CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**AN INQUEST INTO THE DEATH OF STEVEN CLAUDE FREEMAN**
Citation:	**[2018] ACTCD 7**
Court Attendance Dates:	26 July 2016; 19 September 2016; 16 November 2016; 12 December 2016; 20 January 2017; 27-28 February 2017; 1-3 and 20 March 2017; 10 – 11 August 2017; and 21 December 2017.
Date of Findings:	11 April 2018
Before:	Coroner Cook
Legislation and Authorities Cited:	*Coroners Act* 1997 *(*ACT) ss 3C(1)(d), ss13(1)(k), s52, s74 *Anderson v Blashki* [1993] *2 VR 89* *Conway v Jerram, Magistrate and NSW State Coroner* [2011] NSWCA 319 *Harmsworth v State Coroner* [1989] VicRp 87; [1989] VR 989 *March v E & M H Stramare Pty Ltd* [1991] HCA 12; (1991) 171 CLR 506 *Onuma v The Coroner's Court Of South Australia* [2011] SASC 218 *R v Doogan; Ex parte Lucas-Smith* [2005] ACTSC 74; (2005) 193 FLR 239 *Re State Coroner; Ex parte Minister for Health* [2009] WASCA

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WRB Transport v Chivell [1998] SASC 7002

X v Deputy State Coroner for New South Wales [2001] NSWSC 46; 51 NSWLR 312

Appearances and Representation:	James Lawton as Counsel Assisting Coroner Cook with Ms Baker-Goldsmith Mr Ken Archer for the Territory Mr Phillip Walker SC for Dr Luke Streitberg Mr Bernard Collaery for the Freeman Family Mr James Sabharwal for ADON Tasha Lutz
File Number(s):	CD 125 of 2016
Publication Restriction:	Revealing security arrangements and daily routines of detainee or Custodial Officers at the Alexander Maconochie Centre unless release is authorised by the ACT Government.

Part A

FINDINGS

An Inquest having been held by me, **ROBERT COOK,** a Coroner for the Territory, including a hearing conducted at the Coroner's Court at Canberra in the Australian Capital Territory into the death of:

STEVEN CLAUDE FREEMAN

I find that:

1. The deceased was Steven Claude Freeman, an Aboriginal Bundjalung man born 13 February 1991 and aged 25 years at the time of death.

2. Narelle King, a Bundjalung woman originally from Lismore, is his mother and his father was Steven James Freeman. Steven Freeman was the fifth child of six siblings and one of three boys.

3. Steven passed away in the early hours of the morning of 27 May 2017, while sleeping on his bed, inside cell 13 as a prisoner within the Alexander Maconochie Centre (AMC). The AMC is an ACT Government owned and operated correctional facility, located at Symonston, in the Australian Capital Territory.

4. Dr Graeme Thompson declared Steven Freeman deceased at 11:11 AM on 27 May 2016 and a formal certificate of life extinct was made by Dr Jane Van Diemen at 3:15 PM that day.

5. On my direction, pathologist, Professor Dr Johan Duflou conducted a post-mortem examination of Steven on 30 May 2016. The post-mortem report dated 2 July 2016 and the Professor's supplementary report of 9 August 2016 declared the cause of death to be Aspiration Pneumonia secondary to Methadone Toxicity.

6. Aspiration Pneumonia is an inflammation of the lungs and bronchial tubes which occurs after the inhalation of oral or gastric contents.

7. A person given Methadone who is opioid or Methadone naïve may experience an adverse reaction, in that Methadone may cause the consumer to experience respiratory depression, cough suppression and obtundation (less than full alertness).

8. It is these respiratory consequences following the consumption of Methadone that enable the movement of gastric contents up and into the oesophagus and then into that person's lungs.

9. Steven made an application to be placed on the ACT Health Methadone Maintenance Program (MMP) at the AMC on 5 April 2016.

10. Steven had opioid history while at the AMC, the extent of which is unknown but it appears to have been minor. The first recorded evidence of Steven having used an opioid substance occurred on 12 December 2015 when he was found to have Buprenorphine, an opioid, in his possession. Steven further tested positive to Buprenorphine following urinalysis of the sample taken on 12 December 2015.

11. Further, there is the AMC medical officer Dr Luke Streitberg's Patient Progress Note said to record Steven's representation to the Doctor that Steven was smoking heroin while he was at the AMC in the months prior to his medical assessment to enter the MMP; that Steven represented to the Doctor that Steven had used heroin two days prior to the assessment; Steven is further recorded as having conveyed to Dr Streitberg he was considering using heroin intravenously and further that he was incurring '*debt'* as a consequence.

12. There is also limited evidence of Steven having non authorised access to Methadone referred to as '*drinks*' provided by other detainees. A '*drink*' is the regurgitation of a prisoner's oral Methadone dose after it has been administered and supervised by the dispensing medical staff. It is regurgitated into a container by the detainee, where it is mixed with water or disguised with orange juice for re-consumption by another detainee.

13. Methadone received in this manner is diluted, although as to what extent is not known, as it will all largely depend on what is in the stomach of person giving up

the '*drink'*, on any particular day. Ordinarily, Methadone is not absorbed by the body until 20 minutes after it has been consumed.

14. While I acknowledge there is some history of opioid use I am satisfied Steven had an extremely low use of opioids. As I accept the findings set out in both the post-mortem report and the supplementary report provided by Prof Dr Duflou that Steven was likely to have been a low user of opioid substances even to the extent that he may have been opioid naive.

15. Based on the evidence from the pathologist, the toxicologist, Steven's personal history and other sources identified in my reasons, I am satisfied that Steven was also more likely than not to have been a low consumer of '*Spit Methadone*' at the time of entering the MMP given that it is diluted both being a product of regurgitation then being mixed subsequently with either water or orange juice.

16. Dr Streitberg, notwithstanding the absence of any independent evidence before the Doctor at the time of the consultation that Steven was opioid dependent, accepted Steven's representations that he was a heroin user while within the AMC, had previously been smoking heroin and was considering using it intravenously having last used two days before the assessment. In doing so it was recorded by the Doctor that Steven was incurring debt as result of Steven's heroin use.

19. While there is evidence of Steven taking a '*drink*' and an instance of having used Buprenorphine in December 2015[1] while in custody. At the time of making his application to the AMC's Hume Health Centre to be placed onto the MMP, Steven had 15 days earlier received the results of a urinalysis which showed no presence of illicit substance in his system.

20. The Dr Luke Streitberg following his medically assessed Steven for placement onto the MMP at the Hume Health Centre. Following that assessment Steven was placed onto the MMP.

[1] P537-8 Coronial Brief Volume 2 of 3 Exhibit 2

21. Methadone is a Schedule 8 Drug. Steven required a prescription to legally obtain it. Dr Luke Streitberg, the assessing Doctor at the Hume Health Centre, issued a prescription for Steven Freeman to receive 30mg of Biodone (Methadone) daily.

22. The first dose was given to Steven following the medical assessment at 10:40 AM on the morning of 25 May 2016. Notwithstanding there was no authorisation for the prescription from ACT Health until the next day. Although the relevant guideline allows for a first dose to occur without receipt of the authorisation. This may create an inconsistency in the Schedule 8 prescription and dispensing laws.

23. Steven received a second dose on the morning of 26 May 2016 at 8:50 AM. On that day the ACT Health provided its authorisation approving dosing for Steven of up to 120 mg of Methadone daily.

24. The amount of 30 mg of Methadone fell within the therapeutic, toxic and lethal range. Steven received no further prescribed methadone from the Hume Health Centre.

25. I am satisfied, pursuant to section 13 of the ACT *Coroners Act 1997* (the Act), that the circumstances of Steven's death constituted a death in custody. As a consequence, I am required by the operation of section 34A(2) to hold a hearing as part of the inquest into Steven's death.

26. I find that, pursuant to section 74 of the Act, the steps undertaken by the supervising medical officer Dr Luke Streitberg at the Hume Health Centre for the placement of Steven onto the MMP did not affect the quality of care, treatment and supervision of Steven Freeman to the extent that it could be said to have contributed to his cause of death.

27. I am satisfied that Dr Streitberg, notwithstanding the absence of any independent evidence at the time before the Doctor, other than the representations of Steven Freeman and the Doctors own observations, that Steven Freeman was experiencing opioid withdrawal. Dr Streitberg accepted Steven Freeman's representations that he in fact was a heroin user while within the AMC, had previously been smoking heroin and was considering using it intravenously having last used two days before

the assessment. In doing it was recorded by the Doctor that Steven was incurring debt as result of Steven's representation as to heroin use. Further, Steven had been recorded by corrections officers on 12 December 2015 is having used the opioid Buprenorphine when he tested positive on urinalysis and he also had more of a substance concealed in a tobacco papers packet.

28. I am satisfied Dr Streitberg, explained the rights and responsibilities of Methadone use, and the risks associated with Methadone use. Steven's signature on the Rights and Responsibilities form acknowledges the same. Dr Streitberg having formed the belief that Steven Freeman was in mild withdrawal at the time of the assessment, authorised Steven's placement onto the MMP and subsequently prescribed the amount of 30 mg of Methadone daily.

29. The Patient Progress Note made by the Doctor revealed that Steven had never been on a Methadone maintenance program before. There was no indication that Steven Freeman had relayed to the Doctor that he had consumed '*Spit Methadone*' or any other opioid like Buprenorphine in the past.

30. Further, pursuant to section 74 of the Act, I find that the dispensing of Methadone in accordance with the prescription and policies in place at the time by Hume Health Centre Nurses on 25 and 26 May 2016, did not affect the quality of care, treatment and supervision of the deceased to the extent that it could be said to have contributed to the cause of death.

31. Further, pursuant to section 74 of the Act, I recognise deficiencies and inconsistencies within the MMP administrative frameworks applied by ACT Health focusing on the ACT's Standard Operating Procedures (SOPs), the National Guidelines and a range of supporting literature in determining placement on to a Methadone maintenance program and the appropriate commencement doses. I am however, unable to conclude in this particular circumstance those deficiencies and inconsistencies affected the quality of care, treatment and supervision of Steven Freeman to the extent that it could be said to have contributed to his cause of death.

Matters of Public Safety

32. Methadone maintenance programs have their place both within the broader ACT community and the prison community, all being administered by ACT Health.

33. I provide recommendations for the Government's consideration following my findings that matters of public safety are identified as a result of Steven's placement on to ACT Health's MMP. Such considerations apply to the broader community as much as they do to the AMC detainee community given that ACT Health is responsible for both communities and the authorised dispensing of Methadone within the ACT.

34. These recommendations highlight potential inconsistencies or uncertainties across ACT Health's SOPs, the National Guidelines and matters raised in evidence during the course of the hearing.

35. In regard to the Territory's submissions and the evidence of Mr Bruno Aloisi and Registered Nurse Lutz at hearing, the ACT Government has sought to respond quickly to matters which were identified as the hearing unfolded. It has done this through other jurisdictional visits and at the consequence of other recommendations arising from the Government's self-initiated reviews prior to and following the commencement of this inquest such as the Moss Review and the Health Services Commissioner's Review.

36. It was not appropriate for me to have considered the content of those self-initiated reviews or their recommendations given they came into existence as a consequence of Steven Freeman's death and not prior to it.

37. It should be noted however the Government's position to date appears to have been responsive to the Freeman family's underlying concerns to avoid, so far as systemically and humanly possible, a similar based death in the future.

38. I hope the following recommendations provide Government with the opportunity to address specific issues identified in the course of the hearing. Although not directly

contributing to the cause of death, they were identified as part of the examination of circumstances underlying the manner of Steven's death.

39. **Recommendations**

A. Security and Wellbeing Checks

As an observation, life within a custodial environment appears amongst other things, to be one of repetition, rules, anger, frustration, observation and structure affecting both detainee and corrective officers equally, albeit differently, as they go about their daily routines.

From a Correctional Officer's perspective, complacency through routine can be an adverse consequence of such an operating environment. The procedures in place for the daily muster or headcount requires a Correctional Officer to be fully satisfied as to detainee health and well-being.

This recommendation is not a criticism of Corrections Officers. It is aimed at the complacency derived potentially from inconsistent policies they are required to operate within.

The fact the AMC's own review found it acceptable that '*a foot movement from a detainee was a typical and acceptable response to the morning headcount as most detainees are in bed',* should no longer be deemed to be satisfactory compliance for establishing a detainee's health and well-being.

The morning welfare check on Steven Freeman, while not probably affecting his the quality of his care, treatment or supervision so as to have contributed to the cause of death, did not meet the AMC's then existing procedures.

Further, there is an inconsistency through the internal management review conducted by the AMC at 3.3.3 on page 50 which says that checks do not require a detainee response.

This does not appear to be correct. The first headcount for morning muster as observed on the CCTV recording conducted on Steven Freeman cell on the morning of 27 May 2016 is inconsistent to the AMC's established procedures set out within the Corrections Management (AMC Muster and Headcount) Policy for an account of detainee location, health and well-being.

I acknowledge while not requiring a detainee to formally respond, the policy suggests something more is required to be done then the movement of a foot, given the requirement is that a *face to name positive identification is to be undertaken* as set out within the AMC policy.

Further, the entry into the cell at 10:02 AM by a Corrections Officer did not appear to meet the requirements of a security and well-being check.

My recommendation: The ACT Government should review the then existing practices and to remove inconsistencies in policies and procedures relied upon by correctional services officers so as to ensure prisoner safety and welfare checks through musters and headcounts which require eye contact and facial recognition to be complied with. The extent of compliance with those procedures, given their purpose is to ensure the safety and well-being of a detainee, should be evaluated and tested periodically to ensure they are effective and practical and minimise complacency through their routine application.

B. Physical Education and Training

In the course of the inquest there was anecdotal evidence that there was no effective physical education awareness or daily training offered to detainees other than what they might generate or engage in themselves.

That there is a third of AMC detainee population on the MMP is perhaps unsurprising and is perhaps reflective of the pervasive role drugs are playing within the ACT community.

The fact there is no structured compulsory physical education or training sessions run by ACT Health for detainees was nonetheless startling.

The fact that a prisoner could remain in bed or at least be in their cell from approximately 6:30 PM on the evening before through the morning headcount at 7:45 AM until 11 AM is concerning.

My recommendation: The ACT Government should consider the viability or effectiveness that a daily structured compulsory physical education and training session might have on a prisoner focusing on the prisoner's well-being and rehabilitation coupled with drug rehabilitation counselling. Any consideration of such a course would need, I acknowledge, to be factored into current alcohol and drug support programs within the AMC and the various sentencing periods for detainees.

C. Access to Illicit Substances in Custody

Dr Streitberg on 25 May 2016 makes an entry on ACT Health Progress Note that Steven Freeman reported ongoing heroin use for the '*last few months'* and also consumed two days prior to the assessment. This is a concern given Steven Freeman, for at least the '*last few months'*, had been a detainee at the AMC. It is a further concern given there was no evidence confirming a prior history of opioid-based substance use by Steven Freeman, prior to being remanded in custody.

My recommendation: The ACT Government should ensure that minimising the infiltration of illicit substances into custodial facilities remains at the forefront of screening technology.

D. Cross Agency Referral of Court Alcohol and Drug Assessment Reports

Steven Freeman's multiple prior contacts with the criminal justice and corrections systems suggests that he was well known to ACT Corrective Services.

It would therefore be reasonable to assume that ACT Corrective Services and other government and non-government entities involved in the preparation of sentencing reports were likely to hold significant information about Steven and his personal circumstances and use of illicit substances.

I am unable to ascertain from the evidence presented to me that the sharing of such reports and documents with the Hume Health Centre occurred or was even available. The fact that they existed may have been helpful to the treating doctor at the time of Steven's MMP assessment.

From a privacy perspective personal information may be used or disclosed where that use or disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of any individual as permitted by section 16A of the Commonwealth privacy legislation.

Section 12 of the *Human Rights Act 2004* (ACT) provides that people within the Territory have the right to not have their privacy, family, home, or correspondence interfered with arbitrarily or unlawfully.

However, these are not unfettered rights. These rights can be impinged upon in order to ensure that appropriate action is taken in order to lessen or prevent a serious threat to the life, health or safety of an individual.

Court Alcohol and Drug Assessment Service (CADAS) reports made on Steven Freeman outlined his representations as to his use of illicit substances. The content of that report referred to in my reasons was significantly different to that of the AMC Hume Health Centre induction record, which was also based on Steven Freeman's revelations during that induction.

Had Dr Streitberg had access to that CADAS information it may have assisted in his assessment of Steven Freeman given the inconsistencies in information and his experience concerning the truth of claims made by detainees seeking access to drugs within the correctional facilities.

Steven Freeman was subject to 2 urinalysis tests conducted whilst detained in the AMC: the first on 12 December 2015, which ultimately revealed Steven's use of Buprenorphine an opioid, and the second on 10 May 2016, which returned a negative result. The results of both tests, had they been made available to Dr Streitberg, may have affected his considerations in placing Steven on the MMP or the commencement level of Methadone.

My recommendation: ACT Health should consider obtaining either by consent from a prisoner or through reliance on legislation, a prisoner's medical records and all relevant reports from alcohol and drug perspective created prior to incarceration for incorporating into a detainee electronic medical file for the purposes of an AMC induction or prior to any assessment for access to pharmacotherapy treatment.

Further, for detainees who are placed onto pharmacotherapy programs, such as the MMP, that in the interest of the health and safety of the detainee and his or her well-being, information of this type should be shared with ACT Corrective Services conducting prisoner headcounts and musters for the very purpose of determining a detainee's location, safety and well-being.

Equally, any independent urinalysis results undertaken by ACTCS should be placed on the detainee's medical record to enable medical staff to have a complete picture of the detainee's use of illicit substances compared to those substances, if any, prescribed through the Hume Medical Centre.

E. Amendments to the ACT Standard Operating Procedures

The relevant policies and procedures provide that the maximum dose for Methadone was 120 mg with the minimum dose being 2.5 mg. However, the dot point following immediately in the SOP, provides that doses of less than 25 mg will only be prescribed as part of a planned reduction schedule for a maximum of two weeks.

This suggests, if it is correct, that ACT Health adopt a practice that the minimum dose of Methadone would be at least 25 mg. The prescriptive nature of the commencement dose of 25 mg has the potential to remove individualised treatment options and to direct medical staff including those making prescriptions to a '*one fits all'* approach in the setting of the commencement of Methadone level.

My recommendation: The ACT SOP's should be reviewed and the focus should be on prescribing individualised treatment setting out the parameters for commencement doses of Methadone for instance be anywhere from 5 to 20 mg with the ability to increase daily on medical review only.

F. Detainee self-prescribing each Sunday increased doses of Methadone

The current practice of allowing a detainee to increase each Sunday by up to 5 or 10 mg their existing Methadone dose without medical review is a safety concern.

My recommendation: The SOP should be reviewed to ensure that those who have only recently commenced on the Methadone program not be allowed to self-prescribe increases for a set period of time to ensure they are in a physiological sense, capable of accommodating the increased amount of Methadone. Further and in the alternative, the ACT Government should consider whether not it is even appropriate to allow such increases to occur for a Schedule 8 drug.

G. Clarifying inconsistences between ACT SOPs and Guidelines and the National Guidelines

A number of documents were tendered in evidence before the court they included the National Guidelines for Medication-assisted Treatment of Opioid Dependence (April 2014), Justice Health Services Standard Operating Procedures for the Management of adult patients receiving Opioid Replacement Treatment at the AMC and the ACT Health, ACT Opioid Maintenance Treatment Guidelines (ACTOMTG). In my reasons I set out a number of provisions which highlighted a number of inconsistencies between those relevant documents.

The detail for instance of the National Guidelines provide a clear approach to induction and immediate follow-up services for a person being commenced on methadone. The use of the terms Guidelines and Standard Operating Procedures can have an effect on the person subject to them in that SOP's set a defined course to follow were as guidelines only offer guidance.

The National Guidelines offer a very detailed approach to the assessment, induction and immediate medical services to be provided to a person commencing on methadone. The National Guidelines appear comprehensive, informative and easy to follow. Albeit recognising the discretion in commencing levels of methadone. They provide relevant forms and checklists.

While I acknowledge the work of Justice Health Services, as put into evidence through RN Lutz, in making amendments to relevant guidelines to rectify the deficiency as to the 2 to 3 hour medical follow-up after first dosing of methadone and other significant changes the review should not stop there.

My Recommendation: ACT Justice Health Services to consider whether or not adopting the National Guidelines to replace the ACTOMTG and incorporating random urinalysis or blood tests where there is no objective medical history of opioid dependence prior to placement on to the MMP.

DATED 11 April 2018 **R. M. COOK**

CORONER

Part B

CONDOLENCES

Steven Claude Freeman was a young indigenous Australian aged 25 at the time of his death.

I pass on my sincerest condolences to Steven's mother, Narelle King, and the Freeman family and friends, many of whom attended each day of the hearings.

I apologise in advance to the family that expressions and terms used in my findings in explaining the manner and cause of Steven's death may sound and read in a direct and uncaring manner. They are not intended that way.

REASONS and DETAILED FINDINGS

Summary of Events

1. Steven Claude Freeman was an Aboriginal man from the Bundjalung people[2]. Steven was born at the Woden Valley Hospital in the Australian Capital Territory on 13 February 1991 to his mother, Narelle King, a Bundjalung woman originally from Lismore[3] and his father, Steven James Freeman. He was the fifth child of six siblings and one of three boys.[4]

2. Steven commenced a relationship with Laiken Hyland in 2011[5]. From that union his daughter Makiyah was born on 4 December 2011.

3. From his early teens Steven had experienced significant engagement with the criminal justice and corrections system within the ACT.[6]

[2] Exhibit 7 statement of the Narelle Denise King Page 2
[3] Exhibit 7 statement of the Narelle Denise King Page 1.
[4] Statement of Gregory Paul Ayton Coronial Brief Volume 1 of 3 p20
[5] Ibid, p21 and Exhibit 7 statement of the Narelle Denise King Page 2
[6] Exhibit 7 statement of the Narelle Denise King Page 2.

4. Steven's prior criminal history in and of itself is not directly relevant to the events and circumstances of his death.

5. However, the fact of his multiple prior contacts with the criminal justice and corrections systems means that he was known to ACT Corrective Services.

6. It would therefore be reasonable to assume that corrective services and other government and non-government entities involved in the preparation of sentencing reports were likely to hold significant information about Steven, his personal circumstances and use of illicit substances that may have been helpful to the treating doctor at the time of the assessment.

7. Official ACT Corrective Services intake documents, as well as progress notes, mental health assessments and other sources indicate Steven was a young person who mostly presented as being quiet and polite.[7]

8. Those records further reveal Steven was a regular user of tobacco, alcohol and cannabis commencing such use between the ages of 11 and 13, with the latter 2 substances, at a moderate to heavy use.[8]

9. Prior to Steven's return to the Alexander Maconochie Centre (AMC) in April 2015, Steven had only one other known history of illicit drug use, that being methamphetamine (Ice).

10. A Court Alcohol and Drug Assessment Service (CADAS) report compiled in November 2015, revealed Steven reached the level of smoking eight points of methamphetamine every second day, reducing down to about five points most days for about four months prior to being in remanded in custody in April 2015.[9]

11. There is no evidence of opioid use prior to Steven's entry into the AMC in April 2015.

[7] Ibid, p21
[8] Ibid, p21
[9] Ibid, p22

12. The CADAS report details more drug use than that disclosed on the AMC's Hume Health Centre medical induction record i.e. such as his use of Ecstasy. That in itself reveals that Steven was not entirely forthcoming with AMC medical staff about his illicit substance use.

13. ACT Health records and those records held by the Winnunga Nimmityjah Aboriginal Health Service concerning Steven, and information from his friends and family, do not disclose other known medical conditions or illnesses saving Attention Deficit Hyperactivity Disorder (ADHD) in Steven's early years.[10]

14. In particular evidence from Steven's family was that it was highly unlikely that Steven ever used heroin.[11]

15. On 5 April 2016, Steven, having remained in custody, made an application to be assessed for placement on the AMC Methadone Maintenance Program (MMP).

16. On 25 May 2016 Steven engaged in a medical assessment before Dr Luke Streitberg. Dr Streitberg, a General Practitioner, was engaged by ACT Health at the relevant time to provide medical services at the Hume Health Centre located at the AMC.

17. Dr Streitberg has sufficient experience in the prescribing of Methadone in a custodial environment.[12]

18. Prior to the medical assessment on 25 May 2016 there was no objective or independent medical record before the treating doctor at the Hume Health Centre that would indicate that Steven was a heroin user or otherwise opioid or Methadone dependent.

19. Based on the information conveyed to Dr Streitberg by Steven and the Doctor's own knowledge, experience and training the Doctor prescribed 30 mg Biodone (Methadone) daily to Steven.

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[10] Ibid, p22

[11] Exhibit 7 statement of the Narelle Denise King Page 2.

[12] Witness statement of Dr Luke Streitberg dated 17 February 2017 paragraphs 11 to 35

20. Steven only received two prescribed doses of Methadone prior to his death. The first dose of 30 mg was on the 25 May 2016 at about 10.40 AM, almost immediately after his medical assessment conducted by Dr Luke Streitberg.

21. Steven's second dose occurred at about 8:50 AM on 26 May 2016 and is partially captured on CCTV monitoring.

22. On the morning of 27 May 2016 at about 11 AM, Steven's cellmate Jermaine Goolagong was unable to wake Steven.

23. AMC custodial officers ran to Steven's cell and commenced cardiopulmonary resuscitation in a frantic effort to revive Steven.

24. Despite best efforts Steven was unable to be revived.

Cause of death

25. A post-mortem revealed the cause of Steven's death as - Aspiration Pneumonia secondary to Methadone Toxicity.

The Necessity of a Hearing

Section 13 of the Act

26. Jurisdiction over Steven's death arises under paragraph 13(1)(i) of the ACT *Coroners Act 1997* (the Act), which provides that a coroner must hold an inquest into the manner and cause of death of a person who dies in custody.

Section 52 of the Act

27. Section 52 of the Act that an inquest establish the identity of the deceased, where and when the death happened, and the manner and cause of death. Ordinarily, establishing such matters does not require a hearing.

Section 3C of the Act

28. Section 3C of the Act defines a 'death in custody' as a death at a corrections centre. It is not in dispute that at the time of Steven's death he was a detainee at the AMC, a corrections facility owned and operated by the ACT Government in the ACT.

29. I am satisfied having regard to the evidence set out below that Steven was a detainee at the AMC at the time of his death and that as such, his death occurred as a death in custody for the purposes of the Coroners Act. As a consequence, I am required by the operation of section 34A(2) to hold a hearing as part of the inquest into Steven Freeman's death

Section 74 of the Act

30. Section 74 of the Act requires that an inquest into a death in custody must include in the record of the proceedings of the inquest, findings about the quality of care, treatment and supervision of the deceased that, in the opinion of the coroner, contributed to the cause of death.

31. In determining issues that arise within the scope of an inquest, the standard of proof to be applied is the civil standard, namely the balance of probabilities (*Anderson v Blashki* [1993] 2 VR 89 per Gobbo J).

32. Should I be drawn to forming a criticism or an adverse finding against anyone based on information put before me, then I have sought to ensure such *weight is given to the presumption of innocence and exactness of proof [as] expected,* should I have

otherwise formed the view that that presumption is rebutted. (Dixon J in *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-363).

33. I acknowledge the court is not given power to conduct an enquiry beyond the scope of what is relevant to the manner and cause of death. In *Conway v Jerram, Magistrate and NSW State Coroner* [2011] NSWCA 319, their Honours Campbell JA and Young JA at [30] stated:

> *Nevertheless, in construing the expression 'manner of death' in a broad way, the court must bear firmly in mind the limits to the coroner's jurisdiction..... ...It is clear that a coroner has a wide, but not unlimited, mandate to hold or not hold an inquest concerning the death of a person. When an inquest is held, the scope depends on all the circumstances. The inquest may be held to determine who is the deceased, when and how he or she died and this is the primary purpose of the inquest. It is important that extraneous factors do not get in the way of that primary duty. Just what is the scope of the inquest, is a matter for the coroner; a matter to be exercised using proper discretion and common sense...*

34. In *R v Doogan; Ex parte Lucas-Smith* [2005] ACTSC 74 the Full Court of the Australian Capital Territory Supreme Court said at [29]:

> *A line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative.*

35. In *Onuma v The Coroner's Court Of South Australia* [2011] SASC 218 citing from *WRB Transport v Chivell* the Court considered the Coroner's powers under the *Coroner's Act 2003* (SA) and the meaning of the words "cause and circumstances", used in s 21 and s 25 of that Act. Lander J (with Prior and Mullighan JJ agreeing) provided a meaning of the word "cause" at [9]:

> *Clearly enough 'the cause and the circumstances' must be two different things. If it was otherwise there would be no reason for Parliament to have included both words.*
>
> *The cause of a person's death may be understood as the legal cause. In determining those events which may be said to give rise to the cause of the death, the Coroner is not limited by concepts such as 'direct cause', 'direct or natural cause', 'proximate cause' or the 'real or effective cause'. Nor is the Coroner limited to a cause which is reasonably foreseeable. The cause of a person's death in respect of the Coroner's jurisdiction is a question of fact which, like causation in the common law must be determined by applying common sense to the facts of each particular case: Mason CJ, March v E & M H Stramare Pty Ltd [1991] HCA 12; (1991) 171 CLR 506 at 515...That is a factual inquiry which only has, as its boundaries, common sense.*

36. His Honour Justice Toohey in *Annetts v McCann* [1990] HCA 57 at [12] properly places my role in context when he cited the following passage:

> *…once again it should not be forgotten that an inquest is a fact-finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance…*

37. I confirm my commitment to having at the forefront of my mind that this inquest was not about the apportioning of blame or determining guilt concerning anyone associated, if any one at all, with Steven's death.

38. Nor is it my role to judge the actions of people in determining the key issues, by viewing such actions with the benefit of hindsight, nor should I allow any witness in

the giving of evidence before the inquiry to do the same, saving for comparison reasons only.

Key Issues

39. The key issues arising from the evidence put before me at the hearing may appropriately fall under four specific headings:

A. *Was Steven opioid or Methadone naïve?*

B. *Did Steven undergo an appropriate medical assessment for the purposes of placement on to the MMP?*

C. *Did prescribing and commencing Steven on a daily dose of 30 mg of Methadone affect the quality of Steven's care, treatment or supervision contributing to his cause of death?*

D. *Having been prescribed Methadone did the quality of care, treatment and supervision of Steven contribute to his cause of death?*

Evidence and the Conduct of the Hearing

40. Numerous statements, documents and testimony were placed before me in the course of the hearings which ran over 9 days. These days were often disjointed or disrupted for one reason or another. Importantly, however, it was at no fault of anyone appearing before the enquiry. It related solely to previous commitments of those appearing, including representatives and witnesses, and ensuring that all the relevant evidence was available.

41. Deaths requiring the exercise of the coronial jurisdiction are not planned events. Accordingly, it was appropriate and proper to give consideration to existing diary commitments of all involved. This of course had an unintentional consequence of causing delay in the coordinating of and securing of hearing dates from all concerned.

42. Having regard to the four key issues I have identified as a result of the hearing, some of the evidence received will not be set out in detail within my reasons. This is because once the evidence as to cause of death became known, and the circumstances became clearer, the scope of my attention became focused on the four key issues.

43. The fact that other evidence is not mentioned expressly in my reasons does not mean it has not been reviewed and considered.

Preliminary Findings of Fact that Set the Background

44. The deceased Steven Claude Freeman was remanded in custody on 28 April 2015, following the execution of a first instance warrant.

45. On intake into the AMC, Steven was subject to a significant assault resulting in serious injuries[13]. He was treated in the Intensive Care Unit (ICU) of The Canberra Hospital. His condition was listed as critical.

46. On 2 May 2015, while receiving treatment in ICU, Steven woke up from a coma. Two days later he was assessed for post-traumatic amnesia.

47. On 7 May 2015 Steven was subsequently cleared by hospital staff for discharge and returned to the AMC[14].

48. On 10 June 2015 following a bail application, Steven was bail refused and remained in custody at the AMC until his death.

49. A CT scan performed approximately four months after the assault reported resolution of the intracranial haemorrhages and no intracranial pathology. There was no evidence of post-traumatic epilepsy.

[13] Exhibit 7 statement of the Narelle Denise King Page 3
[14] Ibid

No connection between assault and death in May 2016

50. Placing these past events into context with the current matters, I am satisfied that there is little or no relevant connection to the 2015 events and the cause of death, as determined by the pathologist Prof Dr Johan Duflou, on 30 May 2016 being - Aspiration Pneumonia, secondary to Methadone toxicity.

51. That initial finding accords with my directions to all the parties when the matter was first listed for a directions hearing that my primary focus was on all relevant interactions, decisions and policies concerning Steven's application to enter the AMC MMP and events that followed and not those associated with his assault in 2015.

Steven found with Buprenorphine

52. On 12 December 2015 Steven was found to have Buprenorphine, an opioid, in his possession and subsequent urinalysis revealed that he also tested positive to its presence. Potentially revealing more than a one off use.

Application by Steven to be placed on the Methadone program

53. On 5 April 2016 Steven submitted a request to ACT Health, Justice Health Services, to be placed onto the AMC Methadone program.

Urinalysis 10 May 2016

54. On 10 May 2016 Steven was subjected to urinalysis which did not reveal the presence of illicit substances.

Assessment by the Hume Health Centre

55. On 25 May 2016 Steven was approved for placement onto the Methadone Maintenance Program (MMP) by Dr Luke Streitberg at the Hume Health Centre located at the AMC.

56. At 10:40 AM that day Steven was subsequently administered a 30 mg dose of Methadone syrup. The Methadone is considered to be absorbed in the stomach 20 minutes after consumption. The absorption after 20 minutes does not refer to the peak effect period of Methadone - *it takes hours to reach peak physiological effect on the body.*[15] However its effect only lasts generally for a period of 24 hours hence the endeavour to consume daily at approximately the same time each day.

Second dose of Methadone

57. On 26 May 2016 8:50 AM, Steven was administered a second 30 mg dose of Methadone syrup at the prison cell hub by two registered nurses.

58. Despite close monitoring of the dispensing of Methadone by the Registered Nurses and Custodial Officers present, it is still possible for patients to divert doses, generally by regurgitation[16] after leaving the Health Centre or dosing point within the detainee cell hub.

Prisoner morning headcount and well-being check

59. At about 7:52 AM on 27 May 2016 two Custodial Officers were conducting the morning prisoner headcount on each cell. The Officers arrived at Steven's assigned 2 man cell No.13.

60. Also assigned that cell was Mr Jermaine Goolagong, a friend to Steven.

61. Mr Goolagong said in his evidence he provided a verbal response to the correctional officers by responding to his name being called out.

62. CCTV images show the cell door being closed, then opened, closed and reopened again as Custodial Officer Stockheim realises he has not received a response from Steven.

[15] Witness statement of Dr Luke Streitberg paragraph 21 dated 17 February 2017
[16] Witness statement of Dr Luke Streitberg paragraph 21 dated 17 February 2017

63. Custodial Officer Stockheim's evidence was that he observed Steven's foot twitch and he took that as sufficient for the purposes of the morning prisoner welfare check and headcount.

64. A further check of Cell 13 was conducted at 10:02 AM by a Corrections Officer however, nothing was reported from that security and well-being check in relation to Steven Freeman who was on his bed at that time.[17]

Steven found deceased

65. Mr Goolagong recalled seeing Steven throughout the morning lying on his bed with his arms behind his head. Mr Goolagong subsequently showered, then turned on his TV and lay on his bed.

66. Mr Goolagong then got up and swept the cell room floor and returned to bed listening to the radio. He recalled Steven was still and remained lying on his bed in the same position.

67. At about 9:50 AM, Mr Daniel Craft attended Cell 13 to view photographs on Mr Goolagong's computer. Mr Craft observed Steven to be lying on the bed with his hands behind his head with headphones on and he was otherwise trying to be quiet so as not to disturb Steven.

68. At some time between then and 10:55 AM Mr Goolagong said to Steven: "Get up cuz". Steven did not respond. Mr Goolagong touched Steven and felt that he was cold and unresponsive so he left the Cell to alert others.

69. Mr Ivan Djerke a detainee responded and entered Cell 13 at 10:56 AM where he formed the view Steven had passed away.

70. Mr Djerke directed Mr Goolagong notify custodial officers. A 'Code Pink' was sounded and Corrections Officer Paulose was the first to arrive in response, and subsequently followed by Corrections Officers and Dr Graeme Thompson.

[17] Annexure B to Statement of Don Taylor Acting executive Director of ACT Corrective Services dated 10 February 2017

71. Dr Thompson assessed Steven for signs of life, none were present, he directed cardiopulmonary resuscitation action initiated by Correctional Officers be ceased and declared Steven deceased at 11:11 AM, 27 May 2016.

72. Dr Jane Van Diemen subsequently declared life extinct at 15:00 hours on the same day.

The Post-Mortem

73. I directed Prof Dr Johan Duflou to conduct an autopsy at the ACT Forensic Medicine Centre at Philip in the ACT.

74. Prof Dr Duflou provided an 11 page autopsy report[18] on 2 July 2016 having conducted an autopsy on Steven on 30 May 2016. The Professor declared the likely cause of Steven's death to have been Aspiration Pneumonia secondary to Methadone toxicity. Prof Dr Duflou subsequently provided a second supplementary report on 9 August 2016.

Evidence and reasons supporting my findings

75. Having regard then to those preliminary factual findings and the four key issues, I am required by law to determine whether or not the quality of care, treatment and supervision of Steven contributed to the manner and cause of death.

[18] Located between pages 140 and 141 of the Coronial Brief Volume 1 of 3 Exhibit 2

A. Was Steven Opioid and Methadone Naïve?

Objective evidence

76. Steven's mother, the evidence of other detainees and certainly those documents relevant at the time of Steven's entry into the AMC in April 2015 and following his entry into the AMC, reveal Steven had a disposition for the use of tobacco, alcohol and cannabis methamphetamine and possibly ecstasy.

77. There is little or no evidence of Steven having a prior opioid or Methadone history outside of the AMC.

Court Alcohol and Drug Assessment Service

78. Tamara Schwarz, a Court Drug Diversion Clinician, on 16 November 2015 entered onto an ACT Health Progress Note the detail of Steven's drug use,[19] following a telephone conversation with Steven on 13 November 2015.

79. This assessment was for the purposes of a CADAS report required for Steven's Court appearance on 17 November 2015 on charge 12130 of 2014 in the ACT Magistrates Court.

80. Steven reported alcohol use and an uptake of amphetamine since he was seen by CADAS in 2010. The entry set out that Steven denied medical health problems or receiving medications at the AMC.

81. From that note I am satisfied there was no identification by Steven of any opioid dependency or the use of opioid replacement therapy or Methadone.

82. I am further satisfied the CADAS report formally records the assessment on 13 November 2015[20] that there is no record that Steven consumes an opioid-based

[19] P955 Coronial Brief Volume 3 of 3 Exhibit 2

substance and reconfirms Steven's use of alcohol, cannabis and ecstasy (MDMA). I note the last two are missing from the assessment conducted at the Hume Health Centre in April 2015, although it notes his use of amphetamine (Ice) prior to his admission.

Steven's Family

83. Steven's mother Mrs Narelle King advised police that Steven was not a known user of opioids including heroin.[21]

Police enquiries

84. Police located minimal evidence of any other illicit substance use by Steven.

85. Police did however confirm evidence of possible opioid use by Steven on 12 December 2015 at about 1:20 PM.[22]

86. Correctional Services staff conducted a search of the AMC remand cottage common areas, as well as a frisk and metal detector search of detainees' rooms in the cottage. Steven was being accommodated in these facilities and in particular Remand Cottage 2 at the time.[23]

87. Inside a 25 g pouch of tobacco were Tally Ho cigarette papers belonging to Steven there appeared to be a small piece of plastic, peach in colour located within the 'Tally Ho' packet.

88. The item was suspected of being Buprenorphine, an opioid used to treat opioid dependence. While Steven was being escorted to the admissions building for the purposes of drug testing, he admitted to having '*smoked bupe'* (the detainee abbreviation for Buprenorphine) a couple of days ago.

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[20] P957 Coronial Brief Volume 3 of 3 Exhibit 2
[21] Ibid, p22 and Exhibit 7 Statement of the Narelle Denise King Page 2
[22] P538 Coronial Brief Volume 2 of 3 Exhibit 2
[23] p23 Statement of Gregory Paul Ayton Coronial Brief Volume 1 of 3

89. A urinalysis conducted on Steven on 12 December 2015 returned a positive sample for Buprenorphine[24].

90. I am satisfied that results of Steven's urinalysis reveal the presence of Buprenorphine and the fact that Steven had more Buprenorphine in his possession supports a finding that Steven used the opioid more than once, at least in 2015.

Hume Health Centre Induction of Steven April 2015

91. AMC Justice Health Services are required to perform a number of tasks relating to new detainees entering the AMC under their Standard Operating Procedures (SOPs).[25]

92. A Registered Nurse (RN) is required to complete a Health and Risk Assessment form with the new detainee. Following that, the RN contacts the on-call medical officer and advises them of any health issues and/or medication needed for the new detainee.

93. A current pattern of opioid use is to be established, as well as a history of alcohol and other illicit or licit drug use.[26]

94. It appears the induction notes recorded for Steven did not disclose any previous opioid or Methadone use other than the use of cannabis, nor were there any notes disclosing any previous opioid treatment or referral to any relevant service regarding opioid use and/or treatment.[27]

95. As earlier indicated Steven had included his use of Methamphetamine (Ice) but not Ecstasy (MDMA) as disclosed in his CADAS report in November 2015. I am satisfied this reveals, at least on that occasion and when being assessed by Dr Streitberg, Steven intentionally or inadvertently concealed his illicit substance use.

96. Further, a urinalysis test conducted 10 May 2016 reveals Steven had a negative result to any illicit substance.[28]

[24] P540 Statement of Gregory Paul Ayton Coronial Brief Volume 2 of 3 - Douglass Hanley Moir Pathology report dated 15 December 2015
[25] Ibid, p57
[26] Ibid,p58
[27] Ibid, p58
[28] Annexure B - Statement of Don Taylor Acting Executive Director ACT Corrective Services marked as Exhibit 6

Jermaine Goolagong

97. Jermaine Goolagong gave evidence by way of statement and oral evidence at hearing. Mr Goolagong was a long-time friend of Steven, both tied together by family history and interaction both inside and external to the AMC.[29]

98. Mr Goolagong entered the AMC in early 2016 and was placed in Cell 13 with Steven.

99. Mr Goolagong said he and other detainees advised Steven against entering the MMP. Mr Goolagong recalled Steven had said to Mr Goolagong words the effect of: '*it was all right to go on to the MMP and that he just wanted to make his time go quicker'*.

100. Mr Goolagong had never known Steven to be an opioid user and only knew Steven to consume '*Cannabis'* and '*Ice*'. Although he could not recall when Steven first consumed Methadone.[30]

101. Mr Goolagong is recorded as saying to Steven that Methadone was only for '*druggos*' and that Steven had said to him '*give me two days and if I don't like it I will stop'*[31]

102. Mr Goolagong is recorded as saying that Steven appeared to be stoned to him the day before his death that he said to Steven: '*I hate seeing you like this*' and '*You're scaring me*'.[32] To which Steven is said to have replied '*it's all good'.*[33]

103. Mr Goolagong said he did not see anything to suggest Steven was using drugs in the AMC. Further, he said he had warned Steven that '*you had to be a heroin user to be on Methadone'*.

104. Mr Goolagong believed Steven had '*lied to the doctor in order to get onto the MMP'* by claiming he was using twice a day. [34] While this is not recorded in the Doctor's assessment notes as to '*using twice a day*', I am satisfied it reveals the possibility that

[29] Statement of Gregory Paul Ayton Coronial Brief Volume 1 of 3 p98
[30] Ibid p99
[31] ibid p99
[32] Ibidp99
[33] Ibid 99
[34] Ibid p100

Steven was prepared to not to be forthcoming in the assessment to gain access to Methadone.

Ivan Djerke

105. Mr Djerke was a detainee at the AMC prior to and at the time of Steven's death. He was accommodated in Accommodation Unit South. He claims to have had a good relationship with Steven. He gave evidence by way of statement and oral evidence at hearing.

106. Mr Djerke said he had been concerned because staff had put Steven on Methadone, and he told Steven that he should not be on it[35]. Mr Djerke explained that he had been on heroin for 25 years and that he had told Steven that '*Methadone is not something that he should play with'*.

107. Mr Djerke recalled that Steven had commenced using Methadone two days earlier and that Steven had told him, '*he just wanted to do his time easier'*.[36]

108. Mr Djerke said he was very concerned as he knew the deceased was not a user of heroin or other opioids and that he was disappointed in Steven for using Methadone.

109. Mr Djerke said he could clearly see the Methadone was '*knocking Steven around'* that he '*wasn't the same bloke'*. He was clearly '*stoned*' however Steven had told Mr Djerke that Steven would '*stop using the Methadone every third day'*.[37]

110. Mr Djerke said he was aware that Steven was getting a '*few drinks'*. That is Steven was consuming Methadone regurgitated from other inmates' stomach and subsequently mixed with water or orange juice. [38]

[35] Transcript 21/30
[36] Transcript p21/44
[37] Statement of Gregory Paul Ayton Coronial Brief Volume 1 of 3 p7
[38] Transcript p21/30

111. Mr Djerke however did not however see Steven ingest '*a drink'* only having seen him afterwards, whereupon he observed Steven to be '*drunk*'.

Daniel Craft

112. Daniel Craft, also a detainee at the AMC prior to the time of Steven's death, said he had known the deceased for about 10 years. He recalled he did not know Steven used heroin or other opioids. He recalled Steven starting to use Methadone in the last couple of days which Mr Craft thought was '*weird'*.[39]

113. Mr Craft recalled '*telling Steven off* 'for getting onto the Methadone program. He said that Steven said he would miss every second day. Mr Craft recalled the process to get onto the Methadone program was '*to tell them (*being relevant medical staff I infer*) you are using drugs and that you do not want to use syringes in jail and they will put you on it'.*

114. He recalled that the Methadone was not affecting Steven that much, other than that Steven had an itchy nose[40] (a possible side effect of Methadone).

115. Mr Craft recalled Steven taking a dose in the accommodation unit the next morning and that he did not see Steven take anything else besides Methadone. Mr Craft stated that he recalled being upset that Steven had started on the program.[41]

Stephen Kopec

116. Stephen Kopec was a detainee and friend of Steven before and at the time of his death. He largely confirmed earlier evidence as to the movements of Correctional Services and Mr Djerke and Mr Goolagong as to the discovery of Steven's death and events that followed. His evidence was that Steven had started on the Methadone program two days before and Steven was not a user of opioids. Mr Kopec said he was surprised that Steven was on the Methadone program. He last recalled seeing Steven

[39] Statement of Gregory Paul Ayton Coronial Brief Volume 1 of 3 p8
[40] Statement of Gregory Paul Ayton Coronial Brief Volume 1 of 3 p8
[41] Ibid p8

about 6:30 PM on 26 May 2016 just prior to lock in. Mr Kopec said Steven seemed fine.

117. Mr Kopec recalled when he asked Steven why he was on Methadone Steven had responded with words to the effect of: he '*felt like it'*.[42] Mr Kopec recalled Steven had a second dose on Thursday morning of 26 May 2016.

118. Mr Kopec added that he did not notice anything about Steven's behaviour in regards to the Methadone, although he recalls Mr Goolagong telling him that Steven had been acting differently and saying that Methadone smashes people, making some dopey and drowsy.

Dr Angela Sungaila

119. Dr Angela Sungaila is a Forensic Physician specialising in Toxicology at the Victorian Institute of Forensic Medicine, based in Melbourne.

120. Dr Sungaila provided a report on 6 September 2016,[43] having read both reports of the pathologist Prof Dr Duflou.

121. Dr Sungaila says that Methadone is favoured by users because it has a strong opioid effect, in that it is more sedating.[44]

122. Dr Sungaila's evidence that the blood level of Methadone found in Steven on autopsy was relatively low (albeit within the reported therapeutic, toxic and lethal levels) supports the finding made by Dr Duflou.

123. She however thought the actual level of Methadone within Steven's body after dosing may have been slightly higher than that was recorded, as metabolism would have

[42] Statement of Gregory Paul Ayton Coronial Brief Volume 1 of 3 p8
[43] P147, Coronial Brief Volume 1 of 3 Exhibit 2
[44] P150, Coronial Brief Volume 1 of 3 Exhibit 2

continued to occur after Steven became unconscious and before aspiration pneumonia had developed.[45]

124. This of course differs to Prof Dr Duflou whose finding is that in all '*likelihood the pneumonia aspect may have been present for a number of hours prior to death and potentially for a day or so longer'*.

125. Nonetheless, Dr Sungaila believed that the low level of Methadone present in Steven's blood was of such a level that it would support a conclusion that Steven was opioid naive at the time he was placed on the MMP. [46] She added: *'It is accepted that there is overlap of these levels depending on the attributes of the person'*.

126. Dr Sungaila opined that it was highly likely that Mr Freeman was opioid naive in that his use of heroin was minimal, if at all.[47]

Pathologist Professor Dr Duflou

127. I earlier referred to the primary report of the pathologist Prof Dr Duflou and his supplementary report of 9 August 2016.

128. At page 3 of the Professor's primary report he set out the following findings[48]:

> *At autopsy, there was no evidence of recent injury. Specifically, no needle puncture marks were identified in the usual sites for administration of drugs. …*
>
> *Toxicological testing revealed the blood Methadone level of 0.15mg. No other drugs, poisons or therapeutic substances, were detected.*
>
> *The cause of death in this case appears to be aspiration pneumonia. In all likelihood, that pneumonia had been present for a number of hours prior to*

[45] P150 Coronial Brief Volume 1 of 3 Exhibit 2
[46] Ibid – paragraph 13
[47] Annexure J p151 paragraph 20, Coronial Brief Volume 1 of 3 Exhibit 2
[48] Annexure E - P150 Coronial Brief Volume 1 of 3 Exhibit 2 post-mortem report page 3

death, and potentially for a day or longer. A person, especially if a young adult, generally has highly effective mechanisms for the prevention of aspiration of foreign material into the lungs, unless there is some interference with such reflexes.

In the absence of significant neurological disease including epileptic seizures, neurologically induced swallowing difficulties and conditions such as multiple sclerosis, the most common cause of aspiration is intoxication by a drug.

In this case, the only drug present was Methadone, and the only confirmed administration of that drug was about one and a half days to 2 days prior to death, dependent on time of death Methadone has a prolonged half-life of between 15 and 55 hours, and therefore the Methadone detected in the deceased's blood could still be the consequence of that administration. However, I do not exclude a second administration of the drug at some later time as an entirely reasonable possibility - this would of course be highly dependent on whether the deceased had access to Methadone at a later time.

The level of Methadone in the deceased is difficult to interpret - it is within the therapeutic, toxic and lethal ranges for the drug, and as such no absolute statement can be made that the drug had caused death in this case[49]. [My emphasis added]

However, assuming the deceased was in fact a naive opioid user, i.e. he had not consumed heroin or other opioids in the recent past, the level would be sufficient to cause at least a degree of respiratory depression, cough suppression and obtundation, and could have resulted in significant and potentially life-threatening toxicity. This in turn could then reasonably be expected to continue to aspiration pneumonia.

[49] Annexure E - P150 Coronial Brief Volume 1 of 3 Exhibit 2 post-mortem report page 4

129. On 9 August 2016 Prof Dr Duflou provided a supplementary report regarding the toxicology report and his recording of a single dose of 30 mL of Methadone said to have been given to Steven on the morning of 25 May 2016.

130. Prof Dr Duflou had only reported that one dose of Methadone had been given on 25 May and no further doses were provided. The doctor properly records that the information provided to him was incorrect.

131. In the supplementary report he properly records that Steven:

> *'…was not given 150 mg of Methadone, but two doses of 30 mg not 30 mL one at 10:40 AM on 25 May 2016 and the other at 8:50 AM on 26 May 2016. And that because Methadone is a Schedule 8 drug the entries made in the schedule 8 drug register indicate that 30 mg of Biodone (or Methadone) were signed out for administration to Mr Freeman on those two dates and at those times.*'

132. At paragraph 10 of his supplementary report, Prof Dr Duflou records that by the time he writes the supplementary report it was becoming evident that:

> *Steven was a naive opioid user when administered Methadone, in that neither the medical records of the deceased, discussions with fellow detainees gave any indication of current opioid use apart from a single buprenorphine test on 12 December 2015*.[50]

133. Prof Dr Duflou went on to say at paragraph 16, that he formed the view that as his previous calculation was based on the administration of only one dose, the fact that there were two doses administered to Steven and the second dose of Methadone was administered closer to the time of death, reinforced his opinion that the aspiration pneumonia, which caused death, was the result of Methadone toxicity.

134. I am satisfied at the completion of a lengthy cross-examination by the respective representatives assisting the enquiry that Prof Dr Duflou's evidence was essentially

[50] P142 of the Coronial Brief Volume 1 of 3 Exhibit 2

unchallenged as to his key findings, particularly as the ratios of the breakdown products which supported his conclusion that Steven was opioid naive.

135. I am further satisfied that I should not exclude the possibility that Steven may have taken, in the period before his death and after being prescribed Methadone, additional Methadone via a '*drink*'. There is, after all, the evidence of Mr Djerke that Steven had told him Steven was on the '*done*' and taking a drink here and there.

136. I am however, unable to determine why Steven would take a drink, given he consumed his prescribed 30 mg of pure Methadone syrup with water on the morning of 25 May 2016 and his fellow detainees have said Steven was only trying Methadone to see how it went.

137. It remains possible that Steven's addiction to a combination from use past and present of other illicit substances, such as the earlier use of Buprenorphine and the historical identification of Tramadol in his hair, and the taking of a '*drink'* was creating withdrawal type symptoms for him which he wanted to allay. However, the continued taking of '*drinks*' after having been successfully prescribed Methadone is hard to reconcile given the evidence that Steven could have sought a further increase from 30 mg, given ACT Health had approved an amount of 120 mg daily in its authorisation to Dr Streitberg.

138. Attempting to determine opioid or Methadone naïveté is also clouded by Steven's activity on 14 February 2016 when at about 6:10 PM he was observed by custodial officers to be crawling under the fence of the remand cottage area to retrieve an item he claims item was for a football. It is noted that he refused to undergo a urinalysis and as a consequence of the refusal is declared to have failed the test - that is to be illicit drug free.

139. Steven had had only two doses of prescribed Methadone and both the toxicologist and pathologist assessments were that the Methadone level was low.

140. Even if Steven's consumption of '*Spit Methadone'* continued after the morning of 25 May it was more likely than not given the low level of Methadone in his system to have either been significantly diluted or all-but non-existent.

141. In addition I also have the negative urine test conducted on 10 May which revealed Steven had no illicit substances as result of that analysis.[51]

142. That of itself , given it is 15 days before his assessment with Dr Streitberg, is not proof that Steven was not consuming illicit substances, particularly given as Dr Sungaila's evidence '*was that the morphine derivative of heroin doesn't stay in the blood very long'*.[52] The inference I draw is that on a random test there is no evidence of opioids or Methadone or any other substance.

Findings

143. The deceased was Steven Claude Freeman, an Aboriginal man born 13 February 1991 and aged 25 years at the time of death. Narelle King, who is a Bundjalung woman, originally from Lismore is his mother and his father is Steven James Freeman. Steven Freeman was a fifth child of six siblings and one of three boys.

144. Steven Freeman passed away on 27 May 2017, while a prisoner within the Alexander Maconochie Centre (AMC). The AMC is an ACT Government owned and operated correctional facility, located at Symonston, in the Australian Capital Territory.

145. Dr Graeme Thompson declared Steven Freeman deceased at 11:11 AM on 27 May 2016 and a formal certificate of life extinct was made by Dr Jane Van Diemen at 3:15 PM that day.

146. On my direction, Pathologist, Professor Dr Johan Duflou conducted a post-mortem examination of Steven Freeman on 30 May 2016. The post-mortem report dated 2

[51] Annexure B p30 -statement of Don Taylor dated 10 February 2017
[52] Transcript Day 2 page 225 line 47

July 2016 and the Professor's supplementary report of 9 August 2016 declared the cause of death to be - Aspiration Pneumonia secondary to Methadone Toxicity.

147. Aspiration Pneumonia is an inflammation of the lungs and bronchial tubes which occurs after the inhalation of oral or gastric contents.

148. A person given Methadone who is opioid or Methadone naïve may experience an adverse reaction, in that Methadone may cause the consumer to experience respiratory depression, cough suppression and obtundation (less than full alertness).

149. It is these respiratory consequences following the consumption of Methadone that enable the movement of gastric contents up and into the oesophagus and then into that person's lungs.

150. Steven Freeman made an application to be placed on the ACT Health Methadone Maintenance Program (MMP) at the AMC on 5 April 2016.

151. Steven Freeman had opioid history while at the AMC, the extent of which is unknown but it appears to have been minor. The first recorded evidence of Steven having used an opioid substance occurred on 12 December 2015 when he was found to have Buprenorphine, an opioid, in his possession and in his body following confirmation of urinalysis.

152. Further, there is the AMC medical officer Dr Luke Streitberg's Patient Progress Note said to record Steven's representation to the Doctor that Steven was smoking heroin while he was at the AMC in the months prior to his medical assessment to enter the MMP; that Steven represented to the Doctor that Steven had used heroin two days prior to the assessment; Steven is further recorded as having conveyed to Dr Streitberg he was considering using heroin intravenously and further that he was incurring '*debt'* as a consequence.

153. There is also limited evidence of Steven having non authorised access to Methadone referred as '*drinks*' provided by other detainees.

154. A '*drink*' is the regurgitation of a prisoner's oral Methadone dose after it has been administered and supervised by the dispensing medical staff. It is regurgitated into a container by the detainee, where it is mixed with water or disguised with orange juice for re-consumption by another detainee.

155. Methadone received in this manner is diluted although as to what extent is not known as it will all largely depend on what is in the stomach of person giving up the '*drink'* on any particular day. Ordinarily Methadone is not absorbed by the body until 20 minutes after it has been consumed.

156. While I acknowledge there is some history of opioid use I am satisfied Steven had an extremely low use of opioids or Methadone, as I accept the findings set out in both the post-mortem report and the supplementary report provided by Prof Dr Duflou that Steven was likely to have been a low user of opioid substances even to the extent that he may have been opioid naive.

157. I am further satisfied based on the evidence from the pathologist and the toxicologist, Steven's personal history and other sources identified in my reasons, that Steven was also more likely than not to have been a low consumer of '*Spit Methadone'* at the time of entering the MMP given that it is diluted both being a product of regurgitation then being mixed subsequently with either water or orange juice.

158. In terms of the Methadone prescribed to Steven, the first dose of 30 mg was given following the medical assessment at 10:40 AM on the morning of 25 May 2016. The second dose was given on the morning of 26 May 2016 at 8:50 AM. On that day the ACT Health provided its authorisation approving dosing for Steven of up to 120 mg of Methadone daily.

159. Dr Streitberg, notwithstanding the absence of any independent evidence before the Doctor at the time of the consultation that Steven Freeman was opioid dependent, accepted Steven's representations that he was a heroin user while within the AMC, had previously been smoking heroin and was considering using it intravenously

having last used two days before the assessment. In doing so it was recorded by the Doctor that Steven was incurring debt as result of Steven's heroin use.

160. While there is evidence of Steven taking a '*drink*' and one instance of having used Buprenorphine in December 2015[53] while in custody, at the time of making his application to the Hume Health Centre to be placed onto the MMP Steven had 15 days earlier received the results of a urinalysis which showed no presence of illicit substance in his system.

161. Observations of Steven by Mr Goolagong and Mr Djerke that on 26 May 2016 Steven looked tired[54], was drowsy, appeared drunk, looked stoned,[55] had slurred speech, was acting out of character, and was restless overnight on 25 May 2016 indicate potential opioid toxicity following Steven's commencement onto the MMP.[56]

162. Importantly however, and inconsistent with the cell mates' assessments of Steven, is the compelling evidence of Steven captured by CCTV recording as he moved around his cell hub on the 26 May 2016.

163. A review of the CCTV recording reveals an active person, engaging with detainees and moving fluidly and without impediment.

164. There is the evidence of Mr Craft and Mr Kopec who made observations that Steven was showing no effect from his consumption of Methadone.

165. While I acknowledge the competing evidence, I am drawn to the finding that as is recorded on the CCTV footage on the evening of 26 May 2016, Steven can be observed shaking hands and engaging with other detainees before the night-time cell lock.

[53] P537-8 Coronial Brief Volume 2 of 3 Exhibit 2
[54] P160 Coronial Brief Volume 1 of 3 Exhibit 2 Q&A 56
[55] P160 Coronial Brief Volume 1 of 3 Exhibit 2 Q&A 55 and 56
[56] P151 Coronial Brief Volume 1 of 3 Exhibit 2 Dr Sungaila Toxicologist

166. Steven was not outwardly displaying any apparent loss of his physical motor skills[57] although he may have been showing facial indicators such as those expressed by his cellmate.

167. I am satisfied that Steven sought the use of Methadone to make '*life easier*' for him at the AMC. That is – '*to pass away the time'*. His intention was perhaps not to have it every day, but to see how he went and if he did not like it he would stop using it.

168. I am satisfied of that based on the information provided by his cellmate Mr Goolagong[58] and others detainees earlier identified, particularly the record of conversation with Stephen Kopec, that Steven was not woken up on the morning of 27 May 2017 as he had informed Mr Kopec the night before, that Steven was going to miss taking his Methadone the next day. As he only '*wanted to have it two days in a row or perhaps two days on one day or 2 days off'*.

169. From Steven's perspective, the fact that he communicated this to other detainees, suggests that Steven was not intending to consume Methadone every day.[59]

170. That also suggests that Steven's application to enter the Methadone program was potentially not because he had some background using heroin or other opioid substance dependency; rather it was more likely than not that he was simply entering the MMP so as to '*make life easie*r' during his time in custody.

171. There is also the historical connection to Methadone in Steven's hair sample analysis conducted by the Victorian Institute of Forensic Medicine[60] (VIFM). That analysis was unable to exclude the possibility that the positive result for methadone in the hair was contributed to by the two doses Steven was prescribing consumed on the 25 and 26 May 2016 however, they noted it was unlikely.

[57] See our Annexure A
[58] P155 Coronial Brief Volume 1 of 3 Exhibit 2 police record of conversation with Jermaine Goolagong
[59] P239 Coronial Brief Volume 1 of 3 Exhibit 2 police record of conversation with Stephen Kopec
[60] Exhibit 11 - Victorian Institute of Forensic Medicine, VIFM Certificate of Analysis (22nd February 2017)

172. Further, I note note that VIFM could not exclude that the methadone detected was ingested prior to the 48 hours in which methadone was officially ingested in accordance with the prescription of methadone from the 25 May 2016.

173. Importantly, the IFN were unable to determine at what point in time in the last six months with Steven came the contact with either Methadone or Tramadol.

174. I am satisfied that Steven was more probably opioid naive notwithstanding evidence suggesting use of opioid substances at earlier points in time in 2015.

175. I am satisfied that Steven may have had a '*drink*' notwithstanding there was no direct evidence that he had been observed doing so.

176. Even the professional contributions from post-mortem and toxicologists reports do not provide any certainty as to whether or not Steven was opioid or Methadone naïve,

177. I am also satisfied that Steven more likely than not was Methadone naive at the time of assessment and placement onto the MMP given the zero detection of any illicit substance on 10 May 2016 and his only reason, referencing to other detainees, that he was looking at getting on the '*done*' program and the only one piece of evidence that he was taking '*drinks'* being a diluted form of Methadone.

178. Accordingly, notwithstanding there is no positive evidence clearly indicating that Steven was opioid naive or Methadone naïve, I am satisfied that he may have been both opioid and Methadone naive cogently based on the evidence which universally reveals no regular use of either opioids or Methadone at the time of death. I am further comforted based on the pathologist's declaration that aspiration pneumonia was caused by Methadone toxicity.

B. Did Steven Freeman undergo an appropriate medical assessment for the purposes of placement on to the MMP?

Hume Health Centre induction process for new detainees

179. Steven's induction on entering the AMC in April 2015 required he undergo an induction assessment process,[61] administered by Justice Health Services at the AMC Hume Health Centre, on behalf of the ACT Government's Health Directorate (ACT Health).[62]

180. Steven's medical induction was conducted by a Registered Nurse. Steven's medical induction records reveal Steven denied the use of alcohol, benzodiazepines, cannabis, heroin and other opioids, hallucinogens and ecstasy, although he confirmed he smoked 'Ice' daily to the value of $300 a day prior to his admission into the AMC.

181. As to Steven's general well-being, a segregation review[63] conducted on 18 February 2016 reveals that Steven presented dressed neatly and appropriately. During the session, Steven's behaviour was appropriate to the setting and context, with good engagement. Nil odd or unusual behaviour or perceptions were observed within the session.

182. On 5 April 2016 Steven completed a Hume Health Centre request form,[64] having written:

> '*I would like to see the doctor concerning my health please. I want to get on the Methadone'.*

183. The request is dealt with by Registered Nurse Norman on 5 April 2016 and it appears that Steven is placed on the wait list to be ultimately assessed by a medical practitioner Dr Luke Streitberg on 25 May 2016.

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[61] page 1009 Statement of Gregory Paul Ayton Coronial Brief Volume 3 of 3
[62] P552 Statement of Gregory Paul Ayton Coronial Brief Volume 2 of 3
[63] P1006 Coronial Brief Volume 3 of 3 Exhibit 2
[64] P1156 Coronial Brief Volume 3 of 3 Exhibit 2

Standard Operating Procedures and National Guidelines relevant to Dr Streitberg's Assessment 25 May 2017

Mental Health, Justice Health and Alcohol and Drug Services, Standard Operating Procedure

184. At the time of Steven's medical assessment, Dr Streitberg was subject to the ACT Government's Health Department-issued *Mental Health, Justice Health and Alcohol and Drug Services, Standard Operating Procedure* (the SOPs) dealing with the management of adult patients receiving opioid replacement treatment. At the AMC, opioid replacement treatment included Methadone and Buprenorphine and Suboxone.[65]

185. The SOP describes its*:*

> '*Purpose is to set out the procedures and processes for staff to follow in the assessment, induction and ongoing management of patients commencing on the opioid replacement treatment program. The SOP contains the procedures for staff to follow in the administration of Biodone and Suboxone to patients and the organisational management of the Justice Health Services Opioid Replacement Treatment Program'.*[66]

186. Dr Streitberg as the relevant medical officer on 25 May 2016 was required to conduct an assessment to determine first: placement onto the MMP; second: the amount of Methadone; and third: the commencement day.[67]

187. Dr Streitberg said he reviewed Steven's health record prior to his face-to-face assessment. Therein he had information - that is from the induction assessment - that Steven had no history of prior opioid or Methadone use or dependence. The AMC health record revealed to Dr Streitberg that Steven smoked tobacco, drank alcohol and used cannabis and amphetamine (Ice) prior to entry into the AMC.

[65] Annexure E to the statement of Dr Streitberg dated 17 February 2017
[66] Ibid p1122
[67] Ibid p1123 paragraph 2

188. The SOP required all patients must be provided with verbal information together with information on educational opioid treatment program and patient should be offered a copy of '*The Methadone or Buprenorphine Handbook'* prior to consenting to treatment.[68]

189. Dr Streitberg was required to explain expected lengths of time to stabilise a dose as well as the expected benefits and risks of treatment for patients that are opioid dependant.

190. This is not recorded on the Patient Progress Note as having been completed, but the Doctor in his oral evidence was adamant he did take on all the relevant steps during the prolonged interview period afforded through the prison lock down and the consequential restriction on the movement of detainees.

ACT Health's: ***ACT Opioid Maintenance Treatment Guidelines.[69](OMTG)***

191. A further ACT Health policy applying to the determination of the placement of Steven onto the MMP was the ACT Health policy titled the *ACT Opioid Maintenance Treatment Guidelines (OMT Guidelines).[70]*

192. The OMT Guidelines provide at paragraph 3 that they '*are to be used in conjunction with the policies, guidelines and legislation listed below'* which include the following:

a) National Pharmacotherapy Policy for People Dependant on Opioids; and
b) National Clinical Guidelines and Procedures for the Use of Methadone in the Maintenance Treatment of Opioid Dependence (**National Guidelines 2014)**

193. Dr Streitberg acknowledged the application of the National Guidelines to his duties.[71]

[68] Ibid p1124 paragraph 2
[69] Annexure F to the Statement of Dr Streitberg dated 17 February 2017
[70] Annexure F to the Statement of Dr Streitberg dated 17 February 2017
[71] Paragraph 19 - Statement of Dr Streitberg dated 17 February 2017

194. The OMT Guidelines[72] set out the rights and responsibilities for the commencement of treatment on the opioid maintenance treatment. All dosing of Methadone within the AMC was supervised: that is the Registered Nurses conducting the daily dispensing observed the consumption of the Methadone syrup in front of them followed by a cup of water. There was no unsupervised takeaway dosing.

195. The OMT Guideline provide that for new clients not currently receiving opioid maintenance treatment, opioid maintenance treatment is only indicated for those who are opioid dependent; and that induction is to follow the National Guidelines.[73]

The National Guidelines for Medication Assisted Treatment of Opioid Dependence

196. These National Guidelines set out that Methadone has a greater sedating effect and is more commonly associated with overdose than alternatives in opioid substitution treatment.[74]

197. The key objectives of the National Guidelines reveal a focus on the reduction of withdrawal symptoms and unsanctioned opioid and other drug use.[75]

198. Importantly, the National Guidelines provide the following:[76]

> *Methadone is sedating and can cause overdose into high doses, particularly in those with low or opioid tolerance … The greater risk of opioid toxicity in overdose during induction with Methadone necessitates commencing at a low dose and a slow rate of dose increase…*

199. It is these SOPs and Guidelines that backdrop the decision-making of Dr Streitberg and his assessment of Steven coupled with the doctors experience with prescribing Methadone in custodial environments.

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[72] Page 8 - Annexure F to the Statement of Dr Streitberg dated 17 February 2017
[73] National Clinical Guidelines and procedures for the use of Methadone in the maintenance treatment of opioid dependence – page 23 Annexure F to the Statement of Dr Streitberg dated 17 February 2017.
[74] page 129 Annexure L to the Statement of Dr Streitberg dated 17 February 2017
[75] page 130 Annexure F to the Statement of Dr Streitberg dated 17 February 2017
[76] Ibid A4.2

The Medical Assessment

200. Dr Streitberg sets out his expertise within his statement[77] and states he has been prescribing medications including Methadone at the AMC for a number of years.

201. It was a Dr Streitberg's evidence that a third of the detainee population then at the AMC were placed on the Methadone Maintenance Program.

202. Dr Streitberg's recollection of the conversation with Steven and the Patient Progress Note[78] that he made on that day of the assessment being 25 May 2016 did not contain every aspect or detail of his conversation with Steven, which ran for 45 minutes.

203. The doctor said as the AMC was in lockdown at the time, detainees could not be moved from one location to another. As a consequence the consultation ran for 45 minutes being longer normal i.e. 15 to 20 minutes.

204. On 25 May 2016 Dr Streitberg in the course of his interview with Steven made an entry on an ACT Health Progress Note that Steven reported ongoing heroin use for the last few months. This is a concern given Steven for the last two months had been a detainee at the AMC and the fact he was accessing heroin - had in fact consumed heroin - is recorded by the Doctor.

205. During this time Dr Streitberg stated that because he had a longer time to consider the information being given to him by Steven, he formed the view that it would be safer for Steven to be placed on the MMP because Steven had told him he was experiencing withdrawal and was incurring debts.

206. Notwithstanding a Clinical Opiate Withdrawal Scale checklist[79] (COWS) to be administered by a clinician could have been used to '*reproducibly rate common signs and symptoms'* of Steven's alleged opiate withdrawal, Dr Streitberg only recorded the information received from Steven on a Patient Progress Note.

[77] Statement of Dr Streitberg dated 17 February 2017
[78] Page 1158 Statement of Gregory Paul Ayton Coronial Brief Volume 3 of 3 Annexure 114
[79] Annexure I page 122 of the Statement of Dr Streitberg dated 17 February 2017

207. The following sets out the content of the Patient Progress Note[80] where Dr Streitberg makes the following entries of Steven's information provided during the assessment:

- *patient reporting ongoing inhaled heroin use for the last few months*
- *no intravenous use but considering*
- *escalation of use recently, incurring debt*
- *Wants to discuss MMP. Never on before.*
- *Thorough and lengthy D/W [discussion with][81] patient. Re purpose of MMP, use R+R, [increase/decrease] etc.*
- *Patient very receptive to this*
- *Patient agrees to MMP. Last week used 2/7 [2 days ago], no buprenorphine*
- *Imps[Impressions] opioid use - mild withdrawal now*
- *Patient is MMP authorised [tick] - R + R [rights and responsibilities] [tick] – script. [tick]*

208. Dr Streitberg set out in his statement that he had reviewed the health centre request form and available hardcopy health records. He was aware Steven had applied for potential entry onto the MMP a month before the treatment and Steven's history of using amphetamine and cannabis, but noted he said there was no reported opioid use.[82]

209. Dr Streitberg said his focus of the consultation was on Steven's reported problematic drug use and Steven's desire to address it through the MMP.

210. Dr Streitberg asserts that Steven had reported to him that Steven had been smoking heroin and using it on a daily basis or whenever he could get it or had been inhaling heroin for months, and that this was increasing over time and was resulting in Steven incurring a drug debt within the prison.[83]

[80] page 1158 Statement of Gregory Paul Ayton Coronial Brief Volume 3 of 3 Annexure 114
[81] Annexure G to the Statement of Dr Streitberg dated 17 February 2017 is a typed explanatory note setting out the handwritten progress notes made by the doctor on 25 February 2016 at 1030 -the words in the square brackets are the longhand for the abbreviation actually set out in the original progress note page 1158 see footnote 57.
[82] paragraph 43 to 45 - Statement of Dr Streitberg Dated 17 February 2017
[83] paragraph 48 - Statement of Dr Streitberg Dated 17 February 2017

211. This was of concern for the Doctor because non-payment of drug debts or any form of debt within the prison can lead to, and result in, physical violence.

212. Dr Streitberg said that on specific questioning, Steven reported he was considering using heroin intravenously because its cost was, it seems, less than the cost of using inhaled substances. The spread of communicable diseases through intravenous drug taking within the prison population was also identified by the Doctor as a relevant consideration in placing Steven on the MMP.

213. The Doctor stated that Steven reported restlessness, abdominal upset, a sensation of hot/cold and poor sleep amongst other indicia. The Doctor was satisfied that Steven's reported symptoms were consistent with mild opioid withdrawal adding:[84]

> *'Further, that Steven appeared physically uncomfortable during the consultation…*
>
> Dr Streitberg was clear in his evidence that Mr Freeman displayed no signs of opioid drug intoxication during the consultation.'[85]

214. Dr Streitberg's evidence was that during the course of the consultation Steven gave:

> *'A compelling, consistent and concerning history of problematic escalating opioid use suggesting opioid dependence or opioid tolerance'. He described requiring increasing amounts and frequency of use. I observed him to display symptoms and signs highly suggestive of opioid withdrawal, and on this basis, I was satisfied Steven fulfilled the criteria for opioid dependency as per the Diagnostic and Statistical Manual of mental disorders fourth edition and the National Guidelines for medication assisted treatment of opioid dependence, 2014 edition. I identified no contraindications to the use of Methadone maintenance to Mr Freeman's case.'*[86]

[84] paragraph 53 to 54 - Statement of Dr Streitberg Dated 17 February 2017
[85] paragraph 54 - Statement of Dr Streitberg Dated 17 February 2017
[86] paragraph 58 - Statement of Dr Streitberg Dated 17 February 2017

Professor Olaf Drummer

215. Prof Olaf Drummer is a Forensic Pharmacologist and Toxicologist employed as the Deputy Director Academic Programs at the Victorian Institute of Forensic Medicine. Prof Drummer provided a report dated 10 February 2017 on instruction from the Freeman family for an expert opinion in relation to a number of things identified at paragraph 1 of his opinion.[87]

216. Prof Drummer states that there is no defined concentration of Methadone that can be considered safe or necessarily toxic without reference to the likely degree of tolerance to opioids.[88]

217. Equally Prof Drummer refers to the fact that there are no notes which make mention of a possible past heroin use and that '*there was no indication of any recent use let alone a positive assessment of tolerance to opioids'*.[89]

218. It is not entirely clear he says why Steven was prescribed the drug used to treat opioid dependency such as heroin use[90]. There is no indication that Prof Drummer was given the doctor's assessment notes.

219. The Professor equally concluded, having studied Methadone deaths for over 25 years, that a common feature of those deaths, is the inability to assess tolerance to opioids and prescriber safe starting doses, as Methadone has a long half-life causing accumulation of the drug with one daily dosage.[91]

Professor Michael Levy

220. Prof Michael Levy, the Clinical Director for Justice Health Services for the ACT Government, and Dr Streitberg's ultimate supervisor for his work at the AMC, provided a statement and gave oral evidence.[92]

[87] Exhibit 10 - Statement of Prof Olaf Drummer dated 10 February 2017 para 1
[88] Exhibit 10 - Statement of Prof Olaf Drummer dated 10 February 2017 para 5.7
[89] Ibid paragraph 6.2-6.4
[90] Exhibit 10 - Statement of Prof Olaf Drummer dated 10 February 2017 para 6.2-6.4
[91] Ibid para 6.5
[92] Exhibit 12 statement of Prof Michael Levy Clinical Director Justice Health Services ACT

221. Prof Levy conceded that at the time of Steven's death there was no specific care plan as required by section 5.2 of the ACT OMTG. He sought to explain that generally ongoing management was through the documentation of progress notes and prescriptions.[93]

222. Prof Levy was completely satisfied that Dr Streitberg's clinical decision to prescribe Methadone to Steven was appropriate, based on information available and that the relevant entries on Steven's clinical records were compliant with professional standards for the prescription of Methadone to Steve. Urinalysis was not required as it would not have provided any further indicative clinical information what was already self-reported by Steven.[94]

Failure to Conduct Urinalysis

223. Dr Streitberg was challenged as to why he did not use the urinalysis as a tool available to him under the National Guidelines. He conceded that a positive result from a urinalysis would confirm or not confirm the presence of opioids. True enough, as he pointed out, it would not show the specific opioid consumed.

224. However that was not the issue confronting him having regard to the fact that having read Steven's medical history, there was no evidence before Dr Streitberg other than what Steven was saying to him of opioid dependence.

225. I am satisfied the Doctor did not avail himself of any other independent method to confirm opioid dependency that would warrant entry onto the MMP.

226. As suggested by Dr Sungaila: '*If urine drug screens had been done prior to the initiation of Methadone they may have indicated use of illicit opioids'*.[95]

Prof Michael Levy

227. Prof Levy highlighted that the National Guidelines do raise the possibility of obtaining a urinalysis as part of an induction assessment for the Methadone maintenance program.

[93] Paragraph 67 - Exhibit 12 statement of Prof Michael Levy Clinical Director Justice Health Services ACT
[94] Ibid paragraph 79
[95] Annexure J P149 paragraph 20, Coronial Brief Volume 1 of 3 Exhibit 2

However he stated that it had not been the usual practice within Justice Health services as it might have undesirable consequences.

228. Prof Levy explained there were limitations within the testing process in relation to the ability to detect other than only reason opioid usage. Further, it may actually encourage opioid usage prior to a consultation, to ensure a positive test result. And urine samples taken at the Hume Health Centre could not be forensically controlled as the centre was never designed for that purpose, in that a sample could be readily replaced or tampered with.[96] I have some concerns about the plausibility of that statement having regard to the fact that the health centre is inside a prison and movement of prisoners is strictly controlled. Prof Levy however did confirm that urine samples are often taken by ACT Corrective Services at the AMC.

229. Importantly, as raised by Dr Streitberg, the ACT Opioid Maintenance Treatment Guidelines and the National guidelines for medication assisted treatment of opioid dependence did not require a mandatory urinalysis in either a community or custodial setting prior to the commencement of Methadone.[97]

Findings

230. Dr Streitberg's operating environment must be considered and applied to his actions at the relevant time.

231. Part of that operating environment incorporated the Doctor's observations of the prison drug culture and the fact that the use of illicit substances continues at the AMC by detainees.

232. The Doctor stated in order for a detainee to obtain those illicit substances[98] they incur debts from other detainees who by whatever means are able to obtain illicit substances while in custody.

[96] Ibid paragraph 50
[97] paragraph 60 - Statement of Dr Streitberg Dated 17 February 2017
[98] paragraph 11 and 36 to 37 - Statement of Dr Streitberg Dated 17 February 2017

233. The non-payment of drug debts of course can lead detainee to experience physical assaults and other deprivations as they try to repay the debt; that debt may also be incurred by detainee who obtain '*drinks*' being '*spit Methadone*'.

234. The Doctor said for a detainee to divert doses they will often not eat and load their stomach with water prior to their dosing of Methadone. They will carry some form of container in their pocket, or if returning to their room immediately after consuming, to regurgitate the Methadone by inducing vomiting and catch it into the container.

235. This is then sold to another detainee and then consumed by that prisoner.[99] The '*Spit Methadone*' is usually stored in orange juice which disguises both the taste and colour to some degree he said.[100]

236. The Doctor highlighted the dangers with '*Spit Methadone*' is that it will contain an unknown amount of Methadone due to incomplete expulsion and some degree of absorption, and be mixed with gastric contents, including any residual food/drink and stomach acid.

237. The Doctor said this is extremely dangerous as the amount regurgitated is unpredictable, and the amount of water consumed will alter the concentration of the vomited dose.

238. The Doctor further added this process is extremely dangerous for the prisoner attempting to divert, as if they are unable to do so after some period of continued diversion, they will fully absorb their dose which will be too high for their level of tolerance. The risk of transmission of disease is also higher he said.

239. As earlier concluded there is evidence from other detainee Mr Djerke, who knew Steven, and who claimed Steven was taking a '*drink*' as he referred to it, of '*Spit Methadone*' before Steven was prescribed Methadone.

[99] Although it should be noted that Ivan Djerke evidence was that he did not sell spit Methadone, he gave it away.
[100] paragraph 23 - Statement of Dr Streitberg Dated 17 February 2017

240. The ACT Health's form *Opioid Guidelines Rights and Responsibilities for a Recipient onto the MMP* was signed by Steven on 25 May 2016 setting out his consent to opioid maintenance treatment.[101]

241. Although, I note with concern, given that it highlights poor administration where clear and unambiguous administration is required given a Schedule 8 drug is involved, that Dr Streitberg did not co-sign in the medical practitioner space provided.

242. On signing the form Steven acknowledged that in order to commence the opioid maintenance treatment that he had been advised by the prescribing medical practitioner about, amongst other things, the nature of opioid maintenance policies and expectations, side-effects and risks associated with treatment and the risk of other drug use.

243. Dr Streitberg's name appears in the signature block reviewing that on 25 May 2016 Steven was given 30 mg at 1040 hours and on 26 May 2016 was given 30 mg at 0850 hours.[102]

244. Notwithstanding a range of short and long form clinical opiate withdrawal scale checklist[103] (COWS) to be administered by a clinician could have been used to '*reproducibly rate common signs and symptoms'* of Steven's alleged opiate withdrawal, Dr Streitberg did not undertake any of these formalised assessments.

245. The fact that the systems in place that ACT Health did not require the use of such a form in a clinical circumstance for determining the level of withdrawal and to assess the level of physical dependence on opioids is a concern.

246. The Doctor was faced with three competing tensions, the first: his own declared position of being vigilant to attempt to identify patients who are seeking medications for non-therapeutic purposes;[104] the second: ACT Health's approach to the harm

[101] Page 1163 Statement of Gregory Paul Ayton Coronial Brief Volume 3 of 3 Annexure A116 and Annexure K Statement of Dr Streitberg dated 17 February 2017
[102] Page 1166 - Statement of Gregory Paul Ayton Coronial Brief Volume 3 of 3 Annexure A117
[103] Appendix 2 national guidelines for medication assisted treatment of opioid dependence page 185 to 191 Annexure I AND page 122 of the Statement of Dr Streitberg dated 17 February 2017
[104] paragraph 57 - Statement of Dr Streitberg Dated 17 February 2017

minimisation approach in using Methadone in custodial facilities; the third: based on the Patient Progress Notes as recorded by Dr Streitberg, persuasive presentation by Steven setting out his heroin use leading to the conclusion by Dr Streitberg that Steven was suffering mild opioid withdrawal.

247. The fact that the Doctor balanced the risks to this particular detainee by relying upon the detainee's own information that he was using illicit drugs, was incurring 'debt', and was going to be exposed to potentially communicable disease through intravenous heroin use, created it seems to me the perfect environment upon which the information provided by the detainee matched sufficiently, and for all intents and purposes, appropriately the Doctor's understanding of the requirements to be placed on the MMP. Notwithstanding that this was done without any external validation or testing.

248. I am satisfied Dr Streitberg knew what he was looking for in an MMP placement assessment, based on his experience as to symptoms and signs of opioid dependency.

249. I am also satisfied, Steven probably provided responses that were designed to intentionally or inadvertently mislead Dr Streitberg into believing Steven was opioid dependent. This is supported by Detainee Craft whose evidence was that he told Steven to tell the Doctor, Steven was considering '*using a needle and they will put you on it'*, or words to that effect.

250. I am satisfied this part of the critical sequence that led to the prescription and the consumption of at least the prescribed level of Methadone, which met at the same time the therapeutic, toxic and lethal levels.

251. Can I be satisfied on the balance of probabilities that what the Doctor did, by placing Steven onto the MMP, notwithstanding the shortcomings in form use and completion, so affected Steven's treatment, care and supervision so as to be a contributor to the cause of death?

252. I am not satisfied the evidence rises to the required level in order to make that finding. Clearly, I accept the persuasiveness of the factual circumstances that more could have

been done by Dr Streitberg as the assessing doctor in that use of forms within the National Guidelines forms would have made his actions more transparent.

253. Notwithstanding, there was the Patient Progress Note of Steven's representations which provide important background to Doctor Streitberg being persuaded that Steven was suffering mild opioid withdrawal.

254. It was against that background that was also a consideration as to the authorisation of Steven to enter the MMP. This evidence was particularly relevant given Dr Streitberg's adherence to ACT Health's harm minimisation based approach by offering the MMP at the AMC as opposed to an abstinence approach undertaken by other jurisdictions.[105]

255. I am satisfied the medical assessment was appropriate, while recognising not all required forms and tools available were utilised although adequate medical records of the consultation and the exchanges were considered sufficient as was the uncontested evidence Prof Michael Levy.

256. Prof Levy also supported the underlying rationale of Dr Streitberg's decision not to delay placement onto the MMP for urinalysis (although this was not mandatory). As in Dr Streitberg's evidence, it would only confirm for him what he already knew, based on the presentation of Steven that Steven was experiencing mild opioid withdrawal.

257. I acknowledge the National Guidelines raises the prospect that delays in obtaining results from a urinalysis should not delay treatment initiation where diagnosis can be clearly established.[106]

258. The Patient Progress Note made at the time by Dr Streitberg records, albeit in summary form, the important requirements for entry onto the MMP as set within the ACT SOP's and National Guidelines. It was appropriate in the circumstances based on the representations claimed to have been made by Steven to Dr Streitberg.

[105] paragraph 12 - Statement of Dr Streitberg Dated 17 February 2017
[106] paragraph 63 to 65 - Statement of Dr Streitberg Dated 17 February 2017

259. Dr Streitberg's evidence is, in effect, that he accepted Steven at face value as a detainee telling him about symptoms which correlated from the Doctor's training and experience to mild opioid withdrawal.

260. It is difficult to go behind that information as is recorded by the Doctor having been presented to him by Steven and being a note made contemporaneously at the relevant time of the assessment.

261. To the contrary however, an opioid dependent diagnosis was not one that could be said to have been clearly established by Steven's medical history. The patient was presenting as a person showing no opioid dependency in the past on any medical record.

262. When referring to the *National Guidelines for the Medication Assisted Treatment of Opioid Dependence* (National Guidelines) in operation at the Hume Health Centre, Dr Sungaila stated that paragraph 9 of the National Guidelines provided the following:

> *`At A1.2 the guidelines advise that a comprehensive substance use history is essential. Also that urine drug screening is useful to corroborate history and establish recent substance use. Establishing a diagnosis of opioid dependence is a requirement for opioid substitution treatment'.*

263. Further, Doctor Sungalia highlights at A7.4 of the National Guidelines that:

> *'The guidelines for opioid replacement therapy use in prisons recommend that opioid replacement therapy is appropriate if the individual is receiving opioid replacement therapy at the time of imprisonment, is opioid dependent and not receiving treatment or continues unsanctioned use of opioids in prison in a manner which constitutes a significant risk of harm.'*

264. It has been highlighted a number of times that Steven showed no history of being opioid dependent at the time of admission into the AMC. As discussed earlier, I am unable to conclude to the required standard that Steven was in fact opioid dependent.

The evidence is that Steven wanted to '*do his time easier'* and his cellmate and other detainees were aware that Steven was considering entering the MMP for that reason.

265. Detainee evidence suggests Steven was warned against entering the MMP and the detainees had told Steven of Methadone's harm. Their evidence was that Steven had told them he was '*only going to try it and see how it went'*. That history explains the possible extent that Steven may have gone to, in persuading Dr Streitberg through words and mannerisms during the assessment.

266. There is evidence of Steven's consumption of '*Spit Methadone'* and other illicit substances while at the AMC. I am unable to rule out their presence in Steven's bodily systems at the time of his consumption of the prescribed Methadone having been placed on the MMP or at the time of his death. Although in the circumstances common-sense might dictate it was unlikely given Steven had access to pure Methadone syrup.

267. It is Dr Streitberg's evidence in effect that Steven described his symptoms, his current debt situation, his consideration of intravenous heroin use, for the sole purposes of obtaining placement onto the MMP which the Doctor accepted as being genuine.

268. I am satisfied that Doctor solely relied on Steven's representations to him and the Doctor's observations at the time of Steven.

269. For the reasons that I have set out above, I remain satisfied that placement onto the MMP was appropriate in the circumstances and did not affect the quality of the care, treatment or supervision contributing to the cause of death.

270. I recognise had Steven not been placed on the MMP, he would not have been prescribed Methadone. I am however satisfied that the placement on the MMP on its own and as a first step in the process did not in a material way contribute to Steven's cause of death.

271. That is to say there was sufficient evidence before the assessing doctor that opioid use or dependency was present through both the patient's information and the doctor's assessment of symptoms of mild withdrawal as recorded in the Patient Progress Note.

272. I am further satisfied that urinalysis testing was available and could have been used by the Doctor to confirm whether or not Steven was an opioid user or opioid dependent.

273. Urinalysis by itself however, as stated by Dr Sungaila in her oral evidence, in tracking the past use of heroin after it turns into morphine in the body after a couple of days presents as a difficulty in that it does not always register through the analysis process.

274. Importantly, as raised by Dr Streitberg the ACT Opioid Maintenance Treatment Guidelines and the National Guidelines for medication assisted treatment of opioid dependence did not require a mandatory urinalysis in either a community or custodial setting prior to the commencement of Methadone.[107]

275. I am however satisfied that Dr Streitberg establishes a diagnosis of opioid dependence as a requirement for commencement onto an opioid substitution treatment program as required by the National Guidelines.[108]

276. I am not satisfied that the failure to conduct the urinalysis in and of itself, while not best practice, could be said to have affected Steven's treatment, care and supervision contributing to the cause of death.

[107] paragraph 60 - Statement of Dr Streitberg Dated 17 February 2017
[108] Annexure J page149 Paragraph 9 Coronial Brief Volume 1 of 3 report of Dr Sungaila

C. Did prescribing and commencing Steven on a daily dose of 30 mg of Methadone affect the quality of Steven's care, treatment or supervision contributing to his cause of death?

The Prescribing Framework and Warnings

277. As a Schedule 8 Drug, Steven required a prescription to legally obtain Methadone. Dr Luke Streitberg issued a prescription for Steven Freeman to receive 30mg of Biodone (Methadone) daily.

278. An application for approval to prescribe a Schedule 8 controlled medicine for use on the Opioid Dependency Treatment Program was then authorised by ACT Health and that authorisation was sent to Dr Streitberg on 26 May with approval number 243745.[109]

279. The maximum daily dose of 120 mg of Methadone was authorised and valid from 26 May 2016 to 26 November 2016 and signed on 26 May 2016 by a delegate of the Chief Health Officer.[110]

280. The SOP provides that a first dose may be given without waiting for authorisation to be provided.

281. The National Guidelines provide the following:[111]

> *Commence with 20 to 30 mg daily. Lower doses (e.g. 20 mg or less) are suited to those with low or uncertain levels of opioid dependence, with high risk polydrug use or with severe other medical complications. Higher doses (30-40mg) should be considered with caution if clinically indicated, at the discretion of the prescriber.*

[109] page 1160 Statement of Gregory Paul Ayton Coronial Brief Volume 3 of 3 Annexure A115
[110] Ibid
[111] Ibid A4.2

282. The SOP[112] provides that the maximum dose for Methadone was 120 mg with the minimum dose being 2.5 mg. However, the following dot point in the SOP provides that doses of less than 25 mg will only be prescribed as part of a planned reduction schedule for a maximum of two weeks.

283. The Commonwealth Department of Health provides guidance in the use of Methadone and its effects:[113]

> *Methadone is a potent synthetic opioid agonist [a substance which initiates a physiological response]*. ***The major hazard associated with Methadone is the risk of overdose. (my emphasis)*** *This risk is particularly high at the time of induction to a Methadone maintenance treatment and when Methadone is used in combination with other sedative drugs.*
> *The relatively low onset of action and long half-life mean that Methadone overdose can be highly deceptive and toxic effects may become life-threatening many hours after ingestion because Methadone levels rise progressively with successive doses during induction into treatment, most deaths in dispute have occurred on the third or fourth day of treatment.*[114]

284. As to determining the appropriate level to be dispensed, guidance from the SOPs appears to be a start point of not below 25 mg.

285. Dr Streitberg's evidence was that setting the commencement level too low may result in a consumer seeking alternative additional substance use such as '*Spit Methadone*' or another illicit substance.

Prof Dr Duflou

286. Prof Dr Duflou made the observation that the commencement of 30 mg of Methadone administered to Steven fell within the guidelines of both New South Wales and the Commonwealth Government, which I acknowledge is reflected in the National Guidelines.

[112] Page 3 of the ACT MHJHADS SOP
[113] Annexure O to the Statement of Dr Streitberg dated 17 February 2017
[114] Ibid p172

287. Importantly, the Professor stated in his supplementary report:[115]

> '*However it must be emphasised that both those documents relate to the treatment of patients who are opioid dependent - there appears to be no indication that the deceased was dependent on any opioids. I have no expertise in assessing patients for Methadone maintenance treatment and prescribing of opioids in such circumstances …'*

288. It is noted that the Professor's observation was prior to the hearing and there is now evidence set out in Dr Streitberg's Patient Progress Note concerning Steven, Steven having been found in possession of an opioid on 12 December 2015 and further the presence of that opioid in his urinalysis conducted on the same day. Accordingly there is some history although it must also be remembered that Steven had a negative urinalysis on 10 May 2016.

289. And further at paragraph 14:[116]

> O*n the other hand, there was a level of Methadone in the deceased blood which is within the fatal range, albeit at the lower end of that range. As indicated at page 4 of my report of 2 July 2016, the level of the drug in this case is within the therapeutic, toxic and lethal range, the level detected in this case* **could have** *resulted in significant and potentially life-threatening toxicity. I maintain this view. [my emphasis added]*

Dr Sungaila

290. Dr Sungaila reports that the recommended:

> *'…starting dose is 20 to 40 mg for opioid dependence[117]. Mortality is significantly higher in the first two weeks of treatment due to a number of*

[115] P144 Coronial Brief Volume 1 of 3 paragraph 18
[116] Annexure E - P150 Coronial Brief Volume 1 of 3 Exhibit 2 supplementary post-mortem report
[117] Annexure J P149 paragraph 6, Coronial Brief Volume 1 of 3 Exhibit 2

factors one of which includes a difference in Methadone metabolism. Doses as low as 20 mg can be fatal in opioid naive users particularly in the induction phase. This may be due to the accumulation of drug in the tissues.

…

It is not possible to determine a fatal concentration of Methadone because of the overlap between therapeutic levels than the levels found in Methadone deaths… Half the Methadone deaths were due to diverted Methadone and it could be presumed as some to naive users[118]*.'*

…

There can be large differences in Methadone metabolism between individuals and designed pathways are involved in the clearance of the drug. Essentially these are inherited variance in the enzyme system which may give rise to a difference between individuals in the manner of the elimination of the drug from the system.'[119]

291. Dr Sungaila's evidence[120] reveals the complexity as to how any one person being prescribed Methadone may react to it depending on whether they are opioid naive or long time users of opioid treatment therapy.

292. Even more complex it seems to me is, how a prescribing doctor might determine these matters at a medical assessment.

293. Setting a commencing dose of Methadone having regard to the National Guidelines, ACT Health's guidelines and policies, relies on observation and testing.

294. That is the setting of a commencement dose is determined by prescribing a start level, here in the ACT of 30mgs, which is then reviewable through daily observances of the patient. This it is anticipated would enable review to determine whether or not the recipient is experiencing a toxic effect or the dose is insufficient to meet withdrawal symptoms.

[118] Ibid paragraph 8
[119] Ibid paragraph 4
[120] Annexure J P147- p151, Coronial Brief Volume 1 of 3 Exhibit 2

295. Dr Sungaila opined that particular attention is required to have regard to a person's historical information and presenting attributes as to their metabolism given that Methadone may be stored within bodily tissues and studies indicate the risk of death at the beginning of opioid replacement therapy is sevenfold higher.[121]

296. In her opinion it was possible that Steven was vulnerable to overdose because of an enzyme system variant and that he was a slow metaboliser of the drug although such a suggestion she writes is purely speculative.[122]

297. However, in one sense it confirms again the complexity facing a medical officer performing an MMP assessment where there is no detailed history of opioid dependency or use. As the National Guidelines suggest in such circumstances, potentially putting an assessing doctor on notice, a lower commencement dose could possibly be more appropriate. What that lower dose might be of course is uncertain.

298. Dr Sungaila states Steven's blood level of Methadone found at autopsy was relatively low but still fell within the reported toxic and therapeutic levels.[123]

299. The Doctor adds that there is overlap between the therapeutic, toxic and lethal levels depending on the attributes of the person. More importantly the Doctor recognises that the actual level recorded in the post blood toxicology test may have been a little higher because metabolism would have continued to occur after unconsciousness had ensued.[124]

300. As observed by Dr Sungaila:[125]

> *'With the wisdom of hindsight, the Buprenorphine would have been a safer choice for this gentleman. The doctor has not listed any reason for choosing Methadone other than Mr Freeman requesting it. It is possible that Mr Freeman was seeking the sedative effects of Methadone and was aware that he*

[121] Annexure J P147 - 151, Coronial Brief Volume 1 of 3 Exhibit 2
[122] Annexure J P 151, paragraph 22 Coronial Brief Volume 1 of 3 Exhibit 2
[123] Annexure J P150 paragraph 13 Coronial Brief Volume 1 of 3 Exhibit 2
[124] Ibid
[125] P151 paragraph 23, Coronial Brief Volume 1 of 3 Exhibit 2

would not have achieved the same level of sedation with the use of Buprenorphine.'

301. In one sense there is evidence to support the observation given the historical evidence concerning Steven's December 2015 use of Buprenorphine. However, in that sense it is more likely than not he may have been incurring debt for the Buprenorphine and would not have been for the prescribed Methadone.

Dr Streitberg

302. Dr Streitberg said his focus of the consultation was on Steven's reported problematic drug use and Steven's desire to address it through the MMP.

303. Dr Streitberg asserts that Steven had reported to the Doctor, Steven had been smoking heroin and using it on a daily basis or whenever he could get it, or had been inhaling heroin for months and that this was increasing over time and was resulting in Steven incurring a drug debt within the prison.[126]

304. Dr Streitberg said that on specific questioning, Steven reported he was considering using heroin intravenously because its cost was, it seems, less than the cost of using inhaled substances. The spread of communicable diseases through intravenous drug taking within the prison population was also identified by the Doctor as a relevant consideration in placing Steven on the MMP.

305. The Doctor stated that Steven reported restlessness, abdominal upset, a sensation of hot/cold and poor sleep amongst other indicia. The Doctor was satisfied that Steven reported symptoms were consistent with mild opioid withdrawal adding:[127]

'Further, that Steven appeared physically uncomfortable during the consultation. Mr Freeman displayed no signs of opioid drug intoxication during the consultation.' [128]

306. Dr Streitberg's evidence was that Steven during the course of the consultation gave:

[126] paragraph 48 - Statement of Dr Streitberg Dated 17 February 2017
[127] paragraph 53 - Statement of Dr Streitberg Dated 17 February 2017
[128] paragraph 23 - Statement of Dr Streitberg Dated 17 February 2017

'A compelling, consistent and concerning history of problematic escalating opioid use suggesting opioid dependence or opioid tolerance'. He described requiring increasing amounts and frequency of use. I observed him to display symptoms and signs highly suggestive of opioid withdrawal, and on this basis, I was satisfied Steven fulfilled the criteria for opioid dependency as per the Diagnostic and Statistical Manual of mental disorders fourth edition and the National Guidelines for medication assisted treatment of opioid dependence, 2014 edition. I identified no contraindications to the use of Methadone maintenance to Mr Freeman's case.'[129]

307. Dr Streitberg was satisfied that Steven reported symptoms consistent with mild opioid withdrawal,[130] and that he identified no contraindications to the use of Methadone maintenance having regard to his observations and the representations from Steven.[131]

308. Dr Streitberg set out within his statement that he operated in accordance with the ACT Opioid Maintenance Treatment Guidelines and the National Guidelines as to the commencement of a starting dose of 30 mg or less. He considered 30 mg an appropriate starting dose based on the history and presentation of Steven during the consultation. [132]

309. Importantly Dr Streitberg claims, and he is supported by the Clinical Director Professor Michael Levy of ACT Health, that a commencement dose of 30 mg of Methadone for patients exhibiting symptoms and signs of opioid withdrawal was the consistent practice between the medical officers at the Hume Health Centre.[133]

Findings

[129] paragraph 58 - Statement of Dr Streitberg Dated 17 February 2017
[130] paragraph 54 - Statement of Dr Streitberg Dated 17 February 2017
[131] paragraph 59 - Statement of Dr Streitberg Dated 17 February 2017
[132] paragraph 72 - Statement of Dr Streitberg Dated 17 February 2017
[133] paragraph 74 - Statement of Dr Streitberg Dated 17 February 2017

309. Dr Streitberg in his oral evidence was not always the best advocate in his own cause. At times he sought to reframe questions put to him and then answer in his own terms as opposed to answering the question actually asked.

310. This made the Doctor appear evasive and non-responsive to questions calling upon my intervention at times. Overall however, I am have ultimately concluded that his evidence should not be diminished as to its probative value and truthfulness.

311. If anything negative at all, what Dr Streitberg did was a miscalculation in not placing Steven onto a lower daily dose of Methadone, that is to say 20 mg, as prompted where opioid dependency is not known as suggested by the National Guidelines. The difficulty with that conclusion is that the doctor was satisfied Steven was experiencing mild opioid withdrawal based on how Steven was presenting to him.

312. More importantly however am satisfied it relies heavily on hindsight. Such a finding would be unreasonably interpreting observations from the reports of the toxicologist, pathologist and Prof Drummer.

313. Notwithstanding that the highest their assessment of the certainty in ascertaining whether Steven was or was not opioid naive was that it was '*likely*' that he was.

314. It is difficult to reconcile the diverging professional opinions, as Dr Streitberg's assessment from a face-to-face meeting with Steven, reflected in his Patient Progress Note based on representations from Steven, and the Doctor's observations of Steven resulted in Dr Streitberg forming the opinion that Steven was experiencing mild opioid withdrawal.

315. The placement of Steven onto 30 mg daily of Methadone from both the pathologist and the toxicologist reports fell within the therapeutic, toxic and lethal levels.

316. The National Guidelines acknowledge that 30 mg is an appropriate dose falling midway between the lower dose suggestions of 20 mg to the maximum dose of 40 mg. The guidelines suggest where opioid dependence is less certain the appropriate threshold was 20 mg. There is no evidence before me that Dr Streitberg was not

certain as to his belief of Steven experiencing mild opiate withdrawal. There are certainly numerous challenges as to why he did not conduct urinalysis or use relevant forms but none of that I am satisfied strikes at his belief to the point that I should reject the doctor's evidence.

317. I am satisfied that Dr Streitberg properly made a clinical assessment as to Steven's mild opioid withdrawal. Dr Streitberg was persuaded by Steven, as is reflected in the Patient Progress Note, that Steven should be placed on the MMP.

318. I am not satisfied that the prescribing of 30 mg by Dr Streitberg was outside the therapeutic range and inappropriate as a prescription base having regard to all the circumstances and given the influence of the National Guidelines and that ACT Health's own policies appear to set a threshold minimum of at least 25 mg.

319. I do not accept however Dr Streitberg's evidence where he sought to address his prescription of 30 mg to Steven, as opposed to a lesser quantity. Dr Streitberg claims going to 30 mg would avoid a *recipient* from seeking to obtain a top up through non-authorised means such as '*Spit Methadone'* and thereby creating greater risk to themselves. Such a claim is not to borne out in Steven's case, as he had only been the recipient of Methadone on 2 days, knowing that he could ask for more if the amount prescribed was not addressing his withdrawal symptoms.

320. What it potentially reveals is that the Doctor applied an amount recognised by ACT Health through its Opioid Treatment Guideline and SOPs and the National Guidelines. The attempt by the Doctor is to use hindsight as a source of justification in circumstances where he had no evidence before him that a lower dose would not have been sufficient.

321. The fact that it turned out to be an overdose is based on expert opinion about a range of variables which were not fully known to the Doctor at the time. Opioid maintenance treatment programs such as outlined by the National Guidelines, the ACT SOPs and ACT Health's own guidelines fundamentally appeared to rely upon the prescription and subsequent administering of a methadone dose and then

observation of a particular patient to determine if an amount is meeting withdrawal symptoms or is having a toxic effect.

322. Prof Drummer further provides:[134] *the narrow range that separates the desired narcotic effect from serious adverse effects the estimation of the starting dose is critical. A low starting dose and clinical assessment and monitoring is essential to avoid significant opioid withdrawal or increase analgesia*.

323. The Professor earlier in his report recognises that fatal doses can occur from 20 mg.[135] However, in hindsight, he indicates that 10 to 20 mg would have been more appropriate and safe when opioid tolerances are either unknown or even unlikely. The Professor makes no direct contrary claim that 30 mg was inappropriate.[136] The result I am satisfied is that the starting dose is one of informed discretion by an assessing doctor.

324. In such circumstances I am unable to conclude that the prescribing of 30 mg in light of the thresholds in *Briginshaw* that I have earlier set out would place responsibility, in an environment of uncertainty, on the prescribing doctor.

325. Having considered the relevant evidence before me, I do not find that the prescribing and administering of 30 mg of Methadone to Steven had an effect on the quality of his care, treatment or supervision so as to contribute to his cause of death in that it was a prescribed overdose of Methadone.

D. *Having been prescribed Methadone did the quality of the care, treatment, and supervision of Steven contribute to his cause of death?*

326. The National Guidelines provide that all doses of Methadone should be supervised with a patient being reviewed daily during the first week of treatment to correspond to the greatest risk period from Methadone related overdose. The review provides an

[134] Ibid para 6.6
[135] Ibid para 5.6

[136] Exhibit 10 - Statement of Prof Olaf Drummer dated 10 February 2017 para 6.6-6.8

opportunity to assess intoxication or withdrawal symptoms, and patient's general well-being.[137]

327. Importantly, the National Guidelines provide:[138]

> *'Methadone has a delayed onset of action with peak effects achieved two or four hours after dosing…*
> *… Patients should be assessed 2-3 hours after a dose to observe the peak effects of Methadone (assessing for intoxication), and 24 hours after a dose to assess the extent to which Methadone dose is preventing withdrawal.*
> *…*
> *All doses of Methadone should be supervised, where possible, and a clinician (doctor or nurse) should review the patient daily during the first week of treatment corresponding to the greatest risk period from Methadone related overdose. The review provides an opportunity to assess intoxication, withdrawal symptoms, side-effects other substance use and patient's general well-being.'*[139]

328. Kim Wolff from the National Addiction Centre in London writes:[140]

> *Overdose generally presents with the classic triad of CNS depression (reduced level of consciousness from drowsiness or a stuporous state to coma), respiratory depression, and pinpoint (myopic), sluggishly reactive pupils. The main cause of overdose is respiratory depression with pulmonary edema, developing 12 to 14 hours after ingestion especially in naive or weakly tolerant individuals. The edematous reaction is very commonly severe leading to aspiration pneumonia and death from respiratory failure.*

329. Prof Drummer asserts that in light of reports that Steven was intoxicated following his consumption of the first dose of Methadone that any signs of significant toxicity should have stopped any further drug being given.[141]

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[137] National guidelines for medication assisted treatment of opioid dependence on page 23
[138] Ibid A4.2
[139] page 131 Annexure F to the Statement of Dr Streitberg dated 17 February 2017
[140] Annexure M to the Statement of Dr Streitberg dated 17 February 2017
[141] Exhibit 10 - Statement of Prof Olaf Drummer dated 10 February 2017 para 6.6-6.8

Steven's Use of SMS

330. A review of a range of messages received and sent by Steven Freeman at Exhibit 5 reveals some 3 to 4 hours after his first dose of Methadone than Steven at least had the coordination skills to send text messages, to understand messages being sent to him and o reply.

331. It is difficult to assess the value of being able to gauge Steven's ability to comprehend the content of the messages or to ascertain if he was presenting with adverse signs as a consequence of his first use of prescribed Methadone.

332. Despite this by the afternoon of 26 May 2016, Steven appeared to continue to be able to engage through the use of SMS, as late as 4 PM in the afternoon and the content of his responses appeared coherent, directed and responsive to the conversations he was having with the recipients.[142]

Registered Nurse Lutz

333. Registered Nurse Lutz, an employee of ACT Health for some 13 years and located at the AMC Hume Health Centre for 27 months as the ADON,[143] in her evidence addressed the issues of the delivery of Methadone within the cell hubs.

334. RN Lutz clarified that while detainees who commence a Methadone treatment program would normally present for dispensing at the Hume Health Centre in accordance with policy, this was however discretionary if other alternative safe arrangements for dispensing were made, such as in a detainee's accommodation cell hub.[144]

335. RN Lutz further explained that a detainee's dose of Methadone arrived in a pre-labelled container with the amount of the dose inscribed on the label and that the detainees were given the entirety of the contents of the dose mixed with water[145].

[142] Pages 3576 to 3587 Exhibit 5
[143] Ex.14 statement of Mr Tasha Lutz dated 21 July 2017 Asst Dir of Nursing (ADON)
[144] Ibid paragraph 5
[145] Ibid paragraph 6-7

336. Her evidence was that the two registered nurses involved on the day were experienced in the drug and alcohol field.

RN Lutz, following her review of CCTV images of the Methadone dispensing on the morning of 26 May 2016 at 8:40AM, said that Steven presented to the window of his accommodation unit and that he clearly identified himself to nursing staff and was spoken to by Nurse Jane Sheckleton.[146]

337. RN Lutz said she further observed Nurse Hayley Butler to complete a check of the relevant records concerning Steven and make a selection from the prepared bottles of Methadone on the cart. RN Lutz's evidence confirms the Nurses checked the label and the quantity of Methadone where it was then placed into a cup with a quantity of water. It was then handed to Steven, who consumed the contents of the cup. A further container of water was given to Steven which he also consumed[147]. It was RN Lutz's observation that those nurses complied with the relevant regulations for the administering of Methadone to Steven.

338. RN Lutz said that following Steven's death she audited the imprest Methadone stock from which Steven's Methadone was taken and was firm in her view that he had been properly administered 30 mg of Methadone in accordance with his prescription.[148] There was no sustainable challenge to this evidence that a wrong dose may being given to Steven.

339. RN Lutz acknowledged that the starting dose for Methadone is recommended at 30 mg or less.[149]

340. Based on the CCTV images of Steven (see Annexure A) Steven did not appear to behaving in any way which would indicate an adverse effect from the consumption of the Methadone as prescribed to him.

[146] Ibid paragraph 7
[147] Ibid paragraph 8

[148] Para 9 Ex.14 statement of Mr Tasha Lutz dated 21 July 2017 Asst Dir of Nursing (ADON)
[149] paragraph 72 - Statement of Dr Streitberg Dated 17 February 2017

341. On the second day of dosing Steven was observed by Corrections Officers and two nurses in the course of the dispensing of the second dose of Methadone.

342. Steven appears from the CCTV images, to have participated in the recognition, confirmation of dose procedure without anyone being alerted by his presentation that his health was compromised, to the extent given in evidence by Mr Goolagong and Mr Djerke following Steven's doses on 25 and 26 May 2016.

343. This is highlighted by the fact that Mr Djerke, as confirmed in his oral evidence, was in fact standing behind Steven (see CCTV and Annexure A) in the line waiting for that morning dose on 26 May 2016 at 8:40 AM. Mr Djerke can be observed interacting with Steven in a way which further suggests Steven's health was not compromised. Nor does Mr Djerke raise his concerns about stealing having adverse reactions to methadone with medical staff.

344. There is through the dispensing of Methadone on the morning of 26 May no indication that Steven is otherwise affected by the Methadone that he has earlier consumed or any other illicit substance such as Tramadol (which was found in Steven's hair sample analysis but with no clear indication when that had been consumed although potentially within the last six months).

345. The concessions made by Professor Levy in his evidence as to the ineffectual nature of some aspects of the policy and the manner by which it needed to be improved go to matters of public health within the detainee population and the community for those who might enter the Methadone maintenance program provided by ACT Health to both communities.

346. I am not satisfied those concessions by themselves however lead to a finding that they contributed to the manner and cause of death of Steven Freeman.

347. Prof Levy conceded in cross-examination from Counsel Assisting that the medical assessment 2 to 3 hours after the dose to observe the peak effects of Methadone in an

assessment for intoxication set out within the National Guidelines was a deficiency within the ACT Justice Health Services SOPs.[150]

348. I am satisfied the National Guidelines contemplate checking for intoxication in the context of daily dosing. I read the Guidelines on the basis upon which I accept that the opportunity to assess for intoxication which occurred at the next morning dose given to Steven in this case being 26 May 2016.[151]

349. While I note a 24 hour assessment cycle is not consistent with the 2 - 3 hourly check required by the National Guideline I am not satisfied that a check 2 - 3 hours after Steven was given his first dose of Methadone would have revealed any adverse consequence in light of these interactions caught on CCTV, conversation with family - using both telephone and SMS texting - and participation in schedule AMC programs.

FINDINGS

350. The National Guidelines provide that all doses of Methadone should be supervised, with a patient being reviewed daily during the first week of treatment to correspond to the greatest risk period from Methadone related overdose. The review provides an opportunity to assess intoxication or withdrawal symptoms, and patient's general well-being.[152]

351. I am not satisfied I can reach a conclusion on the evidence that there was a failure in the care, treatment and supervision of Steven to the extent that it could be said to have contributed to his cause of death arising from the follow-up supervision of Steven having been placed on the MMP.

352. I say that in particular having reviewed the CCTV footage of Steven on the day (see Annexure A to these findings). Annexure A reveals an extensive range of movement

[150] Inquest into the death of Steven Freeman, Court transcript 10 August 2017 page 636
[151] National Guidelines for Medication Assisted Treatment of Opioid Dependence April 2014
[152] National guidelines for medication assisted treatment of opioid dependence on page 23

and interactions by Steven prior to receiving his Methadone treatment at 8:40 AM to when his cell door is locked early in the evening of 26 May 2016.

353. Prof Levy said having regard to the treatment, care and supervision of Steven that he was unable to determine whether or not Steven was displaying any signs of intoxication at the time of dosing, and was relying upon the nursing staff's experience and close proximity to Steven to make relevant observations of him at the time of dosing.

354. It was the Professor's opinion that Steven's movements that they did not suggest to him that he was exhibiting any compromise of his abilities to communicate awkward that his movements which would be expected if any level of intoxication present. Further he reports that Steven otherwise participated in afternoon programs that day.[153]

355. Prof Levy does concede however that Mr Goolagong's evidence that Steven was snoring heavily in the early hours of the morning of 27 May 2016 suggested signs of intoxication were present.[154]

356. I am not satisfied the observations of Steven's cellmate Mr Goolagong and detainee Mr Djerke enable me to conclude with any degree of certainty that Steven at the time of lock in on the evening of 26 May 2016 was suffering adversely from the second dose of Methadone he had consumed at approximately 8:20 AM that morning.

357. Further, I am not satisfied that that any physical inspection by members of the Hume Health Centre would have disclosed symptoms which would have warranted immediate medical attention because of fear Steven was experiencing Methadone toxicity, outside of the presentation by Steven to them on the morning of 8:40 AM on 26 May 2016.

358. In reaching those conclusions I do not discount the evidence of his cellmate Mr Goolagong and detainee Mr Djerke that Steven may have sounded and appeared to them in the manner they describe, however I place less weight upon that evidence.

[153] Ibid paragraph 58
[154] Ibid paragraph 59

359. I am unable to satisfy myself to the relevant standard of proof that the detainee's description of Steven displaces the evidence of detainees Mr Kopec and Mr Craft, also known to Steven, that Steven was not displaying any adverse effects to having consumed Methadone.

360. When coupled with the account I have recorded at Annexure A, I am not satisfied that any further examination of Steven would have revealed Steven was likely to have been experiencing a toxic reaction to Methadone during the dispensing process and the remainder of the day of 26 May 2017.

361. Accordingly, I am satisfied that the quality of care, treatment and supervision afforded to Steven following the prescription of Methadone, could have been better and more clearly documented, however the deficiencies in that regard, for example, the failure to review Steven within 2-3 hours of his first dose of Methadone that did not contribute to the cause of death.

The Morning of 27 May 2017

362. Prof Dr Duflou's opinion is that Steven's time of death is some time before 5 AM in the morning and certainly before the morning muster check conducted by Corrections Officer Stockheim. He does not rule out the possibility that death may have occurred at about 8:00 AM.

363. However for the reason set out below I am satisfied death occurs sometime between 1:00AM and 5:00AM.

364. The Professor then confirms that[155]:

> *In [his] opinion, the circumstances of the death, the doses of Methadone administered, the autopsy findings, and the level of Methadone in the deceased blood all strongly indicate that death was the result of aspiration pneumonia, which in turn was the result of Methadone overdose.*

[155] Annexure E - P150 Coronial Brief Volume 1 of 3 Exhibit 2 paragraph 12 Supplementary Report Post-Mortem Report page 3

There is in my opinion no doubt that there was aspiration pneumonia-on naked eye examination of the body, there was aspirated gastric contents in the airways, the lungs were about twice normal weight, and the macroscopic appearances suggested aspiration, while on microscopic of the lungs there was extensive bronchopneumonia with aspirated gastric contents in some bronchi.

365. Prof Dr Duflou goes on further to say at paragraph 13 the following:

A person who is otherwise well extremely rarely develops aspiration pneumonia in the absence of external factor. In this case, there was no natural pathology which would reasonably expect the deceased to have suddenly become incapacitated and develop an unprotected airway, and there was no indication of post mortem violence to the body. I note there is now also confirmation in the directions hearing document that the deceased did not suffer from post-traumatic epilepsy.

290. In her report[156] Dr Sungaila sets out a paragraph 3 that '*respiratory depression can occur with doses that may be low in a naive user or quite high in a tolerant individual she says. That aspiration pneumonia is a complication of the unconsciousness state in which the person is in'.*

291. Dr Sungaila describes aspiration pneumonia as being caused by the '*inhalation of stomach contents into the lungs. In an unconscious person there are partially reduced reflexes which normally would allow a person to cough and remove foreign material from their trachea.*'[157] She notes that on a CT scan examination after his death Steven was shown to have a fluid filled trachea.

292. Prof Dr Duflou goes on to make the following observations in his post-mortem report:

Time of death: according to the police investigation, the deceased was checked by corrections officers at about 7:45AM on 27 May 2016. His foot

[156] Ibid p148
[157] P150 Coronial Brief Volume 1 of 3 Exhibit 2

was seen to twitch - if this is correct, the deceased must have been alive at this time. However, the deceased was cold and stiff when checked by his cellmate shortly before 11:00 hours and was confirmed rigor mortis and cold the body cold … Although it is possible that the deceased had been dead for just over three hours when found, it is also entirely possible that the deceased may have been dead for significantly longer than this, given the post-mortem changes observed.

For example, it would be entirely possible for the deceased to have died at some time during the night of 26/27 May 2016. The other cell mate evidence that the deceased was heard to snore during the night. This is often a sign of significant respiratory distress in a person overdosing on opioids especially if there is no prior history of snoring or sleep apnoea.

This would indicate that the deceased was alive during the night, but the absence of snoring when the cell mate woke support the possibility that the deceased died during the night, he was already dead at the time of being checked by corrections officers.

Although the rate of stomach emptying is variable, and can be delayed in the setting of opioid administration, I note that the deceased stomach contained approximately 600 ml of brown opaque fluid with fragments of meat and vegetable. This would place and time of death is more likely being during the night that after 7:45AM on 27 May 2016.

293. At page 11 under the heading '*Lungs*' the Professor's examination showed:

'Early but extensive bronchopneumonia in all sections, with a combination of intra-alveolar haemorrhage and numerous neutrophils. Aspirated gastric contents in association with an inflammatory infiltrate is noted in some bronchi…. Overall the features are those of aspiration pneumonia.'[158]

[158] Annexure E - P150 Coronial Brief Volume 1 of 3 Exhibit 2 Post-Mortem Report page 11

294. Mr Goolagong recalled Steven commenced his first dose of Methadone on the morning of Wednesday, 25 May 2016.

295. Mr Goolagong recalled that after the evening lock-in on the evening of 26 May 2016 Steven lay on his bed and was listening to music. Steven's head was towards the cell door with earphones in his ears and plugged into his computer, which was on a shelf near his bed. He recalled watching TV until sometime between 11 PM and midnight at which time he went to sleep.

296. Mr Goolagong said when he went to sleep, Steven was 'snoring his head off' and was 'really out of it'. Mr Goolagong recalled that Steven was snoring very loud notwithstanding the music in his headphones was blaring.

297. Mr Goolagong recalled that about 1 AM after turning off the music to Steven's headphones that there was no response from Steven as a consequence. Mr Goolagong went back to sleep.

298. When Mr Goolagong woke up on the morning of 27 May 2016, Steven was still lying in the same position on his back, his headphones on his ears and his hands behind his head at the end of the bed closest to the cell door.

299. Mr Goolagong could recall the Corrections Officers completing their morning cell check. They called out both the names 'Goolagong' and 'Freeman'. He recalled answering while Steven was still lying on his bed with his hands behind his head in his earphones in his ears. Mr Goolagong said the morning cell check was to ensure everyone is okay and alive and where they should be.

300. Mr Goolagong thought that Steven was still sleeping so he had his shower, which is located in the cell, he swept the floor and listened to his radio.

301. He thought he should wake up Steven so he approached Steven who were still in the same position and having touched his arm found it really cold. Mr Goolagong recalled using toilet paper to wipe frothy bubbles from Steven's mouth but he could

not remember what he did with the paper. He went to the cell door and called for another detainee saying there was something wrong with Steven.

302. Mr Goolagong recalled Mr Ivan Djerke responded and on entering the cell called out to Steven and after touching Steven said to Mr Goolagong "*he's gone Bruh*".

303. Mr Goolagong said he sat down on his bed and started crying, guards ran into the cell and started trying to help Steven.

Mr Djerke

304. Mr Djerke recalled sometime during the morning of 27 May 2016 Jermaine Goolagong came downstairs and asked him if he could come up, as he thought something was wrong with Steven.

305. On entering the cell Mr Djerke could see Steven had froth on his lips and he formed the view that Steven was clearly deceased. Steven was lying on his back with his hands behind his head. Mr Djerke said he had seen people before who had overdosed and that Steven looked just like they did.

306. Mr Djerke said he noticed the froth on Steven's lips was dry, so he assumed Steven had been deceased for some time. His evidence was that he knew with overdoses that it just happens in your sleep, it just cuts of your windpipe and he would have choked and he could see why Mr Goolagong would not have heard anything.

307. When he touched Steven, Steven felt cold and so he called out for someone to get the guards. When a Corrective Service officer entered the cell Mr Djerke went downstairs. There he found Mr Goolagong upset and crying.

Daniel Craft

308. Daniel Craft said on the morning of 27 May 2016 he entered cell 13 briefly with Mr Goolagong because they were looking at photos. He saw Steven on the bed and

assumed he was asleep. He said they were both trying to keep quiet and not wake Steven up. He recalled Steven was lying on his back with his hands behind his head with earphones connected to the computer.

309. Mr Craft went back down to the common area and was playing a board game. He recalled Ivan Djerke had entered Steven's cell and a short time later screaming for help and saying: '*I think he's dead*'. He recalled a few people ran upstairs to see what was going on and he banged on the window to get the attention of the guards.

Conclusion

As to the events concerning what was afforded to Steven by way of medical assistance through the CPR being applied by correctional officers there can be found no criticism. The assessment by the forensic medical officer in the declaration that Steven was deceased at 11:11 AM were all properly and adequately recorded.

310. There is no challenge as to the application of resuscitation efforts nor do I find any failing in that regard given my acceptance of the Pathologists finding that death had occurred sometime between 11 PM and 5 AM.

311. The cause of death of Aspiration Pneumonia second to Methadone Toxicity is not challenged by those appearing before the inquest

312. The issue which arises however from the recording of the CCTV footage and the actions of ACT Corrective Services is simply the failure to give full effect to the obligation under the relevant procedures at the AMC to conduct a visual well-being and welfare check of detainees; in particular in the morning headcount where only a verbal response is accepted when that would not for instance satisfy a well-being check.

313. That may have resulted in Steven's death being identified many hours before it actually was. There is no criticism from the Freeman family of the Correctional

Officers' performance of their duties nor do I find any my issue is with the inconsistent procedures to which they are required to operate within.

314. Corrections Officer Stockheim in his evidence had empathy for detainees, stating that he took the rights of detainees to have some privacy as to their cell life and afforded them the least disruption to the privacy. Hence he only required a verbal response during headcount and well-being check as is suggested by the relevant procedures applicable to him.

315. It is unlikely that Steven's foot moved as claimed by the Corrections Officer given the extent of rigor mortis: it was probably more likely the effect of reopening the door and the flash of outside light into the cell gave the effect of movement.

316. In any event that procedure needs to be reconsidered and if safety and well-being checks are required then they should be enforced through validation periodically through review of CCTV footage to ensure compliance.

366. I do not intend addressing all those matters raised in submissions by the family under individual headings. I am satisfied I have addressed their concerns that I felt had bearing on my deciding of this matter as the evidence unfolded at hearing and from Counsel's submissions.

367. There is no doubt the circumstances giving rise to the loss of anyone within a detention facility, specifically through the prescription of Methadone approved by a Territory operated entity, is a cause of concern for the Canberra community and in particular the Territory itself, as to whether or not their systems afford appropriate checks and balances and adherence to appropriate policies and guidelines.

368. RN Lutz sets out within her statement the remedial action undertaken by ACT Health as to new procedures as result of cross referencing the *National Guidelines for Medication Assisted Treatment of Opioid Dependence* and the *Justice Health*

Standard Operating Procedures and associated document that were in place at the time of Steven's prescription onto Methadone.

369. Importantly, her evidence highlights the lack of sharing about those on pharmacotherapy treatment programs at the AMC with ACT Corrective Services allowing further observation of detainees who are placed certainly initially on such programs to ensure their safety and well-being. This of course becomes more crucial during first morning headcount and well-being check.

317. I again pass on my condolences to Steven's mother and the Freeman family and his friends and supporters. Their wanting to ensure that appropriate procedures were applied and approval given for Steven to be placed on the Methadone Maintenance Program are appropriately matters for challenge and testing.

318. In their doing so, review of the procedures in operation at the time for placement on to the MMP has highlighted a number of inconsistencies and a need for a clarification on the range of issues effectively dealing with the same subject matter.

319. I note through the evidence provided by Registered Nurse Lutz that those inconsistencies and clarifications have in part already been addressed by ACT Health and the efficiency in that response is commended as it focuses on a better delivery of Methadone Maintenance Programs to both the general community and the prison community within the ACT.

320. I take the opportunity now to thank the representatives of appearing before this inquest. I thank you for the thoroughness of your questions and your detailed submissions, respect for the family and the deceased.

321. In particular I would also like to thank Counsel Assisting, Ms Sarah Baker-Goldsmith, members of the AFP Coronial Unit, and in particular Senior Constable Ayton in the formidable task of putting together a significant brief of evidence, obtaining detailed statements and bringing together all the information which could be

critically analysed and viewed by all the parties involved in this matter to assist the family and the court to understand the manner and cause of Steven's death.

322. I further acknowledge that the Territory provided access to all materials which were relevant to this enquiry and while some of it was sensitive, it was still accessible by the representatives there could be no challenge to the transparency the Government sought to have observed in this enquiry relating to an Aboriginal death in custody.

323. Further, the parties complied with directions on sensitive information and the restrictions on publication that I ordered in place. They of course continue.

324. I attach at Part A, a summary of findings and recommendations arising from the inquest into the manner and cause of the death of Steven Freeman.

R. M. COOK
CORONER

Annexure A

Steven Freeman – AMC Activity – 26 May 2016

TIME	ACTIVITY
ANNEXURE A123	
8:41:19	Steven appears in frame, wearing beanie, hands in pockets, waiting calmly in line behind two other prisoners to approach the dispensing window
8:41:38	Steven frisk searched by CO (quick pat down)
8:41:39-8:41:50	Steven vaguely observing another more boisterous prisoner who lines up behind him
8:41:54-8:42:12	Steven engages in conversation with the prisoner in line behind him
8:41:59	Steven and prisoner behind him play fight; Steven appears at ease talking to this prisoner
8:42:14	Steven approaches dispensing counter
8:42:18	Steven not visible but both nurses are clearly talking with him
8:42:19-8:42:59	Nurses preparing medication for Steven
8:43:01	Steven handed cup of water and medication Steven Drinks the contents
8:43:06	Steven hands cup back to nurse who refills it with water Steven drinks the contents
8:43:12	Steven walks away from dispensing window, to the bottom right of frame. Pace/stride of walk appear regular
ANNEXURE A124	
9:33:56	Steven exits cell 13 wearing grey jacket, tracksuit pants, no beanie. Carefully shuts cell door behind him
9:34:02	Steven starts to walk away from cell 13 but doubles back, appearing to verify that door is locked
9:34:04	Steven walks towards Cell 12, glancing over left shoulder momentarily in the direction of Cell 13.
9:34:05	Steven immediately enters Cell 12, leaving door ajar
9:34:12	Steven exits Cell 12 and walks swiftly into Cell 11
9:34:18	In Cell 11, Steven heads to the right side of the cell, remaining close to the doorway
9:34:45	Steven seen to bend down, with back facing right hand side wall of cell
9:35:00	Steven waving white object around (potentially plastic bag?) as Vosikata hovers in doorway of cell
9:35:15	Steven moves from left side of cell to right side of cell
9:35:23	Steven, scratching head, remains in cell, walks towards left hand side of cell, as Vosikata leaves carrying plastic bag
9:35:54	Vosikata stands in doorway. Steven obscured from view but conversation appears to be taking place
9:35:56	Steven moves forward into cell doorway, standing with hands near neck area, fiddling with jacket zip, talking to Vosikata who is standing outside cell
9:35:58	Steven exits cell 11
9:36:00	Vosikata strokes Steven on back, as if brushing away dirt
9:36:05	Vosikata's hand moves downwards onto Steven's arm, Steven withdraws his arm in a quick movement
9:36:06	Steven walks away from Cell 11, towards Cell 10

9:36:10	Steven approaches the door of Cell 10 and kicks it with his right foot
9:36:11	Steven walks back towards cell 11, continuing to fiddle with neck area of jacket
9:36:16	Steven stands outside doorway of Cell 11, arranging and rearranging jacket
9:36:20	Steven stands nonchalantly outside Cell 11, looking around with hands in pockets. He appears to be fiddling with the waistband of his tracksuit pants
9:36:26	Vosikata exits cell, appears to engage Steven in conversation
9:36:27	Arms outstretched, Steven leans casually back against railing as Vosikata picks up laundry bag.
9:36:30	Steven quickly re-enters Cell 11
9:36:31	Inside Cell 11, Steven appears to be looking at something on left hand side cell wall of cell
9:36:35	Steven moves closer to left hand cell wall, obscured from view
9:36:52	Steven dawdles just inside doorway of Cell 11 as Gray and Vosikata move objects around
9:36:55	Steven exits Cell 11, walking slowly in direction of his cell
9:36:58	Steven changes direction, moving backwards towards Cell 11, to stand in doorway facing in towards cell, engaged in conversation with Vosikata
9:37:41	Steven turns slowly around, looking out through railings over unit floor
9:37:50	Steven walks with purpose back towards his cell
9:37:59	Steven re-enters Cell 13, closing door behind him
9:40:12	Steven exits Cell 13 and walks towards Cell 12
9:40:20	Steven enters Cell 12, leaving door ajar. Steven obscured from view
9:41:29	Steven exits Cell 12, closing door behind him
9:41:33	Steven leans forward quickly, peering at left hand side of upper level
9:41:34	Steven begins to stroll towards his cell
9:41:37	Steven stops briefly outside Cell 13 as if to enter, but continues past it and to the second floor landing
9:41:42	Steven stands on landing looking down onto unit floor. He is talking to detainee on bottom floor who is sitting at a table eating
9:41:50	Steven quickly descends unit stairs, still looking at eating detainee
9:41:48	Two-thirds of the way down the stairs, Steven stops, changes direction, and begins to ascend the stairs. Steven runs up the stairs two at a time
9:42:01	Having reached the top floor, Steven slows, and strolls towards cell 13
9:42:04	Steven opens door of Cell 13 and stops momentarily in doorway, appearing to look into the cell, before re-entering
9:42:15	Steven exits cell and walks briskly to top floor landing
9:42:18	Steven stops on top stair, looking down at CO on bottom floor
9:42:21	Steven turns back around and walks back into Cell 13
9:43:02	Steven exits Cell 13 and walks quickly to top floor landing
9:43:06	Steven rapidly descends stairs and walks to right side of unit floor towards metal tables
9:45:17	Steven appears by glass doors of unit with group of detainees. All members of group are standing casually. Steven has hands in pockets, and glances around occasionally
ANNEXURE A125	
16:25:41	Steven enters corridor through glass doors with group of 4 other detainees. Steven is second from front, and walks with purpose, swinging his right arm with which he holds an object
16:25:45	Steven veers off to his right, peering at metal cage that holds what appears to be clothes
16:25:48	Looking back over his left shoulder, Steven notices the group disbanding, with detainees exchanging handshakes. He stops in his tracks and crosses the corridor to approach a detainee, with whom he shares a handshake and an embrace.

16:25:54	Releasing the other detainee, Steven moves swiftly off in the opposite direction.
16:25:59	Accompanied by two other detainees, Steven approaches the glass door to his unit, and reaches out to open the door. He stops before opening the door, and it appears one of the detainees is responding to something said out of view of the camera
16:26:07	Steven opens the unit door and walks inside, followed by the other two detainees
16:26:11	Steven seen through glass doors strolling casually onto unit floor
ANNEXURE A126	
18:25:26	Steven exits Cell 13, touching beanie, and walks towards pair of detainees standing outside Cell 12
18:25:31	Steven swings arms and pulls shorter detainee into a two-armed embrace
18:25:33	Steven turns back around and dawdles outside door of Cell 13, banging right hand on scanner
18:25:37	Steven shakes hands of detainee all in gray, and also pulls him into a close embrace
18:25:44	Steven leans against door jamb, scratching right arm with left hand and observing interaction between two other hugging detainees
18:25:47	Steven places right hand on left shoulder of detainee who walks past him, engaging him in conversation
18:25:52	Steven aims a small, (friendly) kick at detainee as he walks away
18:25:55	Another detainee approaches and Steven swings his right arm out, locking his right hand in a handshake with the other detainee. Again, Steven embraces this detainee
18:26:00	Steven is approached by a detainee, and leans nonchalantly against door jamb, with right hand against door jamb, supporting his weight, and his left hand on his hip. Steven crosses his right foot over his left casually.
18:26:07	Steven strolls slightly out of the doorway, observing interactions between detainees with left hand placed lightly on his hip
18:26:08	Other detainees walk away and Steven, with limbs swinging slightly, walks back into Cell 13.
18:26:16	Through doorway of Cell 13 Steven can be seen moving around cell, picking up items
18:26:26	Cell 13 door shut by Goolagong as COs approach for lock down.