



**CORONERS COURT
OF NEW SOUTH WALES**

Inquest:	Inquest into the death of Frank Dwayne Coleman
Hearing dates:	16 July 2025
Date of Findings:	22 October 2025
Place of Findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	State Coroner, Magistrate Teresa O'Sullivan
Catchwords:	CORONIAL LAW – Death in custody – s 23 – Long Bay Correctional Facility – First Nations – methadone – overdose
File number:	2021/196736
Representation:	Counsel Assisting: Dr Peggy Dwyer SC, instructed by Charlotte Ward, NSW Crown Solicitor's Office. Family of Frank Coleman: Ms Jacklyn Dougan-Jones, instructed by Dr Diana Shahinyan of Aboriginal Legal Service. Counsel for Corrective Services NSW: Ms Jillian Walshe, instructed by Mr Phillip Nixon of the NSW Department of Communities and Justice. Counsel for the Justice Health & Forensic Medicine Network: Mr Jake Harris, instructed by Mr Benjamin Ferguson of Hicksons Lawyers.
Protective orders	Non-publication orders made pursuant to s 74 of the <i>Coroners Act 2009</i> and/or the incidental powers of the Court apply in this matter and are available on the Court file.
Findings:	Identity: The person who died is Frank Coleman. Date of death: Mr Coleman died between 8:00pm on 7 July 2021 and 5:24am on 8 July 2021. Place of death: Mr Coleman died at the Metropolitan Special Programs Centre at Long Bay Correctional Complex.

	Cause of death: The cause of Mr Coleman's death is methadone toxicity. Manner of death: Mr Coleman's death occurred after consuming methadone that was supplied to him by another inmate.
Recommendations:	To the Chief Executive, Justice Health and Forensic Mental Health Network NSW (Justice Health)/ the Commissioner, Corrective Services NSW 1. Justice Health, in coordination with Corrective Services NSW, review the models of care and resourcing of Drug and Alcohol assessments for the commencement of opioid agonist therapy (OAT), with a view to increasing access and capacity, and a. Produce a joint report estimating unmet need in the public jail system and outlining the optimum wait time b. Produce a joint mapping report indicating what resources would be necessary to achieve the optimum wait time (including staffing and infrastructure needs) 2. Justice Health, in coordination with Corrective Services NSW: a. assess the viability of Drug and Alcohol reviews being conducted via telehealth, including in-cell, and if deemed viable b. trial providing Drug and Alcohol reviews by in-cell telehealth

Introduction

1. This inquest concerns the death of Frank Dwayne Coleman.
2. Mr Coleman was a First Nations man who was 43 years old at the time of his death which occurred at some point between 8:00pm on 7 July 2021 and 5:24am on 8 July 2021.
3. He died of methadone toxicity, after being supplied with diverted methadone by another inmate, [REDACTED].
4. At the time of his death, Mr Coleman was in the lawful custody of Corrective Services NSW at the Metropolitan Special Programs Centre (**MSPC**) at Long Bay Correctional Complex, at Malabar NSW.
5. Mr Coleman was a much-loved son, father, former partner, and brother and was survived by four of his five children. Many of his family members attended the inquest and it was clear that despite the difficulties Mr Coleman and his family faced, his family and former partner, Skye Hipwell, continued to love and support him.
6. On behalf of the Coroners Court of NSW I acknowledge the grief felt by Mr Coleman's family and friends as a result of his death and offer my sincere condolences for their loss.

The role of the coroner and the scope of the inquest

7. A coroner is responsible for investigating all reportable deaths. The investigation is conducted primarily so that the coroner can make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to make findings as to the manner and cause of the person's death. A coroner may make recommendations, in relation to any matter connected with the death where the coroner considers it necessary or desirable, in relation to matters that have the capacity to improve public health and safety.
8. It should be noted that when a person dies in custody in NSW, it is mandatory that an inquest is held. The inquest must be conducted by a senior coroner. When a person is sentenced to a term of imprisonment, they are lawfully detained in the custody of Corrective Services NSW until their sentence has been served. Prisoners are a vulnerable group in the community, particularly because during the period of detainment, Corrective Services NSW assumes responsibility for their care, as the person is unable to independently take steps to seek medical assistance or other care.
9. I acknowledge that this vulnerability was particularly exacerbated during COVID-19 as there was restricted access to family members and the conditions were harsher than usual given

the need for infection control. I acknowledge that this would have been difficult for Mr Coleman and other inmates during this time.

10. The coronial process represents an intrusion by the State into what is usually one of the most traumatic events in the lives of those who have lost someone close to them. An inquest by its very nature involves the family and friends of a deceased person having to re-live events often several years after their loved one's death, and to do so in a public forum. I acknowledge that this is an entirely foreign, and sometimes distressing experience for those who are dealing with the loss of someone they loved.

The inquest

11. An inquest is a public hearing, held as the final part of an investigation into the circumstances of a person's death. In Mr Coleman's case, it was the culmination of a process that began when his death was first notified to the coroner on 8 July 2021.
12. Much of the material gathered during the investigation into Mr Coleman's death was tendered at the commencement of the inquest in the form of a nine-volume brief of evidence compiled by the officer in charge of the coronial investigation, Detective Senior Constable Felicity Smith, and the Crown Solicitor's Office. At the inquest, the Court heard evidence from Mr Craig Cooper (Service Director, NSW Justice Health and Forensic Mental Health Network (**Justice Health**)).
13. While I am unable to refer specifically to all the documentary and oral evidence in detail in my findings, it has been comprehensively reviewed and assessed.
14. A list of issues was prepared before the inquest commenced. These issues guided the coronial investigation and shaped the conduct of the inquest. At the same time, the assisting team compiled a summary of facts in relation to Mr Coleman's background and death. That final document was circulated to the parties who were asked for their input or comment. A final 'Agreed Facts' document was produced and was tendered during the inquest. I accept that this document accurately summarises much of the important evidence before me. I adopt its content and have incorporated it into my written reasons.
15. The issues identified in the coronial investigation to be explored in the inquest follow.
 - i. Mr Coleman's medical cause of death was methadone toxicity. How was Mr Coleman able to obtain a lethal dose of methadone, given that he was not on methadone replacement therapy?
 - ii. Are there adequate systems in place to prevent the diversion of methadone in custody and in this case, what was the available intelligence that **DJ** was diverting methadone, and was sufficient action taken in response?

- iii. Did Mr Coleman have any underlying medical condition that made him more susceptible to methadone overdose?
- iv. Given Mr Coleman's history of drug addiction, should he have been offered drug replacement therapy and/or any other form of treatment?
- v. Are there any recommendations related to Mr Coleman's death that should be made, for example, access to drug treatment programs or restricting the ability of prisoners to obtain methadone from fellow inmates?

Mr Coleman's personal background

- 16. Mr Coleman was born in Dubbo on 21 September 1977. His mother, Lurlene Langlo, passed away prior to Mr Coleman's death, and Mr Coleman was survived by his father Robert Coleman and his older sister, Katrina Coleman.
- 17. Mr Coleman was the father of five children, four of whom survive him. He was a teenager when the first two, Samantha and later Ayla were born, and he was not heavily involved in their upbringing. Mr Coleman then met Skye Hipwell and together, they had three children, Ricardo Coleman (born 1995 – now passed), Lakota (born February 1999) and Dominic (born January 2001).
- 18. Mr Coleman's mother died in 1981, at which point he and his sister lived with a carer at a Women's Refuge in Kingswood until moving back in with their father.
- 19. Mr Coleman attended Whalan High School, although he had periods of non-attendance and suspension and ultimately ceased attending High School in 1991, when he was 14 years of age.
- 20. In 1994, Mr Coleman commenced a relationship with Ms Skye Hipwell (nee Foyle). Throughout Mr Coleman's latter teen and early adult years, he lived with Ms Hipwell and later their children at several residences throughout the northwestern and western suburbs of Sydney. There were periods where, because of challenges associated with Mr Coleman's drug and alcohol use and consequent behaviour, he moved back in with his father or lived with friends.
- 21. In 1995, whilst serving a term of imprisonment at Mt Penang Juvenile Justice Centre, Mr Coleman engaged in schooling and prior to his release from custody, was accepted to the University of Western Sydney. After his release, he commenced studies at University of Western Sydney, however ceased shortly afterwards.
- 22. Mr Coleman's son, Ricardo Coleman, died on 11 November 2016 from a fatal gunshot wound. This is said to be the catalyst for Mr Coleman's relapse into drug use.

Mr Coleman's drug and alcohol use

23. In 1991 (aged 14), Mr Coleman commenced using alcohol, tobacco and cannabis.
24. In 1994, at the age of 17 years, Mr Coleman commenced using heroin. During this time, Mr Coleman was admitted to a number of rehabilitation centres including Bennelong's Haven and Oolong House, and was a participant of the Methadone Maintenance Therapy Program (**MMTP**).
25. From 2003, Mr Coleman abstained from heroin for a period of three to four years, however in 2006 his alcohol intake increased and in 2007, he re-commenced heroin use. From 2007, Mr Coleman again attended various drug rehabilitation centres and resumed the MMTP, managing to become heroin free at some stage between 2007 and 2016, however during this period he commenced methamphetamine use. After the murder of his son, Ricardo Coleman in 2016, Mr Coleman's drinking and methamphetamine use increased, which continued until his arrest in 2020.

Mr Coleman's criminal history

26. Mr Coleman was charged with 45 offences between the years 1990 and 2020. There are no recorded charges for Mr Coleman between February 2009 and November 2018.
27. Mr Coleman was sentenced to six control orders for periods in juvenile detention and 11 terms of imprisonment in adult detention. Two matters were dealt with under s 32 of the *Mental Health Act*.
28. On 9 May 2020, Mr Coleman was arrested and charged with domestic violence offences involving his then de facto partner. At the time of his arrest for those offences, he was on bail in respect to two unrelated matters (*contravene AVO and damage property and Resist police, damage property, aggravated enter dwelling*).
29. Mr Coleman was refused bail by police and the court and entered the custody of Corrective Services NSW on 9 May 2020 at Amber Laurel Correctional Centre (May 2020) before being transferred to Parklea Correctional Centre (May – June 2020), Wellington Correctional Centre (June – September 2020), Metropolitan Special Programs Centre (September – December 2020), Cooma Correctional Centre (December 2020), Goulburn Correctional Centre (December 2020) and finally Metropolitan Special Programs Centre, Long Bay (December 2020 – July 2021).
30. On 7 June 2020, Mr Coleman was sentenced for the abovementioned domestic violence and contravene AVO and damage property offences. He was given a 13-month overall term of imprisonment, with a non-parole period of 7 months, which commenced 9 May 2020.

31. On 1 December 2020, Mr Coleman was sentenced for the charge of resist police, damage property, aggravated enter dwelling, commencing 23 October 2020 (partially concurrent with the earlier term) and concluding 22 July 2023, with a non-parole period of 1 year and 5 months, which was due to expire on 22 March 2022.

Health issues

32. Mr Coleman had a complex medical history, which included diagnoses of chronic schizophrenia, abuse of alcohol and multiple drugs including methamphetamine, heroin and cannabis, cardiomyopathy, congestive cardiac failure, gastro-oesophageal reflux disease (**GORD**), hepatitis B, hepatitis C, hepatitis D, hypercholesterolaemia, hypertension and thiamine deficiency.
33. Between 2002 and 2003, Mr Coleman was diagnosed with paranoid schizophrenia and was medicated with Zyprexa. Mr Coleman was non-compliant with medication for certain periods, resulting in deterioration and admission to mental health facilities. Between 2002/2003 and 2019, he was admitted on four or five occasions to Cumberland Mental Health and/or Nepean Hospital Mental Health Units.
34. Mr Coleman reportedly survived a myocardial infarction (a heart attack) while undergoing shoulder surgery at Westmead Hospital. Mr Coleman was then reported to have ongoing heart issues and was admitted to Blacktown Hospital in 2017 or 2018 because of this.
35. At the time of his death, Mr Coleman was prescribed the following medications for treatment of his medical and mental health conditions: Aripiprazole 15mg, once per day; Atorvastatin 10mg, once per day; Bisoprolol 2.5mg, once per day; Entresto (sacubitril / valsartan) 49mg / 51mg, once per day; Escitalopram 10mg, once per day; Europagliflozin 10mg, once per day; Metformin 500mg, once per day; Rabeprazole 20mg, once per day; and Spironolactone 12.5mg, once per day. These medications were provided and supervised by Justice Health, and it appears that Mr Coleman was compliant with the provision of these medications.

Medical care in custody

Requests for Medical Assistance

36. There were numerous occasions where Mr Coleman presented to the medical/health clinic of the correctional centre he was housed within and/or submitted the Patient Self-Referral Form (**PSRF**) to be seen by nursing staff. These presentations and referrals related to symptoms including (but not limited to) bilateral pain in feet, legs, arms, chest, shortness of breath and growing stomach (a build up of fluid in the abdomen or ascites). Mr Coleman appeared to have repeated concerns about his heart.

37. On 24 March 2020, clinical notes indicate that Mr Coleman was abstinent from ice use until his son's death, and had a prior history of using methadone to cease heroin use approximately 18 years prior. He reported that he had managed to stay out of gaol for years by ceasing substance use, having stable relationships and regular attendance at church. He sought medication for anxiety and wanted to go to "rehab, not return to same domestic situation".
38. On 30 March 2020, a Mental Health Assessment noted that Mr Coleman had a 20 year history of heroin use, and was currently using crystal methamphetamine, however, no mental health history was reported. Further medical conditions including heart failure, cirrhosis of liver, GORD and myocardial infarction were noted, and Mr Coleman was referred to the psychiatrist and waitlisted for a routine medication review.
39. On same date, a forensic psychiatrist report was completed by Dr Gordon Elliott in response to a Judicial Request dated 20 January 2020 as Mr Coleman was suspected of being a mentally ill person. He was confirmed not to be a mentally ill person, however it was noted that Mr Coleman had chronic schizophrenia. Further, the following was noted:
- "Mr Coleman's mental state does appear to have deteriorated with a relapse into illicit substance use, although it does not appear that he has suffered a frank relapse of psychosis. His substance use has led to a return of volatile behavioural problems and relationship conflict, along with aggressive behaviour."
40. On 31 March 2020, Mr Coleman was released from custody.
41. On 9 May 2020, Mr Coleman was arrested and taken back into custody, and was admitted to Amber Laurel Correctional Centre. On 10 May 2020, a Health Problem Notification Form (HPNF) was completed which noted Mr Coleman's cardiac issues, and pain to his chest, neck, jaws, arms, shoulders and fingers.
42. On 11 May 2020, during an Intake Screening Questionnaire at Parklea Correctional Centre, Mr Coleman reported that he was concerned about his heart medication, as he had not received it.
43. On 10 June 2020, Mr Coleman completed a PSRF, stating "I need my heart checked ASAP and my diet [illegible] checked" (while at Wellington Correctional Centre).
44. On 11 June 2020, Mr Coleman further presented to the Justice Health Clinic with "chest pain"; however, he then advised he did "not have chest pain", and had gone to the Clinic for his "sore feet". He was given Tubigrip to reduce the pressure on his feet and encouraged to elevate his legs.

45. On 12 June 2020, Mr Coleman submitted a PSRF and complained of “constant headaches”, requesting to see the optometrist, and on 23 June 2020, he was seen by a medical officer who recorded that he complained of “tightness of chest for a week”, and constant feet ache and headache.
46. In July 2020, Mr Coleman had further complaints regarding his heart. On 6 July 2020, he completed a PSRF, stating he was “put on a psych medication which messes with my heart rythem [sic] and gives me pains in the chest”.
47. On 11 July 2020, Mr Coleman presented to the Clinic with chest pain, and stated the pain was felt “directly under armpit”. He was transferred to Dubbo Base Hospital for further review, but discharged on 12 July 2020, with a note that he had “no issues”. He was to be reviewed with results of his chest ECG and was advised to return if warning signs presented.
48. On 12 July 2020, records indicate that Mr Coleman was awaiting a cardiology appointment which was to occur in October 2020. On the same date, a HPNF was completed which noted Mr Coleman’s cardiac issues, and placed him in a two-out, lower floor cell placement with access to Justice Health.
49. On 25 August 2020, a PSRF completed by Mr Coleman recorded that he was worried about his weight and fluids, particularly because of his heart condition.
50. On 1 October 2020, Mr Coleman completed a PSRF requesting to know the outcome of his x-ray, as it was an “important outcome on this heart issue”. It was noted that the result of this echocardiogram was not yet available, and he was waitlisted for review by a general practitioner.
51. In 2021, Mr Coleman completed a number of PSRFs seeking medical assistance. In particular, he requested assistance with his legs and feet. On 3 January 2021, he wrote “my legs ach [sic] all the time”, and on 2 April 2021, he requested an appointment regarding a “suspicious looking mark (discoloured) on the outside of [his] left foot”. On 6 May 2021, Mr Coleman noted that both of his feet hurt and requested to see the doctor to arrange “proper fitting footwear”. On 22 June 2021, Mr Coleman noted “the bottom of my feet ache continuously and during walking”. On 2 July 2021, Mr Coleman completed a PSRF, requesting to see the doctor as he hurt his knee and was in pain.

Special Management Area Placement and Risk Intervention Team Protocol

52. While Mr Coleman was in custody, he was placed on several Risk Intervention Team (**RIT**) management plans. This includes on 29 February 2020, due to threats of self-harm (at John Morony Correctional Centre), and on 1 March 2020 for “bizarre behaviour, aggression, agitation, inappropriate talking to self, poor personal hygiene, isolative behaviour”.

53. On 27 June 2020, Mr Coleman said he feared for his safety and wanted protection. A Special Management Area Placement (**SMAP**) protection form was approved, and Mr Coleman was moved to Area 1.
54. On 1 October 2020, Mr Coleman advised he could no longer guarantee his safety and was placed on the RIT protocol. He was moved to an observation cell under RIT conditions.
55. On 3 December 2020, Mr Coleman was discharged from the RIT plan as he said that he could “guarantee his safety and others”. He was placed in a two out cell on the ground floor.
56. On 17 December 2020, Mr Coleman presented to the Cooma Correctional Centre Clinic and advised he couldn’t guarantee his own safety in a normal cell placement. He was subsequently placed on a RIT plan. The RIT plan indicates Mr Coleman was “worried, acting strangely, uncertain as to why he was placed at Cooma CC”, and had “thoughts of self harm and suicide”. He requested to be placed in a camera cell. He was subsequently placed on an active RIT in the MPU observation cell under 24-hour camera observations.
57. On 19 December 2020, Mr Coleman was discharged from the RIT plan. He requested to “sign back into SMAP” as he feared for his safety. He was therefore housed as a SMAP inmate following his discharge.
58. On 21 December 2020, Mr Coleman refused to sign off the SMAP and threatened self-harm.

Requests for access to Opioid Agonist Treatment/Opioid Treatment Program

59. On 4 March 2021, Mr Coleman completed and submitted a PSRF requesting inclusion on the Opioid Agonist Treatment/Opioid Treatment Program (**OAT/OTP**) program, citing “...nightmares about my drug addiction and want to go on either the methadone or bupe programme”, which he said would be “suitable for my heart condition”. He wrote “I am stressed and anxious all the time and I want to be stable for my release”.
60. On 5 March 2021, Mr Coleman completed and submitted a PSRF wanting “help with sleep” requesting a “one-out cell due to paranoia and health conditions (heart issues)”, and “wanting program (methadone) to help cope”.
61. On 5 March 2021, Mr Coleman was seen by Corrective Services NSW psychologist Ms Lillian Ma who recorded that Mr Coleman:

“expressed a desire to be put on a ‘program’, upon prompting he did not mean a program like RUSH or EQUIPS but methadone, which he claimed would manage his ‘depression and anxiety’”.
62. During this session, Ms Ma “assisted Mr Coleman in completing a JH referral due to his illiteracy, listing his request for a one-out, sleep problems, and mental health”. The progress

note further indicates Mr Coleman was to submit the Justice Health referral and notes "Author to email JH advising he may benefit from medication review due to observed symptoms".

63. On 19 March 2021, Mr Coleman completed a PSRF, in which he wrote "I am still waiting to hear about getting into the Bupe or methadone Programs. I am very, very stressed about the situation. I wrote to you a month ago and I still haven't heard anything".
64. On 22 March 2021, Mr Coleman was seen by Corrective Services NSW psychologist Ms Ma as he requested assistance with his anxiety. The records indicate Mr Coleman was not open to discussing coping strategies and declined the techniques offered. The notes indicate "he appeared fixed on getting into a 'methadone' program which he believed would aid his anxiety however would then state of his own accord that he would not be able to receive it due to his liver problems". The case note indicates that Ms Ma had previously emailed Justice Health regarding his concerns.
65. On 6 April 2021, a Drug and Alcohol Clinical review was conducted by Dr Caran Cheung who recorded that Mr Coleman:

"wishes to commence Oat to prevent relapse into opioid use on release from custody. Denies substance use this custody. Cravings for CMA use mainly as he has poor venous access he is craving for heroin less. However thinks he would use if supply was abundant. Prior custody (years ago) he had used IV heroin and smoked non-prescribed Suboxone. Shared injecting equipment".
66. On the basis of her review, Dr Cheung formed the impression that Mr Coleman had a history of opioid use disorder but that he had been abstinent from opioid use whilst in custody for 1 year. There was no evidence of acute intoxication or withdrawal syndrome.
67. At the conclusion of the review, Mr Coleman was agreeable to Nyxoid nasal spray on release. The management plan formulated by Dr Cheung included "review again in 6/12 closer to release date to consider OAT initiation pre-release".
68. On 16 April 2021, Mr Coleman requested to sign off SMAP so he could be moved to another gaol and complete the Involuntary Drug and Alcohol Treatment Program (**IDAT**) program.
69. On 19 April 2021, Mr Coleman saw Corrective Services NSW psychologist Ms Ma for psychological review. The progress notes indicate Mr Coleman wished to stay abstinent from drugs and relapse prevention strategies were discussed.
70. On 28 April 2021, Mr Coleman made a further request for access to OAT to Forensic Psychiatry Registrar Ola Kansour. He indicated he was "paranoid about people when he was using drugs" and asked to see the Drug and Alcohol team for opioids replacement therapy.

He said he was “still craving drugs” and that he was “dreaming about using them while asleep”.

71. On 4 May 2021, Mr Coleman requested to be classified as a C3 so that he could “attend a Drug and Alcohol Rehabilitation Programme in the Community”.
72. On 30 June 2021, Mr Coleman presented to the Long Bay Clinic where he described symptoms experienced in respect to his medical conditions (bilateral pain in feet/ growth of ascites) and requested opiate medications for treatment. This request was refused.

Last movements of Mr Coleman

Events of 6 July 2021

73. At some point between 7:00am and 12:00pm on 6 July 2021, Mr Coleman knocked on the cell door of another inmate, [REDACTED] in cell 6, and asked [REDACTED] whether there was any buprenorphine available in Wing 17. [REDACTED] informed Mr Coleman that there wasn't any buprenorphine, but there was “drink”.
74. Mr Coleman asked [REDACTED] whether he could get one, to which [REDACTED] replied, “Nah. I think my celly does them”, in relation to inmate [REDACTED]. Mr Coleman then requested [REDACTED] ask [REDACTED] “do a drink for him”.
75. [REDACTED] told Mr Coleman that he did not need the “drink”, to which Mr Coleman told [REDACTED] that he had been a heroin addict for nearly 30 years and could handle it.
76. On same date, Mr Coleman, [REDACTED] and [REDACTED] were in the storeroom, nearby the Correctives Office. Mr Coleman asked [REDACTED] for “drink”, to which [REDACTED] agreed to provide him with “half a drink for a cigarette”. [REDACTED] advised he would give the “drink” to Mr Coleman the following morning, in the storeroom.
77. Between 7:00am and 12:30pm, on 6 July 2021, Mr Coleman utilised the Offender Telephone System (OTS) to make 11 phone calls.
78. At 7:06am on 6 July 2021, Mr Coleman contacted his father, Robert Coleman, during which he asked whether Robert Coleman had contacted “Miss” or his grandchildren.
79. At 9:10am on 6 July 2021, Mr Coleman contacted Robert Coleman and asked him to deposit \$50 into his trust account for “buy up”.
80. At 9:47am on 6 July 2021, Mr Coleman contacted Robert Coleman and again asked for \$50 to be deposited into his trust account for “buy up”. Mr Coleman stated that he wanted to purchase toiletries at “buy up”. Robert Coleman refused to deposit funds.

81. At 10:31am on 6 July 2021, Mr Coleman contacted his daughter, Ms Mroziewicz, and asked her to deposit money into his trust account for “buy up”. They then discussed arrangements for Ms Mroziewicz to visit Mr Coleman at the Correctional Centre.
82. At 11:17am on 6 July 2021, Mr Coleman contacted his father requesting money for “buy up”.
83. At 11:53am on 6 July 2021, Mr Coleman contacted Dominic Coleman. During this conversation, Mr Coleman requested Dominic deposit money into his account for “buy up”. Mr Coleman was unable to speak with Dominic and the phone call disconnected.
84. At 12.30pm, Mr Coleman contacted his father and asked again for money to be deposited in his bank account for ‘buy ups’.
85. At some point that afternoon, Mr Coleman and ██████ agreed that Mr Coleman would have “a full drink”, in exchange for “another cigarette or bumpers or whatever”.
86. Between 5:00pm and 5:30pm, Mr Coleman and the other inmates in Wing 17 were in “lock in”. Mr Coleman and inmate ██████ were secured within Cell 8. At some time between 5 July 2021 and 6 July 2021, another inmate, ██████, was advised that Mr Coleman was looking for “drink”, and that he was going to get it from “██████”. It is presumed that “██████” refer to ██████ and ██████. ██████ and two other inmates attended ██████ and ██████ cell, and ██████ told them not to give Mr Coleman any “drink”, as he had a “bad ticker”. Both ██████ and ██████ promised that they wouldn’t give Mr Coleman any drink.

Events of 7 July 2021

87. At approximately 6:15am on 7 July, inmates were “let go” from their cells.
88. At approximately 7:00am on same date, Mr Coleman left Cell 8.
89. Between about 7:00am and 8:25am, the whereabouts of Mr Coleman is largely unaccounted, although at some point that morning, ██████ observed Mr Coleman in the yard.
90. Between 8am and 8:15am, ██████ “woke up to [██████] ... spewing”.
91. At 8:18am, Mr Coleman contacted his father by telephone.
92. Approximately five to ten minutes after ██████ overheard ██████ vomiting, Mr Coleman came to the door of Cell 6. ██████ and ██████ were present.
93. ██████ asked whether he wanted “tang” with it, which Mr Coleman declined. Mr Coleman consumed the first half of the “drink”.

94. Mr Coleman subsequently left Cell 6, and his whereabouts between 8:25am and 9:25am are unaccounted for.
95. At about 9:25am, Mr Coleman returned to Cell 6 and requested the second amount of "drink". Mr Coleman said words to the effect of "the first bit didn't do nothing".
96. ██████ told Mr Coleman to "wait for it to kick in", and that he did not need the second amount. However, Mr Coleman continued to request the second half. ██████ provided Mr Coleman with the remaining "drink", which Mr Coleman took.
97. At some point between 10am-11am, Mr Coleman spoke with his cellmate, ██████. Mr Coleman asked whether ██████ would like to go for a walk with him, which ██████ declined. ██████ says that Mr Coleman was acting strangely and while he was normally "laid back", during this interaction he was "buoyant" with "nervous energy, quicker speech and jerky movements".
98. At approximately 12:00pm, Mr Coleman was in his cell (Cell 8), seated on a chair, with sunglasses on and his arms and legs splayed. ██████ opened the cell door and asked him if he was well. Mr Coleman responded "yeah, yeah", and said he was cold. ██████ thought that Mr Coleman appeared 'high', that his appearance had changed, his speech was dazed and impaired.
99. Between 12:00pm-2:00pm, Mr Coleman's whereabouts are unknown.
100. At around 2:00pm, Mr Coleman exited Wing 17 and walked down the stairs into the yard for muster. While walking to muster, he coughed and spluttered, coughing up either phlegm or a piece of meat which connected with inmate ██████. Prior to or during muster, another inmate ██████ asked Mr Coleman whether he was well, to which he replied words to the effect of, "Yeah, I'm alright. I've just got the flu".
101. At the conclusion of muster Mr Coleman walked towards the stairs to Wing 17. According to ██████, Mr Coleman was unsteady on his feet and had to be helped up the stairs and into the wing. Mr Coleman continued along the lower ground corridor towards his cell. ██████ heard Mr Coleman coughing and spluttering behind him, and advised Mr Coleman that he needed to "go to the nurse". Mr Coleman appeared to disregard ██████ comment and continued walking to his cell.
102. ██████ followed Mr Coleman into Cell 8 and spoke with him. ██████ recalled Mr Coleman was "slow to respond". When ██████ asked whether Mr Coleman was well, Mr Coleman "grunted" in reply.
103. Between 2:00pm and 5:00pm, Mr Coleman left and entered Cell 8 several times. It is not known where he was in between leaving his cell.

104. At some time between 3:00 and 3:30pm, Mr Coleman and ██████ were within Cell 8. ██████ entered the cell and spoke to Mr Coleman. Mr Coleman was standing over the sink and was unable to raise his head. It is unclear whether Mr Coleman had vomited. ██████ said to Mr Coleman, "It's strong isn't it mate". ██████ advised ██████ that ██████ had "sold to [Mr Coleman]", however did not advise what was sold.
105. Sometime after that, ██████ walked to ██████ and ██████ cell and asked ██████ what he could do to assist Mr Coleman. ██████ advised ██████ should "keep him awake".
106. At approximately 3:30pm on 7 July 2021, Mr Coleman attended the enquiries office, MSPC 3, where he asked Corrective Services Officer (CSO) Shiraz to confirm the balance of his trust account. CSO Shiraz noted that Mr Coleman presented as "stable" and his "usual self".
107. At 4:52pm, Mr Coleman called his son, Dominic. In this phone call Mr Coleman's speech was faster than in previous phone calls, and he appeared breathless at times.
108. Between 5:00pm and 5:15pm, Mr Coleman approached and entered Cell 6 and smoked a cigarette with ██████ and ██████. ██████ recalled he seemed "really stoned", and that he "didn't look well".
109. Shortly after this, Mr Coleman returned to his cell, and at some point between 5:30pm and 5:40pm, all inmates were 'locked in' to their cells. Mr Coleman and ██████ were secured within Cell 8.
110. Approximately 15 minutes later, Mr Coleman climbed down from his bunk, and vomited in the toilet. ██████ told Mr Coleman to return to his bed and lay down which he did. Sometime later, ██████ heard Mr Coleman snoring and he put his ear plugs in so that he could get some sleep.
111. About 8:00pm, ██████ heard a bed from within Cell 8 rock and shake against the wall. ██████ was housed in Cell 7 which is positioned next to and shared an adjoining wall with Cell 8. After he heard the bed rock and shake, he heard coughing like that he heard from Mr Coleman earlier that afternoon.

Events of 8 July 2021

112. At around 5:24am on 8 July 2021, ██████ awoke and went to the toilet. He observed vomit on the floor next to Mr Coleman's bed, and then on Mr Coleman's face. He shook him and found Mr Coleman to be unresponsive. At 5:24.26am, ██████ activated the knock up alarm, directed to the Gate, Area 2.

113. At 5:25:04am, CSO Khalil Mesann, positioned at the Gate, Area 2, answered the alarm. ■■■■■ is recorded as saying, "I'm in number 8 and my celly's not moving and it looks like his thrown up throughout the night". CSO Mesann contacted the office in Wing 17. Senior Correctional Officer (**SCO**) Mark Felsch answered and CSO Mesann informed him he had received a 'knock up' alarm from an inmate in Cell 8 and that he was informed that there was something wrong with the inmate's cellmate.
114. About 5:26am, SCO Felsch, CSO Clarke, CSO Cunningham, and CSO Encarnacion attended cell 8. CSO Cunningham unlocked the cell door, and SCO Felsch opened it.
115. SCO Felsch observed Mr Coleman lying on his bunk bed, with his head turned partially to his left. There was vomit and bile on the left side of his mouth, face and neck, on his bedding to the left of his face and neck and dripping from his bunk onto the floor. There was a large amount of vomit and bile on the floor.
116. On seeing Mr Coleman's body, officers immediately called for medical assistance on the radio. Registered Nurses from Justice Health arrived to assist and commenced CPR, which continued until the arrival of paramedics who, after assessment, declared him to be deceased.

Post-mortem examinations

117. On 13 July 2021, Dr Jennifer Pokorny conducted a post-mortem CT scan. The scan showed evidence of previous surgical fixation of the mandible and left proximal femur. The lungs appeared congested however no evidence of significant fluid overload such as large pleural effusions or ascites was apparent.
118. Toxicological analysis detected methadone in the blood at 0.41 mg/L, a level within the reported lethal range. Aripiprazole was detected at a supratherapeutic level, along with therapeutic type concentrations of citalopram, metformin and olanzapine. Low levels of atorvastatin and bisoprolol were also detected.
119. Ultimately, the conclusion reached by the pathologist was:
- "Based on the history and post mortem findings, in my opinion the direct cause of death is methadone toxicity. The deceased's pre-existing heart disease would have reduced his physiological reserve, making him particularly vulnerable to the effects of drug toxicity. Methadone use may also be associated with certain cardiac arrhythmias, and the specific features of the deceased's heart disease, namely the cardiac enlargement and fibrosis, would have increased his susceptibility to this. For these reasons, dilated cardiomyopathy with congestive cardiac failure is given as a significant contributing condition".

Issues

120. Counsel assisting provided a thorough opening address summarising the uncontested evidence that I have relied upon in these findings. I have reviewed all of the evidence and the submissions made by all of the parties and in all matters the conclusions in these findings are my own.

Issue 1 – Mr Coleman’s medical cause of death was methadone toxicity. How was Mr Coleman able to obtain a lethal dose of methadone, given that he was not on methadone replacement therapy?

121. Mr Coleman died shortly after consuming methadone that had been supplied to him by another inmate, [REDACTED]. [REDACTED] was subject to the Opiate Substitute Treatment program in custody. The means of effecting that supply was for [REDACTED] to regurgitate methadone that he had swallowed.
122. At approximately 6:15am on 7 July 2020, inmates were let go from their cells and at around 8:30am, Mr Coleman went to the cell of [REDACTED] and was supplied the first part of the methadone, by way of regurgitation. About 9:25am, Mr Coleman returned to Cell 6 and requested the second amount because he thought the first part didn’t do anything. [REDACTED] allegedly told Mr Coleman to wait for it to kick in and that he didn’t need the second amount, but ultimately, that second amount was provided.

Issue 2 – Are there adequate systems in place to prevent the diversion of methadone in custody and in this case, what was the available intelligence that [REDACTED] was diverting methadone, and was sufficient action taken in response?

Intelligence regarding [REDACTED]

123. [REDACTED] was subject to the Opiate Substitute Treatment program in custody.
124. On 12 January 2021, an extract from Justice Health progress notes reads:
- “OST review. Suspicious diversion of Methadone. Patient has been held in clinic for 20 mins. after dosing due to recent information from another inmate who accused Patient of diversion.’ Patient has not been caught as such. Patient denies diversion.”
125. On 19 January 2021, [REDACTED] was subject to a Drug and Alcohol review. During this review, he was advised about the consequences of diverting methadone and asked to follow instructions from nurses during his dosing.
126. [REDACTED] methadone dose was reduced from 160mg to 140mg daily. Part of the Drug and Alcohol review on 12 January 2021 included that [REDACTED] was held in the Clinic for 20 minutes after his dosing, due to suspicion of diversion. [REDACTED] was informed that he would

be observed closely. Corrective Services NSW officers were notified on 12 January 2021 that [REDACTED] would be held in the Clinic for 20 minutes after his dose was administered. There are no other records of [REDACTED] being held in the clinic after dosing on any other date. There is no documentation from Justice Health that shows communication between Justice Health staff and Corrective Services NSW regarding suspicion that [REDACTED] had diverted his methadone. There is no documentation within the records of Corrective Services NSW that notification of the suspicion of diversion was received.

127. At the time of Mr Coleman's death, [REDACTED] methadone dose remained at 140mg daily.

Response to [REDACTED] diversion of methadone

128. On 8 July 2021, [REDACTED] disclosed to the Long Bay Correctional Complex Manager of Security that he had diverted methadone to Mr Coleman the night prior. [REDACTED] said he was "being stood over for his methadone".

129. On same day, Registered Nurse Jessica McLoughlan was working at MSPC 2 Long Bay Correctional Centre where she reviewed [REDACTED]. [REDACTED] stated that he had diverted methadone the previous day.

130. On 9 July 2021, Dr Schwanz conducted a phone consultation with [REDACTED] in which he confirmed a history of methadone diversion after being stood over. He stated that he vomited up his methadone and gave it away to another inmate. [REDACTED] declined to provide the name of the inmate who took his methadone. He was advised that his daily dose of methadone would be reduced to 80mg daily from 10 July 2021 and then reduced by 10mg every second day until he was weaned off the program.

131. On 10 July 2021, [REDACTED] was recorded telling a family member during a phone call from custody that he "got stood over for some of me property and methadone...and the bloke that took the methadone ended up dying". [REDACTED] claims of being stood over appear in the context of:

- a. [REDACTED] not establishing on the balance of probabilities in his sentence proceedings, that there was any non-exculpatory duress;
- b. The statement of [REDACTED] that [REDACTED] received cigarettes in compensation;
- c. The report by [REDACTED] that he was aware of [REDACTED] diverting some four or five times in the period from the earliest date of 1 June 2021 to 8 July 2021.

132. On 13 July 2021, LBCC Manager of Security, Paul Coyne, issued a document entitled "Methadone Parades" which included instructions that all inmates who attend the methadone parade are required to remain at the dosing area for 15 minutes following their dose, not just inmates suspected of diversion.

133. On 16 November 2021, police attended the MRRC and offered [REDACTED] an opportunity to participate in a protected suspect interview. However, [REDACTED] advised he intended to obtain legal advice and did not wish to participate in an interview.
134. On 20 September 2024, Gartelmann J convicted [REDACTED] of “Supply prohibited drug – small quantity – T2”, and sentenced him to a Community Correction for a period of 2 years to commence on 20 September 2024, and expire on 19 September 2026.
135. In his evidence, Mr Craig Cooper said he would expect that there would be a written exchange of information between Justice Health and Corrective Services where an inmate was suspected of diverting, although noted that it may not always be the case.

Changes to Opioid Agonist Treatment/Opioid Substitution Treatment Service Delivery

136. The Justice Health Network Drug and Alcohol Service (**the Network**) provides risk assessment and medical management of intoxication and withdrawal from drugs and/or alcohol for all patients on entry to the custodial system.
137. The OAT Program is overseen by the Network Drug and Alcohol Directorate and delivered in collaboration with the Network Operations and Nursing Directorate.
138. At the time of Mr Coleman’s death, methadone was administered as part of the OAT program. Since Mr Coleman’s death, there has been significant change and re-structure to the OAT program, and since 2022, patients are routinely provided with a Depot Buprenorphine (Depot) treatment in preference to methadone.
139. In November 2018, the Network commenced the UNLOC-T Clinical Trial which assessed the feasibility and acceptance of Depot Buprenorphine in the correctional system. The trial was sponsored by NSW Health and was successful. It led to rapid implementation and increased access for inmates requesting opioid substitution treatment (**OST**).
140. From 3 June 2020, in order to minimise the diversion of Methadone concentrate, all [REDACTED]
[REDACTED]
[REDACTED]
141. As at January 2020, approximately 81% of patients who were receiving OAT were on methadone, 14% were on Suboxone, and 5% on Buvidal (Buprenorphine).
142. As at January 2022, approximately 24% of patients receiving OAT were on methadone, with the remaining 76% on Buvidal.
143. As at March 2024, of the 1,821 patients on OAT, approximately 14% (262) were receiving Methadone, with the remaining 86% (1,559) on Depot Buprenorphine.

144. As at 30 June 2025, of the 2,894 patients on OAT, approximately 8.5% (246) were receiving Methadone, with the remaining 91.47% (2,647) on Depot Buprenorphine. Mr Craig Cooper gave evidence that he expects the proportion of patients on Methadone will continue to decrease.
145. The Court received evidence that as Depot Buprenorphine is administered subcutaneously with the Buprenorphine dissolving under the skin, it is more difficult to divert.
146. Mr Cooper gave evidence that Justice Health works with Corrective Services NSW to try and avoid any methadone diversion. He stated that as soon as any diversion is suspected, there would be immediate communication between the clinic staff (those responsible for the OAT administration on the day), and the Corrective Services NSW officers so that they can communicate and keep an eye on the patient.
147. Mr Cooper further noted that as at the time of giving evidence, there were fewer instances of methadone diversion occurring annually than there were at the time of Mr Coleman's death, although noted the importance of continuing to offer methadone as a form of treatment to ensure continuation of therapy and maintenance.

Issue 3 – Did Mr Coleman have any underlying medical condition that made him more susceptible to methadone overdose?

148. Mr Coleman had pre-existing physical health issues including cardiomyopathy, congestive cardiac failure, gastro-oesophageal reflux disease, hepatitis, hypercholesterolaemia, hypertension and thiamine deficiency.
149. In his expert report dated 18 September 2022, Professor Paul Haber, Specialist Consultant Physician, noted that methadone, and other opioids, suppress breathing. Consequently, in respiratory failure, further suppression of respiration may be fatal. Methadone also causes central sleep apnoea and patients with this problem may be better suited to buprenorphine as a safer OAT option.
150. Professor Alison Jones, toxicologist, provided an expert report in this matter, in which she noted that given Mr Coleman's obesity (and likely risk of sleep apnoea and respiratory hypoventilation) and congestive cardiac failure, he was particularly at risk of respiratory depression from methadone. In her view, congestive cardiac failure could be considered as contributory to death from methadone. Evidence contained in the brief of evidence indicates that methadone is contraindicated when a person has prolonged cardiac arrhythmias. On the basis that Mr Coleman had a history of cardiomyopathy and congestive cardiac failure, Mr Coleman was more susceptible to complications arising from the use of methadone.

Issue 4 – Given Mr Coleman’s history of drug addiction, should he have been offered drug replacement therapy and/or any other form of treatment?

151. In his expert report, Professor Haber noted that he would have offered Mr Coleman access to OTP given a knowledge of his clinical status with multiple risk factors for overdose and given his repeated requests for OAT.
152. In his evidence, Mr Cooper said that Mr Coleman met the criteria to be placed on an opioid substitution program, including a past history of drug use, his Aboriginality, and comorbidity in terms of his mental health issues, and was much more likely to be placed on an opioid treatment therapy now than in 2020 given Buprenorphine is much more available. He further said that given Mr Coleman’s history of using ‘ice’, he would have been referred into the Brief Interventions and Groups (**BIG**) program, which is a four-week psychosocial program around relapse prevention, goal setting and managing cravings.
153. I find that given Mr Coleman’s history of drug addiction, he should have been offered drug replacement therapy or another form of treatment.

Issue 5 – Are there any recommendations related to Mr Coleman’s death that should be made, for example, access to drug treatment programs or restricting the ability of prisoners to obtain methadone from fellow inmates?

154. Having regard to the issues and evidence discussed above, senior counsel assisting acknowledged there had been significant changes and improvements undertaken at Justice Health in relation to the provision of OST/OAT programs, however noted there were still lengthy delays for inmates seeking to access these supports.
155. On the basis of the evidence given by Mr Cooper and the evidence contained in the brief of evidence, two recommendations were posed by Justice Health during oral submissions. These proposed recommendations were augmented by senior counsel assisting and are addressed to each to Corrective Services NSW and Justice Health jointly. I will consider each of the proposed recommendations below.

Proposed Recommendation 1

156. Justice Health, in coordination with Corrective Services NSW, review the models of care and resourcing of Drug and Alcohol assessments for the commencement of opioid agonist therapy (OAT), with a view to increasing access and capacity, and:
 - a. Produce a joint report estimating unmet need in the public gaol system and outlining the optimum wait time; and

- b. Produce a joint mapping report indicating what resources would be necessary to achieve the optimum wait time (including staffing and infrastructure needs).
- 157. Corrective Services NSW submitted that the recommendations should be addressed to Justice Health alone, and not include Corrective Services NSW as well. Corrective Services NSW submitted that while it is committed to progressing a solution focused outcome, the proposed changes to include Corrective Services NSW at the outset may cause some difficulty, particularly in respect of the preparation of the reports.
- 158. Corrective Services NSW further submitted that it supported the recommendation in principle, and was willing to review and comment on any proposed report, particularly in relation to the resourcing required to support secure access to health appointments. Corrective Services NSW submitted that it will not be able to provide input into the models of care and resourcing for drug and alcohol assessments or optimum wait times for drug and alcohol review, as this information will sit with Justice Health. It submitted that any input from Corrective Services NSW will relate to the resourcing required to ensure adequate security to meet the optimum timeframe put forward by Justice Health.
- 159. The family of Mr Coleman submitted that given infrastructure is allocated by Corrective Services NSW, its input is vital.
- 160. Justice Health agreed with the position of the family and submitted that the input of Corrective Services NSW into reports about future models of care is vital, as it controls the infrastructure within correctional centres, including locations where assessments may be conducted and technology.
- 161. Taking into consideration the evidence and helpful submissions, I accept that Corrective Services NSW input is vital in the implementation of this recommendation.
- 162. I intend to make this recommendation.

Proposed Recommendation 2

- 163. Justice Health, in coordination with Corrective Services NSW:
 - a. assess the viability of Drug and Alcohol reviews being conducted in-cell telehealth, and if deemed viable
 - b. trial providing Drug and Alcohol reviews by in-cell telehealth
- 164. In his evidence, Mr Cooper noted that Justice Health was operating at capacity in terms of the clinic hours that can be operated and that he was advocating for a trial of in-cell telehealth review assessments that would increase the clinic's capacity to offer OAT/OST programs. He proposed that this would primarily occur for patients' six-monthly or twelve-monthly

reviews and would only be facilitated where the patient had already gone through the initiation process, commenced treatment and were stable.

165. Mr Cooper noted that there are privacy concerns regarding Corrective Services NSW accessing this information by joining the consult, and in circumstances where a patient is in a shared cell. I acknowledge that the consent of the patient would be required in these circumstances.
166. Corrective Services NSW submitted that Strategic Delivery is supportive in principle to assessing the viability of in-cell telehealth for Drug and Alcohol reviews. However, it highlighted significant technological, infrastructure and security constraints that would currently make implementation impractical.
167. Corrective Services NSW further submitted that Statewide Operations is unsupportive of this recommendation, given the logistical constraints, physical environment, significant security and privacy concerns, and technological difficulties. It stated there are currently no technology solutions that would facilitate telehealth in-cell, and any solution would require infrastructure development or a new solution to be procured. Corrective Services NSW submitted that it currently does not have the capacity or funding to implement the recommendation.
168. The family advised they are supportive of the recommendation, however proposed some alternate wording.
 1. Justice Health, in coordination with Corrective Services NSW:
 - a. assess the viability of Drug and Alcohol reviews being conducted via telehealth, including in-cell, and if deemed viable
 - b. trial providing Drug and Alcohol reviews by in-cell telehealth
169. The family further noted that privacy of inmates is an important consideration when implementing a new system, and that at present, there are AVL rooms available across every prison which are used for legal visits. The family submitted that it may be that there is capacity for telehealth to operate by way of creating a new AVL room which would increase capacity for patients to be seen. They submitted that if the recommendation were drafted narrowly, then other options which may be viable would not be explored, although noted that this would not be known until telehealth is looked at as a viable option.
170. The family submitted that this is particularly relevant as Mr Coleman requested again to be seen by the drug and alcohol team for opioid replacement therapy on 4 May 2021 and was then placed on the waitlist to see a drug and alcohol nurse on 5 May 2021. There is no record at the time of his death that he was seen by that drug and alcohol nurse. In those

circumstances, and on the background of Mr Coleman's longstanding addiction and requests for OST, the family wish to see reduced wait times by any viable and safe means. The family wished to ensure that any move to telehealth is a means to increasing access to healthcare and reduce delays, and not to replace face-to-face consults.

171. Justice Health submitted it is supportive of the amendment proposed by the family, and agrees with and supports this recommendation. Justice Health further submitted that in response to the matters raised by Corrective Services NSW, the recommendation does not require implementation of a system where Drug and Alcohol reviews are conducted by telehealth. Instead, it recommends an assessment as to whether it would be viable to do so, and if viable, a trial.
172. Justice Health further raised that in exploring the viability of a telehealth or in-cell reviews, there may be difficult questions to resolve, such as: the logistics of implementing a new system; where, when and how an assessment could occur; the availability of resources including any new technology; the levels of health and custodial staff that are required; whether existing technology can be used; whether the available technology is compatible with systems used by Justice Health NSW; whether the statutory obligation to preserve patient confidentiality can be met; the anticipated cost; the patient experience; the costs and benefits of the proposal. Justice Health submitted that these matters would best be answered by a coordinated response between the two agencies, to ensure that any proposed solution is achievable from a health and custodial perspective.
173. Having regard to the evidence contained in the brief of evidence and the submissions of all parties, I consider that it is necessary for the recommendation to be made and the version as proposed by family is accepted.

Formal findings

174. As a result of having considered all of the documentary and electronic evidence, and the oral evidence given at the inquest, pursuant to section 81(1) of the Act, I make the following findings in relation to the death of Frank Coleman.
 - I **The identity of the deceased:** The person who died is Frank Coleman.
 - II **Date of death:** Mr Coleman died between 8:00pm on 7 July 2021 and 5:24am on 8 July 2021.
 - III **Place of death:** Mr Coleman died at the Metropolitan Special Programs Centre at Long Bay Correctional Complex.
 - IV **Cause of death:** The cause of Mr Coleman's death is methadone toxicity.

- V Manner of death:** Mr Coleman's death occurred after consuming methadone that was supplied to him by another inmate.

Recommendations

175. I make the following recommendations:

To the Chief Executive, Justice Health and Forensic Mental Health Network NSW (Justice Health)/ the Commissioner, Corrective Services NSW

Recommendation 1

Justice Health, in coordination with Corrective Services NSW, review the models of care and resourcing of Drug and Alcohol assessments for the commencement of opioid agonist therapy (OAT), with a view to increasing access and capacity, and

- a. Produce a joint report estimating unmet need in the public jail system and outlining the optimum wait time
- b. Produce a joint mapping report indicating what resources would be necessary to achieve the optimum wait time (including staffing and infrastructure needs)

Recommendation 2

Justice Health, in coordination with Corrective Services NSW:

- a. assess the viability of Drug and Alcohol reviews being conducted via telehealth, including in-cell, and if deemed viable
- b. trial providing Drug and Alcohol reviews by in-cell telehealth

Close of inquest

176. Before I close this inquest, I offer my sincere and respectful condolences to the family of Mr Coleman for their loss. I thank them for their participation and meaningful contributions to the inquest.
177. It is clear that Mr Coleman was supported by the advocacy of his former partner, Skye Hipwell. In her family statement, it was evident that she advocated for Mr Coleman, her family and other prisoners in New South Wales. I agree with what was noted by senior counsel assisting in her opening address, that Ms Hipwell's advocacy has likely made a significant difference for prisoners in New South Wales.
178. I would like to acknowledge and thank Detective Senior Constable Felicity Smith for her work in preparing the brief of evidence and her continued involvement in addressing issues that arose and the assistance she has provided.

179. I would also like to thank my assisting team, Dr Peggy Dwyer SC, instructed by Ms Charlotte Ward of the NSW Crown Solicitor's Office for their professionalism and the excellent work they put into this important inquest.

180. I close this inquest.

Magistrate Teresa O'Sullivan
State Coroner
22 October 2025
Coroners Court of New South Wales