensure that Mr Haenga's physical parameters were monitored because Dr Jones was departing from typical prescription practices in circumstances where Mr Haenga had significant comorbidities.

[102] Exhibit 1, tab 9S.
[103] Exhibit 1, tab 9EA, para 8.1-8.3.

152. In evidence Dr Samuels expressed some reservations about ECG testing. This was because, he said, it may have been difficult to know what to do with the results. This was because a balancing exercise would be required to determine whether the psychiatric risks outweighed the physical risks, or vice versa. In other words, if the ECG test results showed some degree of QT interval prolongation it may still have resulted in continuation of Mr Haenga's psychotropic medication if his psychiatric needs were greater than any physical medical risk. Dr Ellis agreed that reconciling these two considerations was difficult and said that there was no standard formula to apply. However, Dr Ellis explained that even if the ECG test results did not guide treatment in either direction, the absence of *any* testing results meant that there was effectively only one treatment option.

153. Four ECG tests were performed on Mr Haenga whilst he was at Junee: 13 September 2010, 15 November 2010, 15 May 2011 and 21 June 2011. Apart from the test on 15 May 2011 all the tests were performed as part of metabolic monitoring conducted by Ms Workman. It appears that the 15 May 2011 test may have been related to monitoring for pneumonia and septicaemia that Mr Haenga was being managed for at the time.[104]

154. Dr Jones explained in evidence that he was aware that Mr Haenga was undertaking metabolic monitoring because he was on the methadone program and because of his cardiac risk factors. However the results from the monitoring were not sent to Dr Jones. In hindsight Dr Jones said that, ideally, he would have liked for ECG testing to be performed before and after each change in Mr Haenga's medication, or dose of medication. Dr Jones also said that he wished he had been more assertive in encouraging Mr Haenga to take part in ECG testing and that the test results may have provided clinical guidance.

155. **CONCLUSION:** Mr Haenga had been prescribed several antipsychotic drugs and was on the methadone program. These drugs carried the risk of prolongation of the QT interval. ECG testing would have been beneficial in the management of Mr Haenga's care in order to guide his treatment, and inform the question of how best to manage his physical and mental health needs, and their associated risk factors.

156. The NSW Ministry of Health and Justice Health have produced a guideline, information bulletin and resource with respect to the use of metabolic monitoring and ECG testing. Each of these documents is discussed further below.

157. In her statement Dr Lagios expressed the view[105] that Mr Haenga should have had ECG testing in accordance with a Justice Health document titled, "*Metabolic Syndrome, From Monitoring to Management, A Resource for Health Professionals 2011*" (**the 2011 Metabolic Syndrome resource**). The Metabolic Syndrome resource is a 63-page document. The only reference to ECG testing occurs at page 8 in a table within a section titled "Monitoring Schedule".[106] In the table it appears that ECG is referred to as one of a number of investigatory tests (along with full blood count, kidney function test (UEC), liver function test) to be "*completed as a component of annual health assessment*". No mention is made in the table of the rationale for performing an ECG as part of metabolic monitoring.

[104] Exhibit 3, page 31.
[105] Exhibit 1, tab 9FB, para 21.
[106] Exhibit 1, tab 9FB, Annexure B, page 8.

158. Sections 1.2 and 1.3 of the 2011 Metabolic Syndrome resource deals with Metabolic Syndrome and mental illness and how it is screened and monitored. These sections highlight that there is evidence that mental health patients are up to 4 times more likely to develop metabolic syndrome than the general population, that this increased risk is due in part to weight gain associated with using antipsychotic medication, and there is a need to regularly screen patients prescribed psychotropic medication for the presence of metabolic syndrome. However there is no reference within these sections to ECG testing being used for such screening and monitoring purposes.[107]

159. Counsel Assisting took Dr Lagios to this issue during her evidence. Dr Lagios conceded that she could not locate any reference to ECG testing in the Metabolic Syndrome resource; the reference in the table at page 8 was only identified later in the evidence. Dr Lagios indicated that in such circumstances Justice Health should conduct a review of the 2011 Metabolic Syndrome resource to ensure that ECG testing is specifically referred to.

160. The Justice Health document titled "*Psychotropic Medications – Guidelines for Prescribing and Monitoring Use Within Custodial and Forensic Mental Health Settings 2017*" (**the 2017 Psychotropic Medications guideline**) repeats the same principles described above in the Metabolic Syndrome resource.[108] However it goes further to specifically identify the increased risk of QT prolongation with the use of psychotropic medication and specifies that ECG testing should form part of the initial physical examination of a patient before psychotropic medication is initiated.[109] The Psychotropic Medications guideline additionally specifies that ECG testing should, generally be performed every 12 months as part of a patient's ongoing review[110], and that it should be performed every 6 months if the patient is prescribed quetiapine.[111]

161. Finally, the NSW Ministry of Health published an information bulletin in July 2012 titled, "*Metabolic Monitoring, New Mental Health Clinical Documentation Module*" (**the 2012 Metabolic Monitoring module**). It provides a structured format for the way in which metabolic monitoring is conducted.

162. In evidence Dr Jones said that, currently, when prescribing antipsychotic medication, the use of metabolic monitoring has become more prominent in his clinical thinking, and more a part of his regular day-to-day practice. When asked whether he was aware if ECG testing was required as part of any policy Dr Jones said that he believed it was part of the metabolic monitoring protocol. As the 2017 Psychotropic Medication Guidelines were only published in August 2017, and had not been produced for the inquest by Justice Health at the time that Dr Jones gave his evidence, I infer that by referring to a protocol Dr Jones meant the 2011 Metabolic Syndrome Resource.

163. In evidence both Dr Lagios and Mr Clark agreed that, from the perspective of Justice Health, the core documents which guide clinical staff in carrying out metabolic monitoring are the 2011 Metabolic Syndrome Resource and the 2017 Psychotropic Medication Guidelines. However, in her evidence Ms Te Maru said that only the 2011 Metabolic Syndrome Resource was used as part of Junee's metabolic monitoring policy.

[107] Exhibit 1, tab 9FB, Annexure B, pages 3-4.
[108] Exhibit 13, pages 4, 8.
[109] Exhibit 13, page 9.
[110] Exhibit 13, page 10.
[111] Exhibit 13, page 11.

164. It is evident from the above that there are currently 3 separate documents produced by the Ministry of Health and Justice Health which govern the metabolic monitoring performed by clinical staff in the correctional setting. It is also evident that the 2017 Psychotropic Medication Guidelines specifically highlights the importance of using physical monitoring (including ECG testing) to manage adverse effects in patients prescribed psychotropic medications. It also provides timeframes for the baseline and ongoing frequency of such testing, both in general, and in relation to specific types of psychotropic medication. Whilst the 2011 Metabolic Syndrome Resource contains a table[112] of the medications (which include amisulpride, pericyazine, and quetiapine) which are targeted by metabolic monitoring, there is no specific reference to the use of ECG testing, the reason why ECG testing is of benefit in monitoring the QT interval, nor any information regarding when, and how often, ECG testing should be performed.

165. **CONCLUSION:** There are 3 separate documents produced by the Ministry of Health and Justice Health which govern the metabolic monitoring performed by clinical staff in the correctional setting. Whilst they are intended to be read in conjunction with one another, it appears that Junee has only adopted 2011 Metabolic Syndrome Resource as part of its metabolic monitoring policy. There are clear clinical benefits in all 3 documents being adopted particularly because the 2017 Psychotropic Medication Guidelines specifically address the importance of monitoring (including ECG testing) with respect to patients prescribed psychotropic medication that carry the risk of QT interval prolongation.

166. ***RECOMMENDATION:*** *I recommend that Junee, as part of its metabolic monitoring, adopt the Justice Health 2017 Psychotropic Medication Guidelines and the associated NSW Ministry of health 2012 Metabolic Monitoring module.*

167. The 2017 Psychotropic Medication Guidelines refers to both the 2011 Metabolic Syndrome Resource and the 2012 Metabolic Monitoring module in relation to the requirements for metabolic monitoring.[113] There is no similar cross-reference to the 2017 Psychotropic Medication Guidelines in the 2011 Metabolic Syndrome Resource. Moreover, due to the single reference to ECG testing in the 2011 Metabolic Syndrome Resource, no information is provided regarding the relevance of its use, and how it should be used, as part of metabolic monitoring.

168. For example, although a number of psychotropic medications are identified as being targeted medications as part of metabolic monitoring[114], no correlation is drawn between the medications and ECG testing, nor is any guidance provided regarding when and how regularly ECG testing should be performed. It seems to me that there are obvious practical clinical benefits in ensuring that there is cross-referencing between the 2017 Psychotropic Medication Guidelines in the 2011 Metabolic Syndrome Resource, and ensuring that the use of ECG testing, and its relevance, is specifically addressed in the 2011 Metabolic Syndrome Resource.

169. At the conclusion of the evidence in the inquest a draft set of recommendations was circulated to counsel for the various interested parties. The draft included a recommendation in terms of what is set out in the immediate paragraph above. Counsel for Justice Health submitted that more recommendations to Justice Health were not required and that producing an excessive number of policies would only serve to "*paralyse*" the system. Instead, counsel for Justice Health

[112] Exhibit 1, tab 9FB, Annexure B, page 47.
[113] Exhibit 13, page 7.
[114] Exhibit 1, tab 9FB, Annexure B, page 47.

submitted that an observation should simply be made that the best practice for all clinicians is to simply read the resources that have been provided to them and to exercise their own professional judgment. During the inquest, counsel for Justice Health explored this issue with Dr Jones, Dr Lagios and Mr Clark. The questions posed to these witnesses seemed to suggest that a clinician's understanding, based on their training and need to comply with ongoing registration requirements (with the Australian Health Practitioner Regulation Agency), of what constituted best medical practice would be sufficient to ensure that deficiencies in care did not arise.

170. I think that there are some difficulties with submissions made by counsel for Justice Health. Firstly, Justice Health is under an obligation to follow any policy directive disseminated by the NSW Ministry of Health and to use its own discretion as to how to implement such directives within its own network. Resistance to the use of further policies and guidelines does not seem to sit comfortably with this obligation nor with the submission made by counsel for Justice Health, which I agree with, that the primary objective of Justice Health is to provide adequate and clinically sound health care. Secondly, placing reliance on individual clinicians to use their own training and understanding of best medical practice, without relevant policies and guidelines for unique settings such as the correctional setting, has the potential for variable and inconsistent outcomes. Such reliance would not create public confidence that there is a primary system in place to protect against individual shortcomings. Thirdly it is often the case that policies, and amendments to them, arise because individual shortcomings are identified. Without a primary, overarching system, other clinicians within the system would be deprived of opportunity to learn from such shortcomings. Finally, the need for there to be a review of the 2011 Metabolic Syndrome resource was conceded by Dr Lagios in evidence during the inquest.

171. ***RECOMMENDATION:*** *I recommend that Justice Health revise the 2011 Metabolic Syndrome Resource to include: (a) the provision of sufficient information and guidance to clinical staff regarding the use, and relevance of, baseline and ongoing ECG testing as part of metabolic monitoring; and (b) to cross-refer to the recommended clinical timeframes for ongoing ECG testing as set out in the 2017 Psychotropic Medication Guidelines, in particular in relation to additional monitoring recommended for specific antipsychotic medication.*

15. Findings

172. Before turning to the findings that I am required to make, I would like to acknowledge and thank Mr Peter Aitken, Counsel Assisting and Ms Carolyn Berry, instructing solicitor from the NSW Crown Solicitor's Office. I am extremely grateful for their valuable assistance and their significant contributions during the inquest, and in the many months spent preparing for it. I would also like to thank and express my appreciation for the efforts of the police officer-in-charge of the investigation, Detective Senior Constable Melissa Martens.

173. The findings I make under section 81(1) of the Act are:

Identity

The person who died was Mr Edward Haenga

Date of death

Mr Haenga died sometime between 10:00pm on 8 June 2013 and 7:15am on 9 June 2013.

Place of death

Mr Haenga died at the Metropolitan Special Programs Centre at Long Bay where he was in lawful custody serving a custodial sentence.

Cause of death

The cause of Mr Haenga's death was cardiac arrhythmia.

Manner of death

Mr Haenga died from natural causes in circumstances where complications from his morbid obesity and his use of multiple, concurrent psychotropic medications which carried the risk of QT interval prolongation, probably contributed to Mr Haenga suffering a fatal cardiac arrhythmia.

16. Epilogue

174. During the words spoken by Mr Haenga's father at the end of the evidence in the inquest it was obvious that Mr Haenga's death has had a profound and devastating effect on Mr Haenga's family. Rather than seeking to assign blame, Mr Haenga's father expressed his appreciation for the inquest process and graciously thanked all counsel, solicitors and court staff involved in the inquest. The dignity shown by Mr Haenga's father should be warmly acknowledged.

175. On behalf of the coronial team and the Coroner's Court I would like to offer my sincere and respectful condolences to Mr Pepe Haenga, Mr Haenga's children, Ms Aparacio, and their extended families.

176. I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
6 November 2017
NSW State Coroner's Court, Glebe