CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Michael Raymond Baker
Hearing dates:	26, 27, 29 February and 13 May 2024
Date of findings:	20 June 2024
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate David O'Neil, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody – mandatory inquest – cardiac health – diabetes – sleep apnoea – whether medical care adequately managed in custody – cell placement
File number:	2019/00200952
Representation:	Ms K Zielinski, Counsel Assisting instructed by Ms A Boatman of the Crown Solicitor's Office Ms E Parker of the Aboriginal Legal Service for the family of Mr Baker Mr J Harris, instructed by Ms J Smith of Minter Ellison, representing Justice Health and Forensic Mental Health Network Mr A Singh, instructed by Mr V Musico and Ms S Pickard of the Department of Communities and Justice, representing the Commissioner of Corrective Services

Findings:

I make the following findings in relation to the death of Michael Baker, pursuant to s. 81 of the *Coroners Act 2009* (NSW):

Identity:

The person who died was Michael Baker

Date of death:

Michael died on 25 June 2019

Place of death:

Michael died at Lithgow Correctional Centre NSW

Cause of death:

Michael died from a cardiac arrythmia on a background of hypertensive heart disorder, obesity, diabetes, obstructive sleep apnoea and a combination of the QT interval prolonging medications methadone, mirtazapine, amitriptyline, duloxetine and baclofen.

Manner of death:

Natural Causes

Non-Publication Orders:

Non-publication orders prohibiting the publication of certain evidence pursuant to the Coroners Act 2009 have been made in this inquest. A copy of these orders, and corresponding orders pursuant to s. 65 of the Act, can be found on the Registry file.

Introduction

1 On 26, 27, 29 February and 13 May 2024 an inquest was held into the death of Mr Michael Raymond Baker (Michael).

2 Michael died on 25 June 2019. At the time of his death, he was in the custody of Corrective Services NSW (CSNSW). He was 44 years of age.

3 Because Michael was in custody and accommodated in a correctional centre at the time he died, this inquest is mandatory; Coroners Act 2009 ("the Act"), s. 23(1)(d)(ii), s. 27(1)(b).

4 When someone is in lawful custody they are deprived of their liberty, and the State assumes responsibility for the care and treatment of that person. In such cases the community has an expectation that the death will be properly and independently investigated.

The coroner's role

5 An inquest is a public examination of the circumstances of death. It provides an opportunity to closely consider what led to the death. It is not the purpose of an inquest to blame or punish anyone for the death. The fact of holding an inquest does not imply that anyone is guilty of wrongdoing.

6 The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s. 81 of the Act, namely;

(1) The person's identity;

(2) The date and place of the person's death; and

(3) The manner and cause of the person's death.

7 Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

8 Prior to holding an inquest a detailed coronial investigation is undertaken. Investigating Police compile a brief of evidence and a report is obtained from a forensic pathologist as to the cause of death.

9 The investigation into Mr Baker's death was conducted by Detective Senior Constable Tammy Smyth. As a result of her investigations, a brief of evidence running to 8 volumes was prepared.

10 All the documents and witness statements obtained during the investigation formed part of the brief of evidence tendered during the inquest. All that material and the oral and documentary evidence provided at inquest has been considered in making the findings detailed below.

Background

11 Mr Baker was born on 13 July 1974 and raised by his mother, in Newcastle, with his younger brother Christopher (Chris) Baker.

12 The only surviving relative of Michael is his younger brother, Chris Baker and Chris' two adult children, Brett Baker and Dylan Baker.

13 Michael identified as Aboriginal and was raised on Awabakal land. He, like many First Nations People of his generation, was unaware of which mob or clan he belonged to. His Aboriginality came from his father's side.

14 Michael's upbringing was marred by violence perpetrated by his father within the home. Tragically, Michael bore the brunt of his father's violence. He was also a witness to it as it was perpetrated against his brother and his mother.

15 The solace within Michaels' family home came from his mother who was a loving, caring and kind woman. Michael together with his brother Chris attended a local public school in his early years and later a local Catholic high school. As a result of the family dynamics Michael did not have a large social life outside of school and the family home.

16 Michael attended school up until he was in year 8 and following his parent's separation, he worked at a local fruit market. Following on from this, he worked at the steel works at BHP. In his early adult years, he began work as a welder.

17 Michael's illicit substance abuse impeded his working life. Chris believes that due to their difficult upbringing and exposure to early childhood trauma, Michael began using illicit substances from early on. Michael started using cannabis which later progressed to heroin. Michael also had difficulties managing pain after a work-related back injury. This ongoing pain was also a factor in Michael's continuing heroin use.

18 Michael's substance abuse issues went largely untreated except for being treated on the methadone program.

19 He commenced the methadone program in his youth and remained on the program up until his death.

20 In combination with other factors Michael's substance abuse sadly led and drove the offending which saw Michael interacting with the criminal justice system.

21 Michael was estranged from his father having not seen him since his mother's funeral in 2005.

22 The last time that Chris saw Michael alive was in 2013 when he attended Belmont police station as Michael's support person when Michael was charged with murder. Chris would receive a phone call every few weeks from Michael, usually on a weekend. Chris would also receive the occasional letter from Michael.

23 On 26 October 2013, Michael was charged with murder. At this point in his life, he was living in Windale within the suburb of Lake Macquarie which is in the Newcastle metropolitan area. He entered a plea of guilty to an alternate charge and was sentenced to 7 years 6 months imprisonment, which commenced on 26 October 2013 and was to conclude on 25 April 2021. He received a non-parole period of 5 years, which meant that his earliest release date was 25 October 2018.

24 On 24 August 2018, the State Parole Authority considered Michael's eligibility for release on parole. The authority decided not to release Michael, as he was yet to complete a program to address his offending behaviour of violence. Additionally, there was a need for structured post release plans and Michael's accommodation upon release needed to be finalised.

25 Michael was never released to parole.

Persons with Sufficient interest

26 The following were given notice of having a sufficient interest in the proceedings:

a. Mr Chris Baker, brother of Michael and senior next of kin

b. Corrective Services NSW; and

c. Justice Health and Forensic Mental Health Network (Justice Health)

Witnesses

27 The following witnesses gave oral evidence during the inquest:

a. Registered Nurse, Tracy Taylor

b. Registered Nurse, Bronwyn Bevan

c. Dr Andrew Patrick McClure, Psychiatrist, VMO, Justice Health and Forensic Mental Health Network

d. Associate Professor John Dearin, General Practitioner, VMO, Justice Health and Forensic Mental Health Network

e. Associate Professor Mark Adams, Department of Cardiology at Royal Prince Alfred Hospital

f. Deputy Superintendent David McClean, Corrective Services NSW; and

g. Jamie Lawler, Former Acting Senior Assistant Superintendent at Lithgow Correctional Centre, Corrective Services NSW

28 The following witnesses provided expert reports, and were not required for cross examination:

a. Professor John Carter, Endocrinologist

b. Professor Alison Jones, Forensic Toxicologist

Identified issues

29 An issues list was distributed to the parties prior to the commencement of the inquest:

- Issue 1 - Determination of the findings required by s.81 of the Coroners Act 2009, including as to the identity of the deceased, the date and place of death, and the manner and cause of the person's death.

- Issue 2 - The adequacy and appropriateness of the medical care provided to Mr Baker whilst detained at Lithgow Correctional Centre between September 2018 and 25 June 2019.

- Issue 3 - Whether Mr Baker's diabetes was adequately managed by the Justice Health and Forensic Mental Health Network while Michael was at Lithgow Correctional Centre.

- Issue 4 - Was Mr Baker's cell placement and the decision to place him onto protective custody (PRNA) adequate and appropriate, and in accordance with Corrective Services New South Wales policies.

- Issue 5 - Whether it is necessary or desirable to make any recommendations in relation to any matter connected to Mr Baker's death pursuant to s. 82 of the Coroners Act 2009.

Michael's time in custody prior to returning to Lithgow in 2018

30 Michael had spent some periods of time in custody prior to being bail refused in October 2013.

31 Following his admission into custody in 2013, Michael was first placed at Cessnock for a short period before moving to Lithgow on 8 February 2014. He remained at Lithgow until December 2014 when he was moved to Wellington and then Parklea, before being returned to Lithgow in March 2015. He subsequently spent further periods in Parklea and Cessnock before returning to Lithgow on 7 September 2018 where he remained up until his death on 25 June 2019.

32 There were periods during Michael's incarceration where he found it difficult to get on with his cellmates. At other times he made threatening comments towards corrective officers and on occasion Justice Health employees. On one occasion he was cautioned for taking inappropriate measures to gain a "medical one out" and on another occasion he had sought a medical one out due to difficulty bending his back to fit into the bottom bunk.

33 There were also some difficulties with Justice Health and correctional staff when Michael returned to Lithgow.

34 There is no suggestion in the evidence that Michael was treated adversely due to his problematic behaviour from time to time.

Consideration of the issues

35 I propose to develop these findings by reference to the issues outlined at the commencement of the inquest. I will deal with the statutory findings (issue 1) last and the other issues in order.

Issue 2 - The adequacy and appropriateness of the medical care provided to Michael whilst detained at Lithgow Correctional Centre between September 2018 and 25 June 2019

36 Persons in custody are referred to as inmates by correctional staff and patients by medical staff. On occasions I will use the terminology "patient inmate" in these findings.

37 Following Michael's return to Lithgow, the first detailed recording in the Justice Health electronic records material ("JHeHS") as to Michael's medical conditions was entered into the Drug and Alcohol (D&A) Clinical Review of 31 January 2019. Michael was noted to suffer from hypertensive heart disease, asthma, type 2 diabetes, hepatitis C, methadone dependence, paranoid schizophrenia, intellectual disability, physical disability, scoliosis and visual impairment. In other records Michael was found to also suffer from depression and chronic pain.

38 Michael's prescribed medications as at 31 January 2019 were noted to be: mirtazapine, amitriptyline, duloxetine, clonidine, baclofen, methadone, perindopril, amlodipine, metformin, novomix, paracetamol and quetiapine.

39 Some of Michael's medication was what is known as "supervised medication". This meant that Michael was observed when the medication was provided to him. The purpose of the observation was to ensure the medication was taken when provided. This also meant that Michael was seen twice a day by nursing staff throughout the time he was at Lithgow. In the month prior to his death, Michael was supervised when he was administered methadone, insulin (novomix) and amitriptyline.

40 On 11 October 2018, Michael was seen by the visiting medical officer, Associate Professor Dr John Dearin (Dr). Dr Dearin had seen Michael when he was previously in Lithgow. This was the first occasion that Michael was seen by a doctor following his return to Lithgow in September 2018.

41 Dr Dearin noted that Michael suffered from hypertension, which was inadequately controlled, having been consistently elevated for the past six months. Dr Dearin increased Michael's clonidine to 150 milligrams and directed that Michael's blood pressure be monitored weekly until the blood pressure was down to 130/70 mmHg.

42 Examination of the Standard Adult General Observation Chart (SAGO Chart) reveals that after this consultation there were no blood pressure results recorded until 7 November 2018. Thereafter observations were recorded on 10 November 2018, 15 November 2018, 23 November 2018, 27 November 2018, 15 December 2018 and 13 April 2019.

43 The entries which were recorded in the SAGO chart, coincided with Michael returning from hospital following medical incidents. In October 2018, Michael fractured his ankle and attended Lithgow Hospital. In December 2018, Michael attended the orthopaedic clinic at Nepean Hospital and returned in a moon boot, and the single entry in April 2019 was after Michael's attendance at Lithgow Hospital following a seizure like episode in his cell.

44 The entries which were made reveal that Michael's blood pressure was never 130/70. The recorded readings on Mr Baker's SAGO charts included:

- 130/80 – 7 November 2018
- 148/107 – 10 November 2018
- 160/98 – 15 November 2018
- 118/97 – 23 November 2018
- 162/93 – 27 November 2018
- 140/90 – 15 December 2018
- 148/91 – 13 April 2019

45 It was the evidence of Registered Nurse Tracy Taylor that nursing staff should take and record observations in accordance with policy and procedure and that Mr Baker's observations needed to be done more frequently than appears in the SAGO chart. When asked why it may be that observations were not recorded, nurse Taylor stated that it was possibly that the observations were within range so the nurse wasn't concerned and potentially a time constraint. She further acknowledged that if a patient's observations are taken, they should be recorded because they are looking for a pattern; for her to know that the reading is within the flags doesn't help anyone else or the nurse that sees the patient the next day.

46 On 29 October 2018, Michael was taken to Lithgow Hospital after injuring his right ankle. Michael reported that he had woken up and vomited, he was vague and confused and then rolled his right ankle. He was found to be hyperglycaemic and admitted to taking several "boiled lollies" the night before. The X ray was not determinative, but it was thought there was a possibility of an undisplaced fracture, and it was noted that a CT scan should be considered. There is no evidence a CT scan was ever conducted. On 10 December 2018, on a further X-ray it was noted that "subtle fracture lines were visible".

47 The Psychiatrist at Lithgow, Doctor Andrew McClure had seen Michael in 2014 and 2015. In his statement Dr McClure indicated that he consulted with Michael on 20 October 2018. Given the notes of the consultation referred to Michael having a broken ankle, it seems likely the consultation occurred upon Michael's return from hospital on 29 October 2018. In the consultation Michael complained of back and nerve pain increasing his anxiety. He also described paranoia from time to time. Dr McClure restarted baclofen, a medication for muscle spasm often in the context of back pain and recommended a consultation with the visiting General Practitioner (GP) for review of Michael's fracture and chronic pain, as soon as possible.

48 Dr McClure was asked if it was his usual practice to prescribe baclofen for a patient inmate. Dr McClure pointed out that baclofen is not a psychiatric medication, further stating *"..let's put it that way if a patient gives a history that it was helpful and they've taken it before, at - at a time when they were on the medications they were - they are currently on, and then, given that there's usually a very long waiting time to see the general practitioner, I think, out of a sense of duty to help the patient with their symptoms, I would, from time to time, prescribe something like that".*

49 Whilst not having a specific memory of waiting times to see a GP at Lithgow as at 2018 to 2019, Dr McClure thought inmate patients may wait a couple of months, except in very urgent cases, noting that Dr Dearin attended once a week, on Thursdays.

50 On 8 November 2018, Dr Dearin saw Michael for review of the right ankle. On this occasion Dr Dearin recommended a temporary increase in methadone for Michael's ankle pain. Such increases need to be assessed by the drug and alcohol specialist practitioners. Following Dr Dearin's recommendation Michael did not see a drug and alcohol specialist until 31 January 2019. On assessment the dose of methadone was not increased. Rather, it was split into 120mg in the morning and 30mg in the evening.

51 On 7 December 2018, Dr Dearin prescribed the pain killer pregabalin for 4 weeks. At that time Michael had been on pregabalin for years.

52 On 13 December 2018, Dr Dearin again reviewed Michael and noted he was in a moon boot. Dr Dearin ceased the pregabalin. Dr Dearin explained in evidence that pregabalin

ceased being prescribed for patients in custody, as they tended to divert it. Dr Dearin commenced Michael on duloxetine 60 milligrams daily for pain and depression.

53 On 25 January 2019, Michael again saw Dr Dearin. On this occasion Michael requested to be placed in a one out cell due to his mental health issues, diabetes and loud snoring. Dr Dearin noted that Michael required review for Obstructive Sleep Apnoea (OSA) syndrome.

54 Dr Dearin pointed out that OSA is a significant health problem as it "*....is associated with a whole range of other comorbidities such as worsening of diabetes, worsening of heart disease and an increased risk of associations with obesity".*

55 Associate Professor Adams stated in his evidence that OSA was a "*really major problem for cardiac disease, particularly in terms of heart- heart failure, development of coronary disease, development of arrythmias such as atrial fibrillation, along with the stress on the heart from repeated episodes of hypoxia and not to mention sudden death".* He further stated that a CPAP machine stops these periods of apnoea during the night by keeping the airways open "*....so that you don't get repeated episodes of hypoxia because that causes an increase in blood pressure, it causes an increase in pulmonary pressure as well and both of these things can put a lot of stress on the heart".*

56 A "CPAP" machine is a continuous positive airway pressure machine. The patient wears a mask over their mouth and nose that forces air in at a predetermined level according to what is required to keep that patient's airway open. Once assessed as suffering from OSA, a patient inmate as at 2019 could have had access to a CPAP machine.

57 Unfortunately, when Dr Dearin filled in the referral form for Michael to be tested for OSA he entered the name of another inmate with the same surname as Michael. That inmate was released from custody on 29 January 2019. Michael did not ever have testing for OSA.

58 No clinician or administrative staff picked up on the failure to have Michael appropriately referred for testing despite Dr Dearin having made a note that Michael required testing for OSA.

59 Both Dr Dearin and Associate Professor Adams, on review of the material, were of the opinion Michael suffered from OSA.

60 Dr Dearin did not see Michael after that consultation on 25 January 2019.

61 On 13 April 2019, Michael presented to the Emergency Department at Lithgow Hospital by ambulance accompanied by correctives officers.

62 He had been seen on the monitor to be lying on the floor of his room, one guard reports that he appeared to be moving normally.

63 Another guard stated that she saw him appearing to have a "seizure" – arms and legs shaking and not responding to direction.

64 There was no loss of bowel or bladder control and no tongue biting.

65 Michael had been attended to earlier in the night by an ambulance crew after he was seen to sit bolt upright and proceeded to shoulder charge and kick the door. Michael related this to having a panic attack. His blood sugar level at that stage was 10.

66 A CT of his brain was conducted, with the results interpreted as *"no intracranial haemorrhage, mass effect or skull fracture; Dr Dearin to review with consideration of an outpatient EEG"*.

67 Despite the content of the discharge summary and despite the seriousness of the medical event, Dr Dearin did not see Michael following this incident.

68 Upon questioning as to why neither he, nor any other GP consulted with Michael following this incident, Dr Dearin drew attention to his earlier evidence that the clinic list was generated by the nursing staff, and they triage all the patients unless the patient is brought urgently to the clinic on the day that he is there.

69 Noting he was reliant upon the nursing staff who formulate the list of patients, Dr Dearin indicated that sometimes the list was so long that he could not see all the patients on the day *for a whole variety of reasons*. Dr Dearin went on to note "*...certainly it's a very long time, given his history, ideally, I should have seen him much sooner, but tragically I didn't*".

70 Dr Dearin gave evidence in another part of his examination that an important aspect of his work was reviewing discharge summaries and correspondence relating to patients who had been taken to hospital. Clearly Dr Dearin either failed to review Michael's discharge summary or did not pick up on the requirement to see Michael.

71 Nurse Taylor's understanding in her evidence was that each patient that goes to hospital needs to be seen by the GP within the next week of their return and an appointment would be booked for that. Dr Dearin agreed with one week being an appropriate triage timeframe.

72 From the excel spreadsheet provided by Justice Health to the counsel assisting team it is clear that following Mr Baker's discharge from hospital a GP waitlist appointment was made, however, this was categorised as "priority level" 4 (four) or "routine", which per the policy provided by Justice Health, means seeing a GP within a 12-month timeframe. Consequently, Michael did not see a GP following this very serious incident.

73 After 13 April 2019, the next appointment Michael had, other than attending the clinic for the sole purpose of receiving supervised medicine, was an appointment with Dr McClure on 20 May 2019. Dr McClure noted that Michael said his mental health was *"ten times better now that he was alone in his cell"*. Dr McClure assessed Michael as being *"talkative and digressive, slightly irritable with a neutral mood and no evidence of psychosis"*.

74 On 22 May 2019, Michael had a drug and alcohol telehealth appointment with Dr Kehoe, who changed Michael's split methadone dose to 100mg in the morning and 50mg in the night. An ECG was noted as being within normal limits.

75 The only entry in Michael's clinical notes after 22 May 2019 is an entry on 3 June 2019 by a nurse as to a conversation with Dr McClure which reads in part "*diabetes is*

currently stable, mental health is currently stable therefore no need for patient to be in two out cell placement however as per VMO patient must be in normal cell placement not one out".

76 At approximately 8:35am on 25 June 2019, correctives officers attended Mr Baker's cell to take him for his insulin at the clinic. Upon opening the flap on the door Michael could not be seen. The cell door was opened, and Michael was seen lying face down on the floor in the front of the cell near the clear door. He appeared to be unconscious and unresponsive. A medical response was called. Michael was found to be stiff and cold.

77 Michael was carried out of his cell and CPR was commenced. Multiple nurses arrived and an ambulance was called. The nurses then began to commence CPR.

78 At 8:53am the first ambulance arrived and two paramedics started to apply a defibrillator. During this time CSNSW staff continued to perform CPR on Michael.

79 At 9:06am Michael was pronounced deceased.

80 A subsequent review of the CCTV by the CSNSW Investigations Branch identified that Michael must have passed away at 7:12am, as no further movement from Michael can be seen after this time.

Management of Michael's medication

81 It is convenient to now consider some issues related to Michael's medication regime at Lithgow in 2018 to 2019.

82 Michael's medical conditions and medications are set out in detail above. Diabetes, OSA, high blood pressure and obesity are all significant risk factors for poor heart health and each is associated with QT interval prolongation. Additionally, the medications methadone, mirtazapine, amitriptyline, duloxetine and baclofen can each result in prolongation of the QT interval. As pointed out by Associate Professor Adams the effect of each of these factors on QT prolongation is cumulative.

83 The QT interval is an electrical measurement on an electrocardiogram which reflects the heart's repolarization following contraction, when this interval becomes increased there is a high risk of arrythmia which can cause fainting if it is self-limiting, or where it persists can be fatal.

84 An ECG provides a measure of the QT interval. It is an imperfect assessment tool in that it gives a reading at a moment in time. Nevertheless, regular ECGs are an important investigative procedure, particularly for Michael given his medical conditions and medications.

85 The appropriate management would have involved ECGs in the days after medication changes.

86 Dr McClure indicated that the QTc is *"specifically important when looking at drug interactions between drugs that prolong the QT – QTC*". He suggested that when there was a change in medication there should be an ECG within a week.

87 Associate Professor Adams opined that "*Management of Mr Baker's opioid addiction would likely have been extremely difficult to manage without the use of methadone, however, in this situation regular electrocardiograms*," or ECGs, "*might have been useful to monitor for QT prolongation."*

88 He also gave evidence that "*if you're going to start one of these medications or if you're significantly changing the dose of a medication that's known to increase the QT interval, there should be an ECG after a few days*".

89 The evidence revealed that between 2018 and 2019, when Michael was at Lithgow, ECGs were done on 10 November 2018, 31 January 2019 and 22 May 2019 as well as an in-hospital ECG on 13 April 2019.

90 On 29 October 2018, Dr McClure prescribed baclofen for Michael, as set out above. Dr McClure did not order that an ECG be done. However, one did take place on 10 November 2018. It was appropriate to perform an ECG on 10 November 2018 as it was 6 months since Michael's last ECG. The QTc in that ECG was around the 420 mark, which Associate Professor Adams described as, *"closer to being concerning".*

91 On 13 December 2018, Dr Dearin commenced Michael on duloxetine 60 milligram because of Michael's fractured ankle pain and depression.

92 Michael remained on the duloxetine up until the time of his passing. Dr Dearin accepted that there should have been a review of the continuation of duloxetine noting that he "*didn't know what Michael's mental state was in the intervening five months before he finally passed away*" and that *"as patients are triaged to see me by the nursing staff, if they judged that the patient was benefiting from that drug, they may not have alerted me to the need to review it".*

93 Dr Dearin also indicated he understood that duloxetine posed a risk in terms of QT prolongation and that the risk increased when the drug was prescribed in combination with mirtazapine, amitriptyline and baclofen.

94 Dr Dearin did not order an ECG after reintroducing the duloxetine, despite the evidence at inquest being that ECGs could readily and easily be performed by nurses so long as the patient was available and co-operated.

95 On 31 January 2019, Michael had a drug and alcohol appointment and his prescribed methadone dose was split. An ECG was performed that day. The better approach would have been for Michael to have an ECG a few days to a week after the change in medication regime.

96 The next ECG was conducted in hospital on 13 April 2019 and revealed a QTc of 407 which Associate Professor Adams described as *"kind of not particularly concerning*".

97 On 20 May 2019, when Dr McClure attended upon Michael, he increased his Quetiapine dosage to 200mg at night to assist with sleeping. Dr McClure did not order an ECG. In evidence he indicated that with the benefit of hindsight, it would have been reasonable to order another ECG at that stage.

98 Dr Kehoe conducted an ECG on 22 May 2019. The reported QTc reading of 380 was within normal limits.

Issue 3: Whether Mr Baker's diabetes was adequately managed by the Justice Health and Forensic Mental Health Network while Michael was at Lithgow Correctional Centre

99 As at May 2016, Justice Health had in place a "Diabetes Pathway for Chronic Care" document which included the "Annual Cycle of Care Guide for Adults with Diabetes" (Guide, Diabetes Guide).

100 The guide included "Tests/ Management" that should be undertaken, an indication as to "how often" they should be undertaken and a "target range" where relevant.

101 On 27 September 2018, a nurse saw Michael in relation to ingrown toenails. Michael requested a "diabetic pack" and was advised, by the nurse, after she spoke to the kitchen that it was no longer issued at Lithgow. The diabetic pack was, when available, a food pack with additional food to help avoid hypoglycaemic episodes.

102 Michael reported ongoing chronic joint pain especially in his back and feet and right thumb. Nurse Taylor noted that an appointment would be made for Michael to see a GP.

103 On 11 October 2018, Michael was seen by Dr Dearin who noted that Michael had bilateral ingrown toenails associated with toe cramping in shoes which had inadequate room in the toe box. It was further noted Michael was an insulin dependent diabetic since 2005. Dr Dearin also noted there had been no biochemical review for more than three years and no eye check or diabetic foot check for more than two years.

104 In oral evidence Dr Dearin indicated that diabetic patients should have a biochemical review at least annually. The Diabetes Guide indicated that biochemical review (HBa1C testing) should occur 3-6 monthly, eye examination between 1 to 2 years and foot examination 6 monthly.

105 Dr Dearin provided a certificate for extra wide shoes with adequate toe box width, ordered biochemistry lipids and further blood tests, noted that there was a need for a diabetic eye check and requested that Michael be booked in to see an optometrist.

106 No appointment was made for Michael to see an optometrist.

107 On 20 May 2019 when Dr McClure attended upon Michael, he recommended referral to a podiatrist as soon as possible for review of an inflamed, indurated left first toe with an ingrown toenail, consideration of shoe inserts and diabetic socks. Dr McClure also recommended consultation with the GP regarding these issues. No appointment was made with a GP nor was there a referral to a podiatrist.

108 Issues in relation to Michael's feet had been raised by Dr Dearin in the 11 October 2018 consultation and nothing had occurred since that date. The extra wide shoes Dr Dearin provided the certificate for had not been provided and nothing had been done in relation to Michael's ingrown toenails, despite written requests by him for assistance.

109 Within the patient self-referral documentation tendered at inquest is a note Michael had written which reads "*3 months ago Dearin wrote me up for me to obtain extra wide shoes with adequate toe box i.e.4E width I haven't even been asked what size shoes I take".*

110 On 1 March 2019, Michael wrote on a patient self-referral form "*my feet are very painful where the ingrown toenails are. The doctor was supposed to look at them 5-6 weeks ago on the 25th January, also my sleep is not happening can I see Browyn to talk about having my meds adjusted also can I talk to the NUM about several different matters*". A note at the foot of the document reads "*added to GP wait list re toenails CSNSW to supply pillow to patient".* There was no corresponding addition to the GP waitlist.

111 Michael wrote again on 12 March 2019 indicating that his toenails were five times worse than when he had seen the doctor on 11 October 2018. He indicated that one toenail was lifted up by a centimetre. Michael again noted that Dr Dearin had listed him to get extra wide shoes, but he still had not been given any. Further, he noted that he had been trying to get slippers since August 2018 as the slippers would be better because *"there's no pressure on the toe or toenail".* Once again there was an entry regarding Michael being added to the GP wait list. Again, the GP wait list does not reflect any GP appointment being made.

112 During the consultation on 11 October 2018, Dr Dearin made his observations as to the inadequate control of Michael's blood pressure which has been set out in detail above.

113 Dr Dearin's aim of Michael's blood pressure being monitored weekly and reaching 130 / 70 was well informed by literature relating to inmates suffering diabetes. The Diabetes Guide indicated that blood pressure should be taken upon every visit to a nurse or doctor and that the target range is less than 130/80. The lack of recording of Michael's blood pressure meant that no ongoing assessment was made as to his blood pressure and no adjustment was made to his medication despite his diastolic reading not being recorded as being below 90 on any occasion after 7 November 2018.

114 Associate Professor Adams indicated that the blood pressure readings in isolation would not themselves cause him major concern, however he accepted it would have been better if they were regularly taken and the overall impression of the readings as far as they went did cause concern.

115 In early 2019, in the context of Michael's cell placement, nursing staff raised with Dr Dearin their view that Michael's blood sugar levels were unstable. Consideration of the blood sugar level (BSL) tables kept by nursing staff, reveals that the levels had been high in the second half of 2018 and seemed to be gradually resolving during 2019. Clinical staff were vigilant in recording Michael's blood sugar levels and whilst they were elevated at times, they were under control in May and June of 2019.

116 Another issue relevant to Michael's diabetes was that of weight. The Diabetes Guide indicted that a GP should take weight and waist measurements every six months.

117 The SAGO chart recorded Michael's weight once whilst he was at Lithgow. On 10 November 2018, Michael's weight was recorded as 110kg and his body mass index (BMI) was 34. On 4 July 2018, when Michael was at Wellington his weight was recorded as 114kg. On 29 May 2019, Michael's weight was recorded in the JHeHS records as 109kg. At the time of his death Michael's weight was 113.5 kg with a BMI of 34.9. Thus, at all times Michaels BMI was in the obese range. Contrary to policy, a number of these measurements were not entered on the SAGO chart.

118 Associate Professor Adams stated that it would have improved Michael's health if he had lost weight and that it was important for people that are diabetic on higher doses of methadone to maintain a healthy weight because it can lead to heart disease, stroke and kidney failure, particularly in combination with diabetes and high blood pressure.

119 Associate Professor Adams also pointed out that "*being overweight or obese increases your risk of sudden death quite significantly. People with morbid obesity, or even obesity, have, you know, more than twice the chance of dying suddenly, usually due to a cardiac cause. Now, the reason for that's not quite known, but it has been documented that people with obesity are more prone to arrhythmias, cardiac arrhythmias, and can exhibit some increase in their QT interval as well, which may be what's behind this*".

120 Associate Professor Adams further noted that "*obesity affects the lipids, lipid levels, and things like that, and also, it's much more likely to lead to obstructive sleep apnoea, which is a - a really major problem for cardiac disease, particularly in terms of heart - heart failure, development of coronary disease, development of arrhythmias such as atrial fibrillation, along with stress on the heart from repeated episodes of hypoxia, and, not to mention, increases in sudden death, and these are particularly sudden deaths that'll frequently happen at night, and when I say at night, I mean, while you're asleep, not while you're watching TV*".

121 Dr Dearin noted that losing weight is for some outside prison a matter of bariatric surgery, and for others, a lifetime commitment. Michael's capacity to exercise whilst at Lithgow was limited by the conditions under which he was placed and the injury to his ankle.

122 The evidence was that between March and June 2019, Michael was housed in a cell which included access to a small rear yard for 6 hours of the day, depending on operational requirements. Michael also had access to other parts of the correctional centre and was escorted to the Justice Health clinic at a minimum of twice per day for medication or medical treatment.

123 In response to written questions from the assisting team, Justice Health have provided further information about the steps available to deal with obesity issues in the prison

population at Lithgow Correctional Centre both as at 2019 and currently. Corrective Services industries provides meals for inmates across publicly managed NSW correctional facilities and provides inmates with access to additional items via 'buy ups'. Justice Health can request a therapeutic diet for patient inmates with clinical conditions, however it is noted that standard diets are appropriate for Diabetic patient inmates. There is no therapeutic diet for inmates who need to lose weight. Justice Health also conduct health promotion activities to address numerous health issues, including obesity.

124 There was evidence at inquest that on one occasion a nurse spoke to Michael about diet, exercise, cessation and medication during a "diabetes review".

Comment in relation to issues 2 and 3

125 In making the following comments I make it clear that I fully understand that Justice Health aspires to delivering to patient inmates a standard of care which is the equivalent of care delivered to patients in the community. I not only understand that aspiration but accept that it is genuine and that overall, Justice Health staff are dedicated and hard working.

126 I am also well aware that Professor Carter opined in his report that Mr Baker's diabetes was appropriately managed at Lithgow Correctional Centre and in accordance with Justice Health policies over the last nine months of his life.

127 In expressing this opinion Professor Carter was answering specific questions and his particular focus was upon Michael's blood sugar levels and methadone management. I accept that Michael's blood sugar levels were appropriately monitored in 2019. Nevertheless, despite the fact that Professor Carter was not cross examined, I cannot accept that Michael's blood pressure was appropriately monitored. Additionally, Professor Carter placed the caveat on his opinion regarding the management of Michael's methadone, in indicating that he was not aware of attempts to progressively manage Michael's methadone dosage. The oral evidence at inquest did not reveal any attempts to reduce the dosage. The only change was the splitting of the dosage between night and morning, which occurred twice, and on the evidence was acceptable.

128 Finally by way of introductory comment, I note it was properly accepted in submissions that the prison population includes some of the most vulnerable and medically challenged members of the community. Michael's presentation in particular was complex and required clinical vigilance.

129 The delivery of care delivered to Michael fell well short of an appropriate level in the following areas:

(1) The failure to undertake a biochemical review for more than three years (*prior to Michael's return to Lithgow in September 2018*).

(2) The failure to undertake an eye check for more than two years (*prior to Michael's return to Lithgow in September 2018*).

(3) The failure to undertake a diabetic foot check *(prior to Michael's return to Lithgow in September 2018*).

(4) The failure to make an optometrist appointment after the 11 October 2018 appointment with Dr Dearin.

(5) The failure in providing Michael with appropriate footwear after the 11 October 2018 appointment.

(6) The failure to refer Michael to a podiatrist after the 20 May 2019 appointment with Dr McClure.

(7) The failure to refer Michael to a GP after the 20 May 2019 appointment.

(8) The failure to take, record, and control Michael's blood pressure after the 11 October 2018 appointment.

(9) The failure to effectively refer Michael for testing for presumed OSA after the 25 January 2019 appointment.

(10) The failure to make GP appointments in March 2019 despite notes on the self-referral form indicting such appointments would be made.

(11) The failure to ensure there was GP follow up after Michael's hospitalisation in April 2019.

(12) The failure to undertake or order ECG tests when Michael's medication was changed in October 2018 and May 2019.

(13) The failure to closely monitor Michael's weight.

130 Whilst the inquest did not focus upon Michael's care in custody prior to his return to Lithgow, the failure to undertake diabetic reviews and checks prior to Michael's return to Lithgow indicates that the failings in administering appropriate care to Michael were not limited to his time at Lithgow.

131 The effect of the failings and missed opportunities throughout September 2018 to 25 June 2019 included that Michael's blood pressure was inadequately treated, ECGs were not undertaken when they should have been, not one of the proposed referrals to a specialist occurred, proposed referrals to a GP after 25 January 2019 were either not made, or wrongly triaged, even when entries in self-referral forms indicated that referrals had been made, and Michael's extremely painful feet were never attended to.

132 In each instance of proposed referral to a specialist, a doctor made a clinical note entry requesting a referral and yet nothing happened over the months that followed.

133 The evidence at inquest confirmed the well understood proposition that the very purpose of clinical notes is for other clinicians to read those notes and attend to what the notes raise, require or direct or alternatively discuss the content of the notes with the clinician who has made the note if there is any need to do so.

134 Despite Dr Dearin's clear note as to his requirement regarding blood pressure monitoring, it did not occur to anywhere near the level he directed.

135 It can be readily accepted, on the evidence in this inquest, that despite the Diabetic Guide indicating blood pressure should be taken at each attendance upon a nurse, that it was not required that blood pressure be taken each time Michael attended at the clinic to receive his supervised medication. Furthermore, Dr Dearin did not require as much. What he did require was weekly blood pressure testing and the results were required to be entered on the SAGO charts.

136 While records of Michael's blood pressure had been kept in November and early December 2018, Dr Dearin did not pick up the lack of blood pressure monitoring when he attended upon Michael on 25 January 2019.

137 Dr Dearin gave evidence that it's possible he mentioned the lack of record keeping to the nursing staff however, even if this were the case, Dr Dearin failed to make sure his direction was carried out.

138 Michael died some 30 weeks after Dr Dearin's directive and yet his blood pressure was entered in the SAGO chart on only six occasions, four of which occurred in November 2018. The failure to make a sufficient number of entries meant that clinicians had no opportunity to observe the pattern of Michael's blood pressure, and based on Dr Dearin's October 2018 assessment, it was never adequately controlled.

139 Dr Dearin entering the incorrect name on the referral for OSA testing following Michael's appointment on 25 January 2019 was an unfortunate error. It is likely that this error was made in circumstances where Dr Dearin had an overwhelming workload and is indicative of the type of errors that can be made in an under-resourced GP clinic in a custodial setting.

140 However, Dr Dearin's error should not have been the end of Michael's opportunity to have an appropriate OSA test. Dr Dearin had made a clear note that Michael needed the OSA testing and yet no clinician checked at any stage whether the entry in the note had been followed up, despite the fact that Michael saw nursing staff twice a day every day. Nursing staff made entries in the clinical notes, for example, on the same day as Dr Dearin's entry on 25 January 2019, and only half an hour after Dr Dearin's entry on 28 January 2019 and 29 January 2019 (3 entries).

141 In addition, as set out above, Dr Dearin himself should have seen Michael after the 25 January 2019 consultation, at the very least after Michael's return from hospital in April 2019, and following Dr McClure's attendance upon Michael on 20 May 2019.

142 It is clear Michael should have been seen by a GP within a week of his hospitalisation on 30 April 2019. As set out above the failure of the nurse who entered the appointment in the GP waitlist to properly categorise the urgency of the review did not assist.

143 The importance of there being an appointment is made clear by Associate Professor Adams' observation that it is not unusual for syncopal episodes caused by arrhythmias to be mistaken for generalized seizures, or indeed for the seizure itself to be secondary to a cardiac arrhythmia. It has been observed that arrhythmias can masquerade as generalized seizures.

144 This was a gross lapse in the provision of care to Michael. The episode was clearly a very serious medical episode.

145 As was stressed during submissions the evidence made clear that Michael's comorbidities combined with the medications that he was taking required clinical vigilance, and yet, even after such a serious episode Michael did not receive the care he required and deserved.

146 Doctor's Dearin (11 October 2018) and McClure (20 May 2019) each failed to order follow up ECGs after changing medication that was known to have the potential to lengthen the QT interval.

147 It is important to understand Associate Professor Adams' evidence about ECGs as a tool for assessing QT prolongation. As set out above, ECG's look at the QT length at one moment in time. Thus, as explained by Associate Professor Adams, the ECG at Lithgow Hospital which showed an acceptable QT length did not exclude the possibility that the seizure event had been caused by an arrhythmia.

148 Consequently, it was essential that Michael was reviewed by a GP following his return from hospital so that he could be assessed and if necessary further appointments scheduled. Once again Michael's care was wholly inadequate in this regard.

Why were the opportunities for appropriate care missed

149 It is very difficult to comprehend how there could be so many failures and missed opportunities in relation to the delivery of care to Michael during the months of September 2018 up until his death in June 2019.

150 A theme that emerged during the inquest and that was referred to frequently in submissions, was that Dr Dearin and the nursing staff were subjected to an overwhelming workload.

151 I now set out the evidence which supported that theme.

152 Dr Dearin attended Lithgow Correctional Centre once a week on Thursdays. In 2018 to 2019 there were approximately 400 to 420 inmates at Lithgow. On occasions another GP would also attend the clinic.

153 Dr Dearin's allotted time each Thursday was six hours. The evidence was that Dr Dearin would see six or seven patients in that time as well as attending to discharge summaries, pathology reports, other correspondence and up to two or three hours every week rewriting medical charts. The result was, as Dr Dearin explained in evidence, that he *"worked very much overtime, for which I was never paid"*.

154 Dr Dearin also indicated that sometimes the list was so long that he could not see all the patients on the day for which the appointment was made.

155 Dr McClure gave evidence in relation to prescribing the non psychiatric medication, baclofen for Michael *"given that there's usually a very long waiting time to see the general practitioner, out of a sense of duty to help the patient with their symptoms, I would, from time to time, prescribe something like that"*.

156 Dr Dearin gave evidence that *"patients say they've been waiting six or nine months to see me, but what the - and the patients are triaged by the nursing staff in terms of priority to be seen, so the waiting list is different for different patients, according to their need"*.

157 Nurse Taylor's evidence was that the failure to record observations was most likely due to time constraints.

158 The overwhelming weight of the evidence is that the clinical staff were overworked to the extent that they were unable to properly complete their work.

159 There is no evidence that Michael was deliberately disadvantaged.

160 The only available conclusion is that there were an insufficient number of nursing staff and one GP one day a week for six hours was wholly insufficient even with occasional attendances by other GPs.

Issue 4: Was Mr Baker's cell placement and the decision to place him onto protective custody (PRNA) adequate and appropriate, and in accordance with CSNSW policies.

161 On 25 January 2019, Michael had asked Dr Dearin that he be placed in a one out cell due to his mental health issues, diabetes and loud snoring. Dr Dearin certified Michael as suitable to occupy a single cell. Later that day nurse Taylor completed a Health Problem Notification Form (HPNF) which recommended a two-out placement for Michael due to, as she explained in evidence, her concern about Michael's unstable blood sugars.

162 Prior to 27 January 2019, Michael was housed in 2 unit. On 27 January 2019, a corrective's officer moved Michael to 5 unit following on from information from inmates that Michael would be stabbed if he remained in 2 unit.

163 Despite the two-out placement recommendation of 25 January 2019, Michael refused to have a cell mate and as such a decision was made to place him in an observation cell in 5 unit.

164 On 19 February 2019, Michael was moved into cell 235 in 5 unit where he remained until his death.

165 The evidence was that Michael needed to be kept separate from the other prison population so that he could be observed in an observation cell and for his own safety.

166 I accept that throughout the period 25 January 2019 until his death Michael preferred to be in a cell one out.

167 This view is informed by Michael's request to Dr Dearin on 25 January 2019 and his comment to Dr McClure on 20 May 2019 that his mental health was *"ten times better now that he was alone in his cell"*.

168 On 3 June 2019, Registered Nurse Bevan made an entry in Michael's clinical notes which included that Michael's diabetes and mental health were both now stable. On that same day nurse Taylor completed a new HPNF in which she indicated that Michael was now suitable for "normal cell placement".

169 This changed recommendation meant that Michael was able to be placed in a cell by himself. Correctional staff determined that he should return to one unit however Michael refused to do so and indicated that he wanted to return to two unit as there was no ongoing issue with any inmate within that unit. Despite Michael's view, correctional officers remained of the view that Michael was at high risk of threat and as such he was placed on PRNA (protection non association) and remained in cell 235 in 5 unit.

170 As at the date of Michael's death a more appropriate placement had not been found for him.

171 I have carefully considered the evidence in relation to this issue, and I am unable to conclude that there was any lack of forthrightness in the evidence of correctional officers both written and oral in relation Michael's cell placement. Nor am I able to conclude that there was any breach of CSNSW policy.

Issue 5: Whether it is necessary or desirable to make any recommendations under s. 82 of the Act

172 None of the failures identified above have been found to be causative of Michael's death. It will never be known whether Michael's outcome would have been different had an appropriate level of care had been provided at all times.

173 The fact that the failings were not causative of Michael's death does not however lesson the importance of considering whether any recommendations should be made.

174 The first step is look at what changes have been made since Michael's passing.

Sleep Apnoea and CPAP machines

175 It is clear that Justice Health now have an extensive policy in relation to provision of CPAP machines which enables for far more extensive provision than was available as at 2019. This nevertheless still leaves open the question as to how Justice Health become aware of whether a patient inmate needs testing for sleep apnoea. A question arose as to whether patient inmates should be specifically asked as to whether they have sleep apnoea and/or whether they had used a CPAP machine in the community.

176 In answer to written questions from the assisting team, Justice Health advised that a reception screening tool was completed when Michael entered custody on 27 October 2013 which contained the following question under the heading "Respiratory Disease": "Do you have a diagnosed respiratory disease, use a CPAP machine or two or more risk factors". Michael answered "no" to this question. In accordance with Justice Health policy, Reception Screening Assessments (RSA's) are only completed at the point of reception into custody and are not completed on transfer between correctional centres. As such there was no new RSA undertaken when Michael returned to Lithgow in September 2018.

177 The 2015 version of the RSA contains a question as to whether the patient inmate has ever had sleep apnoea and a question as to whether the patient inmate uses a CPAP machine. This questioning is more extensive and more clearly directed to sleep apnoea then the question in its predecessor screening tool.

178 This still leaves the issue as to patient inmates who develop sleep apnoea in custody and those who have undiagnosed sleep apnoea at the time of reception into custody. Michael told both Dr Dearin and Dr McClure of his loud snoring and the CSNSW notes contain mention of Michael needing to be one out because his loud snoring caused problems for his cell mates.

179 Professor Alison Jones opined that people receiving methadone should be routinely and promptly evaluated and treated for sleep disorders. She recommended that patients who require more than 50 milligrams of methadone should be referred for formal sleep evaluation.

180 The failure to refer Michael for testing for OSA arose in the first instance because of human error and the lack of follow up was due to the excessive workload on clinical staff.

181 In those circumstances I do not propose to make a formal recommendation, but I would encourage Justice Health to continue giving close consideration to the issue of identifying sleep apnoea in inmates, and to the issue of testing inmates on large daily doses of methadone, given the significant damage sleep apnoea can cause to an inmate's heart health.

Methadone

182 All doctors and experts in the inquest acknowledged the risk of QT interval prolongation which accompanied prescribing large daily doses of methadone.

183 In January 2020, Justice Health started providing Buvidal (a hybrid medication which contains buprenorphine) by means of depot (slow release) injections. Depot injections have become the preferred mode of treating opioid dependence unless there are clear and well documented medical reasons as to why this treatment is contra indicated.

184 Depot injections of Buvidal are considered to have at least two advantages over methadone. Firstly, there is a lesser risk of QT interval prolongation, and secondly it is significantly more difficult for patients to divert their dose.

185 As at 29 February 2024, Justice Health had 1,728 patients on treatment for opioid dependence, 86% of whom were on depot Buvidal and 14% of whom remained on methadone.

186 This significant effort to introduce as many patient inmates as possible to depot Buvidal is a very significant step forward in reducing the risk to patients of QT interval prolongation.

Record Keeping

187 Given the significant issues in relation to keeping and considering records of clinical observations Justice Health was asked to advise what education and auditing there is in relation to SAGO charts.

188 SAGO chart compliance is audited statewide on a quarterly basis. Ten charts are chosen at random and examined for compliance. The inquest was told that the most recent audit of SAGO charts at Lithgow resulted in a 96% compliance rate.

189 Mandatory training takes place in line with updates published by the Clinical Excellence Commission. Relevantly in 2019 Lithgow staff were required to attend mandatory "between the flags training", in relation to the parameters of satisfactory readings.

190 Ongoing consideration needs to be given to how to appropriately audit or provide oversight of the failure to enter records. This might require, for example a system of on-the-spot checking by Nurse Unit Managers or co-workers.

191 Given the issues of overwhelming workload raised in this inquest, I don't propose to make a recommendation but again I encourage Justice Health to consider how best to audit and train staff in relation to record keeping on an ongoing basis.

Staffing levels at Lithgow Correctional Centre

192 Somewhat disturbingly both Dr Dearin's oral evidence and documentary evidence provided by Justice Health confirmed that Dr Dearin still attends Lithgow once per week, on Thursday for six (paid) hours. The Justice Health March and April 2024 clinical roster confirmed that he was the only GP who attended at Lithgow in those months.

193 I urge Justice Health, and the Ministers to whom these findings will be provided, to carefully consider that position and the level of nursing staff at Lithgow and take the necessary steps to ensure appropriate levels of care can be provided to all inmates.

An underfunded custodial health service

194 As long ago as the Royal Commission into Aboriginal Deaths in Custody (1987-1991) the predominant area of criticism in relation to failures in custodial care was directed at the (various) Prison Medical Services. The criticisms included performance failures, system failures and communication failures and it was noted that at times there was a "grave departure" from "due care".

195 In an oft quoted speech, Winston Churchill said in 1910:

> *The mood and temper of the public in regard to the treatment of crime and criminals is one of the most unfailing tests of the civilisation of any country A calm and dispassionate recognition of the rights of the accused against the state and even of convicted criminals against the state, a constant heart-searching by all charged with the duty of punishment, a desire and eagerness to rehabilitate in the world of industry of all those who have paid their dues in the hard coinage of punishment, tireless efforts towards the discovery of curative and regenerating processes and an unfaltering faith that there is a treasure, if only you can find it in the heart of every person – these are the symbols which in the treatment of crime and criminals mark and measure the stored up strength of a nation, and are the sign and proof of the living virtue in it." (Winston Churchill, UK House of Commons, 20 July 1910).*

196 Australia is a signatory to a number of international treaties in respect of human rights including the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights as well as the UN Convention Against Torture.

197 Article 10 of the International Covenant on Civil and Political Rights is set out as follows:

All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

198 Article 25 of the Universal Declaration of Human Rights is set out as follows:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

199 Since the Royal Commission into Aboriginal deaths in Custody successive federal and state governments have expressed their commitment to lowering the number of Indigenous deaths in custody. Despite these expressions, the evidence in this inquest overwhelmingly indicates that clinical staff in the custodial environment are overworked to a degree which means that they cannot complete their work to the required standard.

200 This should not be the case in a civilised society and does not meet our international commitments nor government representations.

201 The time has well passed for the custodial health system to be appropriately funded. Michael spent the last months of his life in pain which was clearly identified and treatable. His repeated entreaties for medical recommendations to be attended to were not met.

202 The 2024 Human Rights Watch report on the year 2023, included the following in relation to Australia:

Australia is a vibrant democracy that mostly protects the civil and political rights of its citizens; however, its reputation is tarnished by some significant human rights concerns. These include the cruel treatment of refugees and asylum seekers as well as its failure to address systemic discrimination against First Nations people. Indigenous people are still overrepresented in Australian prisons…..

Indigenous people are significantly overrepresented in the criminal justice system, with Aboriginal and Torres Strait Islanders comprising nearly one-third of Australia's adult prison population, but just 3 percent of the national population….

At least 19 Indigenous people died in custody in 2023.

203 Whilst Michael's death has not been found to have been caused by the many failings to provide him with appropriate care it is inevitable that if the custodial health system continues to be underfunded, deaths in custody will continue to be a blight on our society.

204 A copy of these findings should be provided to the NSW Commissioner of Corrective Services, the NSW Minister for Corrections, the NSW Minister for Health and Regional Health, the Federal Minister for Health and Aged Care, the NSW Minister for Aboriginal Affairs and Treaty, and the Federal Minister for Indigenous Australians.

Issue 1: Manner and Cause of Mr Baker's death and other statutory findings

205 It was common ground amongst Dr Melissa Thompson, who conducted Michael's post-mortem, Associate Professor Adams, Professor Jones and Professor Carter that Michael's death was heart related.

206 Dr Thompson found that the direct cause of death was hypertensive heart disease with diabetes mellitus as a significant contributing condition.

207 Associate Professor Adams attributed the cause of Mr Baker's death to be a fatal ventricular arrythmia due to multiple factors that interacted to cause this arrythmia. The most important of these being his hypertensive heart disease, methadone treatment and medications mirtazapine, amitriptyline, duloxetine and baclofen. He further notes that obesity, diabetes, and OSA have been found to be associated with QT prolongation and that the effect of each of these factors on QT prolongation is cumulative.

208 Professor Jones opined that the most likely clinical explanation of death is sudden cardiac arrest on the background of a structurally abnormal heart. There remains a possibility that drug-induced arrythmias may have contributed to death in this case, and the mechanism of death could've been a sudden ventricular arrythmia as a result of long QT intervals.

209 Professor Carter expressed the view that the most likely cause of death was an arrhythmia (such as ventricular tachycardia), caused by Michael's hypertensive heart disease noting that diabetic microvascular disease of the heart may have contributed to the development of the arrhythmia. His drug therapy, which included methadone, quetiapine and amitriptyline, may have predisposed to the arrhythmia as well.

210 Michael's enlarged heart had microscopic features consistent with the effects of hypertension, including individual myocyte enlargement and patchy interstitial and subendocardial fibrosis. Areas of fibrosis in the heart can disrupt electrical conduction and produce abnormal rhythms (arrythmias) that may be fatal. Enlargement of the heart also impacts a risk of cardiac arrythmia and sudden death.

211 It has to be acknowledged that at autopsy Michael's medications were found to be present upon toxicological analysis. Mirtazapine was found to be present in the supra therapeutic to toxic range, duloxetine and metformin were in the supra therapeutic range and methadone was found to be in the "potentially fatal range".

212 The toxicologist Professor Jones was particularly concerned about the supratherapeutic dose of mirtazapine and how it had additive effect on the methadone and the quetiapine. Professor Jones opined that the prescription regime that Mr Baker was on was not contraindicated, however, it required clinical vigilance.

213 Professor Jones considered that the effects of postmortem drug redistribution, noting the date of Michel's death and the date of autopsy, did not change her view that the level of methadone in Michael's blood was in the potentially fatal range and not reflective of a therapeutic regime. Nevertheless, Professor Jones, in considering Michael's long history of methadone treatment, and studies of methadone concentrations in fatalities reported in the medical literature considered it unlikely that the methadone (level) alone caused Michael's death.

214 For completeness I note that there was an episode of Michael gathering "pills" in late January 2019. At that time, Michael's monthly provision of non-supervised medications was changed to daily allocation. Despite this regime Michael's levels of medications was as set out above. I accept the possibility that Michael somehow was able to obtain, or on occasion consume, medications above the prescribed level. However, I accept that the high level of any particular drug did not, of its own play a role in Michael's death.

215 I am satisfied that Michael died from a cardiac arrythmia on a background of hypertensive heart disorder, obesity, diabetes, obstructive sleep apnoea and a combination of the QT interval prolonging medications methadone, mirtazapine, amitriptyline, duloxetine and baclofen.

Findings section 81 Coroners Act 2009

216 Having considered all the evidence, the findings I make under section 81(1) of the Coroners Act 2009 (NSW) are:

Identity:

The person who died was Michael Raymond Baker

Date of death:

Michael died on 25 June 2019

Place of death:

Michael died at Lithgow Correctional Centre NSW

Cause of death:

Michael died from a cardiac arrythmia on a background of hypertensive heart disorder, obesity, diabetes, obstructive sleep apnoea and a combination of the

QT interval prolonging medications methadone, mirtazapine, amitriptyline, duloxetine and baclofen

Manner of death:

Natural Causes

Conclusion

217 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to the family and extended family of Michael.

218 I would like to especially acknowledge and thank Michael's brother, Mr Christopher Baker for his attendance at the inquest and his family statement.

219 I also thank the officer in charge of the coronial investigation, Detective Senior Constable Smyth, for her efforts in the process of the investigation and work in compiling the initial police brief of evidence.

220 I acknowledge and express my deep gratitude to the assisting team.

221 In addition, I thank the legal representatives for each of the interested parties for their assistance provided throughout the coronial proceedings.

222 I close this inquest.

Magistrate David O'Neil

Deputy State Coroner

Coroner's Court of New South Wales

20 June 2024