CORONERS COURT NEW SOUTH WALES

Inquest:	Inquest into the death of Andrew Gilbertson
Hearing dates:	8 November 2022
Date of findings:	8 November 2022
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate C Forbes, Deputy State Coroner
Catchwords:	CORONIAL LAW-death in custody, cause and manner of death-methadone toxicity-Justice Health-opioid substitution therapy
File number:	2019/289835
Representation:	Mr T O'Donnell, Coronial Advocate Assisting the Coroner Ms Poulios for the Commissioner of Corrective Services NSW Mr Norris for Justice Health & Forensic Mental Health Network

Findings:	**Identity** The person who died was Andrew Gilbertson **Date of death** Andrew Gilbertson died on 15 September 2019 **Place of death** Andrew Gilbertson died at Long Bay Correctional Centre, Malabar, NSW. **Cause of death** The cause of Andrew Gilbertson's death was methadone toxicity **Manner of death** The manner of Andrew Gilbertson's death was misadventure.
Non-publication orders:	Non-publication order dated 8 November 2022 is attached to the court file

IN THE NSW STATE CORONER'S COURT

LIDCOMBE

SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

Introduction

1. This is an inquest into the death of Andrew Gilbertson who died on the evening of 15 September 2019 while he was in custody at Long Bay Correctional Centre.

2. Section 23 of the *Coroners Act 2009* requires a senior coroner to conduct an inquest in cases where a person dies in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

3. The role of a Coroner as set out in s.81 of the *Coroner's Act 2009* ("the Act") is to make findings as to:

   i. the identity of the deceased.

   ii. the date and place of the person's death.

   iii. the physical or medical cause of death; and

   iv. the manner of death, in other words, the circumstances surrounding the death.

4. This Inquest has been an examination of the circumstances around Mr Gilbertson's death and pursuant to s.37 of the *Coroners Act 2009* a summary of the details of this case will be reported to Parliament.

Andrew Gilbertson

5. Andrew John Gilbertson was born on the 8th of June 1977 in the Victorian town of Warragul and had two younger brothers, Stephen, and Peter.

6. The family moved to Foster in Victoria around the time Mr Gilbertson started school, then they moved to live on a farm in Tongala a couple of years later. Mr Gilbertson reportedly did well at school and had a relatively normal childhood.

7. When he was about 11 years old, his parents divorced, and Mr Gilbertson lived primarily with his father. He finished year 10 at school and worked in various jobs. Mr Gilbertson also travelled Australia sightseeing. It was around this time that he began using drugs, mostly just cannabis to start off with.

8. In 1998, Mr Gilbertson's brother Stephen went missing after falling off the back of a fishing trawler in Queensland. This had a devastating effect on Mr Gilbertson and his family. Not long after Stephen's death, Mr Gilbertson was diagnosed with Bipolar and began getting into trouble with the law. He spent some time in custody and struggled to hold down employment when he was in the community. He also began to use heavier drugs like Ice which significantly affected his mental health. He would sometimes stay with his father, but his heavy drug use made it difficult for his parents to have him at home. As such, he spent a significant amount of time homeless and living on the streets.

9. In March 2017, Mr Gilbertson was scheduled under the Mental Health Act for an attempted suicide in Albury.

Incarceration

10. At the time of his death, he was serving a sentence of two years and eight months for offences that occurred in June 2018. He was due to be released on parole on the 11th of October 2019.

11. Upon entering custody, Mr Gilbertson was subjected to a Mental Health Assessment and was deemed to be not at risk to himself or others. He disclosed having used crystal methamphetamine prior to his incarceration.

12. On the 19th of December 2018, Mr Gilbertson was transferred from Junee to Long Bay Correctional Facility.

13. On the 14th of April 2019, Mr Gilbertson had a consultation with a mental health nurse. He disclosed that he had been hearing voices and had injected drugs whilst in custody. Mr Gilbertson was referred to a psychiatrist.

14. On the 24th of July 2019, Mr Gilbertson was subjected to a target search in which he presented a 'gaol made' syringe that was hidden in his underwear. He was internally charged with 'possess drug implement' and the matter was dismissed upon a plea of guilty. He received a seven-day cellular confinement sentence.

15. Mr Gilbertson had made requests to be put on the pre-release suboxone program. This is a program that inmates would begin seven days prior to being released. They required a stable address and to see a drug and alcohol doctor a month prior to commencing treatment to be assessed. On the 5th of September, Mr Gilbertson was interviewed by a nurse and disclosed his drug and alcohol history, including that he had used drugs whilst in custody and had diverted methadone. She booked an appointment for Mr Gilbertson to see the Drug and Alcohol Doctor on the 10th of September. Mr Gilbertson failed to attend this appointment when called for by officers and his appointment was rescheduled for the following week.

Events leading up to his death

16. On Sunday the 15th of September 2019, Mr Gilbertson was locked in his cell with his cellmate, who stated that Mr Gilbertson stayed in bed most of the day watching

television, only coming down to eat or use the bathroom. At some point during the afternoon, Mr Gilbertson's cellmate asked to watch the football on the television, which Mr Gilbertson agreed to. At 7:11pm, Correctives Officers checked on the cell with nothing unusual noted. Mr Gilbertson's cellmate reportedly fell asleep at about 11pm that night.

17. At about 6:20am the next morning, Correctives Officers attended Mr Gilbertson's cell to conduct head checks. Officers noticed Mr Gilbertson's cellmate was walking around the cell while Mr Gilbertson was still lying in bed. Mr Gilbertson didn't respond when Officers called out to him. Officers entered the cell and examined Mr Gilbertson, noting that he didn't appear to be breathing. A medical response was initiated, and CPR commenced by the attending officers. Ambulance Officers arrived shortly after but could not resuscitate Mr Gilbertson, who was pronounced deceased at 6:44am.

Investigation

18. Police attended the scene at approximately 7:20am and established a crime scene for examination. Police received statements from relevant Correctional Staff and Mr Gilbertson's cellmate. Crime Scene Investigators attended and established there were no signs of injury to Mr Gilbertson or anything suspicious but were unable to establish a cause of death. Some medication was found in the cell; however, it was identified to just be Panadol and reflux tablets. When examinations were completed, Mr Gilbertson's body was taken to the morgue in Lidcombe.

19. An autopsy was conducted by pathologist Dr Rebecca Irvine, who determined the cause of death to be 'methadone toxicity'. Dr Irvine noted that the level of methadone in Mr Gilbertson's system was between the nontoxic and lethal range, but that methadone is a long-acting opioid medication which can be fatal even at moderate doses to individuals who have not built up a tolerance to it. It was noted that Mr Gilbertson was not receiving any regular methadone doses for treatment

and, based on his previous admission to the Nurse that he has received diverted methadone in the past, it is safe to assume it was diverted in some way.

20. Statements have been obtained from relevant staff in Corrective Services and Justice Health. Of note is the statement from Mr Stephen Ward, the Acting Service Director for Drug and Alcohol. This statement was prepared in relation to another inquest but addresses the same concerns held by the coroner in this matter. Mr Ward states that in January 2020 Justice Health commenced a new form of Opioid Substitution Therapy, being monthly buprenorphine depot injections. Now, all inmates commencing Opioid Substitution Therapy will be commenced on depot injections instead of methadone, unless the inmate is already on methadone or there are clinical contra-indications. Implementing depot injections prevents the risk of methadone diversion, and so inmates such as Mr Gilbertson, will now be unable to access diverted methadone.

Conclusion

21. On behalf of the NSW State Coroner's Court, I extend my sincere and respectful condolences to Mr Gilbertson's family for their loss.

Findings: s 81 Coroners Act 2009

Identity

The person who died was Andrew Gilbertson

Date of death

Andrew Gilbertson died on 15 September 2019

Place of death

Andrew Gilbertson died at Long Bay Correctional Centre, NSW.

Cause of death

The cause of Andrew Gilbertson's death was methadone toxicity.

Manner of death

The manner of Andrew Gilbertson's death was misadventure.

Magistrate C Forbes

Deputy State Coroner

8 November 2022

New South Wales State Coroner's Court, Lidcombe