QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Micheal Wayne Blutcher**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Rockhampton
FILE NO(s):	COR 2013/3374
DELIVERED ON:	9 May 2016
DELIVERED AT:	Brisbane
HEARING DATE(s):	18 February; 19 – 20 April 2016
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, fentanyl overdose, transdermal patch, access to prohibited drugs in prison.

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper
Queensland Corrective Services:	Ms Kylie Hillard i/b Department of Justice and Attorney-General
Central Queensland Hospital and Health Service:	Ms Kristy Richardson
Ashley Williams:	Mr William Prizeman i/b Legal Aid Queensland

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Introduction

1. On 17 September 2013, fellow inmates found Micheal Blutcher, aged 31 years, unresponsive in his room at the low security farm precinct of the Capricornia Correctional Centre (CCC). The inmates notified correctional staff who called a 'Code Blue' and attended at the room. Nursing staff and members of the Queensland Ambulance Service also attended and resuscitation efforts followed. Those efforts were ultimately unsuccessful and Mr Blutcher was pronounced deceased at the scene.

2. Items were found in his room suggesting recent drug use, including a cut up fentanyl patch, syringes, a tourniquet and other drug implements. He was due for release from prison on 25 October 2013.

3. These findings:

    - confirm the identity of the deceased person, how he died, and the time, place and medical cause of his death;

    - consider whether any third party contributed to his death;

    - determine whether the authorities charged with providing for the prisoner's health care adequately discharged those responsibilities; and

    - consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

4. Detective Sergeant Aaron Bates from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) conducted the investigation into the circumstances leading to the death of Mr Blutcher.

5. After being notified of Mr Blutcher's death, the CSIU attended the CCC and an investigation followed. Photographs were taken of the scene. The investigation obtained Mr Blutcher's correctional records and his medical files from Corrective Services. The investigation was informed by interviews with Mr Blutcher's fellow inmates at the CCC, and statements from all relevant custodial officers at the CCC, medical staff and the QAS. These statements and interviews were tendered at the inquest.

6. Dr Nigel Buxton conducted a full internal autopsy examination. Further photographs were taken during this examination.

7. At the request of the Office of the State Coroner, the CCC provided information with respect to the ability of prisoners to access prohibited items while in custody.

8. I am satisfied that the investigation was thoroughly and professionally conducted and that all relevant material was accessed.

The inquest

9. An inquest was held in Rockhampton from 19 – 20 April 2016. All statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

10. Counsel assisting at the pre-inquest conference, Miss Cooper, proposed that all evidence be tendered and that oral evidence be heard from the following witnesses:

    - Detective Sergeant Bates;
    - CCO Christopher (Tod) Richardson-Newton;
    - CCO Gavin Carswell;
    - CCO Lindsay Reiman;
    - CCO Paul Jorgensen;
    - Donald Shane McDonald;
    - Ashley Ryan Williams;
    - Christopher Luke Mitchell;
    - Daniel Frederick Smith; and
    - Yme Dwarshuis.

11. I agreed that the evidence tendered in addition to the oral evidence from these witnesses was sufficient for me to make the findings required under s. 45 of the *Coroners Act*.

The evidence

Personal circumstances and correctional history

12. Micheal Blutcher was born in Mt Isa on 19 November 1981. He was 31 years of age when he died. Mr Blutcher's father, Ivan Blutcher, confirmed that he had last spoken with his son a couple of months before his death. During that call, his son said he was going to head to Mackay and go fishing when he was released. He said that someone was going to help him get a unit and he asked his father to buy a motorcycle for his daughter. Ivan Blutcher was aware that his son had used drugs. Micheal Blutcher had separated from his partner, Alana, a couple of years ago but their relationship was amicable.

13. In the lead up to the inquest, Ivan Blutcher was contacted by my staff, and advised them that he did not wish to raise any issues with his son's care at the Farm.

14. It was clear from the evidence given by his fellow prisoners and the CCOs at the Farm that Mr Blutcher was a gregarious and happy person, well-liked by those who knew him. I extend my condolences to his family and friends.

15. Mr Blutcher's criminal history started as a juvenile in Rockhampton at the age of 13 years. Over the years, he was consistently before the courts in Rockhampton with respect to property related offences including stealing, break and enter and fraud. He had previously been incarcerated in Queensland for these types of offences.

16. On 27 February 2013, Mr Blutcher was sentenced in the Rockhampton Magistrates Court to a 2-year term of imprisonment for a driving offence and a burglary offence. His court ordered parole release date was set as 25 October 2013. He was initially housed at the Rockhampton watch house, before being transferred to the CCC on 6 March 2013. He remained in the secure unit until he was transferred to 'the Farm' on 11 March 2013. He remained at the Farm until his death.

Medical history

17. Mr Blutcher's medical history included intravenous drug use, hepatitis C and an addiction to nicotine.

18. As part of the induction process by medical personnel at the CCC, he told staff that he had attempted suicide 5 years earlier, but that he had no current suicidal ideation. He self-reported a history of intravenous drug use, and asked to undertake the Hepatitis C program. During a previous period of imprisonment in 2012, Mr Blutcher had informed correctional staff that he had been taking the anti-psychotic medication, Seroquel, and had been injecting OxyContin.

19. During his reception to the Farm on 11 March 2013, Mr Blutcher informed staff that he used non-prescribed Seroquel, Clozanl and Valium. He said that he used these drugs to cope with anxiety as well as morphine, which he had used on a daily basis for the previous 12 months. He informed staff that he had been going through morphine withdrawal during his time in custody at the watch house.

20. Mr Blutcher continued to be provided with Seroquel and Quetiapine while he was in custody at the Farm.

Events leading to death

21. CCTV footage captured the main areas of the residential block within which Mr Blutcher was held, and was helpful in determining the events leading up to his death. That footage was tendered at the inquest. It commences at 5:59am on the morning of Mr Blutcher's death on 17 September 2013.

22. Mr Blutcher is captured on the footage in the accommodation block at 6:04am. According to the evidence of CCO Newton, he was sighted out at the industrial bins outside C block at 6:10am, but Mr Newton did not see Mr Blutcher searching in this area. By 6:50am Mr Blutcher was out of his room conducting work duties.

23. Evidence from Mr Blutcher's fellow prisoners was the only direct evidence about what occurred in the final moments leading up to the death.

24. Ashley Williams gave evidence under compulsion at the inquest. He was in the same residential block as Mr Blutcher and Daniel Smith, and working in the kitchen. Mr Williams had known Mr Blutcher for 3-4 years and was aware that he had access to drugs in prison. Mr Blutcher told him on the

morning of 17 September 2013 that there was 'something coming in that day'. Mr Williams said that he took this to mean OxyContin, which was the usual substance that came in via soft drink cans.

25. Mr Williams recalled that he had observed Mr Blutcher collect a soft drink can in which drugs were concealed three times since he had been at the Farm. Mr Blutcher usually collected the drugs in the vicinity of the industrial bins. These bins were located between the accommodation area's more secure perimeter fence and the lower boundary fence along Etna Creek Road. Mr Blutcher, as the unit cleaner, was responsible for taking 'wheelie bins' outside the perimeter fence to empty these into the industrial bins. Mr Williams denied knowing how the cans came to be placed near the industrial bins.

26. Mr Williams said that he was with Mr Blutcher outside F Block when Mr Blutcher asked a fellow prisoner, Christopher Mitchell, to 'throw a can over the fence for him'. Mr Blutcher had been unable to locate the can when he had looked earlier. Mr Williams confirmed that Mr Mitchell was on mower duty that morning. This meant he had access to outside the accommodation perimeter fence. His evidence was that Mr Mitchell was able to throw the can over the northern fence, near C block. Mr Williams explained that prisoners at the Farm were not subject to constant supervision when working at their allocated jobs. Mr Williams said that he picked the can up when it came over the fence and Mr Mitchell continued mowing.

27. Mr Mitchell was unable to be located and served with a summons to give evidence to the inquest. Because of this, it remains unclear whether Mr Mitchell knew about the arrangement with respect to the drink can or whether he simply did as Mr Blutcher asked of him. However, I can conclude that Mr Mitchell did not have any further involvement with Mr Blutcher on this day.

28. After Mr Williams and Mr Blutcher collected the drink can that Mr Mitchell was alleged to have thrown over the fence, they returned to Mr Blutcher's room (C.03), where Mr Smith was already present.

29. Mr Smith also gave evidence under compulsion. He said that he knew of the arrangement regarding the drink can, which is why he was waiting in Mr Blutcher's room. He had been given the 'thumbs up' by Mr Blutcher after the can was located. He was on duty at the prison laundry but told CCOs that he needed to return to C block to change his shorts.

30. Mr Smith's evidence was that at the time of Mr Blutcher's death, he had been in custody at the Farm for about 2.5 months. His evidence was that there had been a weekly drink can drop for at least 2 months. The can would usually contain OxyContin or morphine, together with marijuana, and was collected by Mr Blutcher.

31. Irrespective of the frequency of the drop off, it was clear on the evidence that the plan was for the drugs to be shared between Mr Williams, Mr Smith and Mr Blutcher. The quantity of marijuana would be otherwise distributed.

On this occasion, Mr Smith also thought that the drug in the can was to be OxyContin. He did not know how Mr Blutcher had sourced the drug, and was not involved in making arrangements for the drink can to be delivered to the Farm.

32. Mr Smith said that after the can was opened in Mr Blutcher's room he saw it contained a fentanyl patch, some 'weed' and three syringes, along with a quantity of gravel. This was apparently used to give the can enough weight to throw over the fence.

33. Mr Williams said that at the time the can was opened, he heard a call for the trolleys to be unloaded in the kitchen. He marked one of the syringes to identify it as his. He had collected some lemon juice from the kitchen (to extract the fentanyl) and took it to the room but he left to attend to kitchen duties, which required him to unload food into the fridge.

34. He said that soon after, he passed Mr Smith in the hallway and was told that he 'had his share'. He also saw Mr Blutcher in the hall. He had soot on his face. Mr Williams assumed this was from heating the spoon to extract the fentanyl from the patch. Mr Blutcher said 'that thing is in my room'. Mr Blutcher was slurring his words and 'his eyes were all over the place'.

35. Mr Williams said that by this time he had changed his mind about taking the drug and told Mr Blutcher 'I'm right thanks'. He had heard 'bad things' about patches and did not want to take risks by using one.

36. Mr Smith said that he injected 9ml from a 10ml syringe and he saw Mr Blutcher inject around 3ml. He said that he then left the room and went back to his duties and that Mr Blutcher was fine when he left his room. He said that one third of the patch had been used at this time and there was two thirds remaining.

37. The CCTV footage captures Mr Blutcher, Mr Williams and Mr Smith entering Mr Blutcher's room for about 5 minutes before 8:00am. Mr Blutcher and Mr Smith both subsequently exit the room. At 8:13am, Mr Blutcher can be seen in the common area and he appears to speak with Mr Williams before returning to his room.

38. This is the last time Mr Blutcher can be seen on the footage. Mr McDonald, the C Block cook, gave evidence that Mr Blutcher walked past him at around this time in the common area, and he asked him how he came to have 'black stuff' on his face. Mr Blutcher did not say what the soot was from. He said that Mr Blutcher seemed OK at that time.

39. When Mr Blutcher returned to his room for the last time, he entered on his own. I am satisfied that he was then the only person in his room. At 8:44am, Mr Blutcher was located unconscious on his bed in his room by prisoners Williams and McDonald, who informed correctional staff.

40. Mr Williams said that he had gone to E block to purchase a can of drink and went to Mr Blutcher's room to share it with him. He found him sitting, leaning

against the wall with a syringe in his hand. He initially thought that Mr Blutcher was 'mucking around' but Mr McDonald came in and said 'he's gone mate'.

41. After CCOs were alerted a Code Blue emergency response was called. Mr McDonald gave evidence that he was trying to pump Mr Blutcher's chest, but there was no response. He saw a tourniquet around Mr Blutcher's arm and a needle was still in his arm.

42. On the arrival of correctional staff, Mr Blutcher was lying flat on his back on his bed and did not respond to verbal commands or shaking. CPR was commenced by prison staff using an 'oxy reviver unit' and an automated external defibrillator. The QAS was also called, and QAS officers were in attendance by 9:04am. Mr Blutcher could not be resuscitated and was pronounced deceased.

43. Afterwards, various items suggesting the use of drugs were found in Mr Blutcher's room including three syringes, a fentanyl patch[1] that had been cut up, lemon juice, a small bowl with some water, a dessert spoon, and a cigarette lighter. The drink can, which had been cut open, was also located and contained wet gravel.[2]

44. After considering the evidence of Mr Williams and Mr Smith, I am satisfied that the transdermal fentanyl patch was cut into three pieces and fentanyl was extracted using lemon juice and heat. Mr Smith injected a quantity together with Mr Blutcher. It was intended that Mr Williams also inject a share of the extract. However, Mr Williams changed his mind and decided not to. I am satisfied that Mr Blutcher then injected Mr Williams' share.

45. Regardless of the amounts each person injected, I am satisfied that Mr Blutcher took an additional amount, which led to the toxicology results at autopsy confirming a lethal level of fentanyl.

Autopsy results

46. Forensic pathologist Dr Nigel Buxton conducted a full internal autopsy on 19 September 2013.

47. Dr Buxton found that there was no evidence of external physical trauma to Mr Blutcher's body which would account for the death. Evidence of persistent intravenous needling with scarring to both antecubital fossae (elbow pits) was identified, as was a fresh puncture wound consistent with self-injection in the left antecubital fossa. Dr Buxton was able to differentiate this fresh puncture wound from the site which the QAS would have used. There was a degree of subcutaneous bruising in the wound, consistent with self-injection, which confirmed that it was made while Mr Blutcher was still alive.

[1] Durogesic - 75mcg/hr

[2] These items are depicted in exhibit F2

48. Toxicology testing revealed a level of fentanyl at 0.02mg/kg, which Dr Buxton was satisfied was a sufficient level to cause death. Dr Buxton could not find any evidence of any natural disease process which might have caused or contributed to the death.

49. Dr Buxton determined that the formal cause of death was from an overdose of fentanyl.

Investigation findings

50. None of the other inmates at the CCC provided information to the investigating officer suggesting foul play. The inmates provided information about to how Mr Blutcher came to be in possession of the fentanyl, which ultimately caused his death.

51. The examination of Mr Blutcher's body and his room at the CCC revealed no signs of violence.

52. The CSIU investigation into Mr Blutcher's death did not lead to any suspicion that his death was anything but as a result of the drug use.

The adequacy of the security and surveillance at the CCC

53. The CCC confirmed to investigating police that the prison did not supply the syringes used by Mr Blutcher, and the fentanyl (in the form of a transdermal patch) was not obtained by any lawful means. Because of this, the inquest investigated the following additional issues:

    1. The adequacy of the security and surveillance surrounding the Capricornia Correctional Centre Farm to prevent prohibited items being accessed by prisoners; and
    2. The adequacy of the surveillance within the Capricornia Correctional Centre Farm to detect prohibited items in the possession of prisoners.

54. Given that the fentanyl was obtained illicitly, the police investigation involved a variety of interviews with inmates at the prison to find out how the fentanyl was obtained. From those interviews, investigating police made a number of conclusions, which I accept and can be summarised as:

    - Sometime before the morning of the death, a soft drink can containing a fentanyl patch and syringes was deposited by unknown person(s) outside the northern fence of the Farm. This was known to Mr Blutcher.
    - Forensic examination of the can and the needles could not identify the person responsible for delivering these items.
    - The drugs were delivered to an unsecured area a member of the public could access with little fear of detection. A public road runs along the north side of the farm approximately 100 metres from the fenced accommodation area. There is a lower boundary fence between this road and the fenced accommodation area. There is limited CCTV monitoring of this area.
    - It is unknown whether Mr Blutcher or someone else facilitated the delivery of these items. A review of Arunta calls made by Mr Blutcher did

not identify any suspicious conversations, coded or otherwise, to suggest that Mr Blutcher organised the delivery of the fentanyl patch, syringes and other items. These arrangements could have been pre-arranged by Mr Blutcher prior to his incarceration, by written correspondence or made through another prisoner.

55. In terms of external security at the time of Mr Blutcher's death, I was provided with information to confirm that a high fence topped with razor wire secured the accommodation area of the Farm. The external area of the Farm is patrolled during the night at various intervals, and those patrols are supposed to be logged in a hand written register. While there were entries completed for the morning of Mr Blutcher's death, it was noted in the lead up to the inquest that there were no entries in the log for external patrols for the night before Mr Blutcher's death, being 16 September 2013.

56. This was clarified by Queensland Corrective Services (QCS) by way of the provision of further sworn statements from the correctional officers on the relevant shift. CCO Baker confirmed that one of his duties over this shift was the external patrol of the compound areas. This duty is carried out in the company of a second correctional officer. Mr Baker affirmed that he conducted external patrols on this particular shift at 21:30, 23:45, 3.00 and 4.30 hours. When conducting the external patrols, he said that he normally walks around the rear of the units, between the units and the fence line. He is assisted by two perimeter lights, which are located at the bottom corner of the Farm compound, in addition to five fluorescent lights on the rear of each unit.

57. While conducting the patrols, Mr Baker looked for anything unusual that may be laying around the compound, anything that may be hanging on the fence, any unauthorised movement of prisoners inside the units. He also checks the secure mesh on the cell windows. Mr Baker provided information that he has, in the past, found contraband items in many different places, such as in paper towel holders, or hidden in clothing in rooms. Since working at the CCC, he has found a mobile phone in a toilet roll, and cigarette lighters hidden in shoes and plumbing in the units.

58. Mr Baker's evidence was that he did not fill out the external patrol log for his patrols on this particular shift. He said that, while not common, this was not the first time he has missed signing logs/registers while on duty. He could not recall why he missed signing the log on this particular shift, and had no independent recollection as to why that might have been the case.

59. I was provided with evidence at the inquest to confirm that there is an external CCTV camera in use at the Farm, which extends to show part of the internal road which leads to the Farm Administration Building, however, that camera had limited effect at night at the time of the death.

60. In the course of my investigation, I requested information from CCC as to what measures (if any) had been put in place by the prison along the northern fence of the farm to prevent prohibited items being thrown over and accessed by the prisoners. The current General Manager at CCC, Yme

Dwarshuis, provided a response. I also heard evidence from Mr Dwarshuis at the inquest. He had been in the role of General Manager since November 2015.

61. Mr Dwarshuis confirmed that the prison farm is located approximately 1.5km from the main centre. The secure area of the Farm is comprised of four accommodation units, a gate vestibule and staff offices as well as a prisoner recreation room and gymnasium. The perimeter fence of the Farm's secure area was described by Mr Dwarshuis as a galvanised chain mesh construction, 3.6 metres in height and topped with approximately 900mm of razor wire.

62. Reference was made during the inquest to the Custodial Operational Practice Directives, which prescribe the frequency of head counts and musters. At the time of the Mr Blutcher's death, the following measures were in place at the CCC Farm, and have been continued as routine practice in the monitoring of the activities of prisoners:

    (a) Random patrols of the prison reserve and the immediate farm surrounds are conducted by Dog Squad officers during the day shift only, as there is no night shift Dog Squad officer on duty. Patrols may identify unauthorised access of the reserve by members of the public or suspicious behaviour by prisoners. Dog Squad officers may challenge any person suspected to be on the reserve without authority. Dog Squad officers may also challenge or report the activities of prisoners undertaking work in any part of the prison reserve where they reasonably suspect that unauthorised activity is taking place.

    (b) The internal fence and surrounding grounds are patrolled and inspected for tampering to the fence or the presence of any contraband items.

    (c) The Intelligence Unit carries out analysis of information gleaned from various sources. Analysis may point to conduct of a prisoner and the secretion of contraband items within buildings or the prison reserve. This analysis will inform the selection of targeted searching of certain prisoners and or locations within the prison reserve or buildings.

    (d) *Any vehicle suspected as being on the reserve without authority will have its details recorded and forwarded to the Intelligence Unit and Queensland Police Intelligence*.

63. Mr Dwarshuis also provided evidence of measures that have been taken by the CCC since Mr Blutcher's death. A new electric fence has been installed, which is located parallel to the existing fence. The fence has sensors that alert staff to potential tempering or attempts by prisoners to leave the Farm perimeter. The fence was installed during August 2015 and has been operational since September 2015.

64. I heard evidence that the Farm is a low security prison facility. Prisoners accommodated at the Farm need to be classified 'Low'. They need to satisfy a range of suitability assessments to be considered for transfer to the site. The focus at this facility is on prisoner rehabilitation as they progress to release, and as such the prisoners are afforded a degree of trust.

65. The prisoners at the Farm do perform a number of duties on the Farm as part of their structured day. The wider area of the Farm covers some 450 hectares of land and its boundary runs along Etna Creek Road for some 1.5km. If prisoners are working within the perimeter fence, they are not directly supervised at all times, but may be subject to random inspections. It is a similar situation for those prisoners working outside the perimeter fence. The gate to the main permitter fence remains open at certain times of the day.

Conclusions

66. I conclude that Mr Blutcher died from an accidental overdose of fentanyl. I am satisfied that none of the correctional officers or inmates at the CCC directly caused or contributed to his death.

67. Coroners have noted a rapid increase in the frequency of deaths resulting from the misuse of prescription drugs, including fentanyl, in recent years.[3] Fentanyl is a highly potent opioid. There is a small margin between a therapeutic dose and toxic dose and there are a number of risks of overdose from fentanyl patch use. The increase in opioid deaths has accompanied the rapid increase in the rates of prescription of these drugs.

68. Deaths related to fentanyl misuse have shown the following characteristics:[4]

- The highest proportion of cases involved deceased aged between 30-39 years;
- 70% of deaths involved males;
- The majority of deaths occurred in a home environment;
- The most common method of administration involved extraction and injection of contents from prescribed fentanyl patches.

69. I am satisfied that that there is no evidence to suggest that Mr Blutcher intended to end his own life. It is likely that he misunderstood the potency of fentanyl, which is 50-100 times more powerful than morphine. He was only a few weeks away from his parole release date, and had kept a 'count down' calendar in his room. He had been oriented towards life after release, including contact with his family.

70. The evidence at the inquest established that there was a simple but effective arrangement in place between three prisoners at the Farm for drugs to be delivered in soft drink cans. As prisoners were able to buy drinks from a vending machine, it was not unusual for a prisoner to be in possession of a can. Mr Blutcher and two others were the consistent recipients of drugs, usually OxyContin or morphine.

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[3] Roxburgh A, Burns L, Drummer OH, Pilgrim J, Farrell M, Degenhardt L. Trends in fentanyl prescriptions and fentanyl-related mortality in Australia. Drug Alcohol Rev. 2013; 32:269–75.

[4] Deaths Related To Fentanyl Misuse – An Update, National Coronial Information System October 2013

71. The arrangement was that the drugs would be concealed in a drink can, and thrown over the external perimeter fence. The prisoner responsible for taking the bins out to the industrial bin in the morning was able to access the drink can and bring it back to the unit block, where the contents would be shared. Correctional officers did not directly supervise the internal unit blocks at all times.

72. Mr Smith recalled that this was a weekly arrangement, and would occur earlier in the week. He said that at the time of Mr Blutcher's death, he had been at the Farm with him for about 10 weeks, and this arrangement had been ongoing, on a weekly basis, for at least 8 weeks.

73. In contrast, Mr Williams only recalled three instances. I do not consider that I need to make a finding about how often the arrangement occurred. However, I am satisfied that it occurred on more than one occasion.

74. Having heard evidence from the correctional officers on shift on the morning Mr Blutcher died, it is clear that the arrangement went undetected by correctional staff. The correctional officers' evidence was that drugs were not often detected in contraband found at the Farm.

75. I am satisfied that a room search would not have necessarily prevented Mr Blutcher's death, as this was not a case where the drugs were concealed within his room for any length of time. The drugs were used within two hours after Mr Blutcher acquired them.

76. With respect to the security and surveillance of the outer northern perimeter of the Farm, I heard evidence that the external CCTV camera was of limited effect at night, and pointed inwards towards the Farm, as opposed to towards public areas. I also heard that the lighting around the perimeter was quite poor, making external patrols difficult.

Findings required by s. 45

77. I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. As a result of considering all of the evidence, including material contained in the exhibits, I am able to make the following findings:

Identity of the deceased - The deceased person was Micheal Wayne Blutcher

How he died - Mr Blutcher died in his room at the Farm precinct of the Capricornia Correctional Centre after injecting a quantity of fentanyl extracted from a transdermal patch. He had obtained the fentanyl after an unknown person (or persons) threw it over the outer prison fence concealed in a soft drink can, undetected by correctional staff.

Place of death – He died at Rockhampton in the State of Queensland.

Date of death – He died on 17 September 2013.

Cause of death – Mr Blutcher died from an accidental overdose of fentanyl.

Comments and recommendations

78. Section 46 of the *Coroners Act*, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

79. It is important to place in context that the Farm is a low security facility, which is focused on prisoner rehabilitation. Prisoners are carefully assessed before given a 'low' security classification. Prisoners who breach the trust placed in them at the Farm are returned to secure custody. As the detection of concealed drugs is a problem in maximum security facilities I accept that there is no easy solution to the problem at low security centres.

80. I have been assisted by QCS in the provision of further information relating to the strategies in place for the detection of concealed drugs in correctional facilities. These include the presence of drug detection dogs, scanning devices, urine screening of prisoners, and random searching of prisoners, visitors and accommodation.

81. In the context of high security prisons, the Queensland Audit Office's recent report on the *Management of privately operated prisons - Performance of private and public prisons*[5] identified that "*illicit drug use remains an area of*

[5] Report No. 11 – 2015-2016, page 42

concern in all Queensland prisons with an average of 12.5 per cent of prisoners testing positive in 2014–15 across Queensland high security prisons". The report concluded that illicit drug use is "*one area where QCS's policy and strategies are not working effectively and is an area of concern for both private and public prisons"*. I note that the CCC had the lowest percentage of prisoners testing positive in the State in 2014-15.

82. Mr Dwarshuis' evidence was that he has already made a request for improvements to external surveillance at the CCC Farm precinct, by way of improved CCTV surveillance and lighting. This request was still under consideration of the time of the inquest.

83. In the circumstances, I accept that QCS has examined the circumstances of Mr Blutcher's death with a view to reviewing systems in place at the CCC Farm to minimise the entry of contraband, including the supervision and surveillance of the boundary fence along Etna Creek Road.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
9 May 2016