CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Stefan Wakeman
Hearing date:	23 August 2023
Date of findings:	23 August 2023
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – mandatory inquest - death of a person in custody — what was cause of death – was care and treatment provided by Justice Health and Corrective Services NSW adequate.
File number:	2019/179888
Representation:	Coronial Advocate assisting the inquest: Sgt A Chytra. Corrective Services NSW: A Poulios, Office of General Counsel, NSW Department of Justice. Justice Health and Forensic Mental Health Network: M Sterry, Justice Health and Forensic Mental Health Network.

Findings:	**Identity** The person who died is Stefan Wakeman born 26 August 1963. **Date of death**: Stefan Wakeman died on 9 June 2019 **Place of death**: Stefan Wakeman died at the Metropolitan Remand and Reception Centre, Silverwater NSW **Cause of death:** Stefan Wakeman died as a result of ischaemic heart disease. **Manner of death:** Stefan Wakeman died as a result of natural causes while in custody.

Section 81(1) of the *Coroners Act 2009 (NSW)* [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.

These are the findings of an inquest into the death of Stefan Wakeman.

Introduction

1. On 9 June 2019 Stefan Wakeman aged 55 years died at the Metropolitan Remand and Reception Centre, at Silverwater NSW.

2. As Mr Wakeman was in custody, the responsibility for ensuring that he received adequate care and treatment lay with the State. Pursuant to sections 23 and 27 of the Act, an inquest is required when a person dies in custody to assess whether the State has discharged its responsibilities.

The role of the Coroner

3. Pursuant to section 81 of the Act a 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, 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.

Mr Wakeman's life

5. Stefan Wakeman was born on 26 August 1963 to parents Margaret and Thomas Wakeman. He was the youngest child of the family, with two sisters Lynne and Beverley, and three brothers Geoffrey, Garry and Christopher. The children were raised in the area of Boolaroo, near Newcastle New South Wales.

6. Mr Wakeman did not marry or have children. During his teenage years he had a number of falls and accidents which left him with ongoing pain in his legs and feet. In his teens he also commenced drinking alcohol and using cannabis, and in later years other illicit drugs.

7. In his adult years Mr Wakeman had many periods of imprisonment. He was last released from custody on 19 December 2012. Mr Wakeman's sister Lynne told investigators that in between periods of incarceration, her brother always managed to find work.

8. At the inquest, Mr Wakeman's mother Margaret and his sister Lynne attended by way of AVL. They cared about Mr Wakeman, and throughout his years in

prison they had visited him very regularly. His death came as a shock to them, and they wondered if he had been properly cared for.

9. At the time of his death, Mr Wakeman was lawfully in the custody of Corrective Services NSW [CSNSW]. He had been arrested on 23 January 2017 for a number of offences. He was refused bail and was referred to the Mental Health Review Tribunal, as a result of which he was classified as a forensic patient. Mr Wakeman had been diagnosed with acquired brain injury, probable psychotic illness and substance use disorder in remission.

10. On 25 January 2019 the Mental Health Review Tribunal determined that the current order for Mr Wakeman's detention was to continue. Mr Wakeman was assessed as not fit to be tried, and unlikely to become fit to be tried for at least another 12 months.

11. Following this decision Mr Wakeman was transferred to the Metropolitan Remand and Reception Centre [the MRRC]. He was placed into protective custody due to his fear of being assaulted by other inmates. Mr Wakeman was housed in pod 18, cell 552. On 1 June 2019, another inmate was moved into the same cell with Mr Wakeman. There were no reported incidents between them.

Mr Wakeman's health and treatment in custody

12. Mr Wakeman had a long history of alcohol and polypharmacy abuse, including methamphetamine, cannabis and benzodiazepines. As noted, he also had a known history of acquired brain injury and cognitive impairment.

13. In addition, Mr Wakeman suffered a number of medical conditions. These included chronic pain, erythromelalgia (a vascular disorder), chronic obstructive airways disease secondary to smoking, Tourette's disorder, substance-induced mood disorder, and cheilitis granulomatosis which is a lip disease. He had previously undergone an olecranon bony spur removal in 2016 and had liver cirrhosis.

14. On 8 December 2016, during a time when he was not in custody, Mr Wakeman overdosed on opiates and was involved in a motor vehicle accident. He suffered a cardiac arrest secondary to opiate overdose and respiratory arrest. He was taken to John Hunter Hospital Newcastle where his condition improved following a parenteral naloxone injection.

15. On 30 January 2017 a medical emergency was called for Mr Wakeman in custody, as he was suffering chest pain. He described feeling chest tightness as well as pins and needles in his fingertips. He explained that he had

previously been on gabapentin medication for nerve pain but that he had not taken this medication since being in prison. Gabapentin is a controlled medication in prison and prescriptions often need to be reviewed for clinical appropriateness.

16. An electrocardiogram of Mr Wakeman's heart was performed, which showed no acute changes but did show evidence of a resolving cardiac injury following his cardiac arrest the previous year. Mr Wakeman's cardiac chest pain and symptoms had resolved during the review, and it was considered that the feeling of tightness was secondary to anxiety or withdrawal from drugs or medication.

17. Mr Wakeman had been reviewed by the visiting General Practitioner [GP] on 23 February 2017. He was prescribed gabapentin, and Seretide for his chronic obstructive pulmonary disease. His heart sounds were found to be normal and his chest was clear, and all other clinical observations were normal.

18. On 29 January 2019 Mr Wakeman was found with stockpiled medication in his cell, and as a result he was placed on supervised medication. Throughout May 2019 Mr Wakeman was reviewed by mental health nurses and psychiatrists in preparation for his upcoming Mental Health Review Tribunal hearing. The Tribunal was advised that Mr Wakeman was unlikely to become fit to stand trial.

19. Mr Wakeman requested to see a doctor on 30 May 2019, due to backpain that was radiating down to his leg. He was put on the waitlist to see a GP and was given Neurofen for the pain.

20. During a mental health review on 7 June 2019, a clinical note was made that Mr Wakeman was limping when walking due to pain from his back to his knee. The possibility was raised this may have been due to sciatica, as he had a history of back surgery. It was confirmed that Mr Wakeman was already on the waitlist to see a GP.

21. On 6 June 2019, Mr Wakeman had a telephone conversation with his mother and his sister Lynne. He told them that his leg had been hurting and that he still hadn't seen a doctor. In her statement, Lynne said that her brother had been very upset about the pain.

22. At the time of his death, Mr Wakeman was on a 'semi-urgent' GP waitlist to review his pain management medication. The expected wait time for this kind of appointment was 3-14 days, and Mr Wakeman had been on the list for 12 days. He was also on the Primary Care Nurse waitlist for a chronic disease screen for his lung disease, the Adult Ambulatory Mental Health Waitlist for his routine quarterly metabolic monitoring, and the waitlist to see a psychiatrist for his six-monthly mental health review.

The circumstances of Mr Wakeman's death

23. On 9 June 2019 an unrelated incident caused Mr Wakeman's area to be locked down. CCTV footage showed Mr Wakeman exiting his cell at 1.46pm and leaning on the guard rail of the landing outside his cell. At 1.47pm he returned to his cell, and his cellmate joined him a short time later. The cell was then secured by a correctional officer.

24. According to CCTV footage, at 2.08pm correctional officers looked through the window of Mr Wakeman's cell as part of their head check duties. Nothing unusual was reported. The cell light was turned off at 3.21pm. There were no recorded emergency call button activations from Mr Wakeman's cell.

25. At 6.08pm, a Justice Health Registered Nurse and three correctional officers entered Mr Wakeman's cell and gave medication to his cellmate. The nurse then called out Mr Wakeman's name several times, but she received no response. The cellmate told them: '*He has been asleep all day'.*

26. One of the correctional officers then shook Mr Wakeman's shoulder and called out his name. The officer noticed Mr Wakeman's eyelids flutter, but he did not otherwise respond.

27. A medical response was immediately called and the nurse commenced CPR. The medical response team arrived at 6.15pm, followed by NSW Ambulance paramedics at 6.33pm. Mr Wakeman could not be revived, and he was pronounced deceased at 6.40pm.

28. Police interviewed Mr Wakeman's cellmate. He told them it had been a normal day. Mr Wakeman was drowsy which was not unusual with his medication. He had sat on the edge of his bed for twenty minutes before lying down and going to sleep. The cellmate heard Mr Wakeman snoring after they had been locked in. In his experience, it wasn't unusual for Mr Wakeman to snore loudly and then sleep quietly for a period. At some point Mr Wakeman had stopped snoring that evening, but his cellmate didn't take any notice as this was not unusual

29. Mr Wakeman's cellmate also told police that when the nurse came to open the door, he had turned on the cell light and tried to wake Mr Wakeman up by shaking him on the arm and saying: '*Oi, Stefan, pills, pills',* but he had not responded. He was lying on his side facing into the middle of the cell. His cellmate recalled being able to see Wakeman's chest rising and falling earlier in the afternoon, but the cell had become too dark to see anything by the time of the evening medication round.

30. Mr Wakeman's cellmate had not noticed anything unusual in Mr Wakeman's behaviour that day or in the lead up to his death.

31. At 8.20pm that evening NSW Police arrived, and Mr Wakeman's cell was secured and searched. Inside Mr Wakeman's shorts pocket they found four yellow-coloured capsules, which were later identified as gabapentin. This was one of Mr Wakeman's prescribed medications.

32. There were no injuries on Mr Wakeman's body, nor any evidence to suggest a struggle.

The cause of Mr Wakeman's death

33. An autopsy was performed by forensic pathologist Dr Istvan Szentmariay. On examination, Mr Wakeman's major coronary arteries showed up to 40-50% narrowing due to calcific atherosclerotic changes. Microscopic evaluation showed even more severe narrowing by up to 70-80% of one of the major coronary arteries supplying the heart muscle.

34. An examination of Mr Wakeman's lungs showed emphysema, very early pneumonia and mild changes of the airways. These features are frequently seen in patients with bronchial asthma. Toxicology showed no detectable alcohol, and potentially non-toxic levels of methadone, clozapine, mirtazapine and quetiapine. Traces of ibuprofen and diclofenac, which are used to treat pain and inflammatory diseases, were reported. Additional toxicological testing was performed, which showed a non-toxic level of gabapentin.

35. Dr Szentmariay concluded that the cause of Mr Wakeman's death was ischaemic heart disease. He noted that the medications detected have known side effects, however there was no toxicological cause of death identified. There were also no suspicious internal or external findings identified.

36. Mr Wakeman did not have any formal diagnosis of ischaemic heart disease prior to his death. For this reason, Dr Szentmariay was asked to consider whether there was any link between his ischaemic heart disease, and the leg and back pain which he had been reporting in the weeks leading up to his death. This was a matter of some concern to Mr Wakeman's family.

37. Dr Szentmariay found no convincing evidence that Mr Wakeman's leg and back pain was a symptom of pre-existing ischemic heart disease. Dr Szentmariay explained that aspects of Mr Wakeman's extensive clinical history may have predisposed him to the development of ischemic heart disease. This condition could have remained clinically silent without presenting any symptoms. Dr Szentmariay noted that in 1-2% of cases, sudden death may be the first sign of ischemic heart disease. He commented further that some drugs used in the treatment of mental illness such as those prescribed to Mr Wakeman, are associated with an increased risk of cardiac arrythmia.

38. On the basis of the above medical evidence, I find that the cause of Mr Wakeman's death was ischemic heart disease. There is no evidence that another person caused Mr Wakeman harm, or that his death was caused by an accident or other form of misadventure. The manner of his death was by natural causes.

Was Mr Wakeman's care and treatment at MRRC adequate?

39. The evidence does not disclose any deficiency in the medical care given to Mr Wakeman which may have caused or contributed to his death. Overall, his health problems were properly managed during his time in custody, and appropriate decisions were made and implemented about his medical treatment.

Conclusion

40. On behalf of the coronial team I offer my sincere and respectful condolences to Mr Wakeman's family. I hope that this inquiry and inquest has reduced their concerns about his death.

41. I also acknowledge the assistance I have received from Coronial Advocate Sergeant Amanda Chytra, and the officers of NSW Police Force who conducted the coronial investigation.

Findings required by s81(1)

42. 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 Stefan Wakeman born 26 August 1963.

Date of death:
Stefan Wakeman died on 9 June 2019

Place of death:
Stefan Wakeman died at the Metropolitan Remand and Reception Centre, Silverwater NSW

Cause of death:
Stefan Wakeman died as a result of ischaemic heart disease.

Manner of death:
Stefan Wakeman died as a result of natural causes while in custody.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner

Date
23 August 2023