CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Robert Maxfield
Hearing date:	9 March 2021
Date of findings:	9 March 2021
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of inmate at Cooma Correctional Centre – cause of death multi drug toxicity.
File number:	2019/181202
Representation:	Coronial Advocate assisting the inquest: Sgt K Mackay. Justice Health and Forensic Mental Health Network: N Szulgit. The Commissioner, Corrective Services NSW: A Smith, Department of Communities and Justice.

Findings:	**Identity** The person who died is Robert Maxfield. **Date of death**: Robert Maxfield died between the dates of 9 and 10 June 2019. **Place of death**: Robert Maxfield died at Cooma Correctional Centre, **Cause of death:** The cause of Robert Maxfield's death is multiple drug toxicity. **Manner of death:** Robert Maxfield died as a result of an accidental drug overdose, while he was in lawful custody at Cooma Correctional Centre.

Non publication orders

Orders prohibiting publication of certain evidence pursuant to section 74(1)(b) of the *Coroners Act 2009* [the Act] have been made in this inquest. A copy of these orders, and corresponding ones pursuant to section 65(4) of the Act, can be found on the Registry file.

Section 81(1) of the Act requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of Robert Maxfield.

Introduction

1. On the morning of 10 June 2019 Robert Maxfield aged 45 years was found unresponsive, lying on his bed in the cell which he shared with another inmate at Cooma Correctional Centre. Mr Maxfield had been an inmate there since 24 March 2019. He would have been eligible for release on 27 February 2020.

2. Since Mr Maxfield was in lawful custody at the time of his death, an inquest into the circumstances of his death is mandatory pursuant to sections 23 and 27 of the *Coroner's Act 2009*.

The role of the Coroner

3. The Coroner must make findings as to the date and place of a person's death, and the cause and manner of death.

4. In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

The post mortem report

5. An autopsy examination was performed by forensic pathologist Dr Johan uflou. Dr Duflou did not find any significant injuries, but did locate healed scars on Mr Maxfield's arms, suggestive of prior self harm.

6. Toxicological analysis of Mr Maxfield's blood detected methadone, at a level which in Dr Duflou's opinion might be expected to cause death from respiratory depression. Further testing indicated that Mr Maxfield had likely been ingesting methadone for at least one and a half months prior to his death. Dr Duflou also found the presence of the antidepressant mirtazapine at a level that was capable of causing somnolence as a side effect.

7. Dr Duflou found the cause of Mr Maxfield's death to be multiple drug toxicity, with methadone likely to have been the drug with the qpredominant adverse effect.

Mr Maxfield's life

8. Robert Maxfield was born on 20 June 1973. He had a long de facto relationship with Veronique Kovacovic which was still current at the time of his death. The couple had three children Nathan, Jason and Jeremy. Mr Maxfield worked casually as a concreter.

9. Mr Maxfield struggled with dependence on illicit drugs. He attempted rehabilitation and had participated in the methadone program.

Mr Maxfield's medical history

10. Mr Maxfield had a medical history of gastro-oesophageal reflux disease and he had a single kidney. He had also been diagnosed with schizophrenia and depression for which he used the prescription drugs olanzapine and mirtazapine. From March 2019 Mr Maxfield was incarcerated at Cooma Correctional Centre where he was classified as minimum security and shared a cell with another inmate.

11. While he was in custody Mr Maxfield received his prescribed medications in a monthly pack for him to self administer. The last pack he received before his death was on 29 May 2019.

12. Between January 2019 and May 2019 Mr Maxfield had regular reviews of his blood pressure, pulse, temperature and weight. The results were all within the normal range. He underwent a psychiatric review via telehealth on 8 May 2019. In the opinion of the psychiatrist he did not display suicidal thoughts, and his dosage of olanzapine was reduced. There was a plan to review his mirtazapine dose in the future.

The events of 9 and 10 June 2019

13. Mr Maxfield's activities on the day and evening of 9 June 2019 were not unusual for him. He took some exercise and played cards with fellow inmates. At about 3.20pm he and his cell mate went into their cell for the afternoon and evening. According to his cell mate, Mr Maxfield lay on his bunk, which was the bottom bunk, and watched TV.

14. A heavy snorer, Mr Maxfield dozed until 7.30pm when his cell mate asked him if he was awake. Mr Maxfield responded with a moaning sound, then returned to loud snoring. The cell mate went to sleep at about 8.30pm. Although he awoke at times throughout the night he did not hear Mr Maxfield snoring.

15. A head check was conducted at approximately 8.05am the next morning. Correctional officers found Mr Maxfield lying on his bunk, with his legs over the side of the bed. He was cold to the touch and did not respond to their efforts to rouse him.

16. Correctional officers commenced first aid and CPR, which was continued by ambulance officers when they arrived at 8.16am. However Mr Maxfield could not be revived and he was pronounced deceased at 8.26am.

What was the source of the methadone?

17. I have noted that the cause of Mr Maxfield's death was found to be multidrug toxicity, with methadone detected in his post mortem blood at relatively high concentrations.

18. In Australia methadone may only be legally sourced through a treatment program. It is usually administered as a treatment substitute for heroin and other opioids. There is such a program for inmates within Cooma Correctional Centre; however at the time of his death Mr Maxfield was not an authorised participant.

19. It must be assumed that Mr Maxfield ingested the methadone as a result of having obtained it without authorisation. The methadone may have been brought into the Correctional Centre covertly, or he may have obtained it from within the Centre. Mr Maxfield was known by other inmates to ingest illicit drugs when he could obtain them.

20. Since Mr Maxfield had not received any visitors while he was at Cooma Correctional Centre, he could not have obtained the methadone directly from any visiting members of the public. It is possible he received it indirectly by these means, for example from an inmate who had obtained it as a result of a visit. It is also possible of course that he obtained it unlawfully from Correctional Centre staff.

21. The other possibility is that he obtained it from a participant in the Correctional Centre's methadone treatment program. The prison takes measures to reduce the opportunity for participants to divert their authorised dose to other inmates. The participant is directed to swallow his or her liquid dose under the supervision of Justice Health staff. The inmate is then given a drink of water and directed to swallow it, then to speak their MIN number or open their mouth. This process is observed by correctional officers.

22. Despite this, there is evidence that methadone diversion continues to occur. Inmates may manage to avoid swallowing their dose; alternatively the dose may be regurgitated and provided to another inmate for payment.

23. The evidence does not allow me to conclude exactly how it was that Mr Maxfield obtained access to the methadone detected in his post mortem blood.

24. It was encouraging to hear evidence that Justice Health has trialled a new practice for its opioid treatment program. It involves the use of the opioid buprenorphine in place of methadone. Buprenorphine is delivered to the inmate via a monthly subcutaneous injection. It is expected this procedure will reduce the prevalence of opioid diversion.

25. I have noted that the antidepressant mirtazapine was also found in Mr Maxfield's post mortem blood, at a higher than expected level. Mr Maxfield's prescribed doses of mirtazapine were delivered to him in his monthly medication pack. An audit of his medication pack revealed that had he been dosing at the prescribed level, there ought still to have been 16 mirtazapine tablets remaining in his pack at the time he died. These were not located in Mr Maxfield's cell. It is not possible on the evidence to conclude what exactly Mr Maxfield had been doing with his mirtazapine medication. Given the levels in his post mortem blood, it appears likely he was exceeding his prescribed amount.

Conclusion

The time, place and cause of Mr Maxfield death are able to be established on the evidence. As to the manner of his death, there in insufficient evidence that he ingested the methadone and mirtazapine with the intention of ending his own life.

There is no evidence that deficiency or inaction on the part of CSNSW or JH contributed to Mr Maxfield's death. Steps are taken by both agencies to reduce the harmful practice of medication diversion among inmates. While more stringent measures might be possible, these may have the effect of discouraging participation in important opioid treatment programs, as well as adversely affecting the day to day life of inmates. Similar considerations apply to steps which might be taken to reduce the incidence of visitors to the prison who might attempt to introduce contraband items.

For these reasons I do not see any basis for making recommendations in this inquest.

I thank Coronial Advocate Karissa Mackay for her assistance in the preparation and conduct of this inquest.

I convey to Mr Maxfield's family my sincere condolences for his death.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity
The person who died is Robert Maxfield.

Date of death:
Robert Maxfield died between the dates of 9 and 10 June 2019.

Place of death:
Robert Maxfield died at Cooma Correctional Centre,

Cause of death:
The cause of Robert Maxfield's death is multiple drug toxicity.

Manner of death:
Robert Maxfield died as a result of an accidental drug overdose, while he was in lawful custody at Cooma Correctional Centre.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner, Lidcombe

Date
9 March 2021