CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Benjamin John Batalha**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2017/2767
DELIVERED ON:	2 September 2021
DELIVERED AT:	Brisbane
HEARING DATE(s):	7 June 2021
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, cause of death not determined, availability and misuse of prescribed and non-prescribed medication in custody, information sharing, polypharmacy.

REPRESENTATION:

Counsel Assisting:	Mr Matthew Hickey
Queensland Corrective Services:	Ms Amanda Bain, Crown Law instructed by Ms Vanessa Price
GEO Group:	Ms April Freeman, instructed by Mr Doug Johnson, Ashurst
WMHHS:	Ms Holly Ahern

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Introduction

1. Benjamin Batalha was aged 35 years when he was found deceased at the Arthur Gorrie Correctional Centre (AGCC) on 28 June 2017. He was found unresponsive in bed in a single cell at 8:00am. Statements taken from prisoners housed in adjoining cells suggested he could be heard snoring loudly up until around 1:00am, after which no further noise was heard.

2. AGCC is the remand prison for South East Queensland. From 1992 until 30 June 2020, it was operated by GEO. As of 1 July 2020, the State of Queensland through Queensland Corrective Services (QCS) has operated and managed the centre.

3. The forensic pathologist was unable to determine Mr Batalha's cause of death. Toxicology showed several different drugs at therapeutic levels. Only one drug was near toxic levels (a prescribed anti-depressant). Possible causes of death included an unheralded heart attack, mixed drug toxicity, and epilepsy/seizure.

4. Mr Batalha had been seeing a psychiatrist since 19 January 2017. The psychiatrist provided a statement outlining his treatment and the medications prescribed.

5. The psychiatrist advised that he had not prescribed all the medications which Mr Batalha was using at the time of his death (some were prescribed by a Visiting Medical Officer), and that there were three non-prescribed medications found in his system at autopsy (an opiate and two antipsychotics).

The investigation

6. The Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) and the Office of the Chief Inspector (OCI) investigated the circumstances leading to Mr Batalha's death. Detective Senior Constable Steven Peake led the QPS investigation. He submitted a report dated 21 June 2019 that was tendered at the inquest.

7. Detectives from the CSIU arrived at the scene at 10:49am. They found Mr Batalha on the floor of the walkway and into the entry of Cell 16 in Unit B1, covered by a doona. There were no obvious injuries. Mr Batalha was identified by fingerprint examination.

8. CSIU officers commenced the process of taking statements from staff and inmates of the Unit. They took steps to seize relevant records and interrogated the AGCC's Information and Offender Management System (IOMS).

9. Detective Senior Constable Peake spoke to intelligence officers at AGCC and made arrangements for statements to be obtained from officials at the prison. He also seized the relevant CCTV footage. Medical Records from the Princess Alexandra Hospital (PAH) and AGCC were also obtained. Prisoners accommodated in the Unit were interviewed by detectives from CSIU. No issues of concern were raised by those prisoners relating to Mr Batalha's health or welfare.

10. An examination of Mr Batalha's cell located two prescription tablets concealed in an empty sugar package and an empty asthma inhaler. Subsequent analysis confirmed the tablets were Quetiapine (Seroquel). All personal items and clothing in the cell were also photographed.

11. I am satisfied that the QPS investigation was professional and thorough, and that all relevant material was accessed.

The inquest

12. A pre-inquest conference was held in Brisbane on 17 March 2021. Mr Hickey was appointed as Counsel Assisting and leave to appear was granted to Queensland Corrective Services and the GEO Group, operators of the AGCC at the time of the death. The following issues were considered at the inquest:

    - The findings required by s.45(2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death;
    - Whether Mr Batalha’s care at Arthur Gorrie Correctional Centre and/or West Moreton Hospital and Health Service (WMHHS) was appropriate and sufficient;
    - The availability of non-prescribed medication to Mr Batalha at Arthur Gorrie Correctional Centre; and
    - Whether there are any further recommendations which can be made which could prevent deaths from happening in similar circumstances in the future.

13. The inquest was held in Brisbane on 7 June 2021. All the statements, records of interview, medical records, photographs, CCTV footage and materials gathered during the investigation were tendered at the inquest. Oral submissions were heard from the represented parties following the conclusion of the evidence. These were supplemented by written submissions.

14. The following witnesses were called to give oral evidence at the inquest:

    - Dr Ian Home, Senior Forensic Physician, Clinical Forensic Medicine Unit
    - Mr Steven Joyce, Health Services Manager, AGCC
    - Dr Aboud, Clinical Director, PMHS
    - Dr Stewart, Consultant Psychiatrist, PMHS

15. I am satisfied that all the material necessary to make the findings required under the *Coroners Act 2003* (Qld) was placed before me at the inquest.

The evidence

Personal circumstances and correctional history

16. Mr Batalha had previous custodial episodes in Western Australia, New South Wales and Queensland. He was sentenced by the Drug Court at Cairns on 11 February 2009 for multiple burglary, property and drug offences. He received a total of three years imprisonment and was placed on an Intensive Drug Rehabilitation Order. This order was vacated on 10 September 2009 at the Beenleigh Magistrates Court, and he was resentenced to a total of 2 years and 6 months for the original offences. He was released on parole on 21 March 2013. Mr Batalha had periods of imprisonment in Western Australia from 2000 - 2006 and New South Wales in 2016.

17. Within two weeks of his release in NSW, Mr Batalha was on remand for armed robbery and assault police offences allegedly committed at Southport on 9 June 2016. He entered custody at the Brisbane Correctional Centre (BCC) on 17 June 2016. He was transferred to AGCC on 12 December 2016.

18. On entry to BCC in June 2016, Mr Batalha disclosed a medical history of psoriasis and asthma. Mr Batalha also disclosed daily use of methamphetamines, back pain and a history of mental health issues including anxiety and depression. He had been prescribed Prozac in custody in NSW.

19. Mr Batalha's former partner said they had a daughter together who is now a young adult. She said that he was a recreational drug user when they met but this led to more frequent use of heavier drugs such as "Speed". He then moved to Queensland to live with his mother. He later received a large sum of money which he dissipated within three months.

Brisbane Correctional Centre

20. On 3 November 2016, Mr Batalha was assaulted at BCC and received puncture wounds to the top of his head and a "deep scratch" injury to his throat.[1] These wounds were inflicted with a plastic knife and a plastic pen casing. Mr Batalha did not wish to make a complaint to police, and the incident was consequently not investigated by the CSIU. The reasons for the assault are not known.

21. On 9 November 2016 Mr Batalha went to the PAH for treatment of ongoing back pain. He asked for pain medication including pregabalin or tramadol. He was also prescribed venlafaxine and mirtazapine at BCC.

22. On 23 November 2016, Mr Batalha was assaulted again and sustained significant fractures of his left orbital and temporal bones, which required surgical repair. He had initially declined medical assistance. He was returned to BCC on 25 November 2016 to await surgery.

23. However, twenty minutes after arriving at BCC he was found on the floor of his cell. He was not responding to voice commands and appeared to be fitting or in severe pain. He was taken back to the PAH and underwent surgery on 28 November 2016.

[1] Ex F1, p 19.

24. There was some confusion about the pain relief prescribed to Mr Batalha on his discharge back to the BCC. The PAH discharge summary indicated he was prescribed oxycodone, diazepam and paracetamol but noted he was taking Lyrica on an ongoing basis. However, he was not on Lyrica at the time, and this was clarified by nursing staff at BCC.

25. On 6 December 2016, Mr Batalha underwent further surgery to his facial injury to treat an abscess/infection. Mr Batalha remained in a medical unit at BCC until his transfer to AGCC on 12 December 2016.

26. Mr Batalha sought extra pain relief on several occasions over subsequent months and regularly advised his mother that he was unhappy with his medical treatment and lack of pain relief.

AGCC

27. Mr Batalha was housed in several units at AGCC in the lead up to his death. He was initially classified as a mainstream prisoner until 18 March 2017, when his classification was changed to protection. Mr Batalha was housed in the protection or the detention unit from that date until his death.

28. On 14 December 2016, Mr Batalha was seen by Visiting Medical Officer (VMO) Dr Abbas for a medication review. He was started on daily pregabalin as an alternative to tramadol.

29. Mr Batalha was then seen by a Prison Mental Health Service (PMHS) clinician on 19 December 2016 for the purpose of an intake assessment. He had been referred to the service by a counsellor following his admission to AGCC.

30. The PMHS clinician recorded that Mr Batalha said he would like to see a psychiatrist due to experiencing night terrors involving 'The Devil'. The clinician also recorded he:

> *"Reports he sees shadows appearing out of side of room which latch on to his arms and head and 'paralyse him'. Reports he is not asleep when this occurs however only occurs at night while in bed".*

31. In the intake assessment, Mr Batalha denied any thoughts of suicide, self-harming behaviour or harming others. It was also noted that Mr Batalha's current medications included Mirtazapine and Lyrica. He discussed a range of psychosocial issues including a recent relationship breakdown and becoming unknowingly involved with outlaw motorcycle gang members associated with his new girlfriend. He said that he had been assaulted in a secure unit at BCC after being accused of sharing information with correctional officers.

32. On 21 December 2016, Mr Batalha was seen again by Dr Abbas. It was noted that Mr Batalha would benefit from taking Lyrica due to his neuropathic pain issues (which arose as a result of motorcycle accident when he was a teenager) with a view to weaning him off that medication after three or four months.

33. Mr Batalha used illicit drugs such as methylamphetamine at various times during the years preceding his death. Another prisoner alleged he was a known drug user within AGCC. On 21 May 2017, he was searched by correctional officers and found to be in possession of medication that had not been prescribed to him. This matter was dealt with under the breach provisions of the *Corrective Services Act 2006* (Qld).[2]

PMHS

34. On 19 January 2017, following the initial intake assessment by the clinician on 19 December 2016, Mr Batalha had an initial appointment with Dr Stewart, who worked as a Consultant Psychiatrist with the PMHS. Dr Stewart was Mr Batalha's treating psychiatrist from this date until the date of his death. Dr Stewart reviewed Mr Batalha on nine occasions between19 January 2017 and 8 June 2017.

35. At the time of Dr Stewart's first review, Mr Batalha was already prescribed the following medications:

    - Mirtazapine 60mg nocte;
    - Venlafaxine 225mg mane;
    - Pregabalin (Lyrica) 225mg bd; and
    - Baclofen 20mg bd.

36. Dr Stewart said that it was his practice not to alter pre-existing doses of medications unless there was an immediate clinical need to do so.

37. Dr Stewart told the inquest that one of the challenges of working in the prison environment was that it was difficult to see everyone on your list regularly because of variables such as patient refusal, lockdowns within the prison and mainstream versus protection prisoner flows.

38. Dr Stewart said that when he initially saw Mr Batalha, he was very anxious after he had been assaulted and was struggling in the custodial environment. This had eroded his resilience and he had limited support, increasing his risk of substance misuse. He subsequently diagnosed Mr Batalha as having an adjustment disorder and mild anxiety and depressive disorder.

39. Dr Stewart did not think Mr Batalha required acute care outside of the prison environment and that coexisting drug and psychiatric diagnoses were common. He thought that the medication that had been prescribed to Mr Batalha was appropriate but that an increased dosage of diazepam would have had increased sedative effects and required review.

40. At the time of Dr Stewart's last review before Mr Batalha's death on 8 June 2017, Mr Batalha was prescribed the following medications:

    - Mirtazapine 45mg nocte;
    - Escitalopram 10mg mane; (in lieu of Venlafaxine)
    - Diazepam 4mg mane and 10mg nocte;
    - Pregabalin (Lyrica) 225mg bd; and
    - Baclofen 20mg bd.

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[2] Ex D5.

41. Dr Stewart noted that at this last review Mr Batalha presented as "settled, reactive with no evidence of any significant mood disturbance such as a major depressive episode". There was no evidence of any significant distress. Dr Stewart was not the prescriber of the Pregabalin or the Baclofen. His plan was to continue the current medication regime and review in one month.[3]

42. Dr Andrew Aboud is the Clinical Director of the PMHS. Dr Aboud agreed that if Mr Batalha was illicitly using medications that were not prescribed to him this may have compromised his health. He also agreed with the assessment of Dr Home in relation to respiratory depression caused by mixed drug toxicity or fatal arrhythmia caused by a combination of drugs as potential causes of death.

43. Dr Aboud considered that the psychiatric care provided to Mr Batalha by the PMHS was 'appropriate and sufficient' in the circumstances following his referral. He was given a comprehensive assessment upon intake and then opened to the PMHS. The initial diagnosis of adjustment disorder was reviewed to one of anxiety and depression with a focus on medication management.

Prescription of Lyrica

44. As noted above, at the end of 2016, Dr Abbas commenced Mr Batalha on Lyrica (pregabalin) for his back pain. This was reviewed by Dr Abbas on 2 February 2017 and his dose was increased to 300mg.

45. It was noted in the clinical file that Dr Stewart should ask Mr Batalha about diverting medications, but Dr Stewart was unsure if he did at this time.

46. On 16 May 2017, the clinical file records that the medication charts for Mr Batalha were rewritten and his Lyrica dose was reduced to 150mg. Illicit usage of medications was noted. While the nursing notes suggested that his Lyrica dose was reduced to 150mg twice daily due to drug diversion behaviour in the detention unit, this was not reflected in the medication charts.

47. On 21 May 2017, Mr Batalha was found in possession of medication not prescribed to him, being four Seroquel tablets and two Risperidone tablets. On 24 May 2017, Dr Abbas saw Mr Batalha again regarding pain management. A discussion regarding the risks of drug diversion was noted and Mr Batalha was placed on a management plan which involved titrating down his Lyrica dose and looking at other options for managing pain. His dose of Lyrica at that stage was noted as being 225mg.

48. Mr Steven Joyce was, at the time of Mr Batalha's death, the Health Services Manager at AGCC. He recalled Mr Batalha and said that his mother had made contact after hours and expressed concern about her son.[4] He said that Mr Batalha was known to have mental health issues, but this was common in a remand centre such as AGCC.

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[3] Ex B7.

[4] Ex. B3.

49. At the inquest, Mr Joyce described the process of medication rounds in units, where prisoners are passed medication from a hatch by a nurse stationed in a fishbowl. They are given water to drink and an officer checks to see that they have swallowed the medication. Where a prisoner was found to be diverting their medication the Health Centre would be made aware and the prisoner would be taken to the Detention Unit and checked by a nurse who would also monitor the prisoner. Schedule 8 drugs are only dispensed at the Health Centre.

50. Mr Joyce said that Lyrica is a highly traded medication in custody and could be taken by chewing or injection. He indicated that it was a third line drug for the treatment of pain relief.

51. Mr Joyce said that Mr Batalha was gradually taken off Lyrica as a decision had been made that prisoners would no longer be prescribed this medication at AGCC, in line with international recommendations and similar decisions being made in other jurisdictions.

52. Mr Joyce's evidence was that there was a policy implemented at AGCC around this time that involved weaning prisoners off Lyrica in order to remove this drug from the centre, given the high trade of the drug between prisoners, levels of abuse and alternative drugs available to manage pain.

53. It would appear therefore that plans had been put into place at the time of Mr Batalha's death to reduce his dosage of Lyrica in line with the policies implemented to deal with drug diversion. In any event, there is no suggestion that Mr Batalha's use of Lyrica had any direct connection with his death.

54. Dr Thomas O'Gorman, Director of the Prison Health Service (PHS) indicated that the provision of primary health care by the PHS is in line with community standards, taking into consideration the complexities and uniqueness of the prison environment. If an inmate received into custody reports that their recently prescribed medications include Lyrica, PHS staff seek collateral information from the community prescribers, and dispensing community pharmacy to ascertain the veracity of what is reported.

55. If the prescription can be rationalised, and is indicated based on a detailed medical history and clinical review, then consideration can be given to prescribing Lyrica. Similarly, an inmate may be commenced on Lyrica whilst in custody if it is clinically indicated.[5]

Events leading up to the death

56. At approximately 2:00pm on 27 June 2017, Mr Batalha was transferred from Cell 19 in Unit B5 to Cell 16 in Unit B1. Unit B5 accommodates prisoners who present as being at risk of injury or self-harm and are subject to higher levels of supervision and mental health assessment. He was housed in this unit from 10 May 2017 to 27 June 2017. Prisoners occupy cells in this unit on a priority basis and are generally moved to other units once issues of risk or concern are addressed.

[5] Statement of 30 March 2021.

57. Upon arrival in Unit B1, Mr Batalha was accommodated in cell 16 (a single occupant cell). All prisoners were locked down at that time. The prisoners were released from their cells at approximately 3:25pm to receive medication from medical staff. They were then free to socialise in the unit and exercise yard until they were issued their evening meals. They attended muster at 4:00pm and were locked down at approximately 4:40pm. He appeared to be in good health at the time of transfer to B1 and interacted positively with several prisoners in the unit before lockdown.

58. Health and security checks of prisoners locked down in their cells were conducted at 4:53pm, 8:48pm, 04:36am and 07:34am by Custodial Correctional Officers. No incidents of concern were raised or recorded at these times. The checks carried out during the night are carried out in a manner so that prisoners will not be continually awakened. A verbal response was not required.

59. At 07:54am a medication round was commenced in Unit B1 while prisoners were locked down. A unit muster was also conducted at this time. At 08:01am a "Code Blue" was called in cell 16 after Mr Batalha was found unresponsive in his bed by correctional staff escorting a registered nurse conducting the medication round. He was lying in bed with the sheet pulled up to his chest. CPR was commenced by prison medical staff, including Mr Joyce, and the Queensland Ambulance was advised. CPR efforts were maintained until the arrival of QAS paramedics at 08:24am when an end of life assessment was conducted. Mr Batalha was pronounced deceased at 08:27am.

Family concerns

60. It was clear that Mr Batalha enjoyed a close relationship with this mother. She raised concerns about the treatment of her son in custody. These were extensive but can be summarised as follows:

> *She stated that she would like the coroner to listen to all the recorded phone calls her son made to her between the time he was stabbed and two days prior to his death as she believes this will help the coroner to decide the cause of death. She stated that her son had detailed to her all his symptoms and problems he was having and that he only shared these concerns with her. She stated both she and her son continually complained that he was not receiving appropriate medical treatment and that she believes his death has been because of this poor treatment and medical complications after being stabbed repeatedly whilst in custody.*[6]

61. The recordings of 39 calls were downloaded and copied to a compact disc. The calls indicated that Mr Batalha felt he was receiving poor medical care in relation to his facial injuries and pain relief, ongoing headaches and blurred vision. He also appeared to be having nightmares and vivid dreams on a regular basis, which may have been affecting his psychological health. He also described seeing God and Jesus. He admitted taking Seroquel to assist sleep (a non-prescribed medication).

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[6] Supplementary Form 1 dated 8 January 2019 – concerns communicated through Bundaberg police.

Autopsy results

62. An autopsy examination was performed on 29 June 2017 by Senior Staff Specialist Pathologist, Dr Rohan Samarasinghe. His report was dated 14 June 2018, and noted that

    - there was no significant gross pathology to explain sudden death;
    - the lungs were congested and oedematous;
    - there was no significant abnormality in the brain that could explain the cause of death;
    - there was widespread contraction muscle fibre necrosis in the left ventricle and anterior papillary muscle in keeping with a perimortem ischaemic event.[7]

63. The toxicology report showed that Mr Batalha had the following drugs in his system in non-toxic ranges:

    - Diazepam;
    - Buprenorphine;
    - C. Citalopram;
    - Mirtazapine;
    - Quetiapine;
    - Paliperidone;
    - Pregabalin.

64. Dr Samarasinghe concluded that cardiac arrest due to an unknown ischaemic event (inadequate oxygen supply around the time of death) was likely given the contraction band necrosis of the left ventricle and anterior papillary muscle, despite there being no significant coronary artery disease or evidence of cardiomyopathy. Specialist neuropathology of the brain did not identify any significant abnormalities.

65. The level of Mirtazapine was noted to be potentially toxic but not in the lethal range. It was noted that effects of other drugs such as Citalopram and Quetiapine could also have played a role due to their ability to produce ECG abnormalities.

66. Ultimately, the exact cause of death could not be determined. The effects of drugs was a possibility, and sudden death from fatal arrhythmogenic cardiac disease or epilepsy/seizure could not be ruled out. Infection was noted as a remote possibility.

Clinical Forensic Medicine Unit Report[8]

67. Dr Ian Home, Senior Forensic Physician at the Clinical Forensic Medicine Unit provided a report dated 10 March 2021.

68. This report confirmed the findings of the autopsy. Dr Home noted that Buprenorphine (opiate analgesic), Quetiapine and Paliperidone (both anti-psychotic medications) as noted in the toxicology report were not prescribed to Mr Batalha.

[7] Ex A3.

[8] Ex A5.

69. Dr Home stated that combining Diazepam with Buprenorphine, Quetiapine and/or Paliperidone can lead to life-threatening additive central nervous system and respiratory depressant effects. Likewise, combining Citalopram with Buprenorphine may have additive central nervous system effects or cause serotonin syndrome, which can be life-threatening as it can lead to seizures and arrhythmias.

70. Dr Home considered that although the precise cause of death was inconclusive, reports of loud snoring prior to Mr Batalha's death, in conjunction with the detection of medications not prescribed to him, raised the possibility that he died as a result of respiratory depression caused by mixed drug toxicity. Alternatively, the combination of drugs detected could have precipitated a fatal arrhythmia.

71. Dr Home saw no reason to be critical of the care provided to Mr Batalha at AGCC, WMHHS and the PAH. He understood and agreed with the management plan that had been put in place on 24 May 2017. On 8 June 2017 he appeared settled and reacting appropriately when seen by the psychiatrist, although complaining of lower back pain. The plan was to continue the existing medication regimen, encourage exercise and meditation to aid sleep and review in one month.

Investigation findings

Office of Chief Inspector Desktop Review[9]

72. The OCI investigated the death or Mr Batalha and the circumstances surrounding its occurrence. The OCI Desktop Review made the following relevant findings:

- The issue of how the death occurred and the specific circumstances of the death are unable to be identified.
- The timeliness and effectiveness of the AGCC management and staff in responding to the incident were appropriate to the circumstances.

CSIU Report[10]

73. Detective Senior Constable Peake provided a report to the Coroner following that investigation. This report noted that Mr Batalha’s associates confided that he struggled with illicit drug use and mental health issues and had been a heavy user of amphetamines before he was incarcerated.

74. The CSIU report also provided a summary of telephone calls between Mr Batalha and his mother during the relevant period. The calls reveal that Mr Batalha felt he was receiving poor medical care in relation to his facial injuries and pain relief, and that he was suffering from hallucinations and vivid dreams. He described astral travel and biblical hallucinations.

75. DSC Peake's report concluded that no concerns had been identified as a result of the investigation relating to the quality of the medical care provided to Mr Batalha as a prisoner at AGCC, BCC or the PAH and that he received adequate medical treatment from qualified medical personnel employed by GEO at AGCC.

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99 Ex D11.

10 Ex A4.

Findings required by s. 45

Identity of the deceased – Benjamin John Batalha

How he died – Mr Batalha was remanded in custody at the time of his death. He had been seriously assaulted in custody and was taking prescribed medication to manage his pain. He also accessed quantities of non-prescribed medication including pregabalin and quetiapine. He was found deceased in his cell at 8:00am after other prisoners heard loud snoring during the night. It is likely he died before 1:30am. While the precise cause of his death was not able to be determined, respiratory depression caused by mixed drug toxicity or fatal arrhythmia caused by a combination of drugs were potential causes of death.

Place of death – Arthur Gorrie Correctional Centre, Wacol Queensland, Australia, 4076

Date of death– 27 - 28 June 2017

Cause of death – Not determined

Conclusions

Availability of non-prescribed medication to Mr Batalha at AGCC

76. Mr Batalha had possession of small doses of medication that had not been prescribed to him on 21 May 2017 and on the day of his death. Mr Batalha had an extensive history of illicit drug use prior to his incarceration.

77. There was also evidence to suggest that Mr Batalha was diverting medication, most likely Lyrica, within the prison environment.

78. At the relevant time, AGCC had systems in place to ensure that medications were kept securely, and they were dispensed appropriately.

79. Breach action was taken against Mr Batalha following the incident on 21 May 2017. He was then reviewed by a VMO within three days to have discussions about the risks of drug diversion and his medication was also reviewed.

80. I accept that Mr Batalha's medications were reviewed frequently. He was seen regularly by the VMO and his treating psychiatrist, who were both aware of his drug diverting behaviour and were taking steps to address it.

81. Dr Abbas had discussions with Mr Batalha about the risks of drug diversion and was in the process of decreasing his Lyrica dose and trialling other options to manage his pain.

82. However, as observed by Dr Aboud, contraband substances (whether illicit drugs or non-prescribed medications) can be sourced by prisoners who are determined to obtain them. The issues regarding Mr Batalha were known to both medical staff and corrective services officers and appropriate steps, such as breach action under the *Corrective Services Act 2006* (Qld) and the review and weaning off medications, was being undertaken.

83. I agree with the submission from GEO that no adverse findings should be made in the circumstances of Mr Batalha’s death, particularly where no definitive cause of death could be identified.

Whether Mr Batalha's care at AGCC and WMHHS was appropriate and sufficient

84. Mr Batalha was received at AGCC on 12 December 2016. Within two days he was seen by a VMO for a medication review. Within seven days he was seen by a PMHS clinician as a result of a referral by a counsellor employed at AGCC.

85. He was subsequently regularly reviewed and attended to by the VMO and his treating Consulting Psychiatrist. There is no evidence to suggest that the treatment and care administered to Mr Batalha by Dr Abbas and other medical staff at AGCC and WMHHS during his time at AGCC was anything but appropriate and sufficient.

86. This is consistent with the findings of the CFMU Report and the CSIU investigation that Mr Batalha received adequate medical treatment from qualified medical personnel employed by GEO at AGCC and those employed by WMHHS.

Comments and recommendations

87. The Australian Institute of Criminology runs a Drug Use Monitoring in Australia program which entails the routine collection of survey and urinalysis data from police detainees across Australia, including the Brisbane watchhouse. The AIC’s most recently published report indicated that in 2020, almost half of the detainees reported using cannabis (47%) and methamphetamine (45%)[11] in the past 30 days. Detainees also reported using benzodiazepines (21%), cocaine (8%), heroin (7%) or ecstasy (5%) in the past month.[12]

88. Unsurprisingly, the strong demand for drugs by offenders in the community is carried over into the prison environment. The prevalence of substance misuse in the prison population was highlighted in the 2016 Report of the Queensland Parole System review.[13] That report contained a suite of recommendations relating to the screening of offenders and the delivery of rehabilitation programs, including an opioid substitution treatment program into all Queensland prisons. Of the 91 recommendations, 82 were supported by the Queensland Government with seven supported in principle.

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[11] A rate of 60% was reported at Brisbane in the first quarter.

[12] Voce, A and Sullivan T, Drug use monitoring in Australia: Drug use among police detainees, 2020, https://doi.org/10.52922/sr78221

[13] https://parolereview.premiers.qld.gov.au

89. The Crime and Corruption Commission's Taskforce Flaxton Report also identified the introduction of contraband, including illicit substances and paraphernalia, as a key corruption risk that also presents a significant risk to the safety and good order of Queensland correctional centres.[14]

90. Dr Aboud said that following the PHS's assumption of responsibility for the delivery of the health services to AGCC in July 2020 he had engaged with the Clinical Director of the PHS, and processes have been established for a PMHS psychiatrist to assist PHS doctors and nurse practitioners to resolve issues of concern involving psychotropic medication prescribing for all prisoners, including those open to the PMHS. A patient journey mapping process is also underway to identify opportunities for the PMHS and PHS to efficiently coordinate care provision.

91. In his evidence, Dr Aboud identified opportunities for systemic improvement in the following areas:

- Information sharing about drug test results between QCS, PHS and PMHS;
- Increased "therapeutic" urine testing;
- Opioid Substitution Treatment Programs;
- Prisoner/patient awareness raising of the risk of opioid misuse.

92. WMHHS submitted that these were areas for potential recommendations under s 46 of the *Coroners Act 2003* (Qld), having regard to the prevalence and availability of contraband substances in prisons and widespread polysubstance misuse. The scale of the problem requires a coordinated and comprehensive approach, including enhanced cognitive behaviour therapy and contingency management.

93. Dr Aboud confirmed that Mr Batalha's presentation was not unusual and said there are opportunities for improvement in the systemic response to the misuse of prescribed substances by persons such as Mr Batalha. He said that this issue is common among most of the clients of the PMHS, although not the primary reason for referral to that service in most cases. Pain killers, sedatives and anti-psychotics such as those used by Mr Batalha are valuable currency within prisons.

94. Dr Aboud said that polysubstance abuse is a problem for many inmates, as well as a challenge for QCS who endeavour to search prisoners, visitors and cells for contraband to stem the flow of drugs into prisons. In order to best manage this, the sharing of information between the three agencies could be improved. Prisoners and patients rarely voluntarily disclose the use or diversion of illicit or non-prescribed substances.

95. Dr Aboud suggested that existing regular interagency meetings in correctional centres could be used to share information about substance use and the results of searches and urine screening. This could be relevant to the treatment being provided by the PMHS or the PHS and should be discussed at all meetings between health and correctional officials.

[14] https://www.ccc.qld.gov.au/publications/taskforce-flaxton

96. Dr Aboud said that he would also support more frequent urine testing of prisoners to enable "proactive assessment" of toxicology. This may impact on treatment decisions. For example, a higher level of mirtazapine than the prescription indicates should be present in a prisoner's system might prompt an adjustment in the prescribed level of the abused drug.

97. The PMHS could also be alerted to the misuse of drugs that were not being prescribed, such as the buprenorphine Mr Batalha was misusing. Dr Aboud described the "parole paradigm" and the "health paradigm" which use urine test results for breach and health purposes respectively. Both are valid purposes, but visibility of the outcomes of testing is required.

98. At the inquest Dr Aboud also noted that an Opioid Substitution Treatment Program was still under consideration for males in most Queensland prisons. Where a prisoner was abusing opioids, the level of opioid intake by prisoners could be monitored and supervised under such a program, noting that drugs such as Subutex are an attractive currency in prison. Notwithstanding, Dr Aboud considered that an OSP would reduce the diversion of opioids and other substances in prisons. This was based on evidence from NSW and Victoria.

99. Dr Aboud said that warnings are currently provided to prisoner/patients on release from prison about the risks associated with resuming opioid use when tolerance to opioids is likely to have lessened while the person was in prison. However, Dr Aboud said that a similar process should also apply to warn all prisoners of the risks of substance misuse on reception into custody.

100. Dr Aboud said that suicide risk is a primary focus of psychologists employed by QCS. The risk of accidental overdose was also a matter that should also be addressed collaboratively, albeit the risk was lower.

101. Ms Ursula Roeder, Assistant Commissioner (AC), Southern Region Command, Custodial Operations, QCS, provided a comprehensive response to the issues raised by Dr Aboud and the s 46 submissions of WMHHS.

102. Ms Roeder noted that the QCS Drug and Alcohol Strategy 2020-2025 "establishes a holistic, enterprise-wide approach to preventing and deterring the supply, reducing the demand and reducing the harm associated with alcohol and other drug use". It covers all QCS operations, including staff and prisoners and offenders under supervision. The three overarching strategic objectives are:

- Prevent and deter supply;
- Reduce demand;
- Reduce harm.

103. AC Roeder said that QCS provides opportunities for prisoners to access a suite of substance misuse programs ranging from lower to higher intensity. Lower intensity programs focus on awareness and education of the harm of substance misuse and available resources and support in the community.

104. Higher intensity programs focus on the development of relapse prevention plans. QCS recognises that relapse is a common occurrence, and therefore participation may occur at several points in a person's engagement. Prisoners self-refer for inclusion in QCS's substance misuse programs as this demonstrates a willingness to engage in a program. Eligibility is determined by sufficient time in custody to complete the program.

105. AC Roeder indicated that QCS supported the suggestion by WMHHS that they introduce a process to provide prisoners with education about the risks of drug abuse/poly pharmacy such as overdose at the point of reception and again, if the prisoner has access to PMHS, when they undergo intake assessment with PMHS.

106. With respect to opportunities for increased psychological support, counselling and or behavioural therapies and contingency management, AC Roeder noted that QCS employs psychologists to provide high quality psychological services that promote the mental health, well-being and safety of prisoners accommodated in correctional centres.

107. QCS runs the Resilience Program in most high secure correctional centres in Queensland. The Resilience Program is a ten-session program that uses evidence-based techniques and concepts to equip participants with a set of skills that can be applied to strengthen their ability to cope, overcome adversity, and manage stress. This program is not directly targeting substance use however it helps prisoners develop positive coping skills which may reduce the need to use substances to self-regulate.

108. The RUSH program is also scheduled to be re-introduced in QCS facilities from late 2021 with a focus on helping participants develop more positive coping skills. The RUSH program is a group program grounded in the use of Dialectical Behavioural Therapy, with evidence indicating that this therapy is useful in treating those experiencing traumatic symptoms.

109. Continued implementation of the Opioid Substitution Treatment (OST) program is included in the Drug and Alcohol Strategy 2020-2025. AC Roeder noted that QCS and Queensland Health (QH) have successfully partnered to establish the OST program in all public women's correctional centres (Brisbane Women's, Townsville Women's and Numinbah), and men's correctional centres in northern Queensland (Lotus Glen and Townsville). OST was also available in Southern Queensland Correctional Centre delivered under contract with QCS by Serco, until 1 July 2021.

110. In June 2019, the Burnet Institute delivered a final report on the benefits and barriers of implementing OST in Queensland correctional facilities. It concluded that the implementation of OST at phase one sites was largely successful, with observed benefits to the health and wellbeing of prisoners, as well as perceived benefits to prison operations.

111. In April 2020, the Therapeutic Goods Administration removed restrictions allowing for broader types of medications to be used in the treatment of opioid dependence. The amendment enabled health practitioners to prescribe long-acting injection buprenorphine medication (LAI-BPN) Buvidal and Sublocade as a clinical option.

112. This revised medication schedule provided an opportunity for QCS and QH to revisit the service model in existing sites and explore benefits to the program for the state-wide rollout. In August 2020, QH and QCS worked together to introduce the use of LAI-BPN in addition to existing medications.

113. AC Roeder said that QH has a robust assessment process to determine eligibility for OST, which is available to prisoners who meet QH's clinical eligibility. The introduction of LAI-BPN has yielded many benefits for QCS and the individuals on the program including reduced dosing regimens, reduced risk of diversion and greater flexibility in correctional centre routines.

114. QCS are currently engaging with QH to develop a plan for roll-out of OST across all correctional centres in Queensland in line with the recommendations contained within the Queensland Parole System Review final report.

115. With respect to the suggestion that QCS/PMHS/PHS utilise the existing regular interagency meetings to discuss outcomes of urine drug screening and implications for existing treatment regimens, QCS proposes making the WMHHS recommendation a regular agenda item at these meetings to discuss whether QCS is able to amend its current Substance Testing Custodial Operations Practice Directive (COPD) to allow PMHS psychiatrists to recommend prisoners for urine drug screening and whether urine drug screening information may be shared with PMHS and/or QH.

116. There are two key reasons this proposal needs to be further explored by QCS. Obligations are imposed on QCS with respect to confidential information in s 341 of the *Corrective Services Act 2006* (Qld). QCS staff are also required under the Code of Conduct to comply with the COPDs.

117. AC Roeder said QCS is pursuing a range of alternative testing methods (including wastewater testing in prisons) to drive efficiencies and support trauma-informed processes and practices. It is intended that wastewater testing will replace random urine testing for prisoners and there will be less individual drug tests undertaken. However, individuals will still be subject to targeted testing. There will be opportunities for PMHS to request testing if this makes operational sense and current policy and procedure is amended to reflect this.

118. It is apparent from the response of AC Roeder that QCS and Queensland Heath are endeavouring to address the systemic issues identified by Dr Aboud and WMHHS that may have assisted in responding to the circumstances leading to Mr Batalha's death. Having regard to that response, and to the implementation of the recommendations from the Queensland Parole System Review, I do not consider that I can usefully make any further recommendations under s 46 of the *Coroners Act 2003* (Qld).

119. The QCS submission to the Parole System Review noted substance misuse is an important risk factor for recidivism and return to custody. The submission also noted there is significant empirical evidence that suggests high rates of co-occurring substance use disorder and mental illness increase the risk of contact with the criminal justice system through poor psychosocial functioning. It is essential that there is ongoing and structured cooperation between QCS, the PHS and PMHS in relation to these issues.

120. I extend my condolences to Mr Batalha's mother, together with the rest of his family and friends. I close the inquest.

Terry Ryan
State Coroner
BRISBANE