IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 6235

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Jacqui Hawkins, Coroner
Deceased:	Shae Harry Paszkiewicz
Date of birth:	2 January 1977
Date of death:	12 December 2017
Cause of death:	1(a) Mixed Drug Toxicity
Place of death:	St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065

INTRODUCTION

1. Shae Paszkiewicz was 40 years old when he died on 12 December 2017 at St Vincent's Hospital, five days after he was found unconscious in Richmond on 7 December 2017. The day before, he was released from the Melbourne Assessment Prison on a Drug Treatment Order. Mr Paszkiewicz was residing with his brother Dean, in McKinnon at the time of his death.

THE CORONIAL INVESTIGATION

2. Mr Paszkiewicz's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Paszkiewicz's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Mr Paszkiewicz, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities. [1]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

7. On 7 December 2017 a worker from North Richmond Community Health found Mr Paszkiewicz unresponsive on the footpath adjacent to the health service at 106 Elizabeth Street in Richmond. The health worker immediately called emergency services and commenced cardio-pulmonary resuscitation (**CPR**). Attending police and paramedics were able to restore Mr Paszkiewicz's pulse, after which he was transported to hospital, however he had suffered a severe hypoxic brain injury and did not regain consciousness, dying four days later.

8. At the time of his death the Medically Supervised Safe Injecting Facility had not opened, however subsequent investigations established that Mr Paszkiewicz obtained an injecting kit from the vending machine located outside North Richmond Community Health approximately 10 minutes before he was first found unresponsive. A used syringe, spoon and cotton swab were found at the scene.

History of drug use and imprisonment

9. Mr Paszkiewicz was 40 years old at the time of his death and had been using drugs regularly since his teens. According to his father John Pascoe, his drug use was episodic and led to several episodes of imprisonment:

> *He was in and out of gaol. He would write to me from prison. He was always sorry for this and that. When he would come out of gaol he would do his parole at my house. The drug cycle just went on and on and on from the age of about 14 to his death. This continued through his twenties and thirties. We always tried to help him with his drug use. He would be good but it was a cycle and he would always fall back into it. He would always say, "Dad, it's so hard".*[2]

10. In a letter dated 1 June 2018 pertaining to the Justice Assurance and Review Office (**JARO**) review of Mr Paszkiewicz's death, JARO confirmed his substantial history of drug-related offending and engagement with Corrections:

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[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] Statement of John Anthony Pascoe, Coronial Brief, p.9.

> *He had served 11 terms of imprisonment with 176 prior convictions. He was first incarcerated on 22 January 1997 on charges of burglary and theft. Mr Paszkiewicz had been charged with a range of offences since 1997, which included a number of offences against the person, drug related offences, and property offences. These convictions resulted in a series of fines, suspended sentences, 13 community based dispositions between 1995 and 2015, and periods of incarceration. He contravened three community based orders, two intensive correction orders and was subject to five terms of parole, some of which were cancelled or varied due to non-compliance and reoffending.*

11. With respect to his drug use, JARO wrote:

> *Mr Paszkiewicz reported smoking cannabis most days from 15 to 35 years of age and that he last smoked in July 2017. He started injecting heroin from the age of 17 and last used the drug before entering custody in August 2017. He commenced sporadic use of amphetamines from 16 years of age and then started injecting methamphetamines from 30 years of age, with last use in August 2017.*

12. It is relevant to note for context that, in addition to drug dependence, Mr Paszkiewicz experienced mental ill health with diagnosed anxiety, depression and acquired brain injury.

Most recent period of imprisonment

13. Mr Paszkiewicz's most recent period of imprisonment resulted from an arrest on 21 August 2017 for burglary and attempted burglary. He was remanded in custody on 22 August 2017 at Melbourne Assessment Prison, then was transferred on 29 August 2017 to Port Philip Prison. He remained in custody there until 6 December 2017, when he was released under a Drug Treatment Order made at the Melbourne Magistrates' Court on the same day.

14. The available material in the coronial brief does not explicitly state his offending on this occasion was drug-related, however this can be inferred as the eligibility criteria for a Drug Treatment Order includes being dependent on drugs and/or alcohol that contributed to the offending.

15. The coronial brief contains Mr Paszkiewicz's JCare electronic medical record of medical care and assessment while in custody, which contains a somewhat inconsistent account of Mr Paszkiewicz's drug use history:

- In a Melbourne Assessment Prison medical reception assessment on 22 August 2017, he was recorded as experiencing benzodiazepine dependency but was not currently

withdrawing from alcohol or drugs. He reported that he had ceased drug use during a previous period of imprisonment and had not used drugs during the previous year.[3]

- On 22 August 2017 a clinical review was conducted and a medical officer recorded that he was "*obviously very benzodiazepine dependent*".[4]

- At a 28 August 2017 clinical review in Melbourne Assessment Prison, a psychiatric nurse recorded that he blamed his offending on methamphetamine use, and he was seeking to have his charges dealt with through the Drug Court.[5]

- When he transferred to Port Phillip Prison, his Interprison Transfer Assessment indicated he was withdrawing from diazepam use and had a history of substance use including heroin and amphetamines but was not currently using them.[6]

- He was assessed by the Port Phillip Prison a Medical Officer on 31 August 2017, at which time a history of drug use was recorded but with no further detail and no associated treatment plan.

- In a medical review on 24 November 2017, Mental Health Nurse recorded that he was considering drug counselling; the treatment plan on this date included "*ongoing education on the effects of illicit drugs on mental state*".[7]

16. The JARO letter noted the following further information regarding Mr Paszkiewicz's drug use which is not contained in the JCare material:

- Upon reception into Melbourne Assessment Prison, on 23 August 2017 he completed a Release Related Harm Reduction session. The contents of the session were not described, but the CPU understands this would ordinarily include drug harm reduction education.

- On 20 November 2017 he was assessed as presenting "*a very high risk in respect to drugs and alcohol*".

- When he was assessed for suitability for a Drug Treatment Order, he *"[…] expressed motivation to engage in services to address his substance misuse and offending behaviour and wanted to remain substance free if found suitable for release. He*

[3] See pages 10-11 of the JCare PDF file.
[4] See page 9 of the JCare PDF file.
[5] See page 8 of the JCare PDF file.
[6] See pages 42-44 of the JCare PDF file.
[7] See page 3 of the JCare PDF file.

acknowledged that over the past 23 years his drug use had impacted all areas of his life."

Release from custody

17. Mr Paszkiewicz was released from prison on 6 December 2017, in receipt of a Drug Treatment Order made at the Melbourne Magistrates' Court on the same day. The Order's two-year supervision and treatment component included conditions such as submitting to alcohol and drug testing as well as detoxification treatment as directed.

18. The only material addressing what Mr Paszkiewicz did between release and his attendance at the North Richmond Community Health injecting kit vending machine the next afternoon, appears to be the letter from JARO.[8] According to JARO, Mr Paszkiewicz attended an intake appointment on 7 December 2017 with an unnamed duty case worker at Community Correctional Services, during which he was provided a copy of his drug court undertaking, completed a suicide and self-harm screening process, and indicated his intention to engage in buprenorphine maintenance therapy for opioid dependence. JARO wrote:

> *At the beginning of the appointment Mr Paszkiewicz disclosed having been anxious the night before and admitted using heroin to relieve the anxiety he was experiencing. He confirmed his contact details and that he was residing with his brother. The intake officer described Mr Paszkiewicz as being easy to engage and very talkative.*

19. JARO reported that on 7 December 2017 Mr Paszkiewicz also attended a drug and alcohol testing appointment, at which the following drugs were detected in the sample provided: heroin, alcohol, pregabalin, amitriptyline, ethanol, morphine and codeine.

IDENTITY OF THE DECEASED

20. On 12 December 2017, Shae Harry Paszkiewicz, born on 2 January 1977, was visually identified by his friend, Tammie Hamilton.

21. Identity is not in dispute and requires no further investigation.

[8] John Anthony Pascoe stated that Shea Paszkiewicz and his brother were meant to see one another on the day after his release, but Shea Paszkiewicz's overdose occurred before this meeting was scheduled to take place. See statement of John Anthony Pascoe, Coronial Brief, p.10.

MEDICAL CAUSE OF DEATH

22. On 13 December 2017, Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on the body of Mr Paszkiewicz and provided a written report of her findings.

23. Dr Parsons reported that she reviewed the medical deposition which showed that Mr Paszkiewicz was brought into hospital with intravenous drug overdose and suspected respiratory arrest. A CT brain scan taken five days after admission to hospital showed features in keeping with an established severe global hypoxic injury with complete loss of supratentorial grey/white matter differentiation and gross mass effect with complete effacement of the sulci and basal cisterns and resultant tonsillar herniation.

24. Toxicological analysis of ante-mortem samples taken at the hospital confirmed the presence of heroin along with benzodiazepines, amitriptyline, pregabalin, paracetamol and lignocaine.

25. Mr Paszkiewicz was an organ donor.

26. Dr Parsons provided an opinion that the medical cause of death was 1(a) mixed drug toxicity. I accept and adopt this cause of death.

CORONERS PREVENTION UNIT INVESTIGATION

27. The death of Mr Paszkiewicz occurred, tragically, in circumstances that Victorian coroners encounter all too often. Australian and international research consistently shows that a person who has spent time in prison is at an elevated risk of death in the community; and the risk of fatal overdose is particularly elevated in the weeks and months immediately following release from prison. Over the past 20 years Victoria's coroners have repeatedly highlighted this risk in their findings and accompanying recommendations.[9]

28. To establish a contemporary context for my investigation, I directed the Coroners Prevention Unit (CPU)[10] to ascertain how many people in Victoria died in a setting of heroin-involved overdose during 2017 and had served terms of imprisonment. The CPU reviewed the

[9] Findings that address elevated overdose risk include finding of Coroner Peter White in COR 2014 1826 delivered 30 January 2015; finding of Coroner Audrey Jamieson in COR 2012 2254 delivered 9 April 2014; finding of Coroner Heather Spooner in COR 2009 3328 delivered 19 December 2012; finding of Coroner Heather Spooner in COR 2000 1941 delivered 24 June 2004. For an exploration of drug-related risks following release from prison in a homicide context, see finding of State Coroner Judge Sara Hinchey in COR 2013 3056 delivered 8 June 2017.

[10] The Coroners Prevention Unit is a business unit in the Coroners Court of Victoria, whose staff support coroners' investigations through activities such as collating data, reviewing evidence, compiling literature reviews, and consulting with relevant experts and organisations. The CPU's central purpose is to identify opportunities to reduce preventable deaths investigated by coroners.

circumstances of 220 relevant heroin-involved overdose deaths and identified evidence in 90 deaths (40.9%) that the deceased had ever spent time in prison. Ten deaths, including that of Mr Paszkiewicz, were found to have occurred within seven days of most recent release from prison.

29. Given that a substantial minority of heroin-involved overdose deaths in Victoria during 2017 were among people who had a history of incarceration, I determined that it would be appropriate to consider the circumstances of Mr Paszkiewicz's death within this broader context, to explore what might be done to reduce fatal heroin-involved overdose in Victoria among people who have served time in prison.

Consultation regarding prevention of post-release heroin overdose deaths

30. To progress this systemic prevention-focused aspect of my investigation, I directed the CPU to write to relevant government and non-government organisations engaged in care and support of current and former prisoners, as well as academic experts who work in this area, seeking their views inter alia on the following:

> *[…] whether you believe there are any gaps in current services, and any new services or alternative approaches that could be considered to reduce the number of former prisoners dying from heroin-involved overdose in Victoria*

31. I received written responses from the following eight relevant organisations and individuals:

- Michael Curtis, Amy Kirwan, Dr Shelley Walker, Filip Djordjevic, Professor Paul Dietze and Professor Mark Stoové from the Burnet Institute.
- Louise Galloway from the Victorian Department of Health and Human Services (**DHHS**).
- Sione Crawford from Harm Reduction Victoria (**HRV**).
- Dr Jesse Young and Claire Keen from the Justice Health Unit, Centre for Health Equity at The University of Melbourne.
- Sam Biondo and David Taylor from the Victorian Alcohol and Drug Association (**VAADA**).
- Marius Smith from VACRO.
- Emma King from the Victorian Council of Social Service (**VCOSS**).

- Dan Nicholson and Prita Jobling-Baker from Victoria Legal Aid (**VLA**).

32. I thank Sam Biondo of VAADA for convening a forum in October 2019 regarding the issues I am investigating, as well as the participants in the forum, who included several of the organisations and individuals who provided submissions.

33. Between them, the submissions were extraordinarily helpful in assisting me to understand the broader context within which Mr Paszkiewicz's death occurred, and what might need to be done to reduce the risk of further similar deaths in the future. The following sections draw heavily on the submissions as I explore these themes.

34. The submissions covered a very broad range of topics and issues and did so in considerable depth. Therefore, I have necessarily condensed and summarised the submissions here to focus on the main recurring themes and issues identified.

Risk of fatal overdose following release from prison

35. I was very grateful to the Burnet Institute, Justice Health Unit and VAADA for including overviews of the recent literature on post-release mortality, confirming that it remains a very significant public health issue. I note the current estimate that drug-related mortality is approximately 32 times higher among people recently released from prison than among the general population; and that substance use disorders and injecting drug use and opioid use are all far more prevalent among people who have been incarcerated than the general population.

Existing programs to reduce risk of overdose

36. Louise Galloway of DHHS provided a very helpful overview of the services that DHHS and the Department of Justice and Community Services (**DJCS**) deliver to reduce drug-related harms among people who use drugs generally, and among people who are released from prison.

37. The general initiatives highlighted by Ms Galloway include localised responses in 'hotspot' overdose locations; free access to naloxone and overdose prevention training for people who are likely to witness or experience overdose; implementation of the Proactive Overdose Response Initiative to reach people who are at higher risk of overdose; the Reducing Harmful Drug Use Through Peer-Led Networks trial through which peer workers use their local knowledge and experience of drug use to reach those who might be at risk of adverse outcomes from drug use; the Medically Supervised Injecting Room; and local community-

based outreach programs focusing on specific cohorts of people who use drugs. Ms Galloway also noted that the DHHS supports delivery of pharmacotherapy and needle and syringe programs.

38. The initiatives specifically targeted at reducing drug-related harms among people while in prison include providing information to all new people entering prison about substance abuse related harms and the range of alcohol and other drug (AOD) treatment modalities and programs available to them; offering a range of treatment options such as education, counselling, group treatment programs and pharmacotherapy; offering an AOD Release Related Harm Reduction session to people preparing for release from prison; and the ReGroup and ReLink pre-release programs to establish transitional supports. Post-release support initiatives include the ReConnect and ReStart programs, and the Yawal Mugadjina program for Aboriginal men and women.

Gaps in existing programs

39. In reviewing the submissions, I identified eight main recurring themes regarding gaps in current programs to reduce drug-related harms among people who use drugs and are incarcerated in Victorian prisons. The following is an overview of each theme.

Drug treatment options in prison are not optimal

40. There was widespread agreement that appropriate drug treatment in prison is a key factor to reduce drug-related harms following release into the community. Dr Jesse Young and Claire Keen noted that incarceration is a "*critical public health opportunity*" to engage vulnerable people including those who experience drug dependence and mental ill health in treatment, and wrote:

> *The majority of individuals who are incarcerated in Australia spend a relatively short time in custody prior to returning to the community. The benefits of health services delivered in prison, and consequences of inadequate health service delivery, are often only realised after people are released from prison and return to their communities, thus the proposition that 'prisoner health is public health'.*[11]

41. A range of shortcomings were identified in the drug treatment opportunities presently offered to people in Victorian prisons. These included:

[11] Young J and Keen C (Justice Health Unit, University of Melbourne), Submission to the Coroners Court of Victoria, 26 October 2019, p.10.

(a) There is a lack of continuity in drug treatment between community health care providers and the Corrections system, for people entering prison.

(b) There are insufficient places in prison drug treatment programs to accommodate demand. This may be in part the result of a substantial increase in the prison population over time, where investigation in programs has not kept pace.

(c) There are often limitations or restrictions on access to drug treatment programs in prison. For example, people being held on remand may be ineligible to access drug treatment programs and harm reduction initiatives.

(d) There is no available evidence to establish whether the drug treatment programs offered in Victorian prisons assist in reducing drug-related harms among people after they are released from prison.

(e) The extant evidence suggests drug-focused therapeutic communities are the most effective available treatment in prison settings to reduce rates of alcohol and other drug relapse, re-arrest and re-imprisonment. However, currently there are no therapeutic community programs available to prisoners in Victoria.

Problems with Opioid Substitution Therapy (OST) program delivery in prison

42. Opioid Substitution Therapy (OST) is a proven effective treatment for reducing overdose risk as well as other drug-related harms among people who use opioids. In simple terms, it involves providing regular doses under clinical supervision of a long-acting opioid to stabilise the person's opioid dependence and manage cravings and mitigate withdrawal.

43. The central importance of OST in reducing opioid-related harms - including overdose - among people in prison and after release into the community, was reinforced across most submissions. The following were the major concerns regarding how OST is currently delivered in Victorian prisons:

(a) People who have been engaged in OST programs in the community, can experience difficulty and delay in continuing the program in prison. This can lead to disengagement from OST and associated poorer health outcomes.

(b) People who are opioid dependent but were not engaged in OST immediately prior to imprisonment, can experience great difficulty in commencing OST while in prison.

(c) OST is prohibited in some prison units.

(d) OST provision can be interrupted (for example during transfer between prisons) and can also be terminated without the prisoner's consent.

Lack of take-home naloxone programs in prison

44. Naloxone (widely known by the brand name Narcan) is a drug that reverses the effects of opioids - including opioid overdose - very quickly upon administration. Take-home naloxone programs entail training in how to recognise and respond to opioid overdose, including how to administer naloxone via nasal spray and/or injection. Naloxone is provided as part of this training, for people to take home and have at hand in case it is ever needed to respond to opioid overdose. The training is suitable for people who use opioids, as well as their family members and others who are likely to come into contact with people who are at risk of opioid overdose. A substantial body of evidence shows that take-home naloxone programs and associated training can reduce mortality and morbidity associated with opioid overdose.

45. There was widespread concern about the lack of a take-home naloxone program in Victorian prisons in the submissions. This was identified as a missed opportunity to reach vulnerable people who use opioids and teach them (a) about overdose risks and how to manage them when using opioids; (b) how to recognise and respond to opioid overdose; and (c) how to administer naloxone. It was also viewed as a missed opportunity to ensure people who use opioids were equipped with this life-saving drug upon release from prison, when they are particularly at risk of opioid-related harms and overdose.

Lack of needle and syringe programs (NSP) prisons

46. Needle and syringe programs (NSPs) have long been a central feature of Australian harm reduction strategies to support people who inject drugs. An NSP is a program whereby people who inject drugs are provided free access to injecting equipment such as needles and syringes, swabs, vials of sterile water and 'sharps bins' for the safe disposal of used needles and syringes. This reduces injection injuries as well as transmission of blood borne disease. The NSP is often embedded in a health service context, which creates opportunities for health workers to engage with and support people who attend to obtain clean injecting equipment. NSPs have been shown to be highly effective (and cost-effective) at reducing drug related harms.

47. The lack of an NSP in Victorian prisons was identified as problematic, both because it would reduce sharing of injecting equipment in prisons (and thus reduce associated adverse outcomes such as disease transmission and infection), and because engagement with an NSP is an excellent opportunity to deliver practical education on safe drug injecting and drug use, which in turn can reduce overdose risk in the community.

Lack of appropriate housing upon release

48. Poor housing options for people exiting prison was a common concern across the submissions. A substantial proportion of people who exit prison do not have suitable, safe and secure housing; often their only immediate option is temporary accommodation such as a rooming house, motel, crisis housing service or boarding house. These insecure housing environments increase the risk of exposure to crime and drug use, and also can compromise access to drug treatments such as OST. As expressed by Emma King from VCOSS:

> *Housing is one of the key social determinants of health. Consequently housing must be central to any public health response to overdose prevention for former prisoners. Currently, half of all people leaving prison can expect to be homeless, or exited to emergency accommodation. Over the past five years, the number of Victorians who have exited from prison into homelessness has grown by 188 per cent. For any transition or post-prison supports to be effective, the critical shortage of safe, secure and affordable housing must be addressed.*[12]

49. The evidence is that this was not a risk for Mr Paszkiewicz as he was to reside with his brother in McKinnon upon his release.

Gaps in discharge planning, support and continuity of care upon release

50. There were multiple gaps identified with discharge planning for people who use drugs, and with ensuring they receive treatment and support when discharge occurs. The main such gaps discussed in the submissions included:

    (a) Responsibility for discharge planning can involve different areas of government (including Justice Health and Corrections Victoria), particularly where health-related issues such as drug use are relevant considerations; and information sharing and collaboration between these government bodies can be very poor.

    (b) Discharge planning for people who use drugs and are held on remand can be problematic because of the uncertain length of time they are in prison.

[12] King E (Victorian Council of Social Service), Submission to the Coroners Court of Victoria, 23 December 2019, pp.2-3.

(c) There is greater demand than availability (and long waitlists) for a range of evidence-based residential drug treatment services. Therefore, people may need to wait a substantial period of time after release before a place becomes available. This issue is compounded by the difficulty of arranging for somebody to be assessed for eligibility to enter a residential treatment service while they are still in prison.

(d) If a person is released from prison not on parole and without a Corrections order of any type, they may not be referred to drug harm reduction programs or services in the community even if they are known to be a person who uses drugs.

Poor retention in OST after release from prison

51. As discussed above, OST is a key harm reduction measure to support people who use opioids; it not only assists in managing opioid cravings and reducing risky opioid use, but also helps people in their everyday work and family and community life. In this context, failure to engage and/or retain a person in OST upon release from prison was identified as heightening risk of drug-related harms including overdose.

52. The main barriers identified in the submissions which compromised people's engagement and/or retention in OST on leaving prison, were:

(a) Residing in unstable accommodation;

(b) Not being engaged in other types of drug treatment in the community together with OST;

(c) The shortage of doctors who deliver OST in the community;

(d) The high daily out-of-pocket cost for dispensing OST medications, which is only subsidised for the first four weeks after leaving prison; and

(e) The lack of referral to OST in the community if the person was not an OST client while in prison.

Lack of information and evidence regarding prisons and health outcomes

53. Fatal overdose after leaving prison is a public health issue and demands a public health response. The starting point for such a response is to understand the frequency and nature of the issue. This enables interventions to be designed and implemented and evaluated, to

establish their impact on the issue. The evidence from evaluation is then used to refine interventions and identify further opportunities to address the issue.

54. The final major concern raised - both directly and indirectly - across the submissions, was that far too little information is available to inform the public health response to reduce overdose risk among people released from prison. Dr Jesse Young and Claire Keen from the Justice Health Unit highlighted the "*profound lack of evidence*"[13] caused by failure to routinely link and make available data on health, social and criminal justice outcomes for people who are engaged in Victoria's corrections system. Sam Biondo of VAADA wrote:

> *A barrier to achieving a best practice approach to preparing prisoners for release is the lack of information and data released by Corrections Victoria. If we don't have the data, we don't know the scale of the issues at hand, or how to best improve outcomes for prisoners on release.*[14]

55. Core information that is either not gathered or not made available includes prison throughput of key vulnerable groups such as people who use drugs; follow-up health outcomes including death among people who have exited prison; and the number of people in prison and people exiting prison who engage in different types of drug treatment.

Opportunities to address these gaps

56. For the eight main gaps identified from the submissions, there were eight corresponding sets of potential opportunities indicated regarding new services and approaches to support people who use drugs and have contact with Victoria's prison system, to reduce drug-related harms after they exit prison. The following is an overview of these eight areas.

Improved drug treatment in prison

57. There were several opportunities identified to improve drug treatment in prison and thereby reduce the risk of fatal and non-fatal overdose following release. These included:

    (a) Drug treatment approaches and programs in prison should be tailored to the specific needs of clients. Aboriginal people, young people, and people who experience a dual diagnosis of substance use disorder and mental illness, were three groups identified as

[13] Young J and Keen C (Justice Health Unit, University of Melbourne), Submission to the Coroners Court of Victoria, 26 October 2019, p.13.
[14] Biondo S (Victorian Alcohol and Drug Association), Submission to the Coroners Court of Victoria, 10 December 2019, p.10.

requiring targeted, culturally appropriate supports to treat their substance use and thus reduce their risk of premature death from overdose following release from prison.

(b) Existing prison-based drug treatment programs should undergo independent evaluation to ensure they are evidence-based and achieve outcomes including increased engagement in treatment post-release and reduction in harms associated with drug use. The evaluation framework should also be applied to any new programs or changes to existing programs.

(c) The cohort of people in prison who use drugs and alcohol intersects with other at-risk cohorts such as those with diagnosed mental illnesses, those who have experienced trauma and adverse childhood events, and those who experience social stressors such as homelessness, unemployment and low educational attainment. A more holistic approach to treating substance use within these contexts would produce better outcomes. On this point, I was very interested to read Sam Biondo from VAADA's commentary on the Norwegian corrections model, with its therapeutic underpinnings and focus on the health and wellbeing of people in prison.

Improved OST coverage and delivery in prison

58. The following were identified as opportunities to improve OST delivery in prison, thereby increasing people's engagement with OST while in prison and reducing their risk of drug-related harm when they exit into the community:

(a) The resourcing and capacity of OST services across prisons be reviewed to determine whether it is meeting demand, and increased where needed so that any person assessed as appropriate for OST can commence without delay.

(b) People entering prison should be assessed for their OST needs in a timely manner.

(c) There should be no barriers to initiating OST treatment in prison.

(d) There should not be a requirement for a person in prison to prove he or she is currently using opioids, before being eligible to access OST.

(e) Ideally people in prison should have access to their preferred OST treatment, rather than being limited to (for example) methadone liquid.

59. Sione Crawford from HRV highlighted that OST delivery in prison is generally very different to OST delivery in the community, and concluded that: *"[…] bringing custodial OST guidelines more into line with those used in the community would increase acceptability and reduce overdose risk for prisoners and those leaving custody*."[15]

Introduction of a naloxone program in prison

60. The submissions I received were strongly in support of introducing a take-away naloxone program and associated training to all prisons. Marius Smith from VACRO articulated the majority position as follows:

> *We believe that Naloxone should be available at all prisons, that it should be available for anyone with opioid addiction at time of release, and that training should be provided to drug and alcohol clinicians – who could in turn train prisoners who participate in AOD programs – at every correctional facility.*[16]

61. Sione Crawford from HRV proposed that Scotland's National Naloxone Program - which has been found to reduce opioid-related mortality among people released from prison[17] - would be a useful model to consider.

Introduction of an NSP in prison

62. An NSP, like a naloxone program, was supported in multiple proposals as an evidence-based initiative that would have public health benefits both in prison and among people leaving prison. Michael Curtis and colleagues at the Burnet Institute explained that while the primary purpose of an NSP is to reduce transmission of blood-borne viruses between people who inject drugs, there are positive benefits in drug treatment engagement more broadly:

> *Evaluations of international prison NSPs have […] consistently found no evidence of increased drug use or the amount of drugs entering correctional settings. On the contrary, some evaluations have found that a prison NSP can increase demand for drug treatment due to contact with NSP staff and services through NSP service contacts.*[18]

63. In the context, it is clear that introducing a prison-based NSP program is relevant to the issue of reducing overdose risk among people leaving prison.

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[15] Crawford S (Harm Reduction Victoria), Submission to the Coroners Court of Victoria, 25 October 2019, p.2.
[16] Smith M (VACRO), Submission to the Coroners Court of Victoria, 27 October 2019, p.4.
[17] Horsburgh K, McAuley A, "Scotland's national naloxone program: The prison experience", *Drug and Alcohol Review*, 37(4), 2018: pp454-456.
[18] Curtis M, Kirwan A, Walker S, Djordjevic F, Dietze P, Stoove M (Burnet Institute), Submission to the Coroners Court of Victoria, 24 October 2019, p.6.

Improved accommodation options for people exiting prison

64. Ensuring that people exit prison into appropriate, stable, secure accommodation was identified as a key priority with both direct and indirect benefits of relevance to my investigation, including reduced risk of harm related to substance use, enhanced engagement in OST and other drug treatment programs, and reduced subsequent engagement with the criminal justice system. Targeted government investment in appropriate social housing, and the adoption of what VCOSS Chief Executive Officer, Emma King, called a "*no exit into homelessness*" policy for people leaving prison,[19] were both strongly supported in the submissions.

Improved transitional support including continuity of care

65. A wide range of opportunities to improve support for people who use drugs and are transitioning from prison to the community were identified, including:

    (a) Increase the resources invested in transition support programs for all Victorian prisoners, to ensure comprehensive and easily accessible support is provided.

    (b) Re-examine the rationale for excluding certain people who inject drugs (including people who leave prison with certain bail or parole conditions) from attending the Medically Supervised Injecting Room in North Richmond, given that supervised injecting attendance creates opportunities to deliver safe drug use education and engage people in drug treatment. Further to this point, people could be provided information about and referrals to the Medically Supervised Injecting Room as part of discharge planning.

    (c) Increase the integration between health care providers in prison and in the community, to promote continuity of care. This includes increased sharing of clinical information from prison health care providers to inform treatment in the community.

    (d) Increase the integration between mental health care and drug and alcohol treatment for people leaving prison, to support particularly vulnerable people who experience both substance dependence and mental ill health.

66. Sam Biondo from VAADA and Emma King from VCOSS both emphasised the importance of properly funded and integrated wraparound services that provide post-release support across the domains of potential vulnerability. Sam Biondo wrote:

[19] King E (Victorian Council of Social Service), Submission to the Coroners Court of Victoria, 23 December 2019, p.2.

> *An exit strategy and transition plan should commence as soon as a person enters prison. It should address an individual's accommodation, medical care, AOD treatment, and education, training or employment support on exit. It is essential that a plan is tailored to each individual, and devised well before the prisoner's release from prison. Care co-ordination should be a key feature when exiting from prison, and well-funded co-ordinated support should be accessible and begin prior to release, to allow for a smoother transition.*[20]

Improved OST retention in transition to community

67. Retaining people in OST after release from prison was identified as a particularly crucial measure for reducing overdose risk and associated mortality. The following three initiatives to achieve this were advocated across the submissions:

    (a) Discharge planning should include not just referrals to OST prescribers and dispensers in the community, but also confirmed appointments with appropriate local services so that upon release a person's OST is not interrupted and engagement is as convenient as possible.

    (b) OST dispensing fees should be subsidised for at least the first three months post-release, so that this expense does not function as a barrier to deter people from continuing in OST.

    (c) Retention is improved and therapeutic outcomes are achieved more effectively when OST is integrated with drug counselling, so this should be part of discharge planning.

Improved reporting on information to inform prevention

68. To develop a better evidence base for reducing drug-related harms including fatal overdose among people released from prison, multiple submissions called for more information to be made public and more data to be made available for researchers regarding who is entering and exiting the prison system in Victoria, and their health outcomes upon release. Specific suggestions included:

    (a) Reporting on the prison throughput of groups such as those who experience substance use disorders, and those who have been diagnosed with mental ill health.

    (b) Enabling routine linkage of health and criminal justice administrative data on people exiting the prison system, through the Centre for Victorian Data Linkage.

[20] Biondo S (Victorian Alcohol and Drug Association), Submission to the Coroners Court of Victoria, 10 December 2019, p.3.

(c) Establishing independent oversight of Corrections-linked data to ensure it can be accessed for appropriate public health purposes (including death prevention) while also protecting the confidentiality of individual people.

69. I found the submissions provided by the eight organisations and individuals to be extremely helpful and important to assist me to understand the complex issues, identify the potential gaps in services and prevention opportunities. I would also like to express my gratitude to Dr Jeremy Dwyer, Manager Research and Data, CPU, for his assistance in requesting and collating the responses to the submissions. I have considered all of the issues in the context of which Mr Paszkiewicz's death occurred which has informed my comments and recommendations below.

FINDINGS AND CONCLUSIONS

70. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

(a) the identity of the deceased was Shae Harry Paszkiewicz born on 2 January 1977;

(b) Mr Paszkiewicz's death occurred on 12 December 2017 at St Vincent's Hospital, Fitzroy, Victoria from 1a) mixed drug toxicity; and

(c) the death occurred in the circumstances described above.

71. Having considered all of the circumstances, I am satisfied that his death was the unintended consequence of the deliberate ingestion of drugs.

72. I convey my sincere condolences to Mr Paszkiewicz's family for their loss.

COMMENTS

73. Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

74. In reviewing the submissions I was struck by how many different factors contribute to overdose risk in people who have exited prison. Furthermore, I noted that many of these factors can interact with one another to exacerbate risk and negative outcomes, as highlighted in the VLA submission from Dan Nicholson and Prita Jobling-Baker:

> *[…] it is difficult for the mainstream criminal justice system to respond to people with severe substance dependence, and they may find themselves cycling in and*

> *out of custody on minor offences, receiving increasingly more severe sanctions. This can impact their mental illness and substance-dependence and impair their ability to rehabilitate outside of the criminal justice system.*[21]

75. The relevant program and service gaps identified in the submissions which need to be addressed to reduce overdose risk among people after prison release, exist in areas that are the domains of several government bodies. Sam Biondo from VAADA explained that this exacerbates an already challenging situation:

> *The gaps that exist can, to some extent, be attributed to a lack of coordination between governments. The* Prison to Work Report *noted that 'This lack of support… is largely a consequence of Australia's federated responsibilities. No one agency or organisation has oversight of prisoner transition into post-release life. States and Territories manage corrective systems, while the Commonwealth manages income support and large employment services. The problem is the lack of coordination between these services and programmes; sometimes within one level of government, and sometimes between different levels of government'. As a result, the various services available to prisoners often operate in isolation, which makes it difficult to navigate.*[22]

76. Sam Biondo concluded:

> *In order to address the high rate of overdose death during the post-release period, there must be greater support given to prisoners, both before and after release, to reduce the likelihood of substance use and overdose. This approach should not be the responsibility of the Department of Justice alone, but rather based on a concerted and whole-of-government approach, and commitment to change current practices.*[23]

77. Dr Jesse Young and Claire Keen from the Justice Health Unit at the University of Melbourne made a similar point in their submission:

> *The senseless loss of life among people released from prison in Australia is a whole-of-government problem requiring a whole-of-government solution. We need to acknowledge that preventing premature death and improving the health and social circumstances of people who cycle through the criminal justice system is an impossible task for one department (i.e., Corrections).*[24]

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[21] Nicholson D and Jobling-Baker P (Victoria Legal Aid), Submission to the Coroners Court of Victoria, 30 October 2019, p.3.

[22] Biondo S (Victorian Alcohol and Drug Association), Submission to the Coroners Court of Victoria, 10 December 2019, p.3. The report referenced here was the Council of Australian Governments, *Prison to Work Report*, December 2016.

[23] Biondo S (Victorian Alcohol and Drug Association), Submission to the Coroners Court of Victoria, 10 December 2019, p.13.

[24] Young J and Keen C (Justice Health Unit, University of Melbourne), Submission to the Coroners Court of Victoria, 26 October 2019, p.11.

78. Adding to the complexity are the overarching policy settings in Victoria and Australia which frame our approach to all drug-related public health issues. Sione Crawford of HRV highlighted these:

> *[…] HRVic believes it crucial to always highlight that our conversation around overdose deaths and former prisoners would be much smaller and less significant if we did not primarily respond to drug use in the community via criminal and custodial means. To put it another way, fewer former prisoners would die of overdose if we did not incarcerate so many people who use drugs.*[25]

79. While this policy context is outside the scope of my investigation, I acknowledge its fundamental relevance to the issues I examined.

80. The broad range of complex intersecting factors that might need to be addressed to reduce the risk of overdose death among people released from Victorian prisoners, and the diverse government and non-government organisations who might need to be involved, were central considerations for me in formulating prevention-focused recommendations

Leading efforts to prevent overdose following release from prison

81. I agree with Sam Biondo, Dr Jesse Young and Claire Keen that no one government department can address the myriad issues underpinning the heightened overdose risk among people who have been incarcerated in Victoria. In these circumstances, a department needs to take responsibility for leading and coordinating efforts across government aimed at reducing drug-related harms in this vulnerable population. This is a public health oriented goal, and therefore I believe the Victorian Department of Health is the appropriate agency to take the lead. Please refer to Recommendation One.

Identifying priorities for action

82. Across the submissions I identified eight recurring themes regarding gaps in current programs to reduce drug-related harms among people who exit Victorian prisons; and eight corresponding sets of opportunities to address these gaps. The submissions included dozens of concrete proposals for interventions that may be effective. There is a clear need for the relevant experts to come together and advise government on priorities and plans of action for the future. Please refer to Recommendation Two.

[25] Crawford S (Harm Reduction Victoria), Submission to the Coroners Court of Victoria, 25 October 2019, p.3.

Enhancing the public health approach to drug harm reduction in people released from prison

83. The public health approach to reducing drug-related harms among people released from prison requires data to understand the nature and prevalence of the harms, to identify potential appropriate harm reduction interventions, and to evaluate whether these interventions achieve their goal. There is also a legitimate public interest in publishing this information, so that Victorians can understand how some of their most vulnerable residents are looked after. Please refer to Recommendation Three.

Introducing a take-home naloxone program to Victorian prisons

84. Among the concrete actions proposed in the submissions, introducing a take-home naloxone program to Victorian prisons stood out as being particularly well supported. Further to this point, Louise Galloway from the Victorian Department of Health and Human Services wrote that the Department of Justice and Community Services was "*currently exploring opportunities to provide prisoners with naloxone on release from prison*".[26] Considering both the weight of support for take-home naloxone programs in prison, and the circumstances in which Mr Paszkiewicz died, I determined to add my support. Please refer to Recommendation Four.

RECOMMENDATIONS

85. Pursuant to section 72(2) of the Act, I make the following recommendations:

Recommendation One:

That the Victorian Department of Health adopt formal responsibility for improving health outcomes and reducing drug-related mortality among people who are released from prison.

Recommendation Two:

That the Victorian Department of Health convene a formal advisory group to guide the identification, prioritisation, implementation and evaluation of policies and programs to reduce drug-related mortality among people who are released from prison. This advisory group should include representatives from government departments and non-government organisations whose work intersects with support of people leaving prison, as well as academic experts.

[26] Galloway L (Victorian Department of Health and Human Services), Submission to the Coroners Court of Victoria, 14 January 2020, p.2.

Recommendation Three:

That the Victorian Department of Health collaborate with the Victorian Department of Justice and Community Safety to link information they hold on all people who enter Victoria's prison system, with a view to producing accurate and timely information on these people and their health outcomes including death within 10 years of release from prison. This information should be collated in consultation with the advisory group (see Recommendation Two) and should be publicly reported on (at least) an annual basis, as well as being made available to researchers who are engaged in efforts to improve these health outcomes.

Recommendation Four:

That the Victorian Department of Justice and Community Safety should immediately introduce a take-home naloxone program (including training in overdose awareness and naloxone administration) to be made available to all people in Victorian prisons who have a history of opioid use and who are preparing to exit prison.

86. Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

- Ms Gaynor Bell, Senior Next of Kin
- Mr John Pascoe, Senior Next of Kin
- Professor Euan Wallace AM, Secretary, Department of Health.
- Ms Rebecca Falkingham, Secretary, Department of Justice and Community Safety
- The Hon. Martin Foley MP, Minister for Health, Minister for Ambulance Services, Minister for Equality
- The Hon. Natalie Hutchins MP, Minister for Crime Prevention, Minister for Corrections, Minister for Youth Justice, Minister for Victim Support
- Ms Emma Cassar, Commissioner, Corrections Victoria
- Professor Mark Stoové, Burnet Institute

- Ms Louise Galloway, Victorian Department of Health and Human Services
- Mr Sione Crawford, Harm Reduction Victoria
- Dr Jesse Young and Ms Claire Keen, Justice Health Unit, Centre for Health Equity, The University of Melbourne
- Mr Sam Biondo and Mr David Taylor, the Victorian Alcohol and Drug Association
- Mr Marius Smith, VACRO
- Ms Emma King, Victorian Council of Social Service
- Mr Dan Nicholson and Ms Prita Jobling-Baker, Victoria Legal Aid.
- Interested Parties
- Senior Constable Stefan Boskovic, Coroner's Investigator

Signature:

JACQUI HAWKINS

CORONER

Date 24 February 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Coroners Act.