IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2007 000363

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: NATHAN TROY CHALKLEY

Delivered On:	30 April 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne
Hearing Dates:	11 and 12 March 2010
Findings of:	PHILLIP BYRNE
Representation:	Ms Piggott of counsel on behalf of the Office of Corrections
Police Coronial Support Unit	Leading Senior Constable Kelly Ramsey

I, PHILLIP BYRNE, Coroner, having investigated the death of NATHAN TROY CHALKLEY

AND having held an inquest in relation to this death on 11 and 12 March 2010
at MELBOURNE
find that the identity of the deceased was NATHAN TROY CHALKLEY
born on 11 April 1979
and the death occurred on 27 January 2007
at 1/19 Tania Street Sunshine
from:

1 (a) TOXICITY TO HEROIN

in the following circumstances:

1. Nathan Chalkley, 27 years of age at the time of his death, resided at 3/19 Tania Street Sunshine.
2. I think it fair to say Mr Chalkley came from a fractured/dysfunctional family. He has been described as a "rebellious teenager", from an early age became an abuser of alcohol and illicit drugs, became involved with police, engaged in criminal activity; all inevitably culminating in spending periods of time in prison. Compounding Mr Chalkley's problems, he also suffered from a number of psychological/psychiatric issues; some formally diagnosed and others suspected - paranoid schizophrenia, Attention Deficit Hyperactive Disorder, Obsessive Compulsive Disorder, anxiety and depression, in respect of which he was prescribed antipsychotic and antidepressant medications. In 2003 he was described by Dr Stella Kwong, a consultant psychiatrist who he consulted both before and after serving the effective three year term of imprisonment, as "angry and bitter". A number of the Court dispositions in the early 2000's resulted in Community Based Orders with special conditions to undergo assessment and treatment for both psychological/psychiatric and alcohol and drug issues.
3. At the Melbourne County Court in August 2005, Mr Chalkley was sentenced to five years imprisonment with three years to serve before being considered eligible for parole. It was noted he had spent 651 days in custody prior to sentencing which was deemed to be time already served.
4. Mr Chalkley served his sentence in several gaols, spending the last 10 months of his sentence in Barwon Prison.
5. He was released from Barwon Prison on 16 October 2006 to serve the last two years of his sentence on parole.

6. Shortly after release upon parole, Mr Chalkley commenced work with Mr George Puksar, a previous employer. On the face, over this time Mr Chalkey seemed to be progressing, apparently complying with the various requirements of his parole; keeping appointments with his corrections officer and consulting a consultant psychiatrist. His partner, Ms Katrina Bull, would come down from Wallan with their two children to drive him to various appointments and stay overnight two or three nights per week at the Salvation Army provided accommodation at Tania Street, Sunshine.

7. As stated, Mr Chalkley worked during the period from mid-October upon his release on parole until December 2006 with Mr Puksar. He worked long hours, six days a week and earned good money although it is clear that some of this hard earned money was spent on heroin. Mr Puskar took a break over the Christmas period and took a holiday; it was proposed work would resume after 22 January 2007. Mr Chalkley also took that time off.

8. That break from work was the commencement of a downward spiral that culminated in the death of Mr Nathan Chalkley on 27 January 2007 due to a heroin overdose. The sequence of events provided by Ms Bull in her statement to the Court makes sad reading. She relates how up until Christmas she considered Mr Chalkley was "working everyday and was doing well". She states with some candour "he was his own worst enemy and I couldn't help him get away from the problems he had".

9. After a postponement of the inquest in February 2009, Coroner Jane Hendtlass conducted a two day inquest on 11 and 12 March 2010. Regrettably, she did not complete a finding prior to her retirement on 31 December 2013. The State Coroner of Victoria, His Honour Judge Ian Gray, has assigned the completion of this Finding into Death with Inquest (finding) to me pursuant to section 96 of the Coroners Act 2008.

10. Since being assigned this file I have conducted, as best one can, a thorough examination of the evidence, including having read all the statements on the Brief of Evidence, examined the exhibits and, perhaps even more importantly, carefully read the 100 page transcript of the inquest held over the two days of 11 and 12 March 2010.

11. I make several general observations before turning to the main issues of contention:

    - Not having had carriage of this matter from the outset brings with it difficulties, especially not having had any input whatsoever until after the formal inquest had been completed.

- Had I carriage of the matter from the outset the prospect is I would not have proceeded to formal inquest (the use of the judicial forensic process) at all, but would have finalised the matter by way of a Chamber Finding.
- I do not agree with my colleague who initially had carriage of the matter that this was a mandatory inquest; little turns on that because mandatory or not an inquest was held.

12. I propose to set out the broad circumstances/facts proximate to the death of Mr Chalkley and then make findings in relation to the three principal issues I believe need attention.
13. After he knocked off work for the 2006 Christmas break, Mr Chalkley, with time on his hands, started to spend time with other residents at the Tania Street address. Ms Bull claims Mr Chalkley was "sucked into their way of life". The other residents referred to by Ms Bull at units 1 and 2 Tania Street were "Robbie and Nicole" (surnames not known to me) in unit 2 and Truc Nguyen in unit 1. It would appear these residents were "known to police".
14. On Friday 26 January 2007, Mr Chalkley returned from work drunk, "plastered" to borrow Ms Bull's terminology. Before dinner he attended Mr Nguyen's unit saying he was going to do an "80/30" – apparently a share in heroin Mr Nguyen had scored. Mr Chalkley returned, shared a pizza with Ms Bull and the children, took some of his prescribed medication (likely including Xanex) and returned to Mr Nguyen's unit. Shortly after Ms Bull observed Mr Chalkley at the driveway passing money to an unidentified female – he was obviously "scoring". She yelled out to her partner, but apparently not hearing her he re-entered Mr Nguyen's unit. Ms Bull locked herself and the children in their unit. She tried to ring Mr Chalkley on his mobile phone but it was apparently switched off. The next morning Ms Bull went to unit 1 and with some trouble roused "the Asian guy", as she called Mr Nguyen, who told her Mr Chalkley was there but he was asleep. She observed Mr Chalkley lying on a mattress inside the doorway. Ms Bull tried unsuccessfully to rouse Mr Chalkley, she observed a syringe next to Mr Chalkley's right arm and concluded he was dead. She rang the 000 emergency number and ambulance paramedics and MFB personnel attended. An ambulance paramedic formally pronounced Mr Chalkley dead and observed that he had been dead for some time.
15. The matter was referred to the coroner who directed an autopsy and ancillary tests. Senior Forensic Pathologist Michael Burke advised death was indeed due to:

    1 (a) TOXICITY TO HEROIN

16. In the final paragraph of Ms Bull's statement she claimed:

"I am frustrated by the fact that he went into jail not using drugs and that he came out with an addiction to heroin. I do not understand how this happened. He was put there to be rehabilitated not to have more problems added."

17. At the inquest that claim was explored at length with counsel for Corrections Victoria, Mr Piggott, vigorously resisting that contention.

18. A careful examination of the transcript of evidence leads me to the view that Ms Bull's belief to Mr Chalkley's naivety to heroin is ill founded. He had conceded to entities involved in his management that he had previous experience with heroin and had, on one occasion, actually overdosed. In fairness to Ms Bull, having heard evidence she said:

    "There's a lot that I've learned today that I wasn't aware of."

    It would appear the understanding Ms Bull and Ms Brodie Rowe had to this issue was based on unreliable hearsay evidence. The suggestion that heroin (as distinct from other drugs) was readily available in Barwon Prison was also explored. Once again the scuttlebutt based on hearsay was demonstrated to be untrue. Mr Piggott cross examined Ms Rowe about her claim that heroin was readily available in Barwon Prison. I think it fair to say Ms Rowe retreated conceding that the information that had been conveyed could have referred to drugs in general including pills (prescribed medications) rather than heroin. I add that Mr Chalkley was subject to 20 urinalysis screens while in custody (some random, some targeted) and all were negative.

19. On this issue of the availability of drugs in prison, Mr Bernard Clements, Acting General Manager of Barwon Prison, gave evidence at the inquest. He spoke to the Victorian Prison Drug Strategy introduced in 2002 designed to improve ways to prevent illicit drugs entering the prison system. Rather than endeavour to encapsulate that relevant part of his evidence I include in this finding a short excerpt from his statement to the Court; Mr Clements said:

    The revised Victorian Prison Drug Strategy was introduced in March 2002. The strategy aims to improve ways to stop illicit drugs entering the prison system by introducing a range of security measures designed to detect drugs and drug use within the prisons and reduce drug use by prisoners.

    The prison uses random and targeted urine and breath analysis to detect drug and alcohol usage. In the period Mr Chalkley was accommodated at Barwon Prison, prisoners were requested to submit to a urine samples on 1781 occasions. Heroin is a member of the opiates family; <u>no urine test results between 22 December 2005 and 16 October 2006 were positive to opiates</u>." (My emphasis)

Another excerpt addresses some of the measures adopted to address the drugs issue:

"By 2006, Barwon Prison had implemented extensive barrier controls and security measures to prevent the likelihood of drugs entering the prison. The prison used drug detector canines on the majority of weekend visits, as well as increased perimeter patrols and searches.

The prison uses random and targeted searches of prison cells, vehicles, prisoners and their property being submitted to the prison. All property is thoroughly searched upon reception at Barwon Prison."

Prison authorities are, and must remain, vigilant.

20. An incident involving Mr Chalkley only days after his release from Barwon Prison amply demonstrates the levels of vigilance brought to bear to seek to keep illicit drugs out of the system. A phone call to a prisoner from Mr Chalkley was intercepted; on 20 October 2006; suspicions were raised. When Mr Chalkley attended the prison on 22 October 2006 Mr Chalkley was strip searched, 0.5 grams of white powder was located; when he became aware Security and Emergency Services Group Officers were called he rushed to the toilets in the visitor waiting room and flushed the white powder down the toilet. Mr Chalkley was charged with serious criminal charges including trying to introduce drugs into the prison; however with his subsequent death the charges were struck out.

21. An internal review of the circumstances surrounding Mr Chalkley's death was undertaken by the Office of Correctional Services Review; a copy of their report was made available to the Court. I propose to address several issues raised in their report.

22. Programs are made available to prisoners in preparation for their release back into the community. Mr Chalkley declined to undertake some of those programs, claiming he had sufficient supports on the outside. He had, however, undertaken individual counselling with a drug and alcohol counsellor. Mr Chalkley's problem with drugs and alcohol was recognised as a potential issue after release. In preparation for release an assessment was carried out by the Australian Community Support Organisation – Community Offenders Advice and Treatment Service (ACSO – COATS). It was noted Mr Chalkley had "problematic substance use" dating back to his teens and suggested "he has a previous peer group entrenched in use and few positive peer supports".

23. In light of those warranted concerns, alcohol/drug assessment and treatment was a core condition of Mr Chalkley's parole.

24. As the ongoing psychological/psychiatric assessment and treatment of Mr Chalkley was referred to Forensicare but did not meet their criteria he was referred to Mid West Area Mental Health Service where he was placed on a waiting list. Mr Chalkley instead re-engaged with Dr Stella Kwong, a consultant psychiatrist he had consulted prior to going to prison. On the face of it he complied with those aspects of his parole.

25. However, I have concluded he didn't engage in drug and alcohol or psychological/psychiatric assessment and treatment in any meaningful sense; he merely went through the motions. As Ms Bull, who drove Mr Chalkley to these appointments, said in evidence, Mr Chalkley conceded to her "I'm just going to tell them what they want to hear".

26. I conclude appropriate pre-release measures were provided, or at least offered, to Mr Chalkley to prepare him for release back into the community. Similarly, I further conclude Mr Chalkley was appropriately managed within established practices and guidelines by Corrections Officers whilst on parole.

27. In the final analysis I formally find Mr Nathan Chalkley died due to heroin toxicity; there is nothing in the evidence to suggest his death was other than accidental.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

1. Drugs in prison have been a perennial problem; all manner of strategies have been adopted in the Victorian prison system to combat the issue. Since 2003, Opioid Substitution Therapy programs have been available to prisoners. The diverting of prescribed medication will continue to be a challenge to the authorities; if there is a perception in the wider community that heroin is available in the prison system then it would appear that this belief is not warranted, indeed it is ill founded.

2. Barwon Prison, in 2006, procured walk through and portable ion scanners calibrated for opiates, the walk through ion scanners are directed at visitors to the prison, the conduit of illicit drugs in the prison system. The portable ion scanners are utilised within the prison as part of the cell searches.

3. The Victorian Prison Drug Strategy and Community Correctional Services Drug and Alcohol have recently been again reviewed and is presently awaiting finalisation before promulgation as Corrections Victoria Alcohol and Drug Strategy.

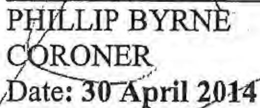
4. I am advised that a recent Victorian Auditor General's report concluded that while illicit drug use was not rife in Barwon Prison – vigilance must be maintained.
5. To the family of Mr Chalkley, I, on behalf of the Court, express my sincerest regret that this matter was not concluded much earlier. I re-iterate I only took over carriage of this matter recently and I have sought to expeditiously progress it to finalisation.

I direct that a copy of this finding be provided to the following:

Ms Katrina Bull

Mr Kevin Anderson, Corrections Victoria

Signature:



PHILLIP BYRNE
CORONER
Date: 30 April 2014