CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of KT
Hearing dates:	16 February 2023 to 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 – overdose of clozapine medication – was mental health care of an appropriate standard – recommendations
File number:	2019/146621
Representation:	Counsel Assisting the inquest: D Ward of Senior Counsel with S Young of Counsel, i/b Solicitors, NSW Coroners Court. KT'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. RN Diyana Buric: K Doust, Solicitor Advocate, NSW Nurses and Midwives' Association.

Findings:	**Identity** The person who died is KT. **Date of death**: KT died between the night of 8 May 2019 and morning of 9 May 2019. **Place of death**: KT died at the Metropolitan Remand and Reception Centre, Silverwater. **Cause of death:** The cause of KT's death is mixed drug (methylamphetamine and clozapine) toxicity. **Manner of death:** KT died while in lawful custody, after overdosing his prescribed medication, clozapine. The evidence does not establish that he ingested the medication with the intention of ending his life.

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* [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

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

Introduction

3. On the morning of 9 May 2019, KT was found deceased in his cell at the Metropolitan Remand and Reception Centre [MRRC], Silverwater. He was 27 years old.

4. At autopsy the cause of KT's death was identified as mixed drug (methylamphetamine and clozapine) toxicity. KT suffered treatment-resistant schizophrenia and had been prescribed with the antipsychotic medication clozapine from June 2018.

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.

KT's life

7. KT was born in 1992, to parents MT and ST. He was the third of five children, with older sisters DT and PT, younger brother LT and younger sister FT.

8. KT grew up in his family home in western Sydney. The family was very involved in their local parish, attending church services, youth groups and choir. KT was very close to his brother LT, who was three years younger.

9. KT's teenage years were troubled, and he spent time in juvenile detention for offences of assault and robbery. This pattern continued in his adult years.

10. In 2012, KT was convicted of further offences, and he entered custody on 1 March 2012. His earliest possible release date was 30 November 2019. However, he was aware that the NSW Attorney General had flagged an intention to seek an order under the *Crimes (High Risk Offender) Act* 2006 for his continuing detention or extended supervision.

11. Between the years 2012 and 2018, KT was transferred between different correctional centres. On 20 November 2018, he was transferred to the MRRC at Silverwater. KT's sister DT made visits to him, and she often discussed his welfare with his case worker and with the Reverend Nau Ahosivi, a chaplain at the MRRC.

12. In 2017, KT's mother ST died from cancer. At this time both KT and LT were in custody, and they were not given permission to attend her funeral.

13. On 21 April 2019, the family received the terrible news that LT had died in the Mid North Coast Correctional Centre, Kempsey. He was only 24 years old. DT came to the MRRC on 25 April 2019, to tell KT this heartbreaking news. She visited him again on 1 May 2019, and she and KT discussed at length the arrangements for LT's funeral, which was to be held on 11 May 2019. KT had lodged an application to be allowed to attend it.

14. KT was not granted permission to attend LT's funeral. Then on 9 May 2019, DT was notified that KT too had died. This second tragedy brought profound shock and grief to the family.

15. The tragic deaths of LT and KT required mandatory inquests under the Act. The inquest into the circumstances of LT's death was held immediately prior to KT's inquest. Although this was done to reduce as far as possible the distress of the family, there can be no doubt that the double inquest was immensely painful for them.

16. DT and FT attended each day of both inquests. Their father MT wanted to attend too, but he suffers ill health and the experience would have been too much for him. Through their lawyer Mr Peerce McManus, DT and FT wanted the court to know that KT loved and honoured his family, and that they in turn loved him. This was apparent in the daily presence of the two sisters throughout the very painful experience of this inquest. It was clear that they and their family loved KT and miss him deeply.

The issues examined at the inquest

17. The inquest examined the following issues:

- The cause of KT's death.
- Was it appropriate for the Justice Health and Forensic Mental Health Network [the JH Network] to diagnose KT with treatment-resistant schizophrenia, and was his treatment for this condition appropriate?
- Did the JH Network maintain appropriate records regarding the prescribing and administration to KT of his medication?
- Did KT ingest the drugs which caused his death with the intention of ending his own life?

18. The court heard evidence about these matters from involved correctional officers and members of KT's treating team. In addition, the court was assisted with expert evidence from the following specialists:

- Professor Alison Jones, specialist physician and toxicologist instructed by the JH Network;
- Dr Danny Sullivan, consultant forensic psychiatrist;
- Dr Shuang Fu, senior forensic pharmacist and toxicologist employed with NSW Police Force; and
- Dr Sarah-Jane Spencer, Clinical Director of Custodial Mental Health, within the JH Network.

The events leading up to KT's death

19. KT had been transferred to the MRRC on 20 November 2018. Between the period 20 April 2019 to 7 May 2019, he shared a cell in the MRRC's G wing with Mr Taloasi George.

20. Mr George gave evidence at the inquest, sharing his observations of KT over the period they had shared a cell. He described KT as a man who generally kept his emotions to himself. Nevertheless, he and KT became friends. They liked to train together, and often talked to each other about their families. Mr George regarded KT as a big brother '*who always tried to keep me out of trouble'*.

21. Mr George was aware that KT took daily medication which caused him to fall asleep very quickly at night. KT had previously told him of a fellow inmate who had collapsed and almost died after taking five pills of valium together with ten pills of clozapine, a medication with which KT similarly was prescribed.

22. On 25 April 2019, DT came to the MRRC to tell KT the tragic news of LT's death. Both wept, and Reverend Ahosivi joined them and prayed with them. KT asked Reverend Ahosivi to help with an application to attend LT's funeral. This the Reverend did, with the assistance of Ms Amber Desai, a Services and Programs Officer. Reverend Ahosivi supported KT's request, considering it '*an important part of his healing process to farewell together with families, friends and Tongan community*'.

23. Mr George told the court that on one occasion after KT had been informed of LT's death, he noticed that KT had a bag under his mattress which contained about thirty yellow tablets. Mr George assumed this was KT's medication, but he didn't ask KT about it as he didn't regard this as his business.

24. Mr George told the court that after LT died KT became *'very down,'* and Mr George thought he was '*going through a pretty bad time'*. This was confirmed by other inmates who knew KT, one of whom described him as '*sad'* and worried about how his father was coping.

25. Mr George went on to say:

> *'After [KT] was told about his brother everyone could see that he changed and was depressed. Other inmates would often say to keep an eye on him and take care of him so that he does nothing stupid. I never thought that [KT] would hurt himself or do anything to himself but I know he was struggling about the death of his brother'.*

26. Following DT's visit to KT on 25 April 2019, two correctional officers spoke with him. They reported that KT '*seemed upset (but not excessively so)'*, and that they had stressed to him the importance of telling staff if he felt unable to cope.

27. DT visited KT again on 1 May 2019, and they talked hopefully about the prospect of KT coming to LT's funeral and being with his family.

28. On 3 May 2019, KT agreed to attend a meeting with psychologist Anne Reuter. Ms Reuter recorded that KT spoke openly about LT's death and that he was *'grieving',* but that *'the boys are supporting him through chats and talks'*. KT denied having any current thoughts of self harm or suicide.

29. On the morning of 7 May 2019, Mr George was transferred out of the MRRC to Lithgow CC. Mr George said he thought this was a mistake, and that given their friendship and the sadness KT was feeling over his brother, it would have been better if he had been allowed to remain with him.

Events of 8 and 9 May 2019

30. On the afternoon of 7 May 2019, all inmates in KT's wing were confined to their cells. This was due to a security incident which did not involve KT. On the following day, the *'lock in'* was extended due to a number of corrective staff being offsite for training. As a result, KT remained alone in his cell throughout the day and night of 8 May as well.

31. At the inquest the court heard that during periods of *'lock in'*, routine contacts with inmates continued. Inmates' meals were delivered to their cells three times a day. In addition, and often at the same time as meal delivery, there was a welfare check. In 2019 this involved correctional officers opening the inmate's cell door to look inside. The court was told that since then cell doors have been fitted with hatches, and that welfare checks and meal deliveries are now carried out through these.

32. On the morning of 8 May 2019, Reverend Ahosivi visited KT to communicate that his application to attend LT's funeral had been declined. The Reverend described KT as being *'calm'*, and they discussed the option of him listening to the funeral by phone. KT asked Reverend Ahosivi to visit his family and explain to them that he couldn't be at the funeral. This the Reverend did.

33. Shortly afterwards that day, Correctional Officer Rajan Sharma became concerned about KT. He informed Assistant Superintendent Simmerdeep Kochhar that KT's brother had died, that KT appeared to be '*a little bit down'*, and that he had been refused permission to attend his brother's funeral. Assistant Superintendent Kochhar then had a conversation with KT in his office. Mr Kochhar acknowledged to the court that he did not know KT, and that the conversation was therefore quite limited.

34. Mr Kochhar asked KT: '*Are you feeling okay? I understand your application for the funeral got rejected*'. KT responded that he was okay. Mr Kochhar then said: '*Are you going to harm yourself? Or do anything stupid?*' According to Mr Kochhar, KT replied: '*I'm coping alright. I'm sad but I'm coping alright*'. Mr Kochhar then told KT that if he needed any help, to speak to the officers.

35. Mr Kochhar told the court that he saw no signs that KT wanted to take his own life.

36. At the inquest Mr Kochhar was questioned about KT's cell placement. It was explained to the court that since 23 January 2019, KT had been classified for '*normal cell placement'*. This meant that according to a Justice Health assessment, he was suitable to be housed either by himself *or* with a cellmate.

37. Given the above, it is apparent that there had been no breach of Corrective Services policy in the fact that KT was occupying his cell alone at the time of his death. However, the question remained whether it would have been appropriate and beneficial for correctional officers to have asked KT if he wanted the support of a replacement cellmate, given the distressing circumstances he was facing.

38. Therefore, Mr Kochhar was asked whether, at the time of the above conversation, he had known that KT did not have a cellmate. He replied that he had not known. He was then asked what he would have done if he had been aware that up until the previous day, KT had been sharing with a cellmate. Mr Kochhar replied that he would probably have asked KT if he wanted to have a new cellmate, for support.

39. Mr Kochhar explained however that it would not necessarily have been a straightforward matter to provide KT with a new cellmate, had he requested one. Potential candidates would have to be asked if they wished to share with KT. In addition, officers would need to be assured that there were no security risks, either for KT or the new cellmate, in their being placed together. I will return to this issue later in the findings.

40. After this conversation KT was returned to his cell. Later he received his evening meal, and at 7.51pm, his medication. In accordance with usual practice, a JH Network nurse placed his three clozapine tablets into his hands and watched him taking them with water. She did not note anything of concern. This was the last time KT was seen alive.

41. At 6.23am the next morning, KT's cell door was opened, and he was found lying face down on floor, unresponsive. He could not be revived, and he was pronounced deceased.

42. KT's funeral, led by Reverend Ahosivi, was held on 31 May 2019.

The cause of KT's death

43. Forensic pathologist Dr Rebecca Irvine performed an autopsy. She noted that toxicological analysis of KT's post mortem blood had detected methylamphetamine and clozapine, with the level of clozapine within the toxic to lethal range. Dr Irvine found no significant injuries. She concluded that the cause of KT's death was mixed drug (methylamphetamine and clozapine) toxicity.

44. In preparation for the inquest, the toxicological results were reviewed by Professor Alison Jones and by Dr Shuang Fu, who had provided a preliminary report to police in order to guide the coronial investigation.

45. Professor Jones commented that post mortem blood concentrations of drugs typically increase following death; nevertheless, when she adjusted KT's levels to take account of this phenomenon, the concentration of clozapine remained within the toxic to lethal range. In her opinion clozapine toxicity was the main contributor to KT's death. Dr Fu concurred.

46. In their oral evidence, Professor Jones and Dr Fu agreed that KT's clozapine concentrations indicated that he had consumed a very large amount of this medication. However, they were unable to ascertain how many tablets he had consumed, and whether he had consumed them all at once or over a period of time. Either way, they agreed that the result for KT would have been rapid and substantial sedation. Additionally, an overdose of clozapine can produce seizure activity. Professor Jones speculated that this may have occurred, given that KT was found lying face down on the floor, with a small laceration on his forehead.

47. Professor Jones and Dr Fu told the court that the amount of methylamphetamine detected in KT's post mortem blood was small. For this reason, Dr Fu thought it unlikely to have contributed to KT's death. However, in her post mortem report Dr Irvine had commented that methylamphetamine can cause sudden death at any concentration, usually as a result of the sudden generation of an abnormal heart rhythm.

48. Professor Jones agreed, stating that the small amount of methylamphetamine detected in KT's blood was still capable of creating an adverse effect, by increasing his risk for malignant rhythms. In contrast with the opinion of Dr Fu therefore, she considered it likely that the methylamphetamine had contributed to KT's death.

49. Professor Jones is a qualified physician in addition to being a specialist toxicologist. With regard to this small point of difference between her evidence and that of Dr Fu, the court would prefer Professor Jones' opinion: namely that the methylamphetamine was likely responsible for an arrhythmogenic effect, in addition to the impacts brought about by the large dose of clozapine KT had ingested.

50. I therefore conclude that KT died as a result of mixed drug (methylamphetamine and clozapine) toxicity. I accept the submission of Counsel Assisting, that the evidence does not enable me to be precise about when KT died. The time of his death can best be given as '*between the night of 8 May and the morning of 9 May 2019*'.

51. I turn now to consider the custodial health care which KT received for his schizophrenia. Specifically, was he appropriately diagnosed with treatment resistant-schizophrenia, and was he appropriately treated for this condition?

KT's diagnosis of schizophrenia and its treatment

52. In custody KT had often been disruptive and had spent periods of time in segregation for this reason. However, on 23 December 2016, JH Network medical staff diagnosed him with chronic schizophrenia. He was recorded as being thought disordered and experiencing command auditory hallucinations and delusions of persecution. It cannot be known for how long this condition had affected KT's behaviour, and the extent to which it may have contributed to his offending.

53. Following this diagnosis, KT's treating team attempted various medications in both oral and depot form, with little success. By January 2018, they had concluded that KT's schizophrenia was most likely treatment resistant. This defines a situation where a patient does not experience remission from symptoms after trialling two separate antipsychotic medications.

54. In June 2018, KT was commenced on the medication clozapine. Clozapine is an oral antipsychotic medication which is usually reserved for patients with treatment-resistant schizophrenia. Its effects are powerfully sedating, and it has other side effects for which a patient must receive regular and close monitoring.

55. A serious risk associated with clozapine is the development of neutropenia, an abnormally low count of a type of white blood cell. This can cause a person to become immune-suppressed. For this reason, throughout the person's first 18 weeks on clozapine, full blood count tests are conducted on a weekly basis to monitor their levels of white blood cells and neutrophils. Thereafter, this testing must be conducted every month, for the duration of the treatment.

56. The court heard evidence from Dr Sarah-Jane Spencer that the JH Network currently has some 30 inmates in its care who are being treated with clozapine. These patients are managed in accordance with the JH Network's Procedure Manual for the Management of Patients on Clozapine.

57. Consistent with these procedures, for the first 18 weeks of his clozapine treatment KT was admitted as an inpatient in Long Bay Correctional Centre Hospital. This was because an inpatient admission is the only practical way by which an inmate can receive testing and monitoring on the required scale. Thereafter, KT received regular and appropriate haematological monitoring of his full blood count. KT was also registered with the JH Network's clozapine monitoring service, whose role is to ensure that the necessary blood tests are performed and reviewed.

58. An additional form of haematological monitoring is sometimes necessary, namely plasma testing to measure the amount of clozapine in the patient's blood. The court heard that this testing is used to determine whether the patient is receiving an amount of clozapine that is within the reference range for therapeutic dosing. Plasma testing may also be ordered when there is concern that the patient is not complying with their clozapine dose.

59. As was pointed out by both Dr Sullivan and Dr Spencer, haematological monitoring on the scale outlined above is costly and is burdensome for the patient. It is for these reasons that clozapine is prescribed only where other medications to treat schizophrenia do not relieve the patient's symptoms.

60. The evidence at inquest revealed that while KT was in custody, in addition to full blood count testing he received clozapine plasma testing on 8 occasions over 2018 and 2019. In his report Dr Sullivan noted that, with one exception which will be further discussed, the results for KT's plasma tests showed satisfactory clozapine levels, indicating that he was receiving a therapeutic dose and that he was compliant with his dosing. This was confirmed by the clinical observations of his treating team, who noted a gradual reduction in his symptoms and generally improved behaviour.

61. Having reviewed KT's treatment records, Dr Sullivan concluded that his diagnosis of treatment-resistant schizophrenia was appropriate, as was the decision to prescribe clozapine. In addition, KT appeared to have been prescribed an appropriate dose, in that it was sufficient to achieve a therapeutic effect.

62. I accept Dr Sullivan's evidence upon these matters.

63. In their evidence, Dr Sullivan and Dr Spencer commented further that the conditions of incarceration limit the response that can be given to inmates like KT who live with a serious mental illness. Dr Sullivan stated that within a prison there are '*constraints on providing other holistic aspects of care for psychotic illness*'. These other types of care include cognitive behaviour therapy, family therapy, and support with finding work.

64. In her oral evidence, Dr Spencer agreed. She noted further that for patients like KT who had been in custody for long periods of their lives, the adverse effects of custodial life probably worsened the effects of their mental illness. KT's family strongly believe that this was the case with KT.

65. The expert medical evidence confirmed that within the constraints imposed by a custodial environment, the treatment which KT received for his mental illness was generally adequate, with the exception of two aspects which will now be examined.

The February plasma test result

66. The first of these was a plasma test which was ordered for KT in February 2019, at the same time as his monthly full blood count test.

67. On 12 February 2019, KT returned a result for the plasma test, showing that his clozapine level was well below the reference range for therapeutic dosing, which is between 350 – 600 micrograms per litre. On this occasion, KT's result was less than 20 micrograms. This was an aberration, as his preceding and subsequent plasma test results indicated satisfactory clozapine levels. The test result did not result in any follow up action by JH Network staff.

68. Dr Sullivan commented that assuming it was accurate, this result suggested that KT had not been complying with his clozapine medication. For this reason, it *'should have prompted urgent reassessment of mental state and exploration of the reasons for non-compliance*'.

69. Dr Sullivan outlined the steps that clinical staff ought to have taken in response to this result. There needed to be a repeat plasma test to confirm the abnormal result. If this confirmed the abnormal result, it would be necessary to investigate if KT had been given his proper doses and if so, whether he had been finding ways to avoid compliance with them. KT would also need to be clinically reviewed to determine if there had been any deterioration in his mental state.

70. In her evidence, Dr Spencer agreed that the abnormal result required the above steps to be taken. She had undertaken a review of KT's medical records to find out why they were not. Her review revealed the following: that the plasma test had been ordered by an enrolled nurse, that no reason for ordering the test had been recorded, that the result had been 'signed off' by a GP rather than a psychiatrist, and that it had not received any follow up response.

71. Dr Spencer told the court that all four features were outside the appropriate JH Network procedures. Ordinarily, such a test would be ordered by the patient's treating psychiatrist or the Clozapine Coordinator, with a reason documented. The test result would be brought to the treating psychiatrist's attention for review. Had these steps been taken, Dr Spencer was confident the aberrant result would not have been overlooked.

72. Dr Spencer speculated that the enrolled nurse who ordered the plasma test had possibly been of the erroneous belief that such a test had to be ordered alongside the routine full blood count. Since the test had not been ordered by a psychiatrist, this could explain why the result was not reviewed and did not receive a clinical response.

73. In response to this incident and others, Dr Spencer told the court that the JH Network has initiated a Pathology Review Project, with the aim of addressing concerns about pathology processes within the Network. She said that in addition to KT's case, there had been other instances where nursing staff had ordered pathology testing without documented reasons, and where there was no follow up of the results by the treating clinician.

74. In his evidence, Dr Sullivan welcomed the Pathology Review Project as '*an admirable quality improvement activity*'. I endorse this comment and am encouraged that the JH Network's pathology processes are receiving serious attention.

75. In addition, the JH Network has issued an electronic reminder to its staff about the need to obtain the approval of a JH Network doctor before ordering pathology.

76. As it happened, a review of KT's medical notes indicated to both Dr Sullivan and Dr Spencer that despite the low clozapine result in February 2019, there had been no deterioration of his mental state around that time. I conclude therefore that this lapse in JH Network procedures did not contribute to KT's tragic death.

The missing Medication Chart

77. The second aspect of KT's medical care concerned the disappearance of his Medication Chart for the period 23 April to 29 April 2019.

78. On 30 April 2019 Registered Nurse Diyana Buric was unable to locate KT's Medication Chart, which recorded the administering to him of his daily clozapine dose. When the Chart was found later that day and was reviewed, it did not contain any entries after 22 April 2019.

79. This meant that in relation to the period 23 April to 29 April 2019, JH Network staff were unable to determine if KT's daily clozapine doses had simply not been recorded, or if he had not received any clozapine at all. If the latter was the case, then in accordance with the JH Network's Procedure Manual for the Management of Patients on Clozapine KT would have to immediately return to a starter dose of clozapine, to be titrated upwards with weekly monitoring for a period of six weeks.

80. However, when a JH Network doctor spoke with KT on 30 April 2019, he told her that he had in fact been given all his clozapine doses, with the exception of the previous night. For this reason, it was determined that he could continue on his current dose of 300mgs daily. Fortunately, therefore it appears that the misplacing of KT's Medication Chart did not have any adverse impact upon his health.

81. At the inquest, Dr Spencer concurred with the evidence of RN Buric that it was not uncommon for patients' medical records to go missing. This was particularly the case when inmates were transferred from one correctional centre to another, or between different units within the one correctional centre.

82. I accept the submission made on behalf of KT's family, that a high standard of care is rightly expected of JH Network staff, given that inmates are largely not in a position to manage their own health care. As can be seen with KT's case, if medication charts go missing there are serious implications for the safety of patients who require a strict monitoring regime.

83. For this reason, it was encouraging to hear evidence that the JH Network is in the process of introducing electronic medical records for all inmate patients. Dr Spencer and RN Buric stated that the introduction of electronic records could be expected to reduce the incidence of medical records being misplaced.

The manner of KT's death

84. The remaining issue is whether it can be said that KT overdosed his clozapine medication with the intention of ending his life.

85. KT did not leave any notes for family or friends indicating an intention to end his life. His custodial health records include some previous episodes of self harm, in the form of self-inflicted cuts to his forearms. In addition, during a hospital admission KT had reported having hallucinations in which voices commanded him to harm himself and others. It is significant however that these episodes preceded his commencement on clozapine, and that after this point KT's symptoms of hallucinations abated.

86. There can be no doubt that during his last days KT was suffering deep sadness and distress. His much loved brother LT had died, and he would be unable to share his grief with his family at LT's funeral. His friend Taloasi George had gone, and KT was facing an extended lock in period alone in his cell. He had already spent many years in custody, and the foreshadowed High Risk Offender application raised the possibility of an unknown further period of incarceration.

87. When considering what KT's intentions may have been, it is also relevant to observe that had he been minded to take his own life, he probably had the knowledge and the means to do it. In the opinion of Dr Sullivan, since he had been using clozapine for some eleven months, he was almost certainly aware of its heavily sedating effects, and that an overdose would be risky.

88. However, it is to be noted that none of the people who had contact with KT in his last days, including Mr George, Reverend Ahosivi, Correctional Officer Sharma, Assistant Superintendent Kocchar, and psychologist Ms Reuters, had the impression that he intended to take his own life.

89. Furthermore, in the opinion of Dr Sullivan the immensely sad events of KT's last days did not of themselves mean that he was at increased risk of suicide. Dr Spencer agreed, noting that KT had many reasons to seek the escape of heavy sedation, without necessarily the intention to end his life. In their opinion, it would not be surprising if KT had felt the strong need for some respite from his emotional pain.

90. Ultimately, Dr Sullivan and Dr Spencer concurred that it was simply not possible to know what KT's intention was when he ingested the clozapine that night.

91. In submissions, Mr McManus told the court that KT's family had carefully considered the evidence. They had concluded that KT had not intended to take his own life, despite the great sadness that he was feeling. Similarly, Counsel Assisting submitted that the evidence was not sufficient to establish that KT's intention was to suicide.

92. These submissions are well supported by the evidence. I accept them and will record that the manner of KT's death was an accidental overdose, in the sense that it cannot be established that he took the additional clozapine with the intention of putting an end to his life.

93. A question arises as to how it was that KT had apparently managed to obtain sufficient amounts of clozapine to overdose upon it on the night of 8 May. The answer to this is not known. Although KT received his daily clozapine dose on a supervised basis, Dr Sullivan noted that inmates can become adept at retaining medication in the mouth, or regurgitating it after administration.

94. Of note, Dr Spencer told the court that pharmaceutical companies had not yet succeeded in producing clozapine in a slow release injectible form, a mode of delivery which would have the benefit of reducing opportunities to stockpile it or to divert it.

Should correctional officers have placed KT with a new cellmate?

95. KT's family were saddened and frustrated that correctional officers had not foreseen that he might need the support of a cellmate, when Mr George was transferred to Lithgow CC on 7 May 2019.

96. It does not appear that Mr George's transfer, in the midst of KT's family tragedy, prompted any consideration of whether KT ought to be left alone in his cell at this time of need. There was certainly an opportunity to consider this on 8 May 2019, when Correctional Officer Rajan Sharma raised his concern about KT's emotional state with Mr Kochhar. KT's family believe that a replacement cellmate may have been able to prevent KT's death, either by providing him with emotional support, or at the least by raising the alarm when he was overdosing on his medication.

97. In his evidence, Dr Sullivan cited research which found single cell placement to be a significant risk factor in prison suicides. Nevertheless, he noted that some inmates, perhaps including KT, preferred to be left alone at times of distress. Dr Spencer agreed.

98. Even so, both Dr Sullivan and Dr Spencer agreed that it would be beneficial for inmates in KT's situation to at least be asked if they would like to have the support of a cellmate. They considered this would be a humane measure and would increase the inmate's sense of autonomy in the management of their grief.

99. It is for this reason that Counsel Assisting proposed the recommendation which appears, in slightly amended form, as Recommendation 1 below. Recommendation 1 incorporates amendments proposed by KT's family, and I am satisfied that it has the potential to improve inmate welfare. CSNSW has advised through their representatives, that the recommendation in its amended form is supported in principle. They note that consultation will be needed to ensure that the change aligns with other CS policies and procedures.

100. Two other recommendations were proposed by Counsel Assisting. Both are supported by KT's family, CSNSW and the JH Network. I am persuaded that they too are necessary and desirable. One seeks to ensure that Serious Incident Reports of deaths in custody which are made to CSNSW authorities contain the forensic pathologist's finding as to cause of death. The third proposal is intended to assist the work of the JH Network's Pathology Review Project.

Conclusion

101. I offer sincere sympathy to the family for the tragic loss of KT and of his brother LT. I thank DT and FT for their participation in this inquest on behalf of their family.

102. I thank the outstanding assistance I have received from the assisting team, and from the Officer in Charge of the coronial investigation, Detective Senior Constable Alexander Turner.

Findings required by s81(1)

103. 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 KT

Date of death:
KT died between the night of 8 May 2019 and morning of 9 May 2019.

Place of death:
KT died at the Metropolitan Remand and Reception Centre, Silverwater.

Cause of death:
The cause of KT's death is mixed drug (methylamphetamine and clozapine) toxicity.

Manner of death:
KT died while in lawful custody, after overdosing his prescribed medication, clozapine. The evidence does not establish that he ingested the medication with the intention of ending his life.

Recommendations pursuant to s82

To the Commissioner of Corrective Services (NSW):

1) That consideration be given to a procedure whereby, if an inmate is classified for normal cell placement and has recently experienced a traumatic event in their life, including the death of a family member, Corrective Services NSW consider the appropriateness of their cell placement, and take steps to:

    a) ask the inmate whether they have a preference to be placed with a cellmate (noting that a range of other factors will also influence the ultimate decision as to cellmate placement), and

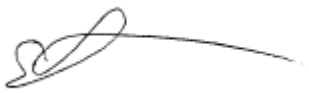
    b) where the inmate is alone, consider whether it is necessary to make observations or otherwise check in on the inmate at reasonable appropriate intervals.

2) That consideration be given to a procedure whereby the Serious Incident Report author reporting on a death in custody contact the police officer in charge of the investigation, to request updating information as to cause of death, prior to signing off on the Serious Incident Report.

To the CEO, Justice Health and Custodial Mental Health Network:

1) That consideration be given to providing a copy of the Court's findings in this inquest to the team working on the Pathology Review Project, with a view to informing that Project's consideration of how to regularise the ordering and signing off of clozapine serum level tests.

I close this inquest.



Magistrate E Ryan
Deputy State Coroner
Lidcombe, 23 March 2023