IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 3211

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	Laurie Henry Cartledge
Date of birth:	31 May 1972
Date of death:	On or about 28 June 2017
Cause of death:	Heroin toxicity in the setting of ischaemic heart disease
Place of death:	Ascot Vale, Victoria

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of LAURIE HENRY CARTLEDGE

without holding an inquest:

find that the identity of the deceased was LAURIE HENRY CARTLEDGE

born on 31 May 1972

and that the death occurred on or about 28 June 2017
at 7/40 Ascot Street, Ascot Vale, Victoria, 3032

from:

1 (a) HEROIN TOXICITY IN THE SETTING OF ISCHAEMIC HEART DISEASE

Pursuant to section 67(1) of the *Coroners Act 2008*, I make findings with respect to the following circumstances:

BACKGROUND

1. Laurie Cartledge was the brother of John, Billy, Julie and Dale. He had a history of drug use, including heroin and served several custodial sentences for various offences, often related to illicit drug use.
2. Mr Cartledge had a medical history of an acquired brain injury (**ABI**) that was sustained when he was hit in the head with a hammer and was a person with intellectual disability.
3. Between 2 September 2016 and 8 March 2017, Mr Cartledge was incarcerated at Port Phillip Prison. He was then transferred to Loddon Prison for the remainder of his sentence.
4. On 6 April 2017, Australian Community Support Organisation (**ASCO**) Community Offender Assessment and Treatment Services (**COATS**) conducted a pre-parole Forensic Assessment Report. The assessment recommended referral to drug and alcohol counselling and a neuro-psychological assessment to ascertain Mr Cartledge's level of cognitive functioning. Mr Cartledge's case manager liaised with an organisation that conducts neuro-psychological assessments, but Mr Cartledge declined to engage.

5. A Parole Suitability Assessment (**PSA**) was conducted on 7 April 2017. Among other things, the assessment considered Mr Cartledge's failure to comply with previous parole orders and flagged concerns that he would fail to utilise the supports provided to him and continue to lack engagement. The PSA recommendation was Mr Cartledge was not suitable for release.

6. At a parole hearing on 24 May 2017, that advice was noted by the Adult Parole Board. Nevertheless, Mr Cartledge was granted parole on 27 June 2017 and his parole period was due to end on 26 September 2017.

7. Mr Cartledge's parole conditions included a requirement that he undergo assessment to determine his suitability for treatment of drug and alcohol abuse or dependency and if deemed suitable, a requirement that he engage in treatment. He was also to submit to drug and alcohol testing and report to his supervising community corrections officer twice a week.

CIRCUMSTANCES IMMEDIATELY PROXIMATE TO DEATH

8. On 6 June 2017, while still incarcerated at Loddon Prison, Mr Cartledge was linked with a case worker for the Jesuit Social Services ReConnect Program (case worker)[1] who was to assist Mr Cartledge with housing and fitting back into the community.

9. The case worker noted that Mr Cartledge was not part of the methadone program whilst in jail and assumed at the time that Mr Cartledge would not leave prison with a drug addiction. He also understood that Mr Cartledge did not have a ready source of drugs in any of his friends or family members.

10. On 27 June 2017, Mr Cartledge was collected from Loddon Prison by his case worker and together, they went to Vincent Care for household items, and got purchased some food for the house including a barbequed chicken, which they dropped off at Mr Cartledge's new residence in the afternoon.

11. Mr Cartledge asked his case worker for a lift to a friend's house. He was still wearing his prison greens but said he would only be there for a minute. The case worker was suspicious and told Mr Cartledge that he would not drive him to get

[1] ReConnect is a post-release support program provided by Jesuit Social Services to support prisoners with individual and complex needs as they transition from prison back to the community.

drugs. Mr Cartledge reportedly went quiet and denied that was why he needed a lift. The case worker gave Mr Cartledge a talk about harm minimisation and his likely reduced tolerance to drugs before he dropped him off in Fitzroy.

12. At 4:07pm, Mr Cartledge withdrew three hundred dollars from an ATM in the Fitzroy shopping precinct.

13. The following day, 28 June 2017, at about 9am, Mr Cartledge went to a meeting with Corrections in Broadmeadows with his case worker who noticed he was walking much slower than usual. After the meeting, which took between about 30 and 40 minutes, Mr Cartledge walked much faster ahead of his case worker as though he was in a hurry to be somewhere else. Later when they went to Ascot Vale to sign some lease documents, Mr Cartledge said he wanted to leave because his hand hurt.

14. The pair returned to Mr Cartledge's accommodation where the case worker observed that Mr Cartledge had not unpacked his food shopping from the day before and the barbequed chicken was still sitting on the bench. Nor had he unpacked any clothes or personal belongings.

15. The case worker returned the next morning on 29 June 2017 to take Mr Cartledge to a drug and alcohol counselling appointment. When Mr Cartledge did not answer the door, he left a note under the door. The same day, Mr Cartledge was expected to make his own way to an appointment at Corrections. When he failed to do so, the case worker went to Mr Cartledge's home and sent him about four text messages, with no response.

16. On 4 July 2017, the Adult Parole Board issued a warrant for the return of Mr Cartledge to prison for breaching his parole. The Victoria Police Fugitive Taskforce attended Mr Cartledge's home on the same day but could not raise him and the attendance of a locksmith was arranged.

17. On 5 July 2017, the Fugitive Taskforce attended again and when they looked in the window, they saw a man slumped in the loungeroom.

18. Victoria Police attended a short time later and immediately commenced a coronial investigation. Mr Cartledge was found in a kneeling position, face down on the

carpet with a chair immediately behind him. He appeared to have fallen out of the chair and to have been deceased for some time.

19. The police found no signs of forced entry with all doors and windows to Mr Cartledge's residence locked except for one window on the northern side, which was about 15 centimetres ajar. Police conducted a search of the premises. On the mantlepiece, they found a plastic spoon, a hard, rock like substance, a brown paper bag containing several sealed syringes and a used syringe. The barbequed chicken was still sitting on the bench.

20. Interrogation of Mr Cartledge's mobile phone indicated that it was last used on 27 June 2017.

MEDICAL CAUSE OF DEATH

21. On 12 July 2017, Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**) reviewed the circumstances of the death as reported by police to the coroner and post-mortem computed tomography scans of the whole body and performed an autopsy on the body of Mr Cartledge in the mortuary at VIFM.

22. The post-mortem examination revealed acute subcutaneous haemorrhage in the right antecubital fossa and associated focal foreign body type inflammatory infiltrate, consistent with intravenous drug use, severe single vessel coronary artery atherosclerosis[2] associated with cardiomegaly and myocardial fibrosis and no evidence of injury or significant trauma.

23. Dr Francis observed that severe coronary artery atherosclerosis (up to 90% stenosis), is significant for someone in Mr Cartledge's age group.[3] She noted that risk factors for coronary artery atherosclerosis include increasing age, smoking, hypertension, family history, diabetes mellitus, obesity, male sex and other factors such as hyperlipidaemia (high cholesterol).

[2] According to Dr Francis, coronary atherosclerosis occurs when there is a build-up of cholesterol and other material in the blood vessels supplying oxygen and other nutrients to the heart. This accumulation of material narrows the vessels and when this occurs, the amount of oxygen supplied to the heart is compromised and the ability of the heart to supply the body with oxygenated blood is compromised.

[3] Given Mr Cartledge's relatively young age, Dr Francis recommended that family members attend their general practitioner for assessment of their own cardiac health/risk factors.

24. Routine toxicological analysis of post-mortem specimens detected 6-Monoacetylmorphine[4] (6-MAM), morphine and codeine in blood, consistent with the recent use of heroin, as well as a therapeutic level of the antidepressant mirtazapine.

25. Dr Francis advised that the interpretation of post-mortem toxicology results is complicated by multiple factors including post-mortem redistribution, idiosyncratic drug reactions, drug metabolism, the time interval between the consumption of the drug and death and the potential for the development of tolerance to a drug.

26. Heroin acts as a depressant of the central nervous system (**CNS**) as it reduces the rate and depth of breathing and can lead to the cessation of the breathing reflex. Death may result from the pharmacological properties of the drug. Death may also result as a complication of unconsciousness caused by a non-fatal overdose in which the unconscious person may suffer airway obstruction either due to posture or airway obstruction due to vomit.

27. In the setting of CNS depression, underlying coronary artery atherosclerosis would exacerbate the systemic effects of a compromised airway/hypoxia. Furthermore, Dr Francis advised that it is not possible to exclude respiratory restriction arising from the awkward position in which Mr Cartledge was found, as a potential contributing factor to death.

28. Dr Francis concluded her report by attributing Mr Cartledge's death to *heroin toxicity in the setting of ischaemic heart disease*.

JUSTICE ASSURANCE AND REVIEW OFFICE

29. The Justice Assurance and Review Office (**JARO**) conducted a review of Mr Cartledge's death. With respect to case management, Mr Cartledge met with case managers frequently whilst incarcerated. The case managers liaised with other service providers and Mr Cartledge's disability clinician was involved with his case management during his imprisonment.

30. At Port Phillip Prison, Mr Cartledge participated in the *12 Hour Intellectually Disabled Substance Misuse Program,* however, he received a low rating for his

[4] This is a heroin-specific metabolite. Within minutes of injection into a person, heroin is converted to morphine via the intermediary compound 6-MAM.

participation in the program. His report stated that he was unable to identify the negative impacts of drug use and needed prompting when challenged about the associated harms.

31. Specialised Offender Assessment and Treatment Services (**SOATS**) Disability Support Pathways (**DSP**) completed a file review and considered Mr Cartledge to be a high risk of general offending and referred him to the Social Problems and Offence Related Thinking (**SPORT**) program via Port Phillip Prison's Disability Forensic Assessment and Treatment Service (**DFATS**). However, the referral did not transfer with Mr Cartledge to Loddon Prison.

32. Mr Cartledge completed the *Transition Assistance Program – Release Related Harm Reduction* program at Loddon Prison on 6 June 2017 in which the harms associated with drug use in the community were discussed. Mr Cartledge's report did not include notes about his participation or engagement with the program.

33. Mr Cartledge participated in pre-release programs via the ReGroup program[5]. Due to Mr Cartledge's ABI and intellectual disability, Loddon Prison's disability clinician recommended he be enrolled in Relink Level 2, which is a pre-release program with one-on-one transitional support for prisoners with significant and complex transitional needs. Referral to ReLink Level 2 triggers an automatic referral to ReConnect.

34. According to JARO, staff involved in Mr Cartledge's case management endeavoured to provide him with assistance, explore the availability of services and encourage engagement with services, however, he often declined to engage with services.

35. With respect to Mr Cartledge's parole induction, initially, Carlton Community Corrections Services (**CCS**) were meant to case manage him, however due to a change in residence, Mr Cartledge fell within the ambit of Broadmeadows CCS. A handover took place between the two services. Mr Cartledge's CCS case manager was not available on the day of his parole induction, but an interim case manager met with him and Mr Houston.

[5] The ReGroup program provides general information and referral services to all exiting sentenced prisoners.

36. According to the CCS case notes, a Suicide and Self-Harm Screening Checklist (**SASH**) was not completed (and should have been) at Mr Cartledge's parole induction. However, there were no mental health concerns evident and Mr Cartledge denied any issues when questioned. The CCS indicated that Mr Cartledge's engagement during parole induction was limited due to his ABI and intellectual disability, and he appeared not to fully understand what he was being asked. Consequently, the case manager focussed on Mr Cartledge's immediate transitional needs and confirmed his next appointments instead. It was anticipated that Mr Cartledge's case manager would complete the SASH screening checklist at the next appointment.

37. JARO identified that it took five days for CCS to learn that the ReConnect case worker had been unable to contact Mr Cartledge after his parole induction. The CCS made several attempts over the next four days to contact Mr Cartledge and his ReConnect case worker. JARO suggested that Corrections Victoria consider ReConnect's notification processes, particularly in circumstances when repeated efforts have been made to contact a parolee. This would allow the CCS to make an informed decision about the parolee's risk level and to formulate appropriate case management strategies. Corrections Victoria accepted the suggestion.

38. Ultimately, JARO found that Mr Cartledge's custodial management met the standards prescribed by Corrections Victoria and that there were several examples of high-quality case management and efforts made by staff to encourage Mr Cartledge to engage with services.

39. JARO also found that Mr Cartledge's preparation for release and management by CCS was appropriate except for issues with his parole induction and communication with his ReConnect worker. They considered that case managers closely considered Mr Cartledge's complex needs during the preparation for release period and management while on parole.

40. A Justice Health review of Mr Cartledge's medical records while in custody found the healthcare provided to him while in custody was in accordance with the Justice Health quality framework.

41. JARO observed that Mr Cartledge returned a negative urine screen on reception to Loddon Prison and although he had a history of drug use in the community and

prior drug-related offending, of the 13 urine samples taken over the past 15 years, there was only ever one positive result (in 2011) which related to prescription medication.

CONCLUSIONS/FINDINGS

42. I find that Laurie Henry Cartledge late of 7/40 Ascot Street, Ascot Vale, Victoria died at home on or about 28 June 2017 from *heroin toxicity in the setting of ischaemic heart disease* in circumstances of an accidental or inadvertent overdose. There is no suggestion in the available evidence that Mr Cartledge intentionally took his own life.

43. Sadly, the phenomenon of recently release prisoners dying of drug overdose is well-known to Victorian coroners. It is generally accepted that this reflects the deceased's use of drugs, which are more readily available when at liberty, at a time of reduced tolerance due to abstinence or near abstinence.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments on matters connected with the death, including matters relating to public health and safety or the administration of justice.

1. It is not uncommon for Victorian Coroners to see the death of recently released prisoners from drug overdose.

2. Australian and international research[6] shows that in the first weeks after release from prison, a person is at a markedly elevated risk of dying from a drug overdose. For regular opioid users, factors that contribute to this elevated risk include a period of enforced abstinence in prison that causes the user's opioid tolerance to decrease so that a formerly tolerated dose can have fatal effects upon release from prison. There

[6] See for example Graham A, "Post-prison Mortality: Unnatural Death Among People Released from Victorian Prisons Between January 1990 and December 1999", *Australian and New Zealand Journal of Criminology*, vol 36, no 1, April 2003, pp.94-108; Farrell M, Marsden J, "Acute risk of drug-related death among newly released prisoners in England and Wales", *Addiction*, vol 103, no 2, February 2008, pp.251-255; Merrall ELC, Karimina A, Binswanger IA, et al, "Meta-analysis of drug-related deaths soon after release from prison", *Addiction*, vol 105, no 9 September 2010, pp.1545-1554; Zlodre J, Fazel S, "All-Cause and External Mortality in Released Prisoners: Systematic Review and Meta-Analysis", *American Journal of Public Health*, vol 102, no 12, December 2012, pp.e67-e75; Turban JW, " Can Parole Officers' Attitudes Regarding Opioid Replacement Therapy be Changed?", *Addictive Disorders and their Treatment*, vol 11, no 3, September 2012, pp.165-170.

may also be changes in the purity of available drugs between when the user is received into prison and released from prison, which may contribute to fatal outcomes during post-release drug use.

3. It is apparent that efforts were made while Mr Cartledge was incarcerated to enrol him in pre-release programs designed to equip him with the tools required to abstain from drugs in the community and to educate him about harm minimisation. However, the success of such programs is contingent, at least in part, on the participants ability to understand the content and preparedness to actively engage.

4. As Mr Cartledge was a person with intellectual disability and had an acquired brain injury, the evidence suggests that he may have been unable to fully participate in those programs. The neuropsychological assessment recommended by COATS did not materialise and accordingly, Mr Cartledge's level of cognitive functioning remained opaque. That said, this was not Mr Cartledge's first incarceration and there were previous opportunities to assess his cognitive functioning and improve his access to harm minimization programs.

PUBLICATION OF FINDING

Pursuant to section 73(1A) of the Act, I direct that this finding and comments be published on the Internet in accordance with the rules.

DISTRIBUTION OF FINDING

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

The family of Mr Cartledge c/o Ms Julie Cartledge

Justice Assurance and Review Office

Corrections Victoria

Justice Health

The Adult Parole Board

Signature:

PARESA ANTONIADIS SPANOS

Coroner

Date: 25 February 2020