QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Darren Michael FITZGERALD**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
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FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, availability of opioid diversion & needle exchange programs in prisons, augmentation of intelligence responses at Woodford Correctional Centre, drugs in correctional facilities

REPRESENTATION:

Counsel Assisting:	Mr Craig Eberhardt
Next of Kin:	Mr David Gardiner
Department of Corrective Services:	Ms Kay Philipson

Findings of the Inquest into the death of Darren Michael Fitzgerald

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The *Coroners Act 2003* provides in s45 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organizations granted leave to appear at the inquest and to various specified officials with responsibility for the justice system including the Attorney-General and the Minister for Corrective Services. These are my finding in relation to the death of Darren Michael Fitzgerald. They will be distributed in accordance with the requirements of the Act and a copy placed on the website of the Office of the State Coroner.

Introduction

At the time of his death Mr Fitzgerald was an inmate of the Woodford Correctional Centre where he was serving a sentence of life imprisonment for murder.

At about 2am on 13 June 2004, correctional staffs were conducting a routine head count of unit the unit in which Mr Fitzgerald was housed when they noticed him slumped at his desk. A nurse was called and she and the correctional officers entered the cell. It was immediately ascertained that Mr Fitzgerald was dead.

These findings seek to explain how the death occurred and consider whether any changes to prison policy or procedures would reduce the likelihood of further deaths occurring in similar circumstances.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Because Mr Fitzgerald, was when he died, detained in a corrective services facility, his death was a "*death in custody*"[1] within the terms of the Act and so it was reported to the State Coroner for investigation and inquest.[2]

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened;
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death but as there is no contention around that issue in this case I need not seek to examine those authorities here with a view to settling that question. I will say something about the general nature of inquests however.

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[1] See s10

[2] s8(3) defines "*reportable death*" to include deaths in custody and s7(2) requires that such deaths be reported to the state coroner or deputy state coroner. Section 27 requires an inquest be held in relation to all deaths in custody

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [3]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[4] However, a coroner must not include in the findings or any comments or recommendations statements that a person is or maybe guilty of an offence or is or may be civilly liable for something.[5]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[6]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[7] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[8]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[9]This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that

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[3] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[4] s46
[5] s45(5) and 46(3)
[6] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[8] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[9] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13

finding. As *Annetts v McCann*[10] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

I will now say something about the investigation of Mr Fitzgerald's death. As can be readily appreciated, any death in custody may raise suspicions in the minds of those close to the deceased, that he/she has met with some foul play and/or the authorities have failed in their duty to properly care for the prisoner. It is therefore essential that even when a death appears at the outset not to be suspicious, the investigation is thorough and rigorous. I am satisfied that it was in this case.

As soon as the nurse employed by the correctional centre declared Mr Fitzgerald's life to be extinct, the cell was closed and guards were posted to prevent any interference with the scene. The correctional supervisor of the wing called the Woodford police station and at two general duties officers attended the prison. At about 3.45am the on call detectives from the Corrective Services Investigating Unit (the CSIU) a specialist group from the Queensland Police Service (QPS) who undertake the investigation of all deaths and serious incidents in correctional centres were advised of the death. Two officers from that unit attended the centre about four hours after the death had been discovered. They took control of the investigation. I am satisfied that prior to their arrival correctional officers and the general duties police officers maintained the integrity of the scene from an investigative perspective.

Relevant evidence within Mr Fitzgerald's cell was photographed and witnesses were interviewed and statements obtained. The investigation focussed on establishing the cause of death and on eliminating the possibility of foul play.

On 14 June 2004 an autopsy was conducted by Dr Alex Olumbe a forensic pathologist from the John Tonge Centre.

The CSIU investigation report was received at the Office of the State Coroner in April 2005. Since then, further enquiries into the underlying causes of the death have been undertaken by staff of the Office of the State Coroner with the assistance of counsel assisting.

The inquest

A pre-hearing conference was held in Brisbane on 16 March 2006. Mr Eberhardt was appointed Counsel Assisting. Leave to appear was granted to the Department of Corrective Services and the Aboriginal and Torres Strait Islander Legal Service. The inquest then proceeded over 2 days on 13 and 14 June 2006. Nine witnesses gave evidence and 62 exhibits were tendered.

The evidence

I turn now to the evidence. Of course I can not even summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

[10] (1990) 65 ALJR 167 at 168

Background

Unfortunately I have little information about Mr Fitzgerald's life, other than that contained in his Queensland Police Service (QPS) criminal history and his various prison files. Those records indicate that by the time Mr Fitzgerald was 15, he was already appearing in court charged with criminal offences and over the next 15 years he regularly appeared in court on charges of break, enter and steal, wilful damage, assault and unlawful use of a motor vehicle. As a result of being convicted of some of these offences he was sentenced to short periods of imprisonment. In 1998 Mr Fitzgerald was sentenced to life imprisonment after being convicted of murder.

From the time of that conviction until the time of his death he was incarcerated in the Woodford Correctional Centre and remained under a high security classification throughout.

Mr Fitzgerald's history of drug abuse in prison

On initial assessment, at the commencement of his life sentence, Mr Fitzgerald disclosed a history of drug abuse. Thereafter, whilst in prison he returned positive results to urine drug screening tests on fifteen occasions. He was breached for drug related offences on nine occasions.

In March 2002, June 2002 and February 2004 Mr Fitzgerald was placed on a management plan for drug use. The key aspects of these plans were for him to remain drug free, breach free and maintain acceptable behaviour. This action was initiated as a result of the positive urine tests and as a consequence Mr Fitzgerald was denied contact visits for the duration of the plans. None of the plans succeeded in remedying Mr Fitzgerald's tendency to abuse illicit drugs.

The events surrounding the death

At the time of his death, Darren Fitzgerald was housed alone in cell 15 of unit N17 which held 34 other prisoners. Prison officers describe him as "*a mainly compliant prisoner who was generally easy to manage within the unit."*

He closely associated with his half brother Brian McPartland who was incarcerated in the same unit.

On 11 June 2004, Mr McPartland received a contact visit from his girlfriend, Ms Jodie Loy (nee Manning). Ms Loy was known to Mr McPartland prior to his imprisonment in 2002 but both say they only considered themselves boyfriend/girlfriend from about late 2003 onwards.

Ms Loy denies ever bringing any drugs into the prison, but acknowledges that on one visit an ionscan device which can detects minute traces of illicit drugs indicated that she had been in contact with heroin. She denied having any knowledge of how this occurred and claims the prison authorities at the time accepted her denial and allowed her to continue with the contact visit on that occasion.

It is also noteworthy that later on the 11 June 2004, Mr McPartland telephoned his father Brian Wootton and instructed him to put $980 in Ms Manning's bank account.

Both Messieurs McPartland and Wootton claimed that transaction was a result of Mr McPartland winning the money on the horses. They say Mr Wootton regularly placed bets on his son's behalf. Mr McPartland says he instructed the money be given to Ms Loy to help her with general living expenses. She says she needed no such help. Mr Wootton says he was told to provide the money to Ms Loy so that she could make arrangements to buy things for Mr McPartland's child who lived in North Queensland.

The circumstances of the payment and the inconsistencies in the explanations for it raise a strong suspicion that Ms Loy brought drugs into the prison and that Mr McPartland cuased the money to be transferred to her in payment for this.

Mr McPartland says that he knew Mr Fitzgerald had some heroin in the days before his death because Mr Fitzgerald gave him some of the drug. He would not say where he thought Mr Fitzgerald got the drug from.

Nothing noteworthy or suspicious is known about Mr Fitzgerald's actions on the day of his death. At about 10.00am Mr Fitzgerald went with other prisoners to the oval at the correctional centre. They returned to the unit at about 11:15am.

At about 2pm, Mr Fitzgerald went to the medical unit where he received some analgesic cream for chronic shoulder soreness. He returned to the unit at 2:25pm.

Mr McPartland says he saw Mr Fitzgerald at about 4.00pm and it was obvious to him that Mr Fitzgerald had ingested heroin.

At 6:20pm the lock down procedures commenced. This involved the officers in control of the unit sighting all prisoners and ensuring that each prisoner was securely locked in their individual cells.

Mr McPartland, was housed on the second level on the opposite side to Mr Fitzgerald's ground floor cell. He says that at about 8.00pm he called out to Mr Fitzgerald to see if he was alright. He says he did this because he knew Mr Fitzgerald had been using heroin. He says that although Mr Fitzgerald did not at first respond, after prompting from the prisoner in the cell next to his, Mr Fitzgerald assured Mr McPartland that he was alright and they said good night to each other.

At about 9.00pm a head count was undertaken. The officers who did this say Mr Fitzgerald was alive and sitting at his desk. They claim to have seen him moving as if writing. Another head count was conducted at about 11.00pm. The officer who undertook that inspection says he is sure that there was a prisoner in cell 15 but doesn't remember anything else about the prisoner.

The death is discovered

The next check on the prisoners occurred at 2.00am on the 13 June 2004. On this occasion the officers noticed Mr Fitzgerald slumped over his desk. His reading light

was on and they noticed that his chest did not seem to be rising and falling as would be expected. They knocked on the glass in the door and saw no response or movement from Mr Fitzgerald. The officer rang master control and requested that the officer there use the intercom system to try and communicate with Mr Fitzgerald. The officer at the door of Mr Fitzgerald's cell heard the officer at master control calling over the intercom "*Are you there Fitzy?"* The speaker for that intercom was located near the desk at which Mr Fitzgerald was sitting. He made no response.

On hearing no response and being told that his voice had prompted no movement, the officer at master control called a medical emergency which caused a number of officers including a nurse to attend the cell very quickly. The door was remotely unlocked. No one other than Mr Fitzgerald was in the cell when it was opened. The nurse checked for a pulse on Mr Fitzgerald but could find none. Mr Fitzgerald was laid on the ground and further checks were made. It was apparent to the nurse and the others present that Mr Fitzgerald was dead and had been so for some time. In the circumstances no resuscitation was attempted.

The officers saw an orange syringe cap lying on the desk close to where Mr Fitzgerald's head had been. They also saw a small syringe and a needle on the floor under the desk. Near the cell door on the floor was a cassette tape with the tape unwound from the spools. The tape had a pair of nail clippers secured to one end of it. The prison officers recognised this as a device prisoners use to pass objects from one cell to another. It is referred to as a string line.

The investigation is commenced

The cell was secured and the investigation referred to earlier was commenced. All of the 34 prisoners housed in the unit at the time of the death were interviewed and drug tested. Eight returned positive results for opioids and two returned results that indicated that they had been drinking copious quantities of water, a method frequently used to flush illicit drugs from the system.

A search of the cell and the whole unit was undertaken. On the desk in Mr Fitzgerald's cell there was found a small piece of torn envelope with the word "Fitzy" printed on it. It contained traces of heroin. No finger prints were found on the paper and the handwriting was not able to be identified. There was a spoon on the desk containing remnants of a white fluid.

There were no signs of a struggle in the cell.

Mr McPartland was told of the death by prison officers. He was allowed to view Mr Fitzgeral's body and identified him to the prison officers. Police from Upper Mount Gravatt attended on Mr Fitzgerald's mother at her home and advised her of the death.

Another syringe was found secreted in a boxing mitt in a common area in the unit. When giving evidence Mr McPartland admitted he had secreted it there.

Autopsy evidence

On 14 June, an autopsy was undertaken on the body of Mr Fitzgerald by Dr Alex Olumbe, an experienced forensic pathologist.

Dr Olumbe found no signs of traumatic injury, and no signs of suffocation or asphyxiation on Mr Fitzgerald's body. He did however, find scarring associated with recent and previous puncture marks in the right elbow joint. These were consistent with injury caused by self administered illicit drugs. Toxicology analysis found that Mr Fitzgerald had a total morphine level of 0.57mg/kg in his body. Dr Olumbe said this is the high end of the fatal range.

Dr Olumbe also advised that a person's ability to tolerate high doses of morphine varies quickly with frequency of use. After a relatively short period of abstinence that tolerance can be eliminated leading to inadvertent accidental overdoses easily occurring.

Dr Olumbe also found that the left anterior descending coronary artery had eccentric stenosis reducing the lumen by up to 75%.

Dr Olumbe said in evidence that such stenosis could in itself account for the death and that the effects of an overdose of morphine could exacerbate the problem as morphine repressed respiration and therefore placed greater strain on the heart.

Dr Olumbe gave some evidence in relation to the timing of the death. He noted that the lividity present on the posterior of the body is fixed but that would have occurred whilst Mr Fitzgerald's body was in the mortuary. As he died in an upright position and there was no fixed pooling of blood in the feet it is likely that he died not more than four hours before being found.

Mr Fitzgerald was found to be suffering from Hepatitis C.

The presence of 6-monoacetylmorphine in a urine sample indicated that the heroin in Mr Fitzgerald's body was ingested within twelve hours of death.

I consider that no action of any prison officer or other prisoner caused or directly contributed to the death. I am satisfied that Mr Fitzgerald accidentally caused his own death by unintentionally injecting more heroin than his body could effectively metabolise. I am satisfied that the prison authorities had no information to alert them to the likelihood that Mr Fitzgerald was in imminent risk of harm and that they responded expeditiously and appropriately when they became aware that Mr Fitzgerald may be in need of assistance.

Findings required by s45

I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with this last issue, the circumstances of the death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of the death.

Identity of the deceased – The deceased person was Darren Michael Fitzgerald

Place of death – He died in cell 15 of unit N17 at the Woodford, Correctional Centre, Woodford, Queensland

Date of death – Mr Fitzgerald died on 12 or 13 June 2004

Cause of death – He died from heroin toxicity with a possible contribution from coronary atherosclerosis

Concerns, comments and recommendations

Section 46 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. This case obviously raises for consideration the effectiveness of the efforts by correctional authorities to limit the use of illicit drugs by prisoners.

Drugs in prison

The detrimental effects of drug abuse in prison

The negative impact of drug abuse in the community is well known and documented and requires no comment from me in this case other than to note that all of those destructive and detrimental effects are, with one exception, replicated and magnified when the abuse occurs in prison. The exception is of course road traffic trauma – a significant mercy.

The harm caused by drugs in prison can be clustered into the categories of health, crime and management.

Health risks include the spread of blood born viruses, accidental overdose and newly acquired or maintained addiction.

Crime risks arise as inmates "standover" others to force them to participate in smuggling drugs into and around prisons, suppliers respond with violence to unpaid drug debts and prisoners released with outstanding drugs debts resort to crime to settle those debts. There is also an increased risk of official corruption and a resulting compromise to security if prison officers succumb to the temptation to supply drugs in exchange for the inflated prices that will be paid in the captive market.

Management problems stem from the difficulty of controlling intoxicated prisoners and those committing drug related crimes or fearful of being the victims of such crimes.

The extent of the problem

In the report of the 1996 Commission of Inquiry into drugs in Queensland prisons, Commissioner Mengler said that *"(t)he presence of drugs in prisons is the most serious challenge facing corrections today."*[11] Extensive sampling undertaken by

[11] Report of the Commission of inquiry into drugs in Queensland Custodial Correctional Centres. 1996, p50

an independent agency for that Inquiry led it to conclude that between 16.5% and 21.4% of prisoners in Queensland prisons were using illicit drugs.

The evidence received during this inquest indicates that illicit drug abuse remains a significant problem at the Woodford Correctional Centre and throughout Queensland correctional centres generally. However that evidence reports substantially fewer prisoners now testing positive than in 1996, an improvement for which the department deserves credit.

In summary that evidence is as follows:-

- As part of the investigation into Mr Fitzgerald's death all prisoners in unit N17 were tested. Eight of the thirty four prisoners tested positive and two gave results indicating they had attempted to flush illicit drugs from their bodies - a positive rate of 29% but undertaken with no controls for randomness.

- Random drug tests conducted monthly around the state show that for the period January 2004 to January 2006, the average returning a positive result was 4.7% of all prisoners. Woodford did a little better with the average in the same period being 4.05% although in February 2006, 8.1% of those tested returned a positive result confirming the volatile nature of the data.

- Mr Fitzgerald tested positive to heroin on nine occasions in 2003/04.

The efforts of the Department of Corrective Services to address the problem

I am persuaded by the evidence given by the Manager, Drugs Strategy Unit Offender Programs and Service Directorate that the Department of Corrective Services is making diligent efforts to address this problem. The Department quite reasonably recognises that while the total elimination of drugs from prisons is a worthwhile long term goal it is not achievable in the short term and in the meantime it is essential that harm minimisation strategies be engaged to reduce the spread of blood borne viruses and of death due to overdoses.

I have had some difficulty engaging with these issues because the evidence relevant to it concerns what happened in Mr Fitzgerald's case, what has happened in corrections since and what is proposed by the Department's recently finalised Drug Strategy 2006 – 2011. I will attempt to distinguish between these different perspectives where appropriate.

The Department claims it is undertaking a holistic approach to the reduction of drug related harm by balancing the three goals of supply reduction, demand reduction and harm minimisation. It is appropriate that I deal with each of these strategies individually.

Reducing the supply

The strategies for reducing the amount of drugs entering the prison involve identifying those most likely to attempt to introduce drugs and monitoring those people and others who may be involved with a view to intercepting the drugs. This approach utilises intelligence analysis and searches. These and other policies also aim to deter drug use by prisoners by imposing sanctions on those who introduce or receive drugs in prisons.

Intelligence analysis

The Department indicated that it has an intelligence driven approach to reducing supply that allows it to focus its enforcement efforts most effectively. Intelligence collection, collation and analysis is aimed at enabling the Department to determine which prisoners, staff, contractors or visitors warrant active monitoring. These activities are however resource intensive.

Independent inspectors appointed by the Department to review the circumstances of Mr Fitzgerald's death reported that the intelligence section of Woodford Correctional Centre was under resourced and that it could not adequately process all relevant information. While staff numbers allocated to this section since Mr Fitzgerald's death have increased from three to four, I understand the prison population has increased by approximately 43% in the same period.[12] In real terms, therefore, there has been no increase in the intelligence capability of the centre.

The intelligence manager who gave evidence at the inquest acknowledged that two more intelligence analysts were needed to adequately discharge this function. I am persuaded that unless this section is adequately staffed the assumptions on which the selective searching and surveillance of potential drug smugglers is based will be seriously compromised.

Recommendation 1 – Augmentation of intelligence resources at Woodford Correctional Centre

I recommend that the resources of the intelligence section of the Woodford Correctional Centre be increased to enable the recommendations of the independent inspectors who reviewed the circumstances of Mr Fitzgerald's death to be properly implemented.

Surveillance and searching

Evidence was received that since the death of Mr Fitzgerald a new Ionscanner has been deployed at Woodford. This equipment detects minute traces of drugs on skin or clothing. Previously, this method was only utilised sporadically but the new more mobile device can now be used throughout the prison whenever and wherever it is required.

In addition there has been an increase in the number of drug dogs available and this detection technique is now apparently used three days a week at Woodford.

[12] exhibit 2.6.1 p2

It is apparent from the evidence given at the inquest that the authorities consider that visitors are the principle target of the supply reduction strategies. Far less attention is paid to importation by staff or private contractors with access to the prison. Evidence was received that drug dogs are occasionally deployed at the staff entrance and all staff are subjected to Ionscanning at least once per year. Further, I was told that contractors are escorted when in areas of the centre that can be accessed by prisoners and vehicles entering the centre are searched and generally watched while in the centre. I found this disparity of effort surprising. However, I have no evidence to indicate that it is misguided.

The supply reduction strategy also has deterrence aspects built in whereby visitors who engage in suspicious behaviour are denied contact visits as are prisoners who test positive to drugs.

Further the department is in the process of rolling out greater controls in visits areas

It is apparent that the Department has given careful consideration to how it can most effectively limit the quantity of drugs being smuggled into the prison. Although the death of Mr Fitzgerald proves that these efforts have not been entirely successful, I received no evidence that would enable me to suggest ways in which the supply reduction strategy could be improved.

Reducing the demand

Factors influencing drug use by prisoners

The influences that predispose people in the wider community to abuse drugs are exacerbated in a prison setting.

A significant number of prisoners are driven to offend by their addiction and bring it with them to prison. Once there, boredom, fear, stress, and loneliness are all conditions that can be temporarily alleviated by intoxicants. Peer pressure is also very potent in a closed and violent environment where not fitting in can be dangerous.

So conducive are the factors predisposing prisoners to drug abuse that Commissioner Mengler observed that "*some enter prison not ever having used drugs and leave as drug users.*"[13]

If prisoners leave jail with a drug habit it is more likely that they will return to crime and fail to comply with any post incarceration supervision requirements. The Department has therefore appropriately identified demand reduction as a major plank of its response to illicit drugs.

The Department's demand reduction strategies

The Department says it seeks to help offenders establish "drug free lifestyles" with a number of programs. The Drug Strategy refers to programs that seek to modify

[13] ib id p 50

the attitudes, values and behaviours of those assessed at being of a high risk of drug related harm.

Evidence put before the inquest indicates that Mr Fitzgerald on at least two occasions participated in a “narcotics anonymous” program. It obviously had minimal impact upon his drug using behaviour. Although such programs remain part of the new Drug Strategy it seems the interventions proposed under it are more comprehensive and integrated and reference is made to a residential program where by prisoners are not housed with the main stream prison population during the course.

The strategy also makes reference to the availability of opioid substitution therapy, but a departmental officer who gave evidence about the strategy advised that this response is currently only available in very limited circumstances; remandees or those sentenced to short terms of imprisonment who were already on a methadone program “outside” and pregnant prisoners during their pregnancy. He advised that currently only 14 prisoners qualify to participate in a methadone program.

Opioid replacement therapy

In the broader community opioid substitution therapy or pharmacotherapy is a front line response to heroin abuse. This mainly take the form of methadone or buprenorphine (also know as Subutex) programs that are aimed at responding to the withdrawal symptoms of the drug addicted persons allowing other strategies to be employed to deal with the causes of their drug abuse.

In the course of the Inquest, Mr Fitzgerald's brother, Mr Brian McPartland, gave evidence that Mr Fitzgerald had often expressed interest in Subutex. Such therapy was not available in the Woodford Correctional Centre, or indeed in the general prison population in Queensland at the time of Mr Fitzgerald's death.

It is therefore appropriate to review the evidence as to whether such programs might have prevented this death and/or are likely to prevent similar deaths occurring in the future.

Prior to 1999 opioid dependence was not treated in Queensland correctional centres. If, when an inmate came into the system, he/she was addicted to heroin or already on a government funded and approved methadone program, the inmate was subjected to compulsory withdrawal and/or maintained his/her drug use by accessing illicit supplies.

In 1999 and 2000 a small trial of methadone treatment was undertaken in Townville Correctional Centre and the Brisbane Women’s Correctional Centre. In 2001 these programs were expanded and buprenorphine was also made available.

In 2002, the then Director of Medical Services of the Department of Corrective Services, Dr Tony Falconer, reviewed the use of these pharmacotherapies to manage opiate dependence in the prison environment.[14] In that report, Dr Falconer observed: -

[14] Exhibit 2.12 Evaluation of Pharmacotherapies for Opioid Dependence.

- Injecting drug users have an increased risk of imprisonment, primarily because of the illegal activities that they engage in to generate funds for the purchase of drugs. A number of studies in various countries found a proportion of injecting drug users among prison populations range from 20 - 50%.[15]

- The concentration of injecting drug users among inmate populations suggests that provision of drug treatment within the prison environment might be more cost effective than in the community.[16]

- The findings of a 1997 New South Wales Prison Health Survey were that 32% of females and 21% of males reported that they had injected drugs in prison at some time in the past. Of these, 70% of males and 69% of females stated that they had shared injecting equipment. Between 1% and 3% of inmates who injected drugs in prison reported that the first time they had ever injected was while in custody.[17]

- The dynamic nature of prison population increases the risk of the transmission of infectious diseases such as HIV and Hepatitis C to the wider community.

- Methadone maintenance is widely recognised as the most effective current treatment for heroin dependency and has been proven to be safe and effective within a correctional setting. The evaluation of a large prison methadone programme in New South Wales revealed that it had resulted in a significant reduction of intravenous drug use amongst treated inmates.[18]

- The available evidence would strongly suggest that individuals forced off treatment would be heavily represented among the inmates who subsequently inject heroin in prison and among those who die from accidental heroin overdose, either in prison or soon after release.

- A trial of continuation of pre-existing methadone maintenance treatment commenced at Townsville Correctional Centre in early 1999 and at Brisbane Women's Correctional Centre in late 1999 found that the goals of the treatment programme were met and that there was no adverse operational impact. Expansion of methadone treatment was recommended.[19]

- Buprenorphine (Subutex), which is another withdrawal and maintenance treatment for opiate dependents, was made available within Queensland correctional facilities in late 2001 in accordance with an election commitment of the State Government.[20]

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15 Exhibit 2.12 at p2, citing Gaughwan et al "Behind Bars - Risk Behaviours for HIV Transmission in Prisons, Review", HIV/AIDS and Prisons AIC (1991)

16 ibid p2

17 ibid p2

18 ibid p4, citing Dolan et. al "Methadone maintenance treatment reduces Heroin injection in New South Wales prisons", Drug and Alcohol Review 1998, 17, 153-158

19 ibid p3

20 ibid p3

- Trials of both methadone and buprenorphine found that they are effective treatments for opiate dependence within correctional facilities. Their availability reduced the likelihood of illicit drug use, accidental overdose and the spread of communicable diseases. It is also likely to reduce recidivism.

These factors led Dr Falconer to recommend that:-

- All inmates who enter prison on opiate pharmacotherapy treatment should have the option on continuing such treatment;

- Appropriate inmates not already on treatment should be commenced on opiate diversion treatments during their period of incarceration; and

- Inmates not in treatment who are assessed at being at risk of returning to drug use after release from custody should be considered for commencement of opiate pharmacotherapies prior to release.

Funding was approved for a continuation of the program in 2002/03 but in early 2003 the Minister for Police and Corrective Services advised the department that he would not support a continuation of that funding.

In a memorandum to the Director-General, Department of Corrective Services, dated 17 March 2003, the Executive Director, Policy and Programme Services set out the ramifications of that decision.[21] In that briefing note, that author advised that:-

- Buprenorphine and methadone programs contribute to crime prevention. Research in Australia and overseas has shown that methadone reduces crime by about 30% and buprenorphine halves re-incarceration rates compared to non treated offenders;

- Cessation of the programme will result in increased demand for illicit drugs within correctional centres and a corresponding increase in the use of illicit drugs within correctional centres. The quantum of increase is difficult to predict, but it is generally accepted that untreated drug dependent prisoners are responsible for around 90% of illicit drug use within correctional facilities;

- Cessation of the programme will result in the increased spread of communicable diseases, particularly Hepatitis C between prisoners to the necessity of sharing intravenous drug using equipment. The diseases will be transmitted to members of the wider community when infected prisoners are released;

- Cessation of the programme will result in increased likelihood of opiate related overdoses, particularly in the period immediately following release, due to the loss of tolerance to opiates to heroin users. This will result in

[21] Exhibit 2.13 DCS briefing note, "Ramifications of non funding of expanded buprenorphine and methadone availability", 17 March 2003

avoidable deaths for a number of released prisoners. Assuming that around 5% (this may be conservative) of prisoners are heroin dependent at the time of incarceration, the number of such deaths expected in Queensland each year would be around 20.[22]

On 18 June 2003 the Acting Director-General of the Department of Corrective Services, sent a briefing note to the then Minister for Police and Corrective Services, advising that:-

- Opiate pharmacotherapies could be provided within correctional centres with only minor operational inconvenience;
- Demand for opiate pharmacotherapies amongst the prisoner population was high; and
- It was possible to maintain treatment when transferring between correctional facilities and the community.[23]

The issue was again revisited in a briefing note prepared in December 2005 that recommended to the Minister for Police and Corrective Services that an opioid replacement programme be implemented.[24] That briefing note described the programme as a key component of the Drug Strategy which is critical to both demand reduction and harm reduction.[25]

Evidence was given by an intelligence officer at the Woodford Correctional Centre that an increasing amount of buprenorphine was being smuggled into the Woodford Correctional Centre.[26]

The Manager - Drug Strategy Unit, Offender Programmes and Services Directorate Department of Corrective Services gave evidence at the Inquest. He confirmed the thrust of the documents I have just summarised and said that no new evidence had come to light since their creation to indicate any negative impacts of these therapies. The conclusions and recommendations of those submissions seem well researched, evaluated and reasonable.

The evidence indicates that the use of these pharmacotherapies would:-

- reduce the likelihood of accidental, fatal overdoses of illicit drugs in prisons;
- lessen drug related violence among prisoners;
- lessen the potential for corruption among prison officials;
- reduce incentives for visitors to smuggle drugs into prisons;

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22 ibid p 1 - 2.
23 Ibid p1.
24 Exhibit 2.15 DCS briefing note "Draft Queensland Department of Corrective Services Drug Strategy" 20 December 2005.
25 At page 4
26 T p106 evidence of Mr Craig Steeley

- diminish the spread of blood born diseases among prisoners and their intimate associates when they leave prison;

- reduce drug debts, a driver for post-release crime; and

- improve the reintegration and employment prosects of prisoners who are released free of addiction.

It would seem the re-introduction of these programs is in the interests of prisoners, their families, the correctional system and the general public. The trials and evaluations have been done. I readily recognise that public policy is a matter for government. However, the *Coroners Act 2003* imposes upon coroners the obligation to make recommendations that seek to prevent unnatural deaths and are aimed at improving the justice system and public health and safety.

Recommendation 2 - Re-introduction of methadone and buprenorphine in all correctional centres

I recommend that as a matter of urgency, the Department of Correctional Services establish opioid dependence pharmacotherapy programs utilising methadone and buprenorphine.

Harm minimisation

Consistent with its acknowledgment that it can not eliminate drugs from prisons, the Department claims to have "*operational strategies to reduce the harm caused by (Illicit) drugs."*[27]

Drug use in a prison carries with the same harm risks as in the wider community; namely drug overdose and the spread of blood borne viruses.

The Drug Strategy is said to be pro-active in its approach to harm minimisation but from my reading of it, in reality the strategy seems limited to an information campaign.

Unlike the general community where education is coupled with practical responses such a needle exchange programs, prisoners are offered only counselling. As a result of treating hypodermic needles as contraband, even though Corrective Services has irrefutable evidence that intervenous drug use is occurring, prisoners using drugs are almost certainly sharing syringes.

Authorities also know that a significant number of prisoners have blood borne viruses in their system and that a significant number inject drugs. In those circumstances I believe they are failing to meet their obligation to minimise the risk of harm to prisoners by failing to allow access to clean syringes.

It may be argued that prisoners are not obliged to take drugs. However, an incarcerated person, particularly one with an addiction, can not be said to have a "free will" in this regard. In any event, the same could be said of drug users in the

[27] exhibit 2.3 para 2

general community, yet the government has chosen to minimise the harm to the general population by the needle exchange program.

Even those, whose callousness might permit them to conclude prisoners do not deserve such consideration, can not ignore the risk that prisoners on release will infect family and others with diseases they have acquired in prison as a result of the Department's refusal to allow access to syringes.

Nor can security be validly raised as an objection. Automatically retracting needles are available and in any event there are currently clearly numerous needles circulating in the prison system – two were found in the unit in which Mr Fitzgerald died and none have been used as weapons. A departmental officer gave evidence that in European countries where syringes are routinely available there are no reported incidents of needles being used in this way.

I am aware of no compelling reason why the department's harm minimisation program should not include access to clean syringes.

Recommendation 3 - Clean syringes be made available to prisoners

In view of the inability of the Department of Corrective Services to keep prisons drug free, and in recognition of its obligation to minimise the spread of blood born viruses among the prison population and those prisoners will come in contact with after release, I recommend that prisoners be given access to clean syringes.

I close this inquest.

Michael Barnes
State Coroner
Brisbane
19 January 2007