CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of LT
Hearing dates:	13 February 2023 to 15 February 2023; 21 February 2023
Date of findings:	23 March 2023
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of a person in custody – lethal overdose of methylamphetamine – adequacy of emergency medical response – how did deceased person get access to methylamphetamine – recommendations
File number:	2019/126969
Representation:	Counsel Assisting the inquest: D Ward of Senior Counsel with S Young of Counsel, i/b Solicitors, NSW Coroners Court. LT's family: P McManus, Solicitor Advocate, Legal Aid i/b Legal Aid. The Commissioner, Corrective Services NSW: A Douglas-Baker of Counsel i/b Department of Communities and Justice, Legal. The Justice Health and Forensic Mental Health Network: J Harris of Counsel i/b Makinson d'Apice Lawyers.

Findings:	**Identity** The person who died is LT. **Date of death**: LT died on 21 April 2019. **Place of death**: LT died at the Mid North Coast Correctional Centre, Kempsey. **Cause of death:** The cause of LT's death is methylamphetamine toxicity. **Manner of death:** LT died while in lawful custody, after ingesting small packages of methylamphetamine which had been unlawfully brought into the Mid North Coast Correctional Centre. The packages ruptured, causing his death.

Non Publication Orders

Pursuant to section 74 of the Act, non-publication orders have been made in relation to other evidence. A copy of the orders can be found on the Registry file.

1. Section 81(1) of the *Coroners Act 2009* (NSW) [the Act] requires that when an inquest is held, the Coroner must record in writing their findings as to various aspects of the death.

2. These are the findings of an inquest into the death of LT.

Introduction

3. On 21 April 2019, LT died at the Mid North Coast Correctional Centre [MNCCC] where he was serving a sentence of imprisonment. LT was 24 years old.

4. At autopsy, the cause of LT's death was identified as methylamphetamine toxicity. The evidence strongly suggested that shortly prior to his death LT had swallowed small balloons of methylamphetamine, which had ruptured soon afterwards.

5. When a person is in custody at the time of their death, an inquest is mandatory pursuant to sections 23 and 27 of the Act. The purpose of such inquests is to ensure that there is independent scrutiny of the actions of those who are responsible for the welfare of prisoners.

6. 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.

LT's life

7. LT was born in 1995, to parents MT and ST. He was the fourth of five children, with older sisters DT and PT, older brother KT, and younger sister FT.

8. LT grew up in his family home in western Sydney. His parents separated in the year 2000, and LT and his siblings lived with their father for a period of time. The family was very involved in their local parish, attending church services, youth groups and choir. LT spent much of his time in the company of his brother KT, who was three years older. The two brothers were very close.

9. On 29 August 2014, LT was sentenced to imprisonment for an offence of robbery. Three years later his mother ST died from cancer. At this time both LT and KT were in custody, and they were not given permission to attend her funeral.

10. LT commenced another period of custody on 27 October 2018 for further offences. He was transferred between different correctional centres, eventually arriving at MNCCC on 8 February 2019. His Case Management Officer Samantha Leonard recorded that LT had a history of addiction to methamphetamine and cocaine. She found him to be respectful and open, and he spoke warmly to her about his family, in particular his father and his sister DT.

11. On 21 April 2019, LT received a prison visit from two people. Shortly after this visit ended LT became desperately ill. An emergency medical response was called, but tragically LT died soon after the ambulance arrived.

12. The family was devastated to learn of LT's death. Tragically, less than three weeks later the family received another terrible blow: LT's older brother KT had died in the Metropolitan Remand and Reception Centre in Sydney.

13. The shock and grief that the family must have felt at this double tragedy can only be imagined.

14. As both brothers were in custody at the time of their deaths, inquests were required to be held. The two inquests were conducted one after the other, to reduce as far as possible the distress of the family. But there can be no doubt that the double inquest was immensely painful for them. DT and FT attended both inquests. Their father MT wanted to attend too, but he suffers ill health and the experience would have been too much for him.

15. Through their lawyer Mr Peerce McManus, DT and FT wanted the court to know that LT was a loving and caring brother and uncle, and that his family meant everything to him. Despite their profound grief, DT and FT were present each day of the inquest, and it was clear that they and their family loved LT and miss him deeply.

The issues examined at the inquest

16. The inquest examined the following issues:

- The cause of LT's death.
- How LT got access to the drugs that killed him.
- The adequacy of the emergency response to LT's overdose.
- The response of Corrective Services NSW to findings in the *Inquest into the death of Ossama Al Refaay* 25 October 2019, and to the recommendations of the Special Commission of Inquiry into the Drug 'Ice', January 2020.

17. The court heard evidence about these matters from involved correctional officers and staff employed by the Justice Health and Forensic Mental Health Network [the JH Network], which supplies medical care to inmates in NSW correctional centres. In addition, the court was assisted with expert evidence from the following specialists:

- Professor Alison Jones, specialist physician and clinical toxicologist; and
- Associate Professor Anna Holdgate, senior staff specialist in emergency medicine.

The cause of LT's death

18. An autopsy was performed by forensic pathologist Dr Leah Clifton. She concluded that the cause of LT's death was methylamphetamine toxicity. Analysis of LT's post mortem blood detected the presence of methylamphetamine and its metabolite amphetamine at levels which, Dr Clifton stated, have been seen in fatalities. Dr Clifton found no significant injuries.

19. Significantly, an internal examination performed by Dr Clifton located multiple ruptured rubber balloons in LT's stomach.

20. Professor Alison Jones reviewed the toxicological evidence and the observations of the responders to LT's medical emergency. In her opinion the evidence was consistent with LT having ingested large amounts of methylamphetamine at around 1.00pm, that is within a couple of hours of his death. She described the concentration of methylamphetamine in his post mortem blood as '*very, very large'*, and said that it would have brought about extremely severe clinical effects.

21. This opinion was shared by Associate Professor Anna Holdgate, who described the amount of methylamphetamine in LT's post mortem sample as '*ten times higher'* than any she had seen in her clinical work.

22. Associate Professor Holdgate had viewed video footage tendered at the inquest, which captured the events of the emergency response. She told the court that based on her observations of LT in this footage, his behaviour was entirely consistent with him having received an overdose of methylamphetamine. LT displayed extreme physical agitation, with aggressive and panicked body movements which he would not have been able to control.

23. Professor Jones and Associate Professor Holdgate agreed that for LT, the terminal event was most likely a fatal cardiac arrhythmia, caused by a massive surge of adrenaline as a result of the methylamphetamine. In addition, a rapid rise in LT's core body temperature would have caused significant damage to his muscles and organs, in particular his heart and liver. They concluded that these physiological changes contributed to his fatal arrhythmia.

24. The above evidence strongly supports Dr Clifton's conclusion in her autopsy report that LT died as a result of methylamphetamine toxicity.

The visit to LT on 21 April 2019

25. A central issue at the inquest was how LT got access to the drugs which killed him. From the outset, it was suspected that the methylamphetamine may have been transferred to him by visitors who came to see him on the day he died.

26. On 21 April 2019, two people came to visit LT in prison. One of the visitors, Jordan Adair-Sili, had come to see LT in February 2019 and again the following month. On the March visit, Mr Adair-Sili was accompanied by KH. Notably, in 2016 KH had been prohibited from making contact visits in NSW correctional centres for a period of two years, as a result of having unlawfully given an inmate an amount of tobacco during a visit.

27. On 21 April 2019, Mr Adair-Sili and KH again visited LT, travelling from Sydney to Kempsey for this purpose. They arrived just before midday, leaving a third person in the car about whom almost nothing is known.

28. Over the five days preceding this visit, LT had spoken by phone at least twice with Mr Adair-Sili. In retrospect, some portions of their conversation appear suggestive of an impending plan to bring contraband into the MNCCC. It should be noted however that due to the two speakers' occasional use of dialect, and the generally poor quality of audio, it is not possible to be definitive about this.

29. In a phone call of 17 April 2019, Mr Adair-Sili spoke to LT of '*13 couples, just need to offload them now, know what I mean?.* He asked LT*: '…if she asks me to do it again should I do it?*', to which LT replied '*Yeah*'.

30. Two days later in a second phone conversation Mr Adair-Sili informed LT: *'We are coming up on Sunday'* [that is, 21 April]. LT said: *'Can you tell him, like next time you know*'. Mr Adair-Sili replied: *'Hook it up?'*, to which LT responded: *'Yeah, it's alright, you get me'.*

31. After their arrival at MNCCC on 21 April 2019, Mr Adair-Sili and KH waited in the Visit Processing area for approximately thirty minutes. Some of their movements were captured by CCTV cameras placed in the area. On a few occasions, KH can be seen putting her hands in the waistband of her pants, then bringing her hand up to her mouth.

32. At 12.32pm, both were admitted through the security portal and into the Visit Room. They were directed to Table 24. This was because a correctional officer had '*an uneasy feeling'* about the visitors, and Table 24 was within view of correctional officers and CCTV cameras.

33. Approximately eight minutes passed before LT joined the couple. During this time, CCTV footage shows Mr Adair-Sili and KH purchasing drinks and small packets of food from the vending machine in the Visit Room. While they waited for LT, KH opened the food packets and placed them on their assigned table.

34. When LT arrived in the Visit Room, the cameras captured him giving a hug to Mr Adair-Sili, and then kissing KH on the mouth. All three then sat down, talking. On a number of occasions LT and Mr Adair-Sili can be seen to reach forward to the open food packets, and appear to bring food to their mouths.

35. At 1.05pm, just twenty minutes after LT's arrival, KH told a correctional officer that she had period pain and needed to leave. She did so. Two minutes later Mr Adair-Sili also departed the Visit Room. LT left at the same time, telling Correctional Officer Romano Manna that he was '*busting to go to the toilet'*.

After the visit

36. The brevity of this visit drew suspicion from correctional officers, especially given the distance the visitors had travelled to see LT. Correctional Officer Gary Clark was aware of this. He chatted to LT as he escorted him to the search area, where LT was to undergo a routine strip search. Notably, LT did not make any move to use the toilet. To CO Clark, LT appeared his usual easy-going self, and was not sweating or nervous.

37. The strip search of LT did not detect any contraband, and at 1.16pm, he was escorted back to the cell he shared with inmate Mr Mahmoud Bazzi. The escorting correctional officer, Dylan Alaban, thought LT now appeared jittery and noted he would not make eye contact. LT joined Mr Bazzi in their cell and they shut the cell door.

38. In the following thirty minutes LT was called over the prison PA system three times to attend the pod office. This was due to the suspicions which had been raised by the circumstances of his visit. LT did not attend. Then at 1.48pm an inmate came to the office, calling for help for LT as he was '*throwing up blood'*.

39. Mr Bazzi later gave police an account of what had taken place in their cell. He said that when LT returned from his visit, he told Mr Bazzi he felt '*fucked up'* and that he had something in himself that he had to get out. He was very agitated and was trying to force his fingers down his throat. Mr Bazzi gave him lots of water, but the water wasn't going down. LT then vomited up blood and at least two broken balloons. By then LT was panicking, and he told Mr Bazzi he'd swallowed some ice.

40. According to Mr Bazzi, he said to LT '*we gotta get the nurse bro or you're gonna end up dead'*. LT didn't want this, so Mr Bazzi sought advice from some other inmates. As LT's condition worsened, one of the inmates went to the pod office and raised the alarm with Correctional Officer Melissa Fittler. It was now about 1.48pm.

The response to LT's emergency

41. Correctional Officer Fittler came to LT's cell with fellow officers Dylan Alaban and Shelene Sanders. She saw LT '*behaving in an erratic manner by throwing himself from side to side in the cell'.* He was sticking his fingers down his throat and spitting up blood. Memorably, she said he had '*a mixed look of terror and please help me'*.

42. Mr Bazzi told CO Fittler that LT had '*swallowed about a gram and a half of ice'*. CO Fittler immediately called for a medical response.

43. Responding to the call were two nurses employed by the JH Network. Also responding were members of the Immediate Action Team, including Senior Correctional Officer William Stephens. From this point, the response was captured on a handheld camera operated by a correctional officer.

44. When Mr Stephens entered the cell, he saw LT '*crouching on top of the bed'*, trying to make himself vomit. He was in great distress, thrashing about and unable to keep still. For this reason, Mr Stephens applied handcuffs to LT's wrists, and summoned a wheelchair to take him to the prison clinic.

45. The footage of LT's emergency is distressing to watch, and must have been immensely so for LT's family. Throughout his ordeal LT can be seen to be sweating profusely and gasping with each breath. His limbs continuously thrash about in spasms. Despite the apparent aggression of his actions however, all witnesses were certain that LT was unable to control his body, and did not intend to harm anyone.

46. Once in the wheelchair, LT was unable to sit straight and he rocked violently back and forth, in a manner which A/Professor Holdgate stated was consistent with increasing methamphetamine intoxication. An ambulance had been called at 1.57pm, and it was decided to await its arrival in a nearby empty cell rather than proceed to the clinic. In his statement, Registered Nurse Dhalma Ring explained that he could see that LT needed urgent high level care, and there was nothing in the clinic that would assist.

47. LT was placed onto a bed in the empty cell. RN Ring managed to measure his pulse, which was 150 beats per minute, but he was unable to perform any other observations due to LT's extreme agitation. RN Ring continued to watch for the rise and fall of LT's chest. Correctional officers can be heard speaking to LT, telling him that help was on its way and encouraging him to be calm.

48. The ambulance crew arrived at the cell at 2.21pm. Just prior to this, LT began to shake violently and to speak in an incomprehensible manner to the correctional officers. On arrival, Ambulance Paramedic James Hunt heard him say that he was scared. Paramedic Hunt recorded LT's temperature as 41.9 degrees, indicative according to Associate Professor Holdgate of severe hyperthermia. Assessing that LT was critically ill, the ambulance paramedics set about transferring him onto an ambulance stretcher.

49. Very soon afterwards LT became noticeably quieter. At about 2.30pm he can be seen lying very still on the stretcher as he was carried to the ambulance. Once in the ambulance, Paramedic Hunt confirmed that LT was in cardiac arrest. Advance life support commenced, with CPR, IV access and administration of naloxone, but LT did not respond. He was pronounced deceased at approximately 3.00pm.

The adequacy of the emergency response

50. The opinions of Associate Professor Holdgate and Professor Jones were sought as to whether the response to LT's medical emergency was appropriate.

51. By way of context, Professor Jones explained to the court that there is no antidote medication for methylamphetamine overdose. The only treatment is high quality care within an Intensive Care Unit. Professor Jones said that due to the extremely large amount of methylamphetamine which LT had ingested, there existed only a very narrow window of opportunity to save his life.

52. Associate Professor Holdgate concurred that once LT started showing the signs of overdose, there were only minutes to take the necessary action. He required urgent high level care which was not possible within a prison setting. In an Intensive Care Unit, he would receive deep sedation, combined with intubation and ventilation. In addition, clinicians would apply '*rapid and aggressive cooling measures'* to control his rising body temperature.

53. Associate Professor Holdgate commented that even this level of assistance may not have saved LT: '*Given the severity of his symptoms, even with the best of medical care it is possible and perhaps likely that he would not have survived'*.

54. It must have been heartbreaking for LT's family to hear this evidence.

55. LT's family had viewed the video footage, and it was understandably distressing for them to observe, throughout LT's terrible ordeal, the apparent inactivity of the two attending JH Network nurses. Associate Professor Holdgate was asked about this at the inquest.

56. She agreed that this must have difficult to watch. She explained however that the level of LT's agitation made it very difficult for the nurses to do more than they were doing. LT needed sedation, but they could not deliver this orally due to his extreme physical agitation. This also made it impossible to deliver intravenous sedation and to monitor its cardiac and oxygenation impacts. All that could be done, she said, was to attempt to keep him calm, to try to cool him, to check that he was breathing, and to get him to hospital as rapidly as possible. Associate Professor Holdgate concluded that taking into account the '*very limited*' medical resources available to the JH Network nurses, the simple measures they had performed were an appropriate response.

57. On behalf of LT's family, Mr McManus submitted that while they waited for the ambulance, responding staff could have done more to try to keep LT's body temperature from rising. LT's sisters were distressed to see that on only one or perhaps two occasions did staff apply a wet towel to his head or body.

58. At the inquest Mr McManus asked Associate Professor Holdgate if LT's chances of survival would have been greater, had the involved staff applied cooling measures such as ice packs and wet towels. Associate Professor Holdgate responded that these measures might have been effective in a less severe case of overdose. But LT's hyperthermia was very severe, and she highly doubted that the above steps alone would have been sufficient to achieve temperature control.

59. Regarding this submission, I accept the evidence of Associate Professor Holdgate that it was unlikely the limited cooling methods available at the prison would have increased LT's chances of survival. Nevertheless, I fully understand that it would have been of some comfort to LT's sisters to see more efforts of this kind to reduce his suffering.

60. I accept the submission of Counsel Assisting that once they were alerted to LT's medical emergency, correctional officers and JH Network staff responded appropriately in the circumstances. The amount of methylamphetamine which LT had swallowed was extremely large, and he rapidly became critically ill. The evidence indicates that all involved staff quickly understood the gravity of his situation, and took what steps were available to them.

61. As regards the paramedic officers and their response to LT's cardiac arrest, Associate Professor Holdgate considered this too to have been appropriate. She considered the ambulance response time of 24 minutes to have been within the range that would be expected, given the distance they needed to travel from their base at Kempsey Hospital.

62. I return now to the issue of how LT got access to the methylamphetamine.

Visit procedures

63. I have adverted to the likelihood, on the evidence, that LT ingested the packages of methylamphetamine during the prison visit he received that day.

64. At the inquest, I made the finding that although strong suspicion surrounded the conduct of Mr Adair-Sili and KH before and during the visit, and the proximity of their visit to LT's death, it could not be said that the evidence met the standard required within section 78 of the Act to suspend the inquest and refer the evidence to the Director of Public Prosecutions for consideration of criminal charges.

65. However, the evidence properly raised the question whether there was scope for improvement of procedures at MNCCC in relation to prison visits, so as to reduce the incidence of contraband being introduced through visitors.

66. Our society recognises that visits to inmates by family and friends are integral to a humane custodial system, and are also important for the welfare of inmates and their eventual reintegration into community and family life.

67. Notwithstanding this important principle, it is well established that prison visits are used to bring contraband such as illicit drugs into the jail system, although of course they are not the only method used to achieve this purpose.

68. The transfer of contraband to prisoners is a recurring and very serious problem. It feeds a black market within the prison system. It also exposes inmates to the risk of serious health incidents as a result of the methods they use to conceal its presence. This can result in deaths like LT's, which are a tragedy for the inmate and his family, and are traumatising for fellow inmates and prison staff.

69. CSNSW has implemented policies and procedures aimed at preventing the introduction of contraband into prisons. In relation to visitor-introduced contraband, the relevant document is *Custodial Operations Policy and Procedures 10.1: Visits to inmates by family and friends* [COPP 10.1].

70. At the inquest, Correctional Officer Gary Clarke outlined the procedures that were followed in 2019 when inmates at MNCCC received visitors.

71. LT was classified as a maximum security inmate, and was therefore required to wear a special kind of overalls when receiving a visit. This requirement applied likewise to medium security inmates. The overalls were designed to minimise opportunities to hide contraband which might be passed to the inmate in the course of the visit. They had no pockets, and were fastened at the back. At the conclusion of the visit the inmate was routinely strip searched.

72. For their part, adult visitors to MNCCC received an iris scan on their arrival, to verify their identity. Their personal items, in particular car keys, wallet, and mobile phone, were placed into a locker for the duration of the visit. The visitor's shoes, belts and other property were then scanned through an x-ray machine, while the visitor passed through a body metal scanner.

73. If these procedures detected anything suspicious, a hand wand was passed over the visitor's body. Correctional officers are not authorised to perform body searches of non-inmates. Therefore, if contraband was detected, correctional officers were permitted only to detain the visitor until the arrival of police, who were able to conduct a body search if appropriate. This remains the case.

74. In one important respect, visit procedures have changed since the time of LT's death. The 2019 inquest into the death of Ossama Al Refaay examined the death of an inmate who died in similar circumstances to LT. In that inquest, as with this one, the court heard evidence about the prevalence of illicit drugs within prisons, and the difficulty of preventing their introduction. The following recommendation was made:

> *'That consideration be given to trialling the use of a low dose body scanner for adult visitors visiting inmates at Long Bay Hospital, having due regard to any relevant statutory and privacy considerations'.*

75. In the present inquest a statement was supplied by Mr David Walker, the State-Wide Radiation Safety Manager, Corrective Services NSW. Mr Walker has been engaged in a CSNSW body scanner project for the past two years. He reported that 65 low dose x-ray body scanners are now in use in CSNSW correctional centres, including at the MNCCC. Before contact visits, visitors are scanned with the new machines as a condition of entry into the correctional centre. The machines are also used to scan all maximum and medium security inmates following visits.

76. According to Mr Walker, the new scanners are '*an effective method of identifying contraband*', and regularly identify and prevent its introduction into and within prisons.

77. At the inquest, Correctional Officer Clark observed that a certain level of training and experience has been required to accurately interpret the resulting radiographic images. In his view however, while the introduction of these machines would never eliminate the problem of contraband, it did represent a step forward in preventing it.

78. Correctional Officers Clark and Stephens also spoke positively about the newly constructed Visit Centre at MNCCC. Reportedly the area is larger and less crammed, offering better lines of sight for cameras and supervising officers. In addition, its cameras have been upgraded to produce better quality images and improved coverage.

79. Another recent change at MNCCC has been the removal of food and drink vending machines in the Visit Centre. Officers Clark and Stephens explained that these were removed as a COVID-19 precaution, and that they have not since been restored. Both officers considered that this measure had reduced the frequency of contraband transfer.

80. It would appear therefore that positive changes have taken place since LT's tragic death, in the effort to reduce contraband being introduced through prison visits. It would be naïve however to suppose that these measures will eliminate the problem.

81. It was submitted by Counsel Assisting that given this reality, it is important that those who make decisions in this area are well informed as to the nature and prevalence of illicit drug use within correctional centres, and the methods by which prisoners gain access to those drugs. Such information would help to inform the development of policies to thwart the introduction of drugs into correctional centres.

82. This leads me to the final issue.

The question of recommendations

83. The final issue in the inquest was the response of CSNSW to recommendations made in the *Inquest into the death of Ossama Al Refaay* 25 October 2019, and to the recommendations of the Special Commission of Inquiry into the Drug 'ice' January 2020.

84. The recommendation for low dose body scanners which was made in the 2019 inquest into the death of Ossama Al Refaay has been addressed above.

85. The Special Commission of Inquiry into the Drug 'Ice' was a detailed examination of the prevalence of methylamphetamine use in NSW. This included its use within correctional centres.

86. Recommendation 88 of the Special Commission's report was as follows:

> *'That in conjunction with Justice Health, Corrective Services re-introduce the Drug Use in the Inmate Population research program or equivalent, to better understand drug use in the prison population and inform service responses. Such data should be published on a biennial basis'.*

87. The rationale was that in order to ensure that the rehabilitation needs of inmates were adequate and appropriately adapted, there was a need for CSNSW and the JH Network '*to have a sound understanding of the extent and nature of drug use patterns and trends and drug-related crime in the prison population'.*

88. At the inquest the court heard evidence from Mr Jeremy Tucker, Director of Parliamentary and Executive Services within DCJ. Mr Tucker told the court that during the years 1988 and 2013, CSNSW had conducted inmate surveys every two years into prison drug use. The results were used to inform the security response to drug supply within prisons, and the provision of drug and alcohol treatment programs to inmates. However no comparable research had been undertaken since then, despite the NSW Government having given 'in principle' support to Recommendation 88.

89. Mr Tucker noted that the JH Network is able to extract certain data about inmate drug use through its screening processes when inmates enter custody. For their part, the JH Network responded that their staff would continue to work on ways for sharing the above data with CSNSW, so as to assist in the delivery of Alcohol and Other Drug programs to inmates.

90. Mr Tucker acknowledged that the focus of the above processes was on inmate drug use *before* entry into custody. He agreed that it was important to have reliable and up to date information about the nature and prevalence of drug use during periods of custody as well. To this end, he told the court that a research project is under development, which would involve direct survey of inmates. Mr Tucker said that an officer would be dedicated to undertaking and presenting this research.

91. This is welcome news, but it is clear that this project in still at an early stage of development. For this reason, I endorse the proposal of Counsel Assisting, that a recommendation be made reinforcing the call for reinstatement of the Drug Use research project or an equivalent one. An important purpose of the research project would be to help inform security responses to the introduction of illicit drugs into correctional centres.

92. This proposal is supported by LT's family and by CSNSW.

Conclusion

93. LT's death and that of his brother KT has brought enduring grief and heartache for their family. I offer the family my sincere sympathy for the loss of their brothers, and I thank DT and FT for their participation in this inquest, on behalf of their family.

94. I thank also the outstanding assistance given to the inquest by the assisting team, and by the Officers in Charge of the coronial investigation, Detective Sergeant Zorro Simundza and Detective Senior Constable Dean Rutledge.

Findings required by s81(1)

95. 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 LT

Date of death:
LT died on 21 April 2019.

Place of death:
LT died at the Mid North Coast Correctional Centre, Kempsey.

Cause of death:
The cause of LT's death is methylamphetamine toxicity.

Manner of death:
LT died while in lawful custody, after ingesting packages of methylamphetamine which had been unlawfully brought into the Mid North Coast Correctional Centre. The packages ruptured, causing his death.

Recommendation pursuant to s82

To the Commissioner of Corrective Services (NSW) and the CEO, Justice Health and Custodial Mental Health Network:

1) That the Commissioner, Corrective Services NSW in consultation with the Justice Health and Forensic Mental Health Network, reintroduce the Drug Use in the Inmate Population Research Project or equivalent, to examine:

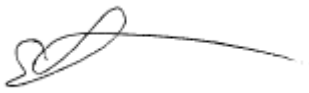
    a) the nature of drug use reported during inmate screening processes by the JH Network;

    b) the nature of drug use otherwise reported during inmate surveys conducted during periods of imprisonment;

    c) treatment options within CSNSW Corrective Centres; and

    d) security responses attempting to interdict the supply of illicit drugs into NSW correctional centres.

I close this inquest.



Magistrate E Ryan
Deputy State Coroner
Lidcombe, 23 March 2023