CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Simon Miles
Hearing dates:	1-5 May 2023
Date of findings:	8 August 2023
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of a First Nations man while on a Compulsory Drug Treatment Order - whether his release to Stage 2.5 of the Community Drug Treatment Program was appropriately planned and managed - whether the Community Drug Treatment Program is delivered in a manner which is culturally appropriate to the experience and needs of First Nations participants.
File number:	2021/339043
Representation:	Counsel Assisting the inquest: J Harris of Counsel i/b NSW Crown Solicitor. Ms Lorraine Browne, Senior Next of Kin: Heather Webb, Trial Advocate, Aboriginal Legal Service. The Commissioner of Corrective Services NSW: A Douglas-Baker of Counsel i/b Department of Communities and Justice, Legal. The Justice Health and Mental Health Network: S Grey of Counsel i/b Makinson d'Apice Lawyers.

Findings:	**Identity** The person who died is Simon Miles. **Date of death**: Simon Miles died on 28 November 2021. **Place of death**: Simon Miles died at Waterloo, Sydney. **Cause of death:** Simon Miles died as a result of heroin and methylamphetamine toxicity. **Manner of death:** Simon Miles died as a result of accidental drug overdose, while he was serving a period of community detention.

Non-publication orders prohibiting publication of certain evidence pursuant to section 74(1)(b) of the *Coroners Act 2009* have been made in this inquest. A copy of these orders, and corresponding ones pursuant to section 65(4) of the Act, can be found on the Registry file.

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

2. On 28 November 2021 Simon Miles died while he was a participant in the Compulsory Drug Treatment Program. As this program is a form of community custody, an inquest into the circumstances of his death is mandatory pursuant to sub-sections 23(1)(a) and 27(1)(b) of the Act.

The role of the Coroner

3. The Coroner must make findings as to the date and place of a person's death, and the cause and manner of their death.

4. In addition, pursuant to section 82 of the Act, the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

Simon's life

5. Simon Miles was born on 23 August 1979. He was a proud First Nations man whose family belonged to Githabul country in southern Queensland.

6. Simon's father passed away in 2004 when Simon was a young man. His mother, Lorraine Browne, is a member of the Stolen Generation, and has survived much trauma and sadness in her life. Simon grew up in the Redfern and Waterloo area of Sydney, with his sisters Tanya, Margaret, Lillian and Amelia, and his brother Robert.

7. The Miles family is a strong one, and they are active in Aboriginal-led community groups working to build a positive future for Aboriginal families. This family commitment is reflected in the voluntary work Simon was undertaking with Aboriginal-led organisation Deadly Connections, in the weeks leading up to his tragic death.

8. Simon was a father himself. His son Koen lives in Queensland with his mother Lauren Jones. In 2013 Simon met his partner Jessica Judd, and their daughter Azariah was born the following year. Jessica and Azariah live in Griffith with Jessica's daughter from a previous relationship.

9. Simon worked in forklifting and carpentry jobs. However for much of his adult life he had a severe heroin dependence. He knew that drugs harmed him and the people he loved, and were the underlying cause of his criminal offending. For his own sake and that of his family he wanted to overcome his dependence.

10. Simon's work on his rehabilitation commenced with a WHOS program in 2006 followed by a period on an opioid substitution program. In 2010 he successfully completed a

Compulsory Drug Treatment Order. This is an intensive drug rehabilitation program under judicial supervision, which will be further described below.

11. Simon then remained abstinent from drugs for a number of years. Unfortunately, he relapsed, commencing with pain killers for a shoulder injury he had received playing rugby some years earlier. His renewed use of pain killers led him back to heroin and methylamphetamine, and to his participation for the second time in the Compulsory Drug Treatment Program.

12. Simon commenced this rehabilitation program on 7 July 2020 while serving a sentence of imprisonment. By late September 2021 he had substantially completed the second of its three stages, and he was living full time in the community in the home of his sister Tanya and her family. Simon was also spending a large part of his time working with Deadly Connections, initially as a volunteer and then in a paid position.

13. Simon spent the morning of 28 November 2021 on a shopping trip with Tanya and her children, then shared lunch with them in Sydney's Chinatown. Later that afternoon he went alone to an apartment block in Pitt Street, Redfern. It is believed that he obtained illicit drugs there, then went to the utilities room under the apartment building to consume them.

14. It was there that Simon's unresponsive body was discovered, at about 7.30pm that night. Police and ambulance services were called, but tragically Simon could not be revived, and he was pronounced deceased.

15. The autopsy report of forensic pathologist Dr Jennifer Pokorny found that Simon had died as a result of heroin and methylamphetamine toxicity. Toxicological analysis detected these drugs in amounts which are considered potentially lethal. Dr Pokorny noted that Simon's heart was slightly enlarged and there was an area of moderate narrowing in one of his coronary arteries. However, these did not appear to have caused any impairment to his heart function.

16. Simon's death came as a terrible shock to his family. They had been encouraged by the progress he was making in the Compulsory Drug Treatment Program, and they were proud of his commitment to changing his life.

17. Simon's passing was especially heartbreaking for his mother Lorraine. With courage and dignity she attended each day of the inquest, supported by her daughters. At the end of the inquest, and with Lillian and Amelia by her side, Lorraine spoke lovingly of her son. She expressed her hope that he was at peace, and that his spirit would send strength and comfort to his family.

18. Lorraine and Lillian Miles also spoke to the court of the need for the Australian community to listen to First Nations people about the solutions they believe will work within their communities.

19. There is a pressing need to find meaningful solutions to the rising numbers of First Nations people in prisons. It is this which drives the high rate of First Nations deaths in custody. The inquest into Simon's death was a deeply distressing experience for his family. But it was also an opportunity to listen to First Nations people reflect upon Simon's experience, and to consider how their perspective may help to shape solutions that better meet the needs of First Nations people like him.

The issues at inquest

20. The inquest examined:

    a) whether Simon's release to Stage 2.5 of the Community Drug Treatment Program was appropriately planned and managed; and

    b) whether the Community Drug Treatment Program is delivered in a manner which is culturally appropriate to the experience and needs of First Nations participants.

21. The evidence included statements and records from the health practitioners who worked with Simon in in his last eighteen months. Some witnesses also gave oral evidence at the inquest. It was evident that they had liked and respected Simon very much and were deeply saddened by his passing.

22. The inquest also heard evidence from experts in areas of relevance to the above issues. These were:

    a) Dr Paul Haber, specialist in addiction medicine, and senior staff specialist at Royal Prince Alfred Hospital Drug and Alcohol Services.

    b) Ms Vanessa Edwige, a Ngarabal woman, registered psychologist, and Director on the Board of Gayaa Dhuwi (Proud Spirit) Australia.

23. The inquest was also assisted with a statement from Mr Keenan Mundine, co-founder of Deadly Connections. Mr Mundine is a friend of the Miles family, and a proud First Nations man with family connections to the Biripi Nation of NSW and the Wakka Wakka Nation in Queensland.

24. As the expert evidence will demonstrate, Simon's heroin dependence was severe. If he had survived, he would have lived his life with an ever-present risk of relapse and overdose. Seen in this light, Simon's determined efforts over many years to overcome his drug dependence do him great credit.

The Compulsory Drug Treatment Program

25. Simon's last period of imprisonment commenced on 4 February 2019. On 2 July 2020, the Drug Court of NSW directed that he serve his sentence by way of compulsory drug treatment detention.

26. The Compulsory Drug Treatment Program [CDTP] commenced in 2006. It operates pursuant to Part 2A of the *Drug Court Act 1988* and Part 4A of the *Crimes (Administration of Sentences) Act 1998*.

27. This intensive drug rehabilitation program is based on principles of therapeutic jurisprudence. It is managed jointly between Corrective Services NSW [CSNSW] and the Justice Health and Forensic Mental Health Network [the JH Network]. It uses a multidisciplinary model with input from staff of CSNSW, specialist health workers from the JH Network, and chaplains.

28. The Drug Court of NSW is the supervising court for the program and oversees its legal aspects.

29. Since the CDTP program commenced, numerous evaluations have found it to be more effective at reducing reoffending than full-time imprisonment. Its purpose is to rehabilitate men whose criminal offending is related to severe drug dependence, in recognition of the strong association between the two. It aims to help participants understand that connection, and to provide intensive support for the challenges which they will face in changing their lives.

30. The court heard that in line with the gross overrepresentation of First Nations people in custody, approximately a third of participants in the CDTP are First Nations men. As a diversion program therefore, the CDTP is an important strategy in meeting a key target of the Closing the Gap framework, namely that of reducing the rate of Aboriginal and Torres Strait Islander adults in incarceration by at least 15 per cent, by 2031.

31. Although the CDTP uses an abstinence focused model of treatment, since 2012 its treatment options have included Opioid Substitution Therapy [OST], described in more detail later in these findings.

32. In brief terms, to be eligible for CDTP a man must be serving a sentence of imprisonment exceeding 18 months and have a long-term drug dependence. Until recently it was a requirement that the person be usually resident within the Sydney metropolitan area. However, in February 2023 the program expanded to its first regional location in Dubbo NSW. This was a direct response to the Special Commission of Inquiry into the drug 'Ice'.

33. Operating from Parklea Correctional Centre in a specialised unit called the Compulsory Drug Treatment Correctional Centre [CDTCC], the Sydney metropolitan program has capacity for up to seventy participants. Its current Director is Ms Linda Ferret.

34. Participants in the CDTP must spend at least six months in each of its three stages. To progress to Stages 2 and 3, a participant is reviewed by a multi-disciplinary team which assesses his progress and considers whether he is suitable to enter community detention. If so, a personal plan is prepared and placed before the Drug Court of NSW. If the Drug Court approves progression, the terms of the personal plan become the conditions of a Community Supervision Order.

35. Participants spend Stage 1 in closed detention in the CDTCC, undertaking therapeutic counselling programs and work readiness training. Key to this phase is the development within participants of an understanding of the link between their substance dependence and their criminal offending.

36. Stage 2 is semi-open detention involving intermittent periods of community leave. Importantly it incorporates regular drug testing. In her evidence, Ms Ferret described drug testing as *'a key component'* of the program, designed to monitor the participant's abstinence while he is out on leave in the community, but also to serve as a protective measure to deter him from relapse.

37. The final Stage 3 is served entirely within the community, in accommodation approved by the Drug Court and under a Community Supervision Order. As will be described, throughout 2021 the Covid-19 pandemic and its associated restrictions disrupted these latter stages in significant ways.

38. From this brief description, it will be seen that CDTP participants need to be highly motivated to make major changes to their thinking and their way of life. Simon had this motivation. Many times he had expressed his desire to be able to return to work and to parent his daughters with his partner Jessica. He understood that his drug dependency was at the heart of his criminal offending, and that the only way to break this connection was by learning to manage his dependence.

On Stage 1

39. Simon entered Stage 1 of the CDTP on 7 July 2020, following an order from the Drug Court. Over the following months he completed therapeutic and group counselling programs, received individual case management, and undertook skills training. He also chose to attend chapel.

40. At the close of Stage 1, Simon's Assessment Report, dated 31 March 2021, noted that he had been '*mature and respectful'*, had gained insight into his substance use and past

criminal activities, and had '*significantly improved confidence in his ability to remain drug free'.* He was *'determined and motivated to continue with his recovery'.*

41. On 7 April 2021, the Drug Court made a Community Supervision Order for Simon, approving his progression to Stage 2 and to semi-open detention. Conditions were imposed for his periods of leave, which included one that he *'.. participate in regular and random drug tests … and searches three times weekly'.*

42. During Stage 1 Simon had had one relapse; in August 2020 he had tested positive for pregabalin, a pain-killing medication for which he did not have a prescription. Simon told his CDTP case coordinator that he had taken this for his recurrent shoulder pain.

On Stage 2

43. Once on Stage 2 Simon underwent drug testing at least three times a week, in compliance with the conditions of his Community Supervision Order.

44. Simon was also fitted with an ankle bracelet to enable electronic monitoring of his movements while he was on community leave. In late April 2021, he had his first overnight leave, escorted by his partner Jessica who travelled to Sydney from Griffith.

45. On his return to CDTCC Simon was required to undertake a urinalysis test, which is standard procedure. For the second time he tested positive for pregabalin, as well as buprenorphine. Simon acknowledged having used pregabalin, again for shoulder pain, but he denied buprenorphine use.

46. Then on 11 May 2021, Simon disclosed to his case coordinator that he had used methylamphetamine, which he had done on an impulse. He was angry with himself for this relapse, and he disclosed to the MDT: *'I think about it [drug use] all the time, I even dream about it'.* He was regressed back to Stage 1 for a period of six weeks.

47. At about this time Simon was considering abandoning the CDTP, as he was hopeful for parole in the not-too-distant future and he very much wanted to return to Griffith to live with Jessica and the girls. It is much to his credit that he decided to remain in the program, telling his treating team that Jessica had encouraged him to stay with it. Simon was approved to return to Stage 2 on 22 June 2021.

48. From June to September 2021, Simon remained at the CDTCC, providing urinalysis samples every two to three days. All were negative for drugs.

The introduction of Stage 2.5

49. In August and September 2021 Simon underwent a number of assessments, in preparation for his next move. These reviews were considered necessary because in

the previous year the CDTP had introduced significant changes to its Stage 2 arrangements.

50. In the ordinary course, Stage 2 participants enjoyed periodic community leave from which they regularly returned to the CDTCC to undertake urinalysis testing and resume their program activities. However, with the intensifying Covid-19 pandemic, the movement of participants between community and prison was felt to involve too great a risk of introducing Covid-19 into the vulnerable jail community.

51. On the other hand, the CDTP did not want to deprive its participants of the benefits of community leave and the opportunity to demonstrate that they were ready to progress to Stage 3.

52. With these good intentions, a new 'Stage 2.5' of Extended Social Leave was introduced. This model brought about significant changes. Instead of having periods of community leave interspersed with returns to the CDTCC, participants were to enter community leave on a fulltime basis. Ordinarily this would not happen until they had been approved to commence Stage 3 of the program.

53. Later there came another significant change. On 14 July 2021, the then Commissioner for CSNSW Peter Severin issued an Instruction, the effect of which was that all drug and alcohol testing for offenders living in the community was suspended from 27 August 2021. It was considered that drug and alcohol testing involved too much contact for participants and health care workers alike, increasing the risk of Covid-19 transmission. In addition, pathology services had become stretched due to the demands of Covid-19 testing. Drug testing was therefore suspended for CDTP participants once they entered community leave on Stage 2.5. It was not reinstated until 4 December 2021.

54. Simon commenced Stage 2.5 on 16 September 2021. In the previous four months he had undergone a total of 44 urinalysis tests. All were negative for drugs. But in accordance with the Commissioner's Instruction of 14 July 2021, Simon had no further drug tests after his release into the community.

55. Whether Simon's CDTP team had paid sufficient regard to the fact that he would not be receiving drug tests and took appropriate steps to mitigate his consequent increased risk for relapse, will be considered later in these findings.

On Stage 2.5

56. Simon's sister Tanya Miles had been assessed to be a suitable sponsor and a positive support for Simon. On 16 September 2021 therefore when Simon commenced Stage 2.5, he moved into Tanya's home in Waterloo. Simon's CDTP team noted however that although he was grateful to Tanya and her family for their support, his deep desire was to return to Griffith to live with Jessica and the children. Simon had voiced this wish a

number of times. This was not only because it would enable him to live with Jessica and the girls, but also because he perceived Griffith to be a safer environment than Sydney's inner city, where he had ready access to former drug associates.

57. While on Stage 2.5 Simon was monitored by field officers via his ankle bracelet. He had some meetings (mostly by phone but on one occasion in person) with his CDTP case coordinator, Mr Paul McGaughey. In addition, he registered with a job search agency, and attended an appointment with Dr Gaudry of the Aboriginal Medical Centre to obtain access to psychological support. This was intended to assist his transition to community living, to improve his prosocial relationships, and to help address his symptoms of depression and anxiety.

58. Simon had a phone consultation on 22 September 2021 with CDTP Clinical Nurse Consultant Elaine Poynter. Simon told her that he felt he was coping well and had not been experiencing cravings for heroin. He also had a meeting via AVL with the CDTP multidisciplinary team on 9 November 2021, in which no concerns were raised.

59. One of the elements of Simon's Community Supervision Order was that he would engage with Aboriginal-led community organisation Tribal Warrior. This was to help him develop new relationships and seek work opportunities, within an environment which was culturally appropriate.

60. This referral did not come to pass, but Simon instead became involved with Deadly Connections through a family friend of the Miles family, Mr Keenan Mundine.

Simon's involvement with Deadly Connections

61. Mr Keenan Mundine is co-founder with Ms Carly Stanley of Aboriginal-controlled organisation Deadly Connections. Deadly Connections aims to directly address the over-representation of First Nations people in the criminal justice and child protection systems.

62. Mr Mundine is a First Nations man with lived experience of drug dependence, having previously undertaken the CDTP. He provided a statement to the inquest, outlining Simon's involvement with Deadly Connections and reflecting on how the CDTP might better meet the needs of its many First Nations participants.

63. In his statement Mr Mundine described how Simon sought his support on 24 September 2021. Simon was *'highly anxious and distressed about his situation'.* He was feeling financially stressed and was worried that he was a burden to Tanya. She had recently lost her job, and he was not permitted either to undertake paid work or to access Centrelink payments until he had reached Stage 3 of the program. Mr Mundine promised to do what he could to help Simon.

64. With the approval of his case coordinator, Simon commenced regular drug and alcohol counselling with Deadly Connections. He was also assisted to open a bank account, renew his driver's and forklift licences, and attend job interviews. He soon became a volunteer worker for Deadly Connections, collecting meals two days a week and delivering them to First Nations families affected by Covid-19 restrictions. On a third day of each week Simon helped organise Deadly Connections' Men's Group. From 22 November 2021, Simon was able to be paid for this work, as the Drug Court had approved his progression to Stage 3.

65. Simon's family was justifiably proud of the work Simon did for his community with Deadly Connections. In his statement Mr Mundine commended Simon as a man who:

> *' … loved his work and he had a big heart. He was the kind of person who would pull over and help any mob he saw struggling … we are still being told by our clients and community that they are looking out for him in his delivery van and they are shocked when they hear the news of his death'.*

66. However, Mr Mundine also expressed the view that the CDTP needs to better link its First Nation participants to First Nation-controlled organisations and provide culturally safe transition plans. This issue will be examined later in these findings.

On Stage 3

67. In November 2021, Simon was eligible to commence Stage 3 of the CDTP. A Progress Assessment Report and Personal Plan were prepared by his multidisciplinary team. These were forwarded to the Drug Court on 12 November 2021 for consideration and approval. Simon's Progress Assessment Report commended him for having demonstrated '*great motivation and desire to successfully reintegrate into the community and avoid future re-incarceration'.*

68. Curiously, both these documents recorded that Simon's risk for relapse while in the community would be managed by '*urinalysis and regular drug testing'*. According to the Personal Plan, while on Stage 3 Simon would '*participate in regular and random drug tests … and searches three times a week'.* The Progress Assessment Report commented that '*urinalysis testing indicates he has abstained from illicit substance use since 11 May 2021'.*

69. In fact, and in accordance with the Commissioner's Instruction, Simon had received no drug tests after his release on to Stage 2.5 on 16 September 2021. This fact was not reflected in the above documents prepared for approval by the Drug Court.

70. The available evidence about what information the Drug Court was provided regarding the Stage 2.5 changes is addressed later in these findings.

71. I will now turn to the issues which were examined at the inquest.

Was Simon's release to Stage 2.5 appropriately planned and managed?

72. Simon's death from drug overdose while in the community raises questions as to whether his CDTP team gave sufficient attention to his risk for relapse in particular in circumstances where he would not be receiving drug testing. Given these circumstances, were appropriate strategies put in place to mitigate his risk?

The Stage 2.5 Risk Assessment

73. From the outset it was clear to Simon's CDTP team that the plan for him to live in Waterloo did increase his risk for relapse. The team was well aware that he had grown up in this area and knew the people and places where drugs could be obtained.

74. This risk was clearly identified in a Risk Assessment which included input from Simon's CDTP case coordinator Paul McGaughey, senior psychologist Ms Denise Constantinou, Clinical Nurse Consultant Elaine Poynter, and Services and Programs Officer Phillip Cook. Although the Risk Assessment document is undated, it appears to have been prepared in consideration of Simon's entry into Stage 2.5.

75. All contributors documented that for Simon, living in the Redfern/Waterloo area presented a risk due to the ready availability of illicit drugs. An additional risk factor was identified, namely the suspension of urinalysis testing for Stage 2.5 participants. Noting this, Mr Cook recommended that to mitigate this risk *'the case coordinator should provide increased case management through regular contact with [Simon]'.*

76. Other features identified in the Risk Assessment were:
    a) Simon's heightened risk of fatal overdose if he were to relapse, given that his tolerance for opioids would have reduced significantly while he was in custody;
    b) a perception that Simon tended to be over-confident and had a potential to overestimate his ability to avoid relapse; and
    c) a risk that his recurring shoulder injury would lead him to '*self medicate'* with non-prescribed drugs.

77. The team members recommended the following risk mitigation measures for Simon when he was released into the community:
    a) regular contact with his case coordinator;
    b) drug counselling and regular meetings with Narcotics Anonymous;
    c) regular monitoring of his physical movements; and

d) engagement with a culturally sensitive service to support his abstinence and provide volunteer work.

78. I have described at paragraph [57] the measures which were put in place when Simon commenced full time community living on 16 September 2021. As can be seen, these incorporated certain elements of the above risk mitigation strategies. Simon's movements were electronically and physically monitored on a regular basis, and he was referred to a culturally appropriate support service for drug and alcohol counselling and social support.

79. However, the evidence raised the question whether Simon's contact with his case coordinator was of a sufficient frequency to help mitigate his risk for relapse.

Did Simon receive sufficient consultation with his case coordinator?

80. The evidence was not entirely clear as to what frequency of contact was contemplated for participants once they entered Stage 2.5.

81. By letter dated 30 March 2020, the then Director of the CDTCC Ms Linda Smith made a request to His Honour Judge Roger Dive, then Senior Judge of the Drug Court of NSW, for approval to alter Stage 2 arrangements during the Covid-19 pandemic. As regards to the plans for drug testing, Ms Smith advised that:

'Drug testing will still occur [for Stage 2 participants], however CSNSW staff will advise of the process in place for continued testing as per CDTCC legislation'.

82. In her letter Ms Smith further proposed that under the new scheme, participants would have 'Extended Leave' whereby they would be given leave passes for a period of one week at a time. At the end of each week, participants would consult with their case coordinator with a view to extending their leave pass for a further week. This was to continue until the participant became eligible for progression to Stage 3.

83. It may be inferred from the above, that the arrangements for Stage 2.5 contemplated drug testing for participants, and consultations with their case coordinator at least once per week.

84. As noted however, from August 2021 all drug testing ceased for Stage 2.5 participants. An alternative method of testing was not put in place. Furthermore, the evidence revealed that Simon did not have consultations with his case coordinator on a weekly basis while he was on Stage 2.5.

85. Simon's CDTP case coordinator Mr McGaughey gave evidence at the inquest. He told the court that he had liked Simon very much, describing him as a bubbly character who was hopeful for his future. His death came as a shock, as Mr McGaughey had thought

Simon was doing well. He had been particularly impressed that Simon had proactively made contact with Deadly Connections and had obtained work with them.

86. Mr McGaughey's records documented that during the period 16 September 2021 to 25 November 2021, he had a face-to-face meeting with Simon on 12 November 2021 and eight telephone consultations. This equated to one consultation per fortnight.

87. At the inquest Mr McGaughey said that he thought he had had more frequent contact with Simon than was recorded, but he could not be sure. In any event he accepted that given the absence of drug testing, it would have been better for Simon if he had had the support of more frequent contact. Mr McGaughey regretted this had not happened.

88. Other members of Simon's CDTP team echoed this regret. Clinical Nurse Consultant Elaine Poynter had worked with Simon since late 2019. She remembered him with affection and said that he had tried very hard to avoid drugs. In her opinion it was regrettable that Covid-19 had prevented Stage 2.5 participants from returning regularly to the CDTCC following their leave periods, as this would have enabled regular drug testing and informal face-to-face monitoring by their treating team.

89. It is not clear when and why the frequency for consultation with case coordinators was reduced from the weekly scheme originally contemplated. Ms Poynter's recollection was that the CDTP had settled upon fortnightly contact for Stage 2.5 participants, because this was more frequent than the monthly contact which Stage 3 participants received. Ms Poynter agreed that on reflection, it would have been better for Simon if the consultations had been more frequent.

90. In hindsight therefore, CDTP staff regretted that Simon had not received more frequent contact, particularly in view of the absence of other safeguards such as drug testing.

91. This sentiment was shared by the current Director of the CDTCC, Ms Linda Ferret. Ms Ferret has filled this role since March 2023 on the back of a lengthy career within CSNSW, much of it working with drug addicted people. At the inquest she expressed strong faith in the CDTP and its capacity to make a real difference for addicted men and their families. She impressed as a sincere person with a passionate commitment to the work of the CDTP.

92. Ms Ferret agreed that the introduction of Stage 2.5 meant that Simon did not experience the more gradual integration into community life that was ordinarily the case for CDTP participants. He did not have the benefit of regular drug testing, nor the ongoing assessment by CDTP staff which was enabled by regular returns to the CDTCC. This, she agreed, had the effect of removing some of the measures designed to mitigate risk for relapse. In hindsight, she said, it justified a decision to provide Simon with more

support in the form of more frequent review with his case coordinator. Ms Ferret expressed her regret that this had not been provided.

93. I accept that the cessation of drug testing and the loss of face-to-face meetings, while unfortunate, could probably not have been avoided. As will be seen, this reflects the opinion of Professor Paul Haber, a specialist in drug and alcohol medicine who provided an expert report and gave evidence at the inquest.

94. However, the weight of the evidence leads me to conclude that once Simon entered Stage 2.5, the consequent risk to him ought to have been mitigated with a higher level of case management than was given.

Was the Drug Court of NSW made aware of the cessation of drug testing for Simon?

95. A related enquiry was the extent to which, if at all, the Drug Court of NSW was made aware that once Simon entered Stage 2.5, he would not be subject to drug testing.

96. I have described above the letter in which the then Director of the CDTCC sought permission of His Honour Judge Dive for approval to alter Stage 2 arrangements. Judge Dive confirmed his approval in an email to Ms Smith on 1 April 2020.

97. As can be seen, Ms Smith's letter confirmed that drug testing would still occur for Stage 2 participants. However, when Commissioner Peter Severin directed the cessation of drug testing for all participants, which became effective from 27 August 2021, it is unclear if this was clearly notified to the Drug Court.

98. A search for documents uncovered only an email from Ms Smith dated 1 September 2021, for '*the attention of the Drug Court Judge'*. In this email Ms Smith advised that *'for the time being we have ceased urine testing for Stage 3'.* It is to be noted that she made no reference to the situation of Stage 2.5 participants.

99. At paragraph [68] I have referred to certain statements contained within documents placed before the Drug Court on 12 November 2021. As acknowledged by Ms Ferret in her evidence, these statements may well have given the impression to those involved with Simon at the Drug Court that urinalysis testing was continuing for him.

100. The evidence at inquest did not provide any basis for concluding that the Drug Court was made aware of the cessation of drug testing for Simon on Stage 2.5. As the supervising Court, the Drug Court ought to have been made aware that on his release into the community Simon would not receive drug testing. It may be inferred that this information would have been relevant to the Drug Court's determination of whether the risks attendant on Simon's release into the community had been mitigated with appropriate conditions and measures.

101. This was readily acknowledged by Ms Ferret in her evidence at the inquest.

Should Simon have been on an opioid substitution program?

102. A related issue which arose for consideration was whether, given his risk for relapse, Simon's health practitioners ought to have taken a more active role in persuading him to undertake opioid substitution therapy. The inquest examined this issue within the context of expert opinion about the nature and strength of Simon's substance dependence.

103. Opioid Substitution Therapy [OST] is also known as Opioid Replacement Therapy and Opioid Agonist Therapy. It involves the use of medications for people with a chronic opioid dependence, to remove their need to source illicit opioids and so reduce the harms associated with this activity. OST became available as a treatment option for CDTP participants in 2012. The CDTP Operations Manual includes guidelines for its use, for the assistance of JH Network staff and officers of the CSNSW.

104. For some years OST was available only by way of daily liquid doses of methadone. By the time Simon was in the CDTP however, advances in pharmacology had enabled OST to be delivered via a monthly injection of slow-release buprenorphine.

<u>The evidence of Simon's health team</u>

105. The court heard evidence that the health professionals who worked with Simon were of the view that he would have benefitted from participation in such a program.

106. Since 2009, psychiatrist Dr Gerald Chew has been responsible for providing CDTP participants with psychiatric care for any co-existing psychiatric conditions. In 2021, he was a member of Simon's treatment team and he recalled Simon well. On 31 August 2021, he had assessed Simon's suitability, from the psychiatric perspective, to progress to Stage 2.5. Dr Chew told the court that he had felt quite positive about Simon's prospects, and he considered that he was suitable to progress.

107. Nevertheless, Dr Chew had assessed Simon's opioid dependence to be strong, noting in particular his history of relapses and overdoses. In his opinion, being on an OST program would have reduced Simon's need to seek drugs and decrease his risk for overdosing by sourcing street opioids of unknown strength and contaminants.

108. However, Dr Chew had not considered it was his role to advocate for Simon to undertake OST, because he was not a drug and alcohol specialist. Therefore, he merely recorded in his patient notes that Simon was not on OST, to bring this fact to the attention of the multidisciplinary team.

109. Prior to entering Stage 2.5 Simon was also reviewed by Dr Judith Meldrum, a staff specialist in drug and alcohol health with the JH Network. Dr Meldrum has extensive experience working in this field, including with many First Nations clients.

110. Like Dr Chew, Dr Meldrum had assessed Simon to be a person with a chronic opioid dependence. As she explained to the court, this is a lifelong condition which carries a high risk of mortality and requires continual management. Chronically dependent patients were at high risk of death if they relapsed, due to their temporary loss of tolerance to the effects of opioids. In Dr Meldrum's opinion, using an opiate replacement was a safe way to manage this risk, provided it was used in correct doses and not with other drugs.

111. Dr Meldrum told the court that her concern for Simon's risk for relapse was heightened when she saw that in addition to his previous relapses and overdoses, he had on two recent occasions used unprescribed pregabalin, a drug which acts in a similar way to opioids and can become addictive. This behaviour reinforced her assessment that his opioid dependence was very severe, and that he had a correspondingly high risk for relapse.

112. Dr Meldrum's patient notes reflect that she discussed the availability of OST with Simon and encouraged him to consider it. She believes she also explained to him that he would be able to receive it by means of a monthly buprenorphine injection.

113. But Simon had expressed to Dr Meldrum that he did not want to use OST, and she did not feel it was appropriate to urge him to do so.

114. Dr Meldrum told the court that in these circumstances, the only other safety measures against relapse and fatal overdose were regular drug testing, drug and alcohol counselling, and easy access to Nyxoid. Nyxoid is a nasal spray which a family member or bystander is able to administer to a person who has overdosed, if they are present at the time.

115. Significantly, while Simon was provided with Nyxoid on his release and was to receive drug and alcohol counselling, he was unable to access the first protective measure identified by Dr Meldrum for patients who were not using OST, namely regular drug testing.

<u>The evidence of Dr Paul Haber</u>

116. At the inquest the court also heard evidence on this subject from Professor Paul Haber, a consultant physician and specialist in addiction medicine. Professor Haber is a senior staff specialist at Royal Prince Alfred Hospital Drug and Alcohol Services. He was asked to provide his opinion as to whether Simon's release on to Stage 2.5 was appropriately planned and managed, in particular his risk for relapse.

117. Professor Haber reviewed Simon's medical history. He was left in no doubt that Simon had a '*complex, longstanding and high-risk polysubstance drug dependence, with*

multiple overdoses and failure of rehabilitative programs'. In his opinion these factors made Simon very vulnerable to fatal relapse. In addition, Simon's history of shoulder pain added to this risk, due to his need for pain relief.

118. Overall Professor Haber was of the view that the conditions which accompanied Simon's release onto Stage 2.5 were appropriate. In his opinion Simon's CDTP team had an adequate appreciation of his risk for relapse.

119. Professor Haber was pragmatic about the non-availability during the Covid-19 pandemic of face-to-face counselling and drug testing. Although these measures would have mitigated Simon's risk of relapse, he recognised that this had to be balanced with the increased risk of infection for Simon and the involved health care workers.

120. However, in Professor Haber's opinion, Simon's non-participation in OST was '*a key factor*' in his overdose death. In his opinion, an abstinence-based treatment program like the CDTP was:

> *' … usually ineffective when people with severe opioid use disorder are returned to a community setting where opioids can be obtained'.*

121. For this reason, while Professor Haber acknowledged that OST had been discussed with Simon and he had been encouraged to adopt it, he was mildly critical of what he perceived as a lack of vigour in the attempts to persuade him. Simon was a high-risk patient with drug dependence at '*an above average level of severity and complexity'.* Accordingly with Simon there needed to be '*an above average degree of persuasion'* to undertake OST.

122. Professor Haber's assessment of the severity of Simon's drug dependence accorded with that of his treating health professionals. The evidence leaves no room for doubt that Simon's degree of dependence was very severe and exposed him to a correspondingly high risk for relapse and death. There was medical consensus that his degree of risk strongly indicated that OST would have been an appropriate risk mitigation step for him.

123. It may further be inferred that Simon's high risk for relapse into drug use in the community carried with it a consequent risk for recidivism into the criminal offending associated with his drug dependence. This of course was not the focus of the inquest, which is concerned with the circumstances surrounding Simon's tragic death and whether anything may be done to reduce the risk of other such deaths. I mention it only as a matter of relevance to the aims of the CDTP, one of which is the reduction of criminal offending.

124. This evidence raised the question as to what guidance is provided to those delivering the CDTP on the use of OST for severely dependent participants, and whether it is adequate.

The CDTP Operations Manual: provisions regarding Opioid Substitution Therapy

125. Part 12 of the JH Network's CDTP Operations Manual [the Operations Manual] contains guidelines for the use of OST as a treatment option for CDTP participants. It is provided that a participant can commence OST at any Stage of the CDTP *'as clinically indicated'.*

126. At Part 12.4 it is noted that with entry onto Stage 2 and access to the community, participants are at increased risk of drug use and overdose. Indicators that a participant should use OST:

> *' … might include a significant overdose history when not prescribed OST or significant history of other associated risks related to opioid use when not on OST'.*

127. In limited circumstances therefore, a participant's multidisciplinary team can require him to commence OST as a condition of remaining on the CDTP. Where opioid use has delayed the participant in Stage 1 or caused him to regress to Stage 1, but he does not wish to commence OST:

> *' .. the [multidisciplinary] case review might recommend that if there is further opioid use the participant will be required to commence OST to remain in the Program. If the risk is assessed as high (e.g. high potential for overdose) then the case review might recommend revocation from the Program if the participant declines the option of OST, or is non-compliant with the treatment'.*

128. It must be accepted that in Simon's case, it would not have been open to the multidisciplinary team to have activated this provision. Simon's relapses in August 2020 and April 2021 involved the use of pregabalin and, in April 2021, methamphetamine as well. Neither of these drugs is an opioid.

129. Nevertheless, in their evidence both Dr Meldrum and Professor Haber expressed concern that Simon had used pregabalin, because it acts in a similar way to opioids. For them, this served to highlight the severity of his opioid dependence.

130. This evidence, together with that of Dr Haber that Simon may not have been suitable for CDTP without the support of OST, prompt the question whether there is a need for review of this Part of the Operations Manual. Specifically, is there a case to reconsider the circumstances in which a participant may be required to commence OST, as a condition of remaining within the CDTP?

131. I accept that there are sound reasons why any proposal to expand the scope of Part 12.4 would require careful consideration. There would presumably be concern that participants might be discouraged from remaining with the CDTP if, in individual cases, undertaking OST was made a condition. Philosophically too, a power to remove a

participant because he chooses not to use OST might be seen as inimical to the CDTP's underlying principle that individuals take responsibility for their own recovery.

132. Nevertheless, based on the evidence at inquest regarding Simon's high risk for fatal relapse, there may be benefit in further consideration of the current provisions regarding the role of OST in the program. I will return to the question of whether this ought to be made the subject of a recommendation shortly.

133. Notwithstanding the above observations, it would not be appropriate for me to express criticism of any member of Simon's CDTP team for the approach which they took to the question of OST in his case. Nor did I receive any submissions urging this course. The Operating Manual provided no basis to require Simon to undertake OST as a condition of remaining in the CDTP. Furthermore, it appears to me that the question of whether it would have been appropriate to pursue this option more vigorously is one where health professional opinion might reasonably differ.

134. I turn now to the final issue for examination.

Is the CDTP delivered in a culturally appropriate manner?

135. The court heard evidence as to whether the CDTP sufficiently acknowledges the cultural needs of its many First Nations participants. This included whether in appropriate cases it would be feasible to permit a participant to reside on country while participating in the program.

136. Ms Vanessa Edwige is a Ngarabal woman and a registered psychologist, who has worked predominantly with the Aboriginal communities of Redfern and Waterloo. She is the chair of the Australian Indigenous Psychologists Association, and a contributor to the Bugmy Bar Book Project. In these roles she has developed extensive experience working with people who suffer the effects of intergenerational trauma. In the report which she provided for this inquest, she emphasised that these effects were a key driver of the disproportionate incarceration of First Nations people.

137. Ms Edwige was asked first to assist the inquest with an understanding of the impact of Simon's cultural background on his offending.

138. Having reviewed material about Simon's upbringing in the Redfern/Waterloo community, Ms Edwige concluded that within his community and family Simon was exposed to substance abuse, domestic violence, social exclusion, incarceration, and the early deaths of relatives. Simon would have felt the effects of all these features as well as intergenerational grief, defined as unresolved grief that is passed on through the generations of a family:

'His exposure to grief and loss through the social determinants that continue to cause grief, experiences of loss and trauma, in my opinion would have been significant'.

139. Ms Edwige was also asked to provide her expert opinion on whether the support provided to Simon during Stages 2.5 and 3 of the CDTP was culturally safe and appropriate for him.

140. In her report Ms Edwige described '*cultural safety'* as a way of practice in which practitioners are:

> *' … open to viewing cultural considerations as integral to their practice, and ongoing reflection and learning as necessary to respond appropriately to those in their care'.*

141. Cultural safety, Ms Edwige said, must also be underpinned by *'models of care that involve consumers and their family in decisions about care'.*

142. In Ms Edwige's opinion there are significant differences which need to be recognised when working with First Nations people. Two of these are the effect of underlying trauma, and the primacy of being connected with family, country and culture. In her view, the effect of underlying trauma on mental health is not always well understood among those who work with First Nations people.

143. Noting that for First Nations people *'services grounded in non-Indigenous perspectives are less than satisfactory',* Ms Edwige commented that Simon apparently did not find attendance at Narcotics Anonymous meetings to be helpful. This was a response which she said she had sometimes noted among First Nations clients, whose emotional vulnerability often made it difficult for them to stand up in a group and tell their story. She also considered that more thought needed to be given to healing programs which were more culturally appropriate, citing by way of example the Gamarada organisation in Redfern.

144. Ms Edwige commended Simon's involvement with Deadly Connections, sanctioned by his CDTP case coordinator. This was, in her opinion, an organisation which worked well to address the social and emotional needs of First Nations people who are returning to the community from prison. She considered the services offered by Tribal Warrior to be likewise appropriate.

145. Ms Edwige was asked for her suggestions as to how the CDTP might be delivered to First Nations participants in a manner that was more culturally appropriate.

146. Ms Edwige had reviewed the key documents guiding the delivery of CDTP, being the Operations Manual, the JH Network's Statement of Commitment to Aboriginal Health,

and the CDTP's Clinicians' Guidelines and Case Management Guidelines. She thought these documents needed to include specific information as to how they related to First Nations people, to better reflect:

> *'… understandings of intergenerational trauma, adverse childhood experiences, Aboriginal understandings of social and emotional wellbeing, the importance of family and acknowledging healing concepts from an Aboriginal perspective'.*

147. She also suggested that the program consider a stronger involvement of families throughout its three Stages and incorporating family in the multidisciplinary meetings and case reviews.

148. Her other suggestions to enhance First Nations engagement included:

    a) highlighting for families and clients the First Nations staff within CDTP and the roles they played;

    b) better alignment with First Nations understandings of social and emotional wellbeing, including cultural concepts of healing; and

    c) incorporating a Cultural Plan alongside the participant's Personal Plan.

149. The statement of Mr Keenan Mundine contained similar reflections. Mr Mundine commended the importance and value of the CDTP. However, based on his own experience and that of people he had worked with, he considered that it needed better resourcing to help people when transitioning from prison to community, and from substance dependence to sobriety. It also needed to be more culturally responsive. By way of example, Mr Mundine thought that more consideration ought to have been given to allowing Simon to undertake Stage 2.5 in Griffith with his partner. I will return to this issue shortly.

150. It is clear, that the policy documents which underpin the CDTP do not specifically refer to how the program might more effectively be delivered to First Nation participants. I accept the evidence of Ms Edwige and Mr Mundine that there would be benefit in reviewing these, to ensure that they better reflect principles of care for First Nations people. The aim would be to consider what modifications to approach and to treatment programs would improve the prospects of success for its First Nations participants.

151. At the inquest Ms Ferret expressed her openness to proposals to make the CDTP more culturally appropriate for its many First Nations participants. She added that as the CDTP Case Management Guidelines are currently under review, there is an opportunity to modify aspects of the program to make it more specific to their needs and experiences. She agreed that such considerations could include:

a) modifying the Stage 1 materials dealing with the causes underlying drug dependence, to include for example the impact of intergenerational trauma;

b) including First Nations staff on the multidisciplinary team, or ensuring they are available to provide advice to it;

c) building connections between participants and First Nations-identifying CDTP staff;

d) involving First Nations-led services in the program at an earlier stage, to build connections with participants well before they commenced their community leave; and

e) exploring placement of First Nations participants on country.

152. Regarding the last point, Ms Edwige was asked whether, from a cultural perspective, it would have been advantageous for Simon to have been permitted to live with his partner in Griffith during Stages 2.5 and 3.

153. Ms Edwige thought that it would have been. Simon would potentially have had the emotional support of Jessica, and benefits to his social and emotional wellbeing from being with the children. It may also have alleviated his feelings of guilt at the thought that he was a financial burden to his sister and her family in Waterloo.

154. Ms Edwige acknowledged possible practical challenges in allowing CDTP participants to reside on country during the program, but she thought it was important that this option was considered. And noting the restricted range of services and support that were actually available to Simon due to Covid-19, Ms Edwige thought that allowing him to live in Griffith while on Stage 2.5 could at least have been considered.

155. In her evidence Ms Ferret expressed her openness to exploring the feasibility of allowing latter Stage participants to reside on country. She commented however that such a decision would need careful consideration. In addition to the likely need for legislative change to the *Drug Court Act 1998* and its Regulations, factors included:

a) whether physical distance might impair the relationship of trust which ideally the participant has with his case coordinator;

b) whether call backs to the Drug Court could be effectively managed on a basis that was not face-to-face; and

c) whether the participant's health, social and welfare needs could be met by the services available in their regional area.

156. Nevertheless, Ms Ferret acknowledged the cultural and emotional benefits that may have flowed to Simon with such a plan. She stated that had his case been under consideration now, the option of him residing in Griffith with his family would be carefully considered.

The question of recommendations

157. Based on the evidence at inquest, Counsel Assisting has proposed that three recommendations be made, as follows:

To the Commissioner for Corrective Services NSW:

1. Consider revising relevant Compulsory Drug Treatment Program (CDTP) policy (following consultation with relevant stakeholders) to provide guidance to staff on the following matters:
    a) describe how the CDTP, including its therapeutic programs, can be delivered to First Nations participants in a culturally competent and culturally safe manner,
    b) identify culturally appropriate services that are available for First Nations participants in the community,
    c) describe the process for assessing the suitability and practicability of a First Nations participant residing on country in a regional area, during Stages 2 or 3 of the CDTP.

To the Chief Executive, Justice Health and Forensic Mental Health Network:

2. Consider revising relevant Compulsory Drug Treatment Program (CDTP) policy (following consultation with relevant stakeholders), to provide guidance to staff as to how the CDTP can be delivered to First Nations participants in a culturally competent and culturally safe manner.

To the Chief Executive, Justice Health and Forensic Mental Health Network, and to the Commissioner for Corrective Services NSW

3. Consider revising relevant CDTP policy (following consultation with relevant stakeholders) to:
    a) provide guidance on the circumstances in which a participant can be required to undertake Opioid Substitution Therapy, as a condition of progressing to Stage 2 or 3 of the CDTP (including where a participant is deemed to be at high risk of relapse), and
    b) describe how a determination about that issue should be documented.

Recommendations 1 and 2

158. The circumstances of Simon's case underline the need, in the case of First Nations participants in the CDTP, for greater acknowledgement of their specific cultural needs. In her evidence Ms Ferret gave strong encouragement to the proposal for a review of

the program's policy and treatment programs, to better reflect the experience and needs of First Nations people.

159. The first Recommendation set out above was supported and endorsed by Ms Douglas-Baker on behalf of the Commissioner for Corrective Services NSW.

160. Recommendation 2 was not opposed by those representing the JH Network, but Mr Gray of Counsel submitted that it was not necessary. At the inquest Mr Craig Cooper, Services Director, Drug and Alcohol, CDTP, had advised the Court that the JH Network's 'Principles of Care' document was under revision.

161. However, the Court did not hear evidence as to the timetable for this review, or what specific areas of the document were to be its subject. For this reason therefore, I make the recommendation.

Recommendation 3

162. It was proposed that this recommendation be made jointly to the Chief Executive of the JH Network and to the Commissioner of CSNSW. It proposes that following consultation, the CDTP guidelines be reviewed to provide guidance as to the circumstances in which a CDTP participant may be required to undertake OST as a condition of progressing to Stage 2 or Stage 3.

163. The evidence highlighted at least two bases in support of this recommendation:

    a) The first, and more narrow basis, consisted of the expert opinion of Dr Meldrum and Professor Haber that Simon's two relapses into pregabalin use were strongly associated with his severe opioid dependence. As noted however, Part 12 of the Operations Manual provides only that '*further opioid use'* may trigger consideration of a requirement to commence OST. The question arises whether in its current formulation the Operations Manual is too restrictive in identifying only further use of the opioids class of drugs as a basis for this consideration.

    b) The second base is the evidence regarding the severity of Simon's opioid dependence and his consequent high risk for fatal relapse (and arguably, for resumption of criminal offending). In my view this evidence suggests the need for consideration of whether on a risk management basis, there is a case for expanding the circumstances in which a participant may be required to undertake OST on entry into the community.

164. This recommendation was not supported either by the Commissioner, nor by the Chief Executive of the JH Network.

165. It was submitted on behalf of the Commissioner that CSNSW staff are not medically trained, and that questions about the appropriateness of OST are better left to the management of JH Network staff.

166. I acknowledge that JH Network staff are responsible for treatment decisions involving the appropriateness or otherwise of OST for an individual participant. However, it must be the case that CSNSW staff are involved in any decision as to whether, in an individual case, the adoption of OST ought to be made a condition of the participant remaining in the program. Therefore, the recommendation is best made on a joint basis.

167. The objections on behalf of the JH Network centred around the voluntary nature of OST as a treatment, and that removal of a participant's choice not to undertake it could undermine his therapeutic relationship with his clinicians and perhaps even his adherence to the program itself.

168. These are legitimate concerns. Nevertheless, it is clear that the existing Part 12.4 recognises there are circumstances where the magnitude of risk to the participant (note '*high potential for overdose*') who declines to undertake OST may outweigh the potential harms associated with removing his personal choice. Based on the evidence, I remain of the view that there would be benefit in reviewing the existing provision, with a view to determining whether it adequately manages that risk.

Conclusion

169. Simon's death was heart-breaking for his mother, sisters and brother, partner, children, cousins and many friends. I hope that in time all those who loved him will find some measure of comfort and healing.

170. I thank Simon's mother and sisters for their patient and generous participation in this inquest.

171. I thank also the assistance provided to the inquest by the assisting team, those representing the interested parties, and Senior Constable Tahra Everson, the police officer in charge of the coronial investigation.

Findings required by s81(1)

172. 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 Simon Miles.

Date of death:

Simon Miles died on 28 November 2021.

Place of death:

Simon Miles died at Waterloo, Sydney.

Cause of death:

Simon Miles died as a result of heroin and methylamphetamine toxicity.

Manner of death:

Simon Miles died as a result of accidental drug overdose, while he was serving a period of community detention.

Recommendations pursuant to s82(1)

To the Commissioner for Corrective Services NSW:

1. Consider revising relevant Compulsory Drug Treatment Program (CDTP) policy (following consultation with relevant stakeholders) to provide guidance to staff on the following matters:
    a) describe how the CDTP, including its therapeutic programs, can be delivered to First Nations participants in a culturally competent and culturally safe manner,
    b) identify culturally appropriate services that are available for First Nations participants in the community,
    c) describe the process for assessing the suitability and practicability of a First Nations participant residing on country in a regional area, during Stages 2 or 3 of the CDTP.

To the Chief Executive, Justice Health and Forensic Mental Health Network:

2. Consider revising relevant Compulsory Drug Treatment Program (CDTP) policy (following consultation with relevant stakeholders), to provide guidance to staff as to

how the CDTP can be delivered to First Nations participants in a culturally competent and culturally safe manner.

<u>To the Chief Executive, Justice Health and Forensic Mental Health Network, and to the Commissioner for Corrective Services NSW</u>

3. Consider revising relevant CDTP policy (following consultation with relevant stakeholders) to:

   a) provide guidance on the circumstances in which a participant can be required to undertake Opioid Substitution Therapy, as a condition of progressing to Stage 2 or 3 of the CDTP (including where a participant is deemed to be at high risk of relapse), and

   b) describe how a determination about that issue should be documented.

I close this inquest.

Magistrate E Ryan

Deputy State Coroner, Lidcombe

8 August 2023