CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Jason Radford
Hearing date:	5 and 6 December 2022
Date of findings:	6 December 2022
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of First Nations man at Junee Correctional Centre – was medical care and treatment appropriate.
File number:	2021/306257
Representation:	Counsel assisting the inquest: M Dalla Pozza i/b NSW Crown Solicitor. Ms Dawn Cremin, Senior Next of Kin: S Rees, Trial Advocate, Aboriginal Legal Service. The Commissioner, Corrective Services NSW: V Musico, Department of Communities and Justice, Legal. The Justice Health and Mental Health Network: Simon Grey i/b Hicksons Lawyers. The GEO Group Australia Pty Ltd: Teni Berberian i/b Sparke Helmore Lawyers.

Findings:	**Identity** The person who died is Jason Radford. **Date of death**: Jason Radford died on 26 October 2021. **Place of death**: Jason Radford died at Junee Correctional Centre, Junee NSW. **Cause of death:** The cause of Jason Radford's death is a fatal cardiac arrythmia which was the result of obstructive sleep apnoea. **Manner of death:** Jason Radford died from natural causes, while he was in lawful custody.

Non-publication 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.

1. 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.

2. On the morning of 26 October 2021 Jason Radford aged 48 years died in his cell at Junee Correctional Centre in western NSW. An inquest into the circumstances of his death is mandatory because he died while he was in custody in a correctional centre. His health care was therefore in the hands of the State.

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.

Mr Radford's life

5. Jason Radford is a First Nations man and a proud member of the Wiradjuri people of Central New South Wales. He was born on 17 February 1973 in Sydney. His mother Dawn Cremin was born in Cobar and she had two other sons, Troy and Craig.

6. When Mr Radford was 18 months old his mother separated from his father, Ken Radford. Mr Radford and his brothers grew up with their father and paternal grandparents in Villawood. Ms Cremin lived nearby and she visited her sons every week.

7. Mr Radford's upbringing was not always a happy one. His mother reports that his paternal grandfather and his father's new partner were abusive towards him. He became a ward of the state when he was twelve years old. By the age of sixteen he was struggling at school and was coming into contact with police and the juvenile justice system. He did not have a stable home and he sometimes lived on the street.

8. As he grew older Mr Radford developed a heroin dependence, and psychiatric conditions of cluster B Personality Disorder and depression. From 2011 onwards he was prescribed quetiapine, a medication commonly used to treat schizophrenia.

9. Mr Radford formed a de facto relationship with Kerry Montgomery and maintained contact with her throughout his incarceration. Ms Montgomery was deeply distressed to learn of his death.

10. Despite his challenging life, Dawn Cremin says that her son was always kind to her. She described their relationship in moving terms:

> *'Jason and I were really good friends. No matter what trouble he got into, I was always by his side. … I used to go to the prison and visit him every week when he was in Sydney. When he was classified to Junee Correctional Centre it was too hard for me to travel but we spoke on the phone every Tuesday.'*

11. It is clear that Dawn and her son shared a strong and loving relationship. Dawn was devastated when she learnt of his death. Through her legal representative she told the Court that day was the worst one of her life, and that in a way it had destroyed her. She grieves the loss of her son and has a deep need to understand how he died.

12. Mr Radford's death, and the sorrow of his mother and his partner, are a tragic human story. In closing submissions, Ms Cremin's legal representative Mr Rees described deaths like Mr Radford's as '*too common and poorly explained*'. He reminded the Court of the unconscionably high numbers of First Nations people who have died in custody. Since the 1987 Royal Commission into Aboriginal Deaths in Custody, these numbers have steadily increased.

13. Australia is not on track to meet targets to reduce First Nations deaths in custody. It is clear that these targets will not be met until action is taken to reduce the very high numbers of First Nations people in prison.

Mr Radford's medical history

14. At the time of his death Mr Radford was serving a sentence of nine years' imprisonment, which had been imposed on 23 January 2016. On 16 February 2019, he was transferred to Junee Correctional Centre [Junee CC]. Junee CC is located 450 km west of Sydney and is privately managed by the GEO Group Australia Pty Ltd [the GEO Group]. Health care to inmates at Junee CC is supplied by employees of the GEO Group, and they are required to adhere to the policies and procedures of the Justice Health and Forensic Mental Health Network [the JH Network].

15. When Mr Radford entered Junee CC, it was recorded that he had a history of injecting heroin use, in addition to conditions of:
    - type 2 diabetes
    - depression and a history of self-harm
    - sleep apnoea
    - cirrhosis of the liver
    - weight problems.

16. While in custody Mr Radford used a Continuous Positive Airway Pressure machine [CPAP] to manage his sleep apnoea. He was also prescribed the mood stabiliser quetiapine, as he suffered psychosis which had been exacerbated by his drug use.

17. At Junee CC Mr Radford's treating doctor was Dr Darren Corbett. Dr Corbett is a GP who works part time at Junee CC.

18. Dr Corbett was aware that in custody Mr Radford was getting access to diverted buprenorphine, which he injected. This led to him developing severe infections. For this reason, Dr Corbett successfully applied for him to receive Opioid Substitution Treatment [OST]. In December 2019, Mr Radford commenced receiving methadone on a supervised basis, as an opioid replacement.

19. Dr Corbett was also aware that the concurrent use of quetiapine and methadone can increase a person's risk for a cardiac abnormality known as QT interval prolongation. This disorder of the heart's rhythm can cause fast and chaotic heartbeats which can lead to sudden death. For this reason, in 2020 Dr Corbett substituted the drug olanzapine for Mr Radford's quetiapine.

20. In addition, Dr Corbett directed that Mr Radford undertake regular electrocardiograms [ECGs], to monitor his heart rhythm. Mr Radford's last ECG was performed on 16 September 2021 and indicated a satisfactory QT interval.

The events of 26 October 2021

21. At the time of his death Mr Radford was the sole occupant of his cell. On the night on 25 October 2021, he entered it as usual and was locked in for the night. CCTV footage shows that no one entered his cell throughout the night.

22. The next morning at 6.30am, when corrective officers entered Mr Radford's cell to wake him, they found him lying on his bed. He was not breathing. Nor was he wearing his CPAP mask; instead, it was hanging on a hook near his bed. The officers immediately called for emergency assistance and commenced CPR.

23. Registered Nurse Petrina Meffert was completing her night shift when she was called to Mr Radford's side. RN Meffert has intensive care qualifications. Leading a team of two other nurses she administered CPR and high flow oxygen.

24. Dr Corbett was called and arrived at 6.52am. An ambulance crew had arrived two minutes earlier, and established that Mr Radford's heart was in asystole, meaning that it had no electrical or mechanical activity. Dr Corbett observed Mr Radford's CPAP machine was switched on and was running, but that his mask was hanging on a hook on the wall.

25. Mr Radford received intravenous adrenaline and atropine, but to no avail. At 7.08am Dr Corbett directed that the resuscitation efforts cease.

26. Seconds later, Dr Corbett observed two instances of ventricular rhythm on the ECG machine. He directed the CPR to recommence, but there was no further electrical activity. At 7.16am resuscitation again ceased, and Mr Radford was pronounced deceased.

The autopsy report

27. Forensic pathologist Dr Allan Cala performed an autopsy examination.

28. Traces of Mr Radford's prescribed medications were found in his blood sample, in non-toxic levels.

29. Dr Cala observed that Mr Radford's heart was enlarged, a condition known as cardiomegaly. His heart also showed signs of a history of obstructive sleep apnoea, in the form of a thickened wall of the right ventricle and of the interventricular septum. Dr Cala commented that cardiomegaly is associated with an increased risk of sudden rhythm disturbance and death. He also noted that obesity is a known cause of cardiomegaly and obstructive sleep apnoea.

30. Dr Cala found the cause of Mr Radford's death to be cardiomegaly, due to obstructive sleep apnoea and obesity. A significant contributing condition was Type 2 Diabetes.

The evidence of Associate Professor Mark Adams

31. The inquest examined whether Mr Radford received appropriate care for his medical conditions while he was in custody. Specifically, was he properly monitored for his risk for cardiac arrhythmias, was his obstructive sleep apnoea appropriately treated, and were the attempts to resuscitate him on 26 October 2021 appropriate?

32. The Court was assisted with an expert report and oral evidence of Associate Professor Mark Adams, specialist cardiologist and head of cardiology at Royal Prince Alfred Hospital.

33. As regards the cause of Mr Radford's death, Associate Professor Adams commented that cardiomegaly is not in itself a cause of death. In his opinion Mr Radford had most likely died as a result of a cardiac arrhythmia, caused by his obstructive sleep apnoea. A cardiac arrhythmia is an irregular heartbeat, which can lead to sudden death.

34. Associate Professor Adams explained that people with obstructive sleep apnoea experience upper airway obstruction during their sleep. This prevents air flowing into their lungs, leading to hypoxia, or the absence of sufficient oxygen to sustain bodily functions. This can create irregular heart rhythms and sudden death.

35. Associate Professor Adams identified other factors which may have contributed to Mr Radford's fatal cardiac arrhythmia, but to a lesser extent than his obstructive sleep apnoea. These were his methadone use, his obesity and his medication of olanzapine.

36. Regarding methadone, Associate Professor Adams did not consider that the dose which Mr Radford had been prescribed at the time of his death was excessive. Nevertheless, he thought it probably had contributed to a prolongation of his QT interval. He considered however that Mr Radford had received appropriate monitoring of this condition, with regular ECGs. Furthermore, in his opinion the results of his ECGs were not concerning. He thought that Dr Corbett might have considered ordering a further ECG once Mr Radford was stable on his latest dose of 50mg, but he added that this was not something a clinician would necessarily do.

37. Associate Professor Adams was asked about the evidence that Mr Radford was not wearing his CPAP mask when he was found unresponsive on his bed (although

as noted, according to Dr Corbett the machine itself was running). Associate Professor Adams stated that if his CPAP mask was not worn on one night, this was unlikely to have caused a significant deterioration in Mr Radford's sleep apnoea. However, not using it '*every other night'* could have an adverse impact.

38. On this issue, I will observe that there is no evidence that Mr Radford did not habitually use his CPAP machine at night. I do note the observation of Associate Professor Adams that rates of non-compliance with CPAP machines are high, even in the community, and that repeated non-use of CPAP machines is harmful. At the inquest however it was not suggested that the GEO Group ought to introduce a practice of monitoring inmates' nightly use of their CPAP machines, and for good reason. For inmates this would be an unduly invasive measure and involve frequent interruptions of their sleep and that of anyone sharing their cell.

39. Nevertheless, it is appropriate that Associate Professor Adams' concerns about non-compliance rates be communicated to the GEO Group, for them to reflect on whether any other steps might be considered to encourage better levels of compliance.

40. The evidence at inquest established that the treatment which Mr Radford received in custody for his obstructive apnoea was appropriate and adequate. This was also the case with the monitoring of his risk for cardiac arrhythmias. The attempts to resuscitate him on 26 October 2021 were also appropriate.

Mr Radford's opioid substitution treatment

41. The inquest also considered whether appropriate decisions were made as to Mr Radford's opioid substitution treatment.

42. It is recognised that there is a potential for methadone to increase a person's risk for prolongation of the QT interval. It is for this reason that Dr Corbett directed regular ECGs for Mr Radford. The inquest considered whether an alternative method of opioid replacement therapy might have been available for Mr Radford, which would have reduced this risk.

43. The Court heard that the NSW Ministry of Health has acknowledged the risks associated with methadone as an opioid substitute. It has responded by introducing a significant change to the opioid substitution program offered in NSW correctional centres. In 2019 the NSW Ministry of Health prepared '*Clinical Guidelines for use of depot injections in the treatment of opioid dependence'*, to

inform clinicians in the proposed use of buprenorphine as an opioid substitute, in place of methadone.

44. Inmates requiring opioid substitution are now commenced on injections of Buvidal, which is the brand name for buprenorphine. The Court heard that the majority of inmates requiring opioid substitution now receive monthly 'depot' injections of Buvidal instead of methadone in liquid form, as previously. Buvidal is administered by way of supervised subcutaneous injections which dissolve the medication under the skin.

45. Depot injections of Buvidal are considered to have at least two advantages over methadone. First, the above *Clinical Guidelines* cite evidence that when compared with buprenorphine, methadone carries a greater risk of prolongation of the QT interval and other risks of arrhythmia. Secondly the administration of depot Buvidal by subcutaneous injection makes it significantly more difficult for patients to divert their dose.

46. The evidence established that at the time of Mr Radford's death, the depot Buvidal program was not yet available at Junee CC. While buprenorphine was available as an alternative to methadone, at that time it was only able to be delivered by way of strips placed under the patient's tongue. This method of delivery continued to present a risk of diversion.

47. Given the above evidence, there can be no criticism of Dr Corbett or of the GEO Group for maintaining Mr Radford on the methadone program. As noted, the evidence also established that Dr Corbett took reasonable measures to monitor Mr Radford's risk for associated cardiac arrhythmias.

48. Unfortunately, the depot Buvidal program was not an available treatment for Mr Radford. Had it been, it might have reduced one of the factors which contributed to his risk for cardiac death.

The question of recommendations

49. It is welcome news that NSW Health has implemented the depot Buvidal program to replace the former methadone regime throughout NSW correctional centres. The evidence is that the Buvidal program improves inmate health and safety by reducing the risk of cardiac arrhythmias, and the harms associated with medication diversion.

50. The implementation of this program obviates the need for the Court to make any recommendations in this area.

Conclusion

51. On behalf of all at the Coroners Court, I offer Dawn Cremin and Kerry Montgomery my sincere sympathy for the loss of Jason. I hope that at the least, this inquest has helped them to understand the medical causes for his passing.

52. I thank those assisting me in this inquest for their support.

Findings required by s81(1)

53. 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 Jason Radford.

Date of death:

Jason Radford died on 26 October 2021

Place of death:

Jason Radford died at Junee Correctional Centre, Junee NSW.

Cause of death:

The cause of Jason Radford's death is a fatal cardiac arrythmia which was the result of obstructive sleep apnoea.

Manner of death:

Jason Radford died from natural causes, while he was in lawful custody.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner, Lidcombe
19 December 2022