CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Ivan Mikic
Hearing dates:	12 & 13 June 2019; 10 & 21 August 2020
Date of findings:	4 September 2020
Place of findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, cause and manner of death, methadone diversion, opioid substitution treatment, head check, Let-Go procedure, Wellington Correctional Centre
File number:	2015/00323811
Representation:	Ms T Xanthos, Coronial Advocate Assisting the Coroner Mr R Greenhill SC for Corrective Services New South Wales Officers D Williams & J Wykamp Mr B Bradley for Justice Health & Forensic Mental Health Network Ms J de Castro Lopo for Corrective Services New South Wales Ms E McLaughlin for the family of Ivan Mikic
Findings:	I find that Ivan Mikic died on 3 November 2015 at Wellington Correctional Centre, Wellington NSW 2820. The cause of Ivan's death was methadone toxicity, with coronary artery atherosclerosis being a significant condition contributing to death. Ivan died from an unintentional drug overdose following self-administration of methadone that had been acquired in circumstances unknown, most likely following an incident of diversion. At the time of his death Ivan was in lawful custody serving a sentence of imprisonment.

Recommendation: Pursuant to section 82(1) of the *Coroners Act 2009:*

To the Governor of Wellington Correctional Centre:

I recommend that consideration be given to providing correctional officers with refresher and/or increased education and training to assist officers with recognising the signs of methadone overdose in an inmate, and the circumstances in which interventional action may need to be taken to ensure that the inmate is alive and well.

Non-publication orders: See Annexure A

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1. Introduction

1.1 At the time of his death, Mr Ivan Mikic was being held in lawful custody at Wellington Correctional Centre. He was serving a custodial sentence which had been imposed in February 2007. On the morning of 3 November 2015 Ivan was found unresponsive in his cell with no signs of life. Emergency services were called but despite immediate attempts to revive Ivan he was later pronounced deceased.

1.2 The subsequent postmortem examination revealed that Ivan died from the toxic effects of methadone. As Ivan had not been prescribed methadone at the time of his death, this raised questions as to how and where Ivan had obtained the methadone, and the circumstances leading up to his death.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. 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.

2.3 A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. Further, in Ivan's case questions were raised as to observations made of him by Corrective Services New South Wales (**CSNSW**) staff several hours before he was found unresponsive, and as to how the toxic amount of methadone came to be in Ivan's system.

3. Ivan's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future. Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore, it is extremely important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way

3.2 Ivan's father, PM, and his mother, OM, were born in Croatia and Germany, respectively. They both came to Australia at a young age and later met and formed a relationship. They had three children together: DM, MM and Ivan, who was born in 1981. Ivan was initially raised in the suburbs of Western Sydney before the family moved to the New South Wales Hunter region.

3.3 Ivan attended primary school but only had a limited education at secondary school level. Regrettably, due to Ivan's interaction with the criminal justice system, he was unable to sustain any meaningful periods of education or employment.

3.4 Ivan met his eventual de facto partner, MB, when they were teenagers. They later formed a relationship and had a son, JBM, together.

3.5 Although Ivan had frequent interactions with the criminal justice system his brother MM said that he acknowledged his past wrongdoings and accepted penalties imposed by the courts, including the most recent sentence that he was serving at the time of his death. According to Martin, Ivan was attempting to make productive use of his time in custody by looking after his health, seeking assignment to work programs and learning to become a better person. Ivan reportedly had aspirations of starting his own business and building his own home upon his eventual release from custody.

3.6 Ivan was known to have a loud personality and to be what MM described as a show off. There is no doubt that Ivan was, and still is, dearly loved by his family. There is equally no doubt that Ivan loved his son enormously and that the experience of being in custody while JBM was growing up was extremely difficult for Ivan. Notwithstanding, Ivan maintained regular contact with JBM and the rest of his family, and did his best to be a good father to JBM even though he was separated from him.

3.7 It is distressing to know that Ivan's life ended in sudden and tragic circumstances, at a time when he was looking and working towards a better future for himself and his son.

4. Ivan's custodial history

4.1 Ivan had previously been convicted of a range of criminal offences as an adult, dating back to 1999. Some of these convictions resulted in sentences of imprisonment.

4.2 On 28 August 2004 Ivan was charged with a number of offences, including an offence of murder. He was received into the custody of CSNSW at Newcastle Court and later bail refused. On 7 April 2006, at the Supreme Court in Sydney, Ivan was convicted of the offences that he had been charged with. Ivan was subsequently sentenced to partially concurrent terms of imprisonment, with the overall effective sentence being one of 24 years imprisonment, commencing on 29 August 2004 and concluding on 28 August 2028, with an overall effective non-parole period of 20 years, concluding on 27 August 2022.

4.3 Following sentencing Ivan was classified as an A2 maximum security inmate. This classification remained in place following reviews conducted in July and October 2015. In about February 2012, Ivan was placed on an active Special Management Area for Protection (**SMAP**) order at his own

request. This is a form of protective custody where inmates only mix with other inmates of the same categorisation. Ivan was initially detained at Goulburn Correctional Centre from 2006 to 2013 and was later transferred to Wellington Correctional Centre on 24 March 2014.

4.4 Upon his arrival at Wellington, Ivan was continuously managed as a SMAP inmate. Due to his classification, Ivan was housed in Cell 71 within the B2 Block (or Pod) along with other SMAP inmates.

5. The events of 2 November 2015

5.1 On 2 November 2015 Wellington Correctional Centre was partially locked down between 11:30am and 3:00pm in order to facilitate a monthly CSNSW staff meeting. This resulted in the B2 inmates, including Ivan, being locked their cells at 11:30am.

5.2 GM was one of the inmates in B2 Pod, in cell 69, two cells from Ivan's cell. After being locked in his cell Mr GM sent Ivan what is known, in the correctional environment, as a "string line". This is a line connected between cells which inmates use to pass small items (such as coffee, sugar, and makeshift wicks to light cigarettes) between themselves. At about 12:30pm Mr GM sent a string line to Ivan's cell and when he retrieved the line he saw that it had some coffee and sugar attached to it, along with a lighted wick. Mr GM yelled out to Ivan that he had received the items and sent a cigarette, via the string line, to Ivan.

5.3 Another one of the inmates in B2 Pod, MT, was working as a sweeper in the Pod whose role was to maintain the general cleanliness of the pod. Available CCTV footage shows that shortly before dinner was served to the B2 inmates, Mr MT stood on the handle of Ivan's cell door so that he could verbally communicate with Ivan through a vent at the top of the door. This occurred on at least seven occasions over a period of around 20 minutes.

5.4 At around 2:30pm Mr MT was asked by one of the CSNSW officers to take Ivan's dinner to him. Whilst standing at the cell door a CSNSW officer, who accompanied Mr MT to Ivan's cell, called out three times for Ivan to get up out of his bed but Ivan did not do so. Mr MT placed Ivan's dinner on a table in his cell and shook Ivan. At the time Ivan was lying on his back with his left leg hanging off the bed. When Mr MT shook Ivan, he heard Ivan moan and noticed that he looked a bit pale. It appeared to Mr MT that Ivan was snoring and he believed that Ivan was asleep.

5.5 At about 3:30pm Mr GM attempted to attract Ivan's attention by calling out to him a number of times. Mr GM received no answer from Ivan, which Mr GM thought to be unusual. At around 4:30pm Mr GM called out to Ivan again number of further times, and continued to do so intermittently up until 6:50pm. On each occasion, Mr GM did not receive an answer.

5.6 At 10:54pm available CCTV footage indicates that the light in Ivan's cell was turned on, with the sound of a shower running heard from the cell a short time later. At 12:19am on 3 November 2015 the light in the cell was turned off, with no further activity recorded on CCTV footage from this point forward.

6. The events of 3 November 2015

6.1 As at November 2015 it was usual procedure for a head check to be conducted in B2 Pod every morning at around 6:20am. This involves correctional officers checking on inmates in their cells to ensure that they are alive and well, ahead of the daily Let-Go procedure, when inmates are let out of their cells, later in the morning. Both the head check and Let-Go procedures will be discussed in greater detail later in these findings.

6.2 On 3 November 2015 Casual Correctional Officer Jeduam Wykamp and First Class Correctional Officer Dianne Williams attended Ivan cell at about 6:24am to perform a head check. CCTV footage recorded Officer Wykamp opening the flap on Ivan's cell door and remaining at the door for about 19 seconds before moving onto the next cell.

6.3 The Let-Go procedure for B2 Pod was performed later that morning. At about 8:10am Casual Correctional Officer Shaun Leggett, who was assisting with the Let-Go in B2 Pod, opened Cell 71 and saw Ivan who appeared to be asleep. Officer Leggett called out to Ivan, "*Hey, wake up*". When Ivan did not move or respond, Officer Leggett called out to Casual Correctional Officer Simon Kennedy and told him that Ivan was "*sound asleep*".[1] Officers Leggett and Kennedy continued opening other cells as part of the Let-Go procedure and once that was completed, they returned to Cell 71 at about 8:12am.

6.4 From the doorway of the cell Officer Kennedy called out to Ivan and told him to get up. When Ivan did not respond Officer Kennedy entered the cell, stood next to Ivan's bunk and again told Ivan to get up. Officer Kennedy touched the back of Ivan's leg twice but Ivan remained unresponsive. Officer Kennedy placed his fingers on the left side of Ivan's neck to feel for a pulse and found none. Officer Kennedy then noticed that Ivan was unconscious, not breathing and saw Ivan's "*skin to be of a blue colour and his eyes glazed and milky*".[2] Officer Kennedy immediately left the cell and went to the landing to call for assistance.

6.5 First Class Correctional Officer Trevor Mackander arrived at Cell 71 a short time later and also attempted to gain a response from Ivan, without success. As this was occurring, other correctional officers also arrived at Cell 71. Senior Correctional Officer Daniel Drury made a radio call to the monitor room to call for an ambulance and medical assistance whilst other officers initiated cardiopulmonary resuscitation (**CPR**) whilst Ivan was still on his bunk. Ivan was subsequently moved to the ground where CPR continued.

6.6 A number of Justice Health & Forensic Mental Health Network (**Justice Health**) nurses arrived on scene a short time later. Registered Nurse (**RN**) Louise Ashton and RN Clair Avery arrived on scene at about 8:15am and began preparing a defibrillator. RN Melinda Pascoe arrived on scene about two minutes later and saw that CPR was already underway. RN Pascoe noted that Ivan had no spontaneous respirations, pulse or heart sounds, and that his pupils were non-responsive.

[1] Exhibit 1, Tab 21.
[2] Exhibit 1, Tab 21.

6.7 RN Soby Uthup arrived at the scene with RN Pascoe and saw that RN Ashton was already assessing Ivan whilst CSNSW officers were performing cardiac compressions. When she arrived, RN Uthup saw that Ivan was not displaying any signs of life.

6.8 Paramedics arrived on scene at 8:28am. Electronic records from the NSW Ambulance case description noted the following: "*[On examination] [patient] unresponsive, pulseless, not breathing. [Patient] face and arms dark blue, peripherally cold, pupils fixed and dilated, [patient] in extremis/unable to open/inspect airway, [patient's] trachea felt stiff/hard…Correctional center [sic] staff started CPR at 0813. Upon gaining this information we realised [patient] was unwitnessed arrest, had been down for >20 mins, potentially longer*".[3]

6.9 With the assistance of correctional officers and Justice Health nurses, the attending paramedics continued CPR until 8:38am. However, despite these efforts, Ivan could not be revived and was subsequently pronounced life extinct.

7. What was the cause of Ivan's death?

7.1 Ivan was subsequently taken to the Department of Forensic Medicine at Newcastle where a postmortem examination was performed by Dr Leah Clifton on 6 November 2015. Toxicological examination detected a blood concentration of methadone at 0.43mg/L which Dr Clifton described as being a potentially lethal level.[4] It was also noted that Ivan had moderately severe coronary artery disease in a single major coronary vessel, but that this pathology alone was unlikely to have resulted in sudden death.

7.2 Ultimately, Dr Clifton concluded that the cause of Ivan's death was methadone toxicity.

8. What issues did the inquest examine?

8.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the matters to be considered. That list identified the following issues:

(a) What were the circumstances leading to the finding of a potentially lethal concentration of methadone in the postmortem toxicological analysis?

(b) As at November 2015 what measures did CSNSW have in place to prevent the unauthorised diversion of methadone by persons who were administered methadone whilst in custody at Wellington Correctional Centre?

(c) As at November 2015 what measures did Justice Health have in place to prevent the unauthorised diversion of methadone by persons who were administered methadone whilst in custody at Wellington Correctional Centre?

[3] Exhibit 1, Tab 29.
[4] Exhibit 1, Tab 3, page 3.

8.2 These issues are considered in more detail below, together with aspects of the manner of Ivan's death.

9. What were the circumstances leading to the finding of a potentially lethal concentration of methadone?

Methadone diversion

9.1 At the time of his death Ivan was not prescribed methadone as part of any Opioid Substitution Treatment (**OST**) program. This therefore meant that the methadone self-administered by Ivan prior to his death had been obtained from a third party source. It is most likely that the methadone was either covertly brought into Wellington Correctional Centre, without authorisation, from an external source, or diverted by another inmate who was prescribed methadone as part of an OST program.

9.2 Whilst the possibility that the methadone administered by Ivan had been covertly brought into Wellington cannot be entirely excluded, the available evidence suggests that it is most likely that the methadone had been diverted. On the afternoon of 3 November 2015, after Ivan had been pronounced deceased, another inmate (JS) informed Senior Correctional Officer Aaron Edwards that, "*The coroner will just have to do a tox screen to see that [Ivan] overdosed on methadone*". When Officer Edwards asked Mr JS where Ivan obtained the methadone from, Mr JS replied, "*He gets it from the other boys, it's putrid drinking other people's vomit*".[5]

9.3 Investing police later obtained a statement from Mr JS in which he explained his general knowledge of the use of methadone whilst in custody. Mr JS said that it was common knowledge that methadone is the main form of currency in B2 Pod, and that it is sold by some inmates to other inmates for money, cigarettes or other personal goods and items which an inmate may purchase as part of their "buy up". Mr JS explained that the process of obtaining methadone involved an inmate, who was on the OST program, being given their dose and then keeping it in their mouth (and not swallowing it) or then regurgitating the methadone into a small bucket. The swallowed methadone is then passed through a t-shirt, with the fabric acting as a filter, so that the collected methadone can then be sold to other inmates.

9.4 Mr JS said that he had previously seen Ivan use methadone "*on many occasions*"[6] and said that he was aware that Ivan had a shortened syringe (described as a "fit") which he kept secreted inside his anus. Indeed, the autopsy identified a 50 millimetre long syringe with attached sheathed needle encased in tissue paper and rubber in Ivan's distal descending colon lumen.

9.5 **Conclusions:** The available evidence establishes that it is most likely the methadone which Ivan self-administered had been obtained by him after being diverted by another inmate who was on an OST program. However, it is not possible to identify exactly when and how the methadone was obtained.

[5] Exhibit 1, Tab 21.
[6] Exhibit 1, Tab 11 at [10].

Rigor mortis

9.6 One aspect of the manner of Ivan's death that was of particular focus during the inquest was the head check performed by Officers Wykamp and Williams at around 6:24am on 3 November 2015. This is because during the emergency response to Ivan being found unresponsive on the morning of 3 November 2015 it was noted by some of the responders that Ivan may have been displaying signs of rigor mortis, suggesting that he had died sometime earlier. Therefore, a question arose as to whether Ivan may have been in extremis, or already deceased, by the time of the head check.

9.7 In her statement RN Pascoe expressed the view that, in her experience as a nurse since 1990 and having seen expired bodies, it is likely that Ivan "*expired a couple hours earlier, perhaps longer*" prior to the emergency response.[7] RN Pascoe explained that she came to this view "*as the jaw was set hard, and the look of the face was set, and [Ivan] had some kind of rigor stiffness that happens after some time of death*".[8] RN Pascoe went on to explain that the stiffness surprised her as she "*was expecting to attend someone that had just expired*" and that Ivan, in her opinion, was deceased "*for a longer time than anyone could have been resuscitated successfully*".[9]

9.8 In evidence, RN Pascoe explained that because Ivan's pupils were fixed and dilated with no response to light, there was some stiffness in Ivan's face, and his face was cold with a slight mottling to the back of his face it appeared that Ivan "*had been expired for a total while*".[10] Further, RN Pascoe was unable to open Ivan's mouth or move his jaw in order to insert a Guedel (oropharyngeal) airway.

9.9 In a statement, Dr Clifton expressed the view that the description by RN Pascoe of Ivan's jaw as being "*set hard*" is suggestive that rigor mortis was establishing, or had established, in the jaw. Dr Clifton explained that rigor mortis is known as the stiffening of muscles after death and develops due to depletion of adenosine triphosphate (**ATP**), which usually acts to relax myosin complexes in muscle fibres. ATP depletion therefore leads to prevention of muscle fibres from relaxing and results in stiffening of muscles.

9.10 Dr Clifton explained that rigor mortis typically begins to develop within two hours after death, beginning in smaller muscles of the body such as the face and jaw, followed by the neck, wrists and ankles, and then the knees, elbows and hips. Dr Clifton explained that it usually takes between six and twelve hours to develop full rigor mortis. It can be accelerated in certain conditions, such as where there has been a high body temperature or warm environment prior to or at death, and its onset can be delayed when the body is in cooler temperatures.

9.11 When asked to provide an opinion as to the length of the post mortem interval, Dr Clifton said this: "*It is difficult to be accurate in the assessment of time since death in any situation. There are many variables and it is acknowledged in the forensic literature that rigor mortis is the most uncertain and most unreliable post mortem event, and caution must be exercised when estimating time since death based solely on rigor mortis. Assuming the assessment of rigor mortis in the jaw is correct, that the ambient temperature in the cell wasn't extremely high and that [Ivan] didn't have*

[7] Exhibit 1, Tab 15 at [3].
[8] Exhibit 1, Tab 15 at [3].
[9] Exhibit 1, Tab 15 at [3].
[10] 12/6/19, T44.46.

an elevated core temperature, and hadn't been engaging in strenuous activity at the time of his death, in my opinion, [Ivan] had likely been deceased for upwards of 2 hours (potentially more)".[11]

9.12 In evidence, Dr Clifton reaffirmed the opinion expressed above and emphasised that there is no way to scientifically and ethically study this process and therefore make a determination as to how long a person has been deceased based solely on rigor mortis. Dr Clifton explained that even if information regarding the variables referred to above was available it would still be difficult to make any accurate determination of the time of Ivan's death based solely on the degree to which rigor mortis had occurred.

9.13 Ultimately, Dr Clifton indicated that the information provided by RN Pascoe that she had difficulty manipulating Ivan's jaw indicated that rigor mortis was establishing in the jaw at the time that Ivan was examined. To Dr Clifton this finding meant that it was not at the commencement of rigor mortis but, rather, well into the process. Ultimately, Dr Clifton opined that it was highly unlikely that Ivan had been deceased for about 15 to 20 minutes, that it was possible he had been deceased for around an hour but that this was probably not the case, and that it was most likely that Ivan was deceased for at least two hours and probably more.

9.14 **Conclusions:** Given the limitations associated with attempting to determine the time of a person's death based purely on rigor mortis, it is not possible to reach any precise conclusion as to when Ivan died. However, the evidence of Dr Clifton indicates that by the time that RN Pascoe noted some stiffness in Ivan's face and was unable to open his jaw to insert a Guedel airway at 8:29am, it is most likely that Ivan had been deceased for upwards of two hours, and potentially longer. It is not possible to reach any conclusion about the extent to which (if any) the post mortem interval exceeded two hours.

Head check

9.15 Dr Clifton explained in evidence that death due to methadone toxicity usually occurs following a period of drowsiness, somnolence or unconsciousness in a person over some hours, although it can also result in instances of cardiac arrhythmia causing a sudden collapse. This in turn raised a question as to whether Ivan was displaying signs of methadone overdose at the time that the head check was performed on the morning of 3 November 2015.

9.16 Section 12.1.9.2 of the CSNSW Operations Procedures Manual (**OPM**), which was in operation as at November 2015, deals with inmate Let-Go procedures. It provides that after a correctional officer identifies the name of an inmate in a cell (by verifying the cell card against the Muster Book) the correctional officer will open the cell door and call the inmate by name. Section 12.1.9.2 goes on to provide: "*If the inmate does not respond the correctional officer will attempt to wake the inmate and satisfy themselves that the inmate is in good health. If an inmate does not readily respond, the correctional officer will assume that some harm has come to the inmate and immediately implement the discovering officer procedures for inmates who self-harm*".[12]

[11] Exhibit 1, Tab 4, page 3.
[12] Exhibit 1, Tab 27.

9.17 These steps are mirrored in the Standard Operating Procedure (**SOP**) for Wellington Correctional Centre relating to Inmate Let-Go Procedures, issued in January 2015. Section 5.6 of the SOP provides: "*A minimum of two officers will conduct Let-Go on each landing. The first officer will unlock the cell door, the second officer will open the cell door, and call the inmate(s) by name(s). If an inmate does not respond (both a verbal and physical response is required) the correctional officer will attempt to wake the inmate and satisfy themselves that the inmate is in good health*".[13]

9.18 Section 5.7 also provides for the discovering officer procedure to be implemented if an inmate does not respond after an officer has made repeated attempts to rouse them. Section 5.8 further provides: "*Officers performing Let-Go procedures will ensure they can physically attest to the fact that all inmates are accounted for and are alive and well prior to moving onto the next cell and continuing with Let-Go*".[14]

9.19 Whilst it is apparent that in November 2015 Wellington Correctional Centre had a SOP in relation to inmate Let-Go procedures, there was no equivalent SOP, or formal procedure document, for the performance of head checks. Craig Smith, the Governor of Wellington Correctional Centre at the time, explained that whilst head checks were not mandated, they were often performed at some correctional centres (including Wellington) as an extra precaution. Governor Smith went on to explain that the purpose of the head check was, consistent with relevant sections of the OPM, to ensure that inmates are alive and well, and that if the check identified a serious incident (such as a security breach) it could be managed prior to the Let-Go procedure. Governor Smith explained that in practice the head check streamlined the morning Let-Go procedure and allowed inmates to be released from their cells in a more timely and efficient manner.

9.20 Senior Correctional Officer David Onions, the Night Senior for B2 Pod, explained that the head check was also performed as it facilitated the transfer of inmates who were required to be escorted from the correctional centre to attend court. Officer Onions described a head check in this way: "'*Head check' is a physical check through the door flap. Officers get a response from the inmate, either verbal or a movement, for example the inmate will shout out, poke his arm or leg out to show he is alive and well*".[15]

9.21 Upon conducting the head check of Cell 71 at approximately 6:24am, Officer Wykamp noted the following in his incident report dated 3 November 2015: "*I asked for a response – as I always do for each cell that I am conducting a head check for. I waited for a few seconds, until I received a response – after receiving a response I then moved onto the next cell. I can't recall the exact nature of the response I received from Cell 71, inmate Mikic, due to having checked a large amount of cells. However, I am aware that I received a response due to always following the same procedure asking for a response from the inmate (or inmates) with the cell, waiting for a response and then when I receive a response I move onto the next cell*".[16]

9.22 In evidence, Officer Wykamp explained that when performing head checks it was his usual practice to open the flap in the cell door and call out to the inmate words to the effect of, "*I just need a*

[13] Exhibit 1, Tab 28.
[14] Exhibit 1, Tab 28.
[15] Exhibit 1, Tab 24 at [6].
[16] Exhibit 1, Tab 22.

response. I just need you to move for me, mate".[17] Officer Wykamp went on to explain that following this an inmate would usually provide a verbal response (by spoken word, rather than a groan or snoring), or move their arm or leg, and that most inmates were aware of the nature of a head check and the time it was usually performed. Officer Wykamp indicated that if he did not receive a verbal or physical response at first instance he would usually bang on the flap of the cell door which then usually elicited a response from an inmate. In the absence of receiving a response following this further enquiry, Officer Wykamp explained that he would seek the assistance of another correctional officer in order to perform first responder duties by opening the cell door in order to assess the situation and the reason for the absence of any response.

9.23 Officer Wykamp said that whilst he could not recall the exact nature of the response given by Ivan on the morning of 3 November 2015 he was certain that he did receive a response. Officer Wykamp explained: "*I know I received a response because if I didn't, I would have done, as I said before, the first responding officer duties. So I always make sure I receive a response. If I didn't get a response, I would have done that, so I wouldn't have moved along*".[18]

9.24 Officer Williams explained in her statement that her usual practice when performing a head check was to open the window flap of each cell door, obtain a clear view of the inmate (turning on the cell light if necessary), call out "*head check*" and expect to hear a verbal response, look for any movement by the inmate and if none was observed, request the inmate to move. Officer Williams said that once she was satisfied that she had heard a response from an inmate, and observed the inmate move, she would move onto the next cell. In evidence, Officer Williams confirmed that it was her usual practice to not move on from a cell until she had received both a verbal response from an inmate and some type of physical movement.

9.25 In relation to the morning of 3 November 2015, Officer Williams agreed that she performed a head check of B Pod with Officer Wykamp at approximately 6:20am. Officer Williams provided this account: "*I did not hear a response from Ivan Mikic. I did not do the head check on his cell. I only heard responses from cells that I attended to on that morning*".[19] In evidence, Officer Williams indicated that she was performing a head check at cell 70 at the same time that Officer Williams was performing a head check in the adjacent cell where Ivan was housed. Officer Williams said that she did not have a particular recollection of the nature of the head check performed by Officer Wykamp, and whether he experienced any difficulty in obtaining a response from Ivan. However, Officer Williams said she did not notice anything about the head check performed by Officer Wykamp that made her believe it had not been performed correctly.

[17] 12/6/19, T21.39.
[18] 12/6/19, T23.10.
[19] Exhibit 1, Tab 23 at [8].

9.26 **Conclusions:** There is no evidence to suggest that Officer Wykamp did not perform a head check at Ivan's cell on the morning of 3 November 2015 in accordance with his usual practice, and the practice that had been adopted at a local level at Wellington Correctional Centre. Whilst Officer Wykamp could not recall the response that Ivan gave when the head check was performed, the available evidence indicates that the response was sufficient to allow Officer Wykamp to continue with the head check of other cells. Having regard to this evidence, and the conclusions already reached above regarding the limitations associated with determining time of death based purely on the onset of rigor mortis, it is most likely that Ivan was not deceased at the time that the head check was performed.

9.27 Notwithstanding, this does not exclude the possibility that Ivan was in the terminal phase of methadone overdose and experiencing drowsiness or somnolence as described by Dr Clifton. Depending on the extent of this presentation, Ivan may still have been able to provide an adequate response to the head check. However, as this remains only a possibility on the available evidence, it cannot be said with any certainty that there was a missed opportunity to identify a serious medical event at the time of the head check and, accordingly, intervene to provide medical assistance.

10. What measures did CSNSW have in place to prevent the unauthorised diversion of methadone at Wellington?

10.1 Section 12.1.11.2 of the OPM dealt with the dispensing of restricted drugs at a Health Centre within a correctional centre. It relevantly provided for a correctional officer to act as a witness to the administration of a restricted drug, which included watching an inmate consumed the drug as directed by a Justice Health nurse, and searching the inmate to ensure that the drug had not been diverted.

10.2 Section 12.1.11.3 of the OPM set out a number of additional controls when dispensing, relevantly, methadone. It noted that whilst Justice Health had its own policy and procedures to follow concerning the dispensation of methadone and controls to minimise the risk of diversion, operational support would be provided by correctional officers to assist in minimising such risk. It relevantly provided that a supervising correctional officer would:

(a) Ensure that the inmate to whom methadone is dispensed is not carrying anything in their hands or in their pockets, except their identification card;

(b) Visually check the inmate's mouth to ensure that it is empty (including ensuring that dental prostheses are removed);

(c) Pat searching the inmate with particular checks of collars, sleeves, pockets and hands.

10.3 During the course of the coronial investigation it became apparent that following Ivan's death, Wellington Correctional Centre adopted a practice whereby inmates who had received their methadone as part of OST were placed in what was described as a holding yard for observation to mitigate the risk of methadone diversion. Governor Smith explained that the procedure was

introduced a short time after Ivan's death (in an attempt by CSNSW to be proactive, as he described it) although he could not say how long it remained in place for. Governor Smith explained that under the procedure inmates from each wing would be brought to have their methadone dispensed to them as a group, with each group subsequently kept in a room (described as a holding yard) whilst the following group had their methadone dispensed to them in turn. Whilst in the holding yard, inmates would be monitored by correctional officers outside of the holding yard, as well as by CCTV cameras within the holding yard. The footage from the holding yard would be displayed on monitors for review by other correctional officers, in addition to reviewing footage from cameras in other parts of the correctional centre.

10.4 Despite these measures, Governor Smith explained that instances of diversion still occurred. Two obvious difficulties associated with this procedure are that inmates could simply turn away from the CCTV cameras in order to conceal any diverted methadone, or inmates could simply divert to other inmates in the same holding yard.

10.5 Governor Smith went on to explain that this procedure continued for a number of months, but was later discontinued because, as he described it, became a "*logistical nightmare*". This is because, Governor Smith explained, the holding of groups of inmates in the holding yard resulted in delaying or preventing the necessary administrative movement of inmates within the correctional centre and out of the centre (to attend court, for example). As Governor Smith described it, the procedure caused other operations within the correctional centre "*to ground to a halt*".

10.6 In evidence, Governor Smith agreed that it was routine procedure for inmates to be locked in their cells for more than 16 hours in pods where there were a high percentage of inmates on methadone (for example, 13 out of 29 inmates in the B2 Pod were receiving methadone). Governor Smith said that the possibility of more frequent checks being conducted of inmates to ensure that they are alive and well had previously been raised at a number of correctional centres, without any change in procedure. However, Governor Smith acknowledged that he could see the benefit in more frequent checks being conducted at correctional centres where methadone diversion is a known problem and where there is a high percentage of inmates receiving methadone and housed in a one-out cell by themselves.

10.7 Counsel for Ivan's family submitted that Ivan was at particular risk of methadone overdose given the following factors:

(a) whilst not receiving methadone as part of an OST program he had a history of opiate addiction

(b) he was housed in a Pod where there was a high percentage of inmates receiving methadone as part of an OST program;

(c) there was a known problem with methadone diversion at Wellington Correctional Centre at the time of his death; and

(d) he was housed in a one-out cell.

10.8 On this basis, counsel for Ivan's family submitted that a recommendation ought to be made to CSNSW that it develop a welfare check policy targeted at inmates known to be vulnerable to the risk of methadone overdose and who may be left unchecked for long periods of time. Counsel for Ivan's family further submitted that recommendations ought to be made to CSNSW that it conduct refresher training in relation to the proper conduct of welfare checks to ensure that correctional officers understand the potential signs of methadone overdose, and that CSNSW conduct an audit of the implementation of its policies in relation to preventing methadone diversion.

10.9 Officers Wykamp and Williams both gave evidence that as part of initial training provided to correctional officers they had received training in relation to identifying signs of potential drug overdose by an inmate. However, both officers indicated that they had not received specific training in relation to identifying signs of methadone overdose. Further, Officer Wykamp indicated that as at November 2015 he was unaware of the signs of methadone overdose.[20]

10.10 **Conclusions:** Counsel for Ivan's family submitted that Ivan was at particular risk of methadone overdose. However caution must be exercised when the assessment of any such risk is considered retrospectively and with the benefit of hindsight. In this regard, the inquest did not receive any empirical evidence that Ivan's past history and the circumstances in which he was housed placed him at any greater risk of a fatal methadone overdose over and above any other inmate. Indeed, although the evidence established that methadone diversion was a known problem at Wellington Correctional Centre, Governor Smith gave evidence that as far as he was aware Ivan's death was the first instance of a fatality related to methadone overdose (although there had been other instances of non-fatal overdose).

10.11 In this regard, it could not be said that an evidentiary basis has been demonstrated in order to recommend that CSNSW implement a welfare check policy for vulnerable inmates at Wellington. No evidence was given at inquest as to how such a policy might be implemented and the type of assessment of inmates that would be required to identify those with particular vulnerabilities. Similarly, the evidence did not establish any systemic shortcoming or non-compliance with relevant CSNSW policies regarding the dispensing of methadone. No witness from CSNSW was asked about this issue at inquest.

10.12 The issue of minimising methadone diversion, where it is frequently used as currency in correctional centres, is a complex and challenging one. Governor Smith acknowledged, on the one hand, the potential benefit associated with increasing the frequency of when inmates are checked on in correctional centres where methadone diversion is a known problem. However, on the other hand, Governor Smith also explained that inmates being locked in their cells for extended periods overnight was routine procedure and that checks which would disturb inmates, particularly when inmates are sleeping, would be likely to cause disharmony, if not open hostility, between inmates and correctional officers.

[20] 12/6/19, T28.33.

10.13 It should be noted that the inquest primarily received evidence regarding methadone diversion only in relation to Wellington Correctional Centre. No evidence was received as to the prevalence of methadone diversion at other correctional centres, apart from Governor Smith noting (as the current Governor of the Metropolitan Remand and Reception Centre (**MRRC**)), that instances of diversion at the MRRC were fewer in comparison to at Wellington due to, according to Governor Smith, the nature of the inmate population.

10.14 It would seem then that the most practical way to address the potential risk of inmates becoming susceptible to methadone overdose at Wellington Correctional Centre is to increase the effectiveness of existing routine checks. This could be accomplished by providing correctional officers with refresher and/or increased training to better recognise the potential signs of methadone overdose. The evidence of officers Wykamp and Williams suggests that specific training in relation to identifying the signs of methadone overdose in an inmate has not been provided to correctional officers, or at least has not been provided since correctional officers undertake their initial training. Whilst the solicitor for CSNSW submitted that such training is already provided to correctional officers as part of their initial training, it was acknowledged that CSNSW would not be opposed to a recommendation being made in this regard. Therefore, I consider that it is desirable to make the following recommendation.

10.15 **Recommendation:** I recommend to the Governor of Wellington Correctional Centre that consideration be given to providing correctional officers with refresher and/or increased education and training to assist officers with recognising the signs of methadone overdose in an inmate, and the circumstances in which interventional action may need to be taken to ensure that the inmate is alive and well.

11. What measures did Justice Health have in place to prevent the unauthorised diversion of methadone at Wellington?

11.1 At the time of Ivan's death Justice Health had in place a number of procedures specifically related to OST which were set out in the Justice Health Drug & Alcohol Procedure Manual (**the Manual**). These procedures were developed for use across the Justice Health Network and were not site specific to Wellington or any other correctional centre. In November 2015, there were 106 patients on the methadone OST program at Wellington.

11.2 OST No. 15 of the Manual deals with *Management of Non-Compliance With/Diversion of OST Medication.* It defines diversion as "*the act of supplying a controlled drug or regulated medication to someone other than whom it was prescribed to, and supply to illicit drug markets. This includes the selling, trading, sharing or giving away of prescription medications to a third party. Diversion may be voluntary or involuntary*".[21]

11.3 OST No. 5 of the Manual sets out a number of procedural steps to be followed by Justice Health staff regarding the dosing of methadone to inmate patients as part of OST. It relevantly provides that when a patient attends a correctional centre health centre for their methadone dose, a correctional officer supervising the dosing will ensure that the patient:

[21] Exhibit 1, Tab 17, page 109.

(a) Has their sleeves rolled up;
(b) Is not holding anything in their hands, other than their identification card;
(c) Is pat searched for containers;
(d) Opens all clothing around the neck to ensure that no plastic bags or containers are secreted; and
(e) Has no absorbent material (such as cotton wool) secreted in their mouth.

11.4 OST No. 5 also provides that there must be only one patient to be dosed at the dispensary window at any time and that the patient must be easily visible and facing the nursing staff during the entire dosing procedure. Further, methadone is to be administered by a registered nurse and the administration of the dose is to be witnessed and checked by a second staff member. Finally, OST No. 5 provides that "*it is the responsibility of the registered nurse to ensure that the dose administered has been swallowed (in the case of methadone)"*[22] *and "to watch the patient as she/he drinks the methadone*".[23]

11.5 Further, the Justice Health *Guide to Management of Diversion & Non-Compliance With Opioid Substitution Treatment* provides a list describing various incidents of actual and attempted diversion so that they may be more readily identified by Justice Health staff, together with action to be taken by staff in response to such incidents.

11.6 As already noted above, several witnesses, including Governor Smith, gave evidence that preventing methadone diversion has historically been, and remains, a challenge at least at Wellington, if not at other correctional centres. It would therefore be unrealistic to consider that the procedures put in place by Justice Health and CSNSW could successfully prevent any diversion of methadone at all.

11.7 Notwithstanding, the inquest did not receive any evidence to indicate that in November 2015 there was some systemic deficiency regarding the application of procedures set out in the Manual pertaining to the management of diversion of methadone. Further, as it is only possible to speculate about how the methadone administered by Ivan might have been obtained, there is also no evidence specifically relating to a possible instance of diversion in this regard (noting that the possibility of the methadone having been introduced into Wellington from an external source cannot be entirely excluded).

11.8 To the contrary, in their evidence both RN Ashton and RN Pascoe were asked about their experience in dispensing methadone to inmate patients. Whilst RN Pascoe had only been involved in such dispensation on approximately eight occasions, RN Ashton was considerably more experienced in dispensing methadone. In their evidence both RN Ashton and RN Pascoe demonstrated a familiarity with the procedures set out in the Manual in relation to preventing diversion. In particular, RN Ashton explained that she was well known for requesting correctional officers to check the mouth of an inmate again if she suspected that the inmate had attempted to

[22] Exhibit 1, Tab 17, Annexure A, page 63.
[23] Exhibit 1, Tab 17, Annexure A, page 64.

divert methadone, and that inmates suspected of diverting were placed in a management cell with minimal furnishings that could be used to conceal diverted methadone.

11.9 Finally, it should be noted that the inquest received evidence from Stephen Ward, the Acting Service Director Drug & Alcohol, Clinical Operations at Justice Health. Mr Ward gave evidence that in January 2020, following completion of a two-year clinical trial, Justice Health commenced providing inmate patients with a new treatment in relation to OST. This new treatment involves inmates commencing an OST program routinely being given a buprenorphine depot injection which lasts for one month. The depot is a subcutaneous injection which dissolves under the skin, and is used as part of OST instead of dispensing methadone.

11.10 In evidence, Mr Ward explained that new inmates entering custody who require OST are commenced on depot injections unless there are clinical contraindications, or the inmate is already receiving methadone. This has resulted in a reduction in the percentage of inmates receiving methadone as part of OST from approximately 90 percent down to approximately 52 percent. Further, as the depot is a subcutaneous injection, Mr Ward gave evidence that it is not possible to divert it and that during its clinical trial Justice Health found no evidence of any instances of diversion. It should be noted that whilst the depot injection is available to inmates entering custody, it is not available to inmates already receiving methadone as part of an OST program. This is because there is currently no medical literature or clinical guidelines in relation to safely transitioning a patient receiving methadone to a buprenorphine depot injection. Mr Ward explained that any such transition could only be conducted with inmates in custody for a significant period of time so that the transition could be closely monitored and clinical contraindications identified.

11.11 **Conclusions:** The evidence establishes that as at November 2015 Justice Health (in conjunction with CSNSW) had in place at Wellington (and other correctional centres) a number of procedures designed to minimise the risk of methadone diversion. There is no direct evidence to suggest that the practice of Justice Health staff was inconsistent with these procedures. Notwithstanding, it is evident that despite these procedures (and similar procedures put in place by CSNSW) instances of diversion still occurred, most likely sometime after and away from the point of dispensing, and most likely by a process of an inmate regurgitating methadone. Whilst it is acknowledged that such practices are difficult to monitor and impossible to prevent, there is no evidentiary basis to make any recommendation that the relevant procedures within the Manual be amended in any way.

11.12 The new treatment introduced recently by Justice Health for administration of buprenorphine depot injections for new inmates entering custody who require OST has resulted in a reduction in the percentage of inmates receiving methadone. This reduction, and the nature of the depot injection itself, has in turn produced the likelihood of instances of methadone diversion. It is hoped that there will be an increased uptake in the number of inmate patients able to receive the depot injection over time.

11.13 In the course of submissions counsel for Ivan's family made reference to OST No. 1 of the Manual which deals with the assessment of inmates for OST. It relevantly provides that its call is "*to ensure that any patient who was commenced on a OST program whilst in custody is clinically appropriate*

for treatment as per the NSW clinical guidelines".[24] Counsel for Ivan's family also referred to one aspect of RN Ashton's evidence in which she indicated that it was her understanding that inmates who were stable on OST would be reassessed every 12 months by a medical practitioner. From these two pieces of evidence, counsel for Ivan's family submitted that because diversion was a persistent issue, and because methadone was known to be used as a form of currency within Wellington, this suggested that a number of inmates were receiving methadone for non-therapeutic reasons. On this basis, counsel for Ivan's family submitted that a recommendation ought to be made to Justice Health to conduct an audit of the implementation and operation of its OST program at Wellington Correctional Centre.

11.14 Clause 1 of OST No. 1 provides that "*all patients entering the correctional system on an Opioid Substitution Treatment (OST) program are maintained on that treatment unless clinically indicated otherwise*".[25] It further provides that any patient requesting to commence on OST Program is to have an initial risk assessment, followed by a drug and alcohol nursing assessment and a drug and alcohol medical assessment which is to be documented in the patient's current health record. OST No. 2 sets out a number of procedures relevant to commencing an inmate on OST. Neither OST No. 1 or OST No. 2 were the subject of any direct evidence during the inquest.

11.15 **Conclusions:** It has already been indicated that there is insufficient evidence to allow for a conclusion to be reached that the methadone administered by Ivan originated from a particular source. Whilst it is most likely that the methadone was sourced from an incident of diversion, it is not possible to reach any definitive conclusion on this issue. This alone means that it is difficult to make the recommendation sought by counsel for Ivan's family. Further, even if it could be definitively established that the methadone administered by Ivan was sourced from an incident of diversion, there is no evidence to suggest that an inmate who was receiving methadone was not clinically indicated to be on the OST Program. This issue was not canvassed during the course of the inquest and no witness was called to address this issue. Therefore, there is no evidentiary basis to make the recommendation sought by counsel for Ivan's family.

12. Findings

12.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Tina Xanthos, Coronial Advocate, for her excellent assistance both before, and during, the inquest. I also thank Inspector Ben Johnson for his role in the police investigation and for compiling the initial brief of evidence.

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

Identity

The person who died was Ivan Mikic.

Date of death

Ivan died on 3 November 2015.

[24] Exhibit 1, Tab 18.
[25] Exhibit 1, Tab 18.

Place of death

Ivan died at Wellington Correctional Centre, Wellington NSW 2820

Cause of death

The cause of Ivan's death was methadone toxicity, with coronary artery atherosclerosis being a significant condition contributing to death.

Manner of death

Ivan died from an unintentional drug overdose following self-administration of methadone that had been acquired in circumstances unknown, most likely following an incident of diversion. At the time of his death Ivan was in lawful custody serving a sentence of imprisonment.

12.3 It is devastating to know that Ivan's passing occurred in sudden circumstances, especially during a period where he had resolved to make changes in his life and had made plans for his future. On behalf of the Coroners Court of New South Wales, I offer my deepest sympathies, and most sincere and respectful condolences, to Ivan's family for their most painful loss.

12.4 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
4 September 2020
Coroners Court of New South Wales

Inquest into the death of Ivan Mikic
File Number: 2015/00323811

Annexure A

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

1. The names (and any photograph or other pictorial representation) which identifies any of the following persons:

   (a) PM;
   (b) OM;
   (c) DM;
   (d) MM;
   (e) JBM;
   (f) MB.

2. CSNSW - Operations Procedures Manual (superseded) - section 12.1 - Version 1.33 Aug 2015 General Matters affecting the Safety Security and Good Order and Discipline of a Correctional Centre;

3. CSNSW Investigations Branch Report into the death of Ivan Mikic;

4. CSNSW Investigation Report Attachment 1 - CSNSW Inmate Profile document - Ivan Mikic;

5. CSNSW Investigation Report Attachment 49 - CSNSW Inmate Profile document - Inmate JS;

6. CSNSW Investigation Report Attachment 50 - CSNSW Inmate Profile document - Inmate GM;

7. CSNSW Investigation Report Attachment 51 - CSNSW Inmate Profile document - Inmate DK;

8. CSNSW Investigation Report Vol 2- Attachment 5 - Inmate List A-Z;

9. CSNSW Investigation Report Vol 2- Attachment 6 - Daily roster of employees at Wellington CC - 2/11/ 15;

10. CSNSW Investigation Report Vol 2 - Attachment 7 - Daily roster of employees at Wellington CC - 3/11/15;

11. CSNSW Investigation Report Vol 2- Attachment 8 - Wellington Standard Operating Procedure (SOP) Let Go Procedure;

12. CSNSW Investigation Report Vol 2- Attachment 9 - Post Duties;

13. CSNSW Investigation Report Vol 2 - Attachment 19 - Offender Telephone lists;

14. CSNSW Investigation Report Vol 2 - Attachment 36 - Inmate Profile Document Inmate TM;

15. CSNSW Investigation Report Vol 2 - Attachment 37 - Inmate Profile Document Inmate SF;

16. CSNSW Investigation Report Vol 2 - Attachment 38 - Inmate Profile Document Inmate JH.

Magistrate Derek Lee
Deputy State Coroner
4 September 2020
Coroners Court of New South Wales