IN THE CORONERS COURT **COR 2018 002478**

OF VICTORIA

AT MELBOURNE

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Darren James Fielding

Delivered On:	30 October 2023
Delivered At:	Melbourne
Hearing Dates:	1-5 and 8-9 August 2022
Findings of:	Coroner Leveasque Peterson
Representation:	Rose Singleton, Counsel Assisting the Coroner Merys Williams, together with Yusur Al-Azzawi, on behalf of the family Ben Jellis, on behalf of Correct Care Australasia Georgina Coghlan KC, together with Julie Buxton, on behalf of Department of Justice and Community Safety
Keywords:	Death in custody, methadone toxicity, Schedule 8 medications, Code Black response

BACKGROUND

1. Darren James Fielding, known by and referred to as DJ, died in Middleton Prison (**Middleton**) some hours after being administered a dose of methadone in accordance with his Opioid Substitution Therapy Program (**OSTP**) on 26 May 2018.

2. DJ was born on 2 October 1988 to Sharon Staines. Although DJ was subsequently adopted, Sharon maintained a relationship with DJ throughout his life.

3. Helen and Keith Fielding had their first child, Lucas, in 1983 and had tried unsuccessfully to expand their family. In 1989 Helen and Keith were approved to become adoptive parents and in January 1990 DJ became a part of the Fielding family. Shortly after this Helen gave birth to their youngest son, Brent, and the family was complete.

4. Helen and Keith always encouraged DJ to have a relationship with both Sharon and his grandmother, Gail, and DJ continued to have contact with them throughout his life.

5. DJ had a busy and happy family life and good friends throughout his primary school years; however Helen recalled that in Year 2 he became quite disruptive at school and his behavioural problems began to escalate. DJ was eventually diagnosed with attention-deficit/hyperactivity disorder (**ADHD**) and after commencing treatment he seemed to settle down.

6. After his first year at high school Helen and Keith noticed a change in DJ. He became quite anti-social and he displayed behavioural problems during his secondary schooling that led to expulsions from more than one school. Eventually, despite the best efforts of his family and specialist treatment, DJ stopped going to school, began to take drugs and to engage in criminal behaviours. His behaviour had a deleterious impact on the family unit as he was sometimes violent, and much of his offending targeted his own family.

7. DJ subsequently became estranged from Keith although his love for his son never wavered. Helen remained in contact with DJ and was supportive of her son.

8. DJ's criminal offending culminated in him serving several terms of imprisonment.

9. Helen reported that during his last period of imprisonment whilst in the Melbourne Remand Centre (**MRC**), DJ wrote to her about a new relationship with Cheyne Hetherington that he had commenced prior to his imprisonment. He seemed happy to have found Cheyne. Helen felt that these letters signified a change in DJ's attitude to life.

10. In her last telephone conversation with her son Helen observed DJ had seemed "full of hope" and committed to his relationship with Cheyne. Poignantly, prior to his death, DJ told Helen he could "not go back to my old ways…"

CORONIAL INVESTIGATION

11. DJ's death constituted "*a reportable death"* under ss 4(1) (b) and 4 (2) (c) of the *Coroners Act 2008* (**the Act**), as his death occurred in Victoria and immediately before his death, he was a person in custody. Pursuant to s 52(2)(b) of the Act, an inquest was mandatory. The hearing commenced on 1 August 2022 and concluded on 9 August 2022.

12. The Coroners Court of Victoria (**the Court**) is an inquisitorial court[1].The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

13. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

14. The circumstances in which the death occurred refers to the contest or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

15. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the prevention role.

[1] Section 89(4) of the Act.

16. Coroners are empowered to:

    a) Report to the Attorney-General on a death[2];

    b) Comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice[3]; and

    c) Make recommendations to any minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice[4].

17. These powers are the vehicles by which the prevention role may be advanced.

18. It is important to stress that coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death. Further, they are specifically prohibited from including a finding or comment, or any statement that a person is, or may be guilty of an offence. It is also not the role of the coroner to lay or apportion blame, but to establish the facts.

19. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles enunciated in *Briginshaw v Briginshaw*[5].

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

20. On 27 April 2018 DJ was remanded in custody at MRC to await sentencing in relation to a number of criminal offences. On 16 May 2018 DJ was sentenced to three months imprisonment.

21. Whilst DJ was in custody at MRC he commenced OSTP. DJ's prescribed dose of methadone for the first seven days of the OSTP was 10mg a day, in keeping with the

[2] Section 72(1) of the Act.
[3] Section 67(2) of the Act.
[4] Section 72(2) of the Act.
[5] (1938) 60 CLR 336.

applicable guidelines. DJ had previously participated in the OSTP and tolerated doses of up to 65mg daily.

22. On each of the first five days of OSTP at MRC DJ was administered his prescribed 10 mg dose of methadone. On four of those five days at MRC, pursuant to the relevant guidelines, DJ underwent clinical observations by prison health staff. The relevant records indicate nothing unusual was recorded with respect to DJ's health during this period.

23. On 25 May 2018 DJ was on day five of the program when he was transferred from MRC to Middleton.

24. The following day, on the morning of 26 May 2018, Registered Nurses (**RNs**) Jennifer Randall and Nkosinmusa Napier commenced preparations for the administration of methadone doses at the Middleton Medical Centre. DJ was one of several prisoners who received their prescribed methadone dose that morning.

25. Over the hours that followed the OSTP several witnesses in the prison stated variously that DJ appeared to have red eyes and seemed "stoned".

26. One of the prisoners provided a statement that he left the Unit which he shared with DJ and other prisoners to have a visit. When he returned, he went in to check on DJ. He saw DJ lying on his back snoring. Satisfied that DJ was sleeping soundly he turned off the light and closed the door behind him.

27. At approximately 3.15 pm the same prisoner returned to the Unit for the afternoon muster and again checked on DJ. At that time he saw DJ lying on his bed with a bucket next to him and DJ was making noises. He also noticed a brown colour around DJ's mouth. The prisoner alerted other members of the Unit and he went back into the room to try and rouse DJ. At that time DJ felt cold to the touch.

28. The prisoners let the prison officers (**POs**) know that something was wrong with DJ.

29. As soon as the POs were notified of DJ's condition, they implemented a Code Black or medical emergency. POs Plowman and Garsed attended to DJ at approximately 3.20 pm.

They observed a foam like substance around DJ's mouth and found he was unresponsive. At that time PO O'Shannessy arrived to assist. Together PO Plowman, and PO O'Shannessy placed DJ in the recovery position and shortly after that medical staff arrived on site.

30. RNs Randall and Napier responded promptly to the Code Black, arriving 2 to 3 minutes later. The examination revealed DJ was not breathing, his pupils were fixed and dilated, and he had no pulse. RN Napier instructed the POs to call an ambulance and the RNs applied a defibrillator to DJ and commenced cardiopulmonary resuscitation (**CPR**).

31. Ambulance Victoria personnel arrived at the prison at approximately 3.35 pm, following a six-minute delay where the prison gates could not be opened. Once this issue was fixed the ambulance officers proceeded directly to the scene and arrived to render assistance to DJ at approximately 3.43 pm. Notes of the scene completed by Ambulance Victoria staff indicate that CPR was being conducted effectively when they arrived and took over.

32. Sadly DJ was unable to be revived by paramedics and was formally pronounced deceased at 4.29 pm on site.

33. Victoria Police attended the prison and commenced an investigation into the circumstances of DJ's death. DJ's room was searched for items that could be connected to the death. Three items were seized including:

    a. two small plastic bags containing a light purple coloured powder substance;

    b. two small plastic bags containing a dark purple coloured powder substance; and

    c. a sample of red liquid from a glass on the desk.

34. All items later tested negative for common drugs or poisons.

OTHER INVESTIGATIONS

35. DJ's death was reviewed by Justice Health, a business unit of DJCS, who produced a a report dated 14 June 2018. The Justice Health Review found, based on a file review of

DJ's medical record, that there was nothing to suggest the healthcare provided to DJ was not in accordance with the Justice Health Quality Framework 2014. On that basis Justice Health made no recommendations for systemic improvements arising from DJ's death.

36. In addition to the Justice Health review, the Justice Assurance and Review Office (**JARO**) also reviewed DJ's death whilst in custody. Generally, when conducting a review JARO aims to:

    a. Identify whether the prisoner's custodial management was appropriate;

    b. Review the prison's management of, and response to, the incident that led to the death;

    c. Identify whether any improvements could be made to reduce the likelihood of such deaths occurring in the future.

37. JARO noted that following a formal staff debrief, a number of opportunities for improvement were identified in regard to Corrections Victoria' response to DJ's death. This included in relation to:

    a. Staff access to the Employee Assistance Program (EAP);

    b. Activation of the Emergency Control Centre;

    c. Staff training in CPR; and

    d. Delays in opening Gate 3.

38. However, JARO was satisfied that these issues had since been resolved.

39. Further, JARO considered that Corrections Victoria had managed DJ effectively during his most recent term of imprisonment, while noting there had been limited ability to engage with him due to the short time he was imprisoned prior to his death. JARO observed that DJ's Individual Management File reflected good case management practice and that DJ had presented as "forward looking, focussed on maintaining contact with family and friends, including addressing the causes of his offending behaviour."

SOURCES OF EVIDENCE

40. Victoria Police assigned Detective Senior Constable Barker to be the Coroners investigator for the investigation into DJ's death. The Coroners Investigator conducted inquiries on my behalf and prepared a Coronial Brief of Evidence (**the brief**) including statements from the forensic pathologist, prisoners who interacted with DJ prior to his death, prison health officers and prison officers as well as representatives of relevant government agencies and attending police and paramedics.

41. In addition to the brief the Court commissioned two expert reports which were appended to the brief by:

    a. Mr Zeff Koutsogiannis, clinical toxicologist and emergency physician, Austin Hospital; and

    b. Ms Thuy-Van Bui, pharmacist, Alfred Hospital.

42. The inquest ran over seven days. The interested parties included DJ's family, Correct Care Australasia (**Correct Care**) and DJCS.

43. Evidence was given by the following witnesses:

    a. Luke Garsed, prison officer

    b. Michael O'Shannessy, prison officer;

    c. Dr Aiza Morat, MRC medical officer;

    d. Phillip Hughes, prison officer;

    e. Emma Wakker, Ambulance Victoria paramedic;

    f. Nkosinomusa Napier, RN at Middleton;

    g. Jennifer Randall, RN at Middleton;

h. Associate Professor Dr Dimitiri Gerostamoulos, Chief Toxicologist and Head of Forensic Sciences, Victorian Institute of Forensic Medicine (**VIFM**);

i. Dr Linda Isles, forensic pathologist, VIFM;

j. Dr Zeff Koutsogiannis, clinical toxicologist and emergency physician, Austin Hospital;

k. Thuy-Van Lam Bui, pharmacist, Alfred Hospital; and

l. Christine Fuller, Chief Nursing Officer and Deputy Chief Executive Officer at Correct Care.

44. In relation to the evidence of RNs Napier and Randall, there was an application made for an order for these witnesses to be excluded from being present in court for one another's evidence. I granted the application in recognition of the probative value of their evidence and the importance of maintaining the integrity of each witness so the evidence could not be subject to conjecture about collusion or recent invention.

45. This finding is based on the evidence heard at inquest, material tendered during the inquest, the brief, as well as submissions made by Counsel Assisting and the interested parties following the conclusion of the evidence. I will refer to the evidence only insofar as it is necessary for me to comply with my statutory obligations and for narrative clarity.

46. I recognise that the passage of time since DJ's death presented a challenge to witnesses who were required to recall events that occurred a long time ago.

SCOPE OF THE INQUEST

47. The following issues were explored at inquest:

a. The medical cause of DJ's death;

b. The circumstances in which DJ's death occurred in the context of his participation in OSTP with a specific focus as set out below:

i. The appropriateness of practices and procedures for ensuring continuity of opioid substitution therapy when a prisoner is transferred between correctional facilities;

ii. The circumstances of the administration of the prescribed dose of methadone that DJ received on the day of his death;

iii. The appropriateness of, and adherence to, clinical practices, policies and procedures at Middleton Prison Health Centre for the administration of methadone;

iv. The appropriateness of and adherence to, record keeping practices, policies and procedures at Middleton Prison Health Centre for the administration of methadone; and

v. The appropriateness of the response of the registered nurses and correctional personnel to the Code Black.

c. Any remedial measures implemented in respect of the OSTP since DJ's death; and

d. The identification of any further issues that might be taken to prevent similar deaths occurring in the future.

IDENTITY OF THE DECEASED

48. On 30 May 2018 DJ's identity was confirmed on the basis of fingerprint evidence. Identity was not in dispute and required no further investigation.

MEDICAL CAUSE OF DEATH

49. On 27 May 2018, Dr Essa Saeedi, Forensic Pathologist at VIFM performed an autopsy on DJ's body.

50. In a report dated 14 August 2018 Dr Saeedi noted a froth plume, heavy lungs with oedema, congestion, and early changes of bronchopneumonia suggestive of aspiration.

51. Dr Saeedi also confirmed the presence of methadone in post mortem blood samples, and indicated in his report that it was possible methadone may have contributed to DJ's death.

52. The toxicology report dated 2 August 2018, indicated the concentration of methadone detected in DJ's blood sample was 0.5 mg per litre.[6] Expert evidence contained in the toxicology report and given viva voce during the inquest established that there is no threshold dose of methadone that is universally considered fatal. However, the level of methadone detected in DJ's blood sample was within the range of methadone concentration observed in fatal cases.

53. Despite these findings, Dr Saeedi was unable to formulate a cause of death and thus DJ's original cause of death was said to be unascertained.

54. On 5 June 2019, a supplementary report was produced by Forensic Pathologist Dr Linda Iles following a secondary review of relevant materials. Dr Iles noted that there were features of acute bronchitis and early bronchopneumonia. She considered that the corollary of such findings is that the death was not rapid in onset. This is consistent with a death from opioid toxicity, which typically involves a preceding period of central nervous system depression. On the other hand, it is not in keeping with a sudden cardiac death. Taking into account all available information, Dr Iles provided an opinion that the medical cause of death was '*1(a) Methadone toxicity*'.

55. Clinical toxicologist Dr Koutsogiannis gave expert evidence during the inquest and agreed with Dr Isles' conclusion.

56. Furthermore, Dr Gerostamoulos noted that observations of DJ's condition were consistent with how one might present as a result of a methadone overdose.

57. Taking into account all available evidence, I am satisfied that DJ's cause of death was methadone toxicity. This proposition was uncontroversial among the interested parties.

[6] At inquest Dr Gerostamoulos gave evidence that a comprehensive screen was undertaken and the screen can detect a variety of drugs or substances including alcohol, prescribed and synthetic drugs and illicit drugs: Transcript of Inquest, page 376.

58. Significantly, there was also evidence to support a finding that DJ suffered from methadone toxicity because he ingested *more than 10mg* of methadone on the day of his death. The following evidence is relevant in this regard:

    a. DJ's prescribed dose of 10mg daily was considered safe and appropriate.

    b. Methadone was the only substance found in DJ's system during post-mortem toxicology testing. There were no illicit substances or medications detected in DJ's system post-mortem which may have interacted with, or increased the levels of methadone, in DJ's system.

    c. Dr Koutsogiannis, in his report, opined that it would be "extremely unlikely" that DJ experienced a methadone overdose if he had only a 10mg dose of methadone, in circumstances where no other substances were found in his system.[7] In his oral evidence, Dr Koutsogiannis went further and said that DJ "would have had to have had more than 10mg [of methadone] on that day" to have died from methadone toxicity in those circumstances. [8]

59. Taking into account all relevant evidence, I find that DJ did in fact ingest more methadone than the prescribed 10 mg in the period proximate to his death.

60. I have undertaken a closer analysis of the evidence with regard to when and how DJ came to ingest more than his prescribed methadone dose later in this finding.

REVIEW OF OSTP AT MIDDLETON

61. Given the medical cause of death it was appropriate to adduce detailed evidence at inquest about the OSTP at Middleton.

62. The OSTP aims to reduce opioid drug use within prisons. Prisoners can enter the OSTP by way of either induction, if they are assessed at high risk of opioid related harm, or by

[7] Koutsogiannis Report, CB 629, [5]
[8] Transcript of Evidence, p 414 (Koutsogiannis). Further, Dr Bui's evidence was that it was it was possible that DJ experienced fatal respiratory depression following ingestion of an inappropriately high dose of methadone instead of a methadone dose of 10mg: Bui Report; CB 643.

way of a maintenance program, if the prisoners were on a community substitution programme in the community prior to their incarceration.

63. Correct Care is the provider for primary healthcare services at Middleton Prison and as such, Correct Care has responsibility over the operation of OSTP at Middleton. At the time of DJ's imprisonment, the most relevant Correct Care policy in place was titled '*CS12.3 Opioid Substitution Therapy Program issued February 2017*' (**2017 Correct Care OSTP Policy**). This policy governed the practices and procedures for OSTP in a custodial setting.

Days 1-5 of OSTP

64. DJ was assessed and subsequently approved to enter the OSTP whilst he was at MRC.

65. The 2017 Correct Care OSTP policy stipulated that a prisoner must undergo a review by the prescribing practitioner within the first five days of commencing the programme. Christine Fuller gave evidence that in practical terms a five-day review was not always able to be undertaken by the prescribing practitioner and it was accepted practice that an available medical practitioner could undertake the review in such circumstances.

66. DJ was on his fifth day of OSTP when he was transferred from MRC to Middleton. He was therefore due to be reviewed by a medical practitioner.

67. It is clear from the evidence that there was no appointment made by either MRC or Middleton for the five-day review. There is no recorded appointment in DJ's JCare record and Ms Fuller gave evidence that an appointment would ordinarily be recorded in JCare. As such, I find that DJ did not receive a five-day review at either MRC or Middleton as was required by the policy.

68. RN Randall completed a transfer assessment of DJ on 25 May 2018 but was unaware that DJ had not undergone his five-day review. RN Randall also gave evidence that at that time the only way she could have become aware that DJ had missed his five-day review was by undertaking a thorough review of the prisoner's file. RN Randall in this context

observed that there was not "*time to go right through their notes so you just sort of presume that you know, where they have come from has done what was required"*[9].

69. I accept the evidence given by RN Randall that, had she been aware DJ had missed the five-day review she would have made an appointment for DJ to see a medical practitioner at the next available opportunity.

70. Further, I am satisfied that at the time of DJ's death, Correct Care did not have a formal mechanism in place to ensure that, in the event of prisoner transfers, clinical staff at the receiving prison are made aware of milestone dates for clinical reviews and other medical appointments, including the OSTP five-day review.

71. Despite this administrative deficiency and the departure from policy, I am not satisfied that the failure to conduct a five-day review contributed to DJ's death. Whilst it is highly desirable that a review is conducted within the recommended timeframe, noting that evidence was heard that prisoners are particularly vulnerable to methadone toxicity during this period, there is ample evidence that the low dosage that DJ was prescribed during the relevant period was both safe and appropriate.

72. In evidence Ms Fuller advised the Court that this gap had now been addressed by the introduction of a system that automatically generates a list of a prisoner's pending appointments from the transferring prison and this is recorded in JCare. Ms Fuller indicated that this list is available to the receiving nurse who conducts the transfer assessment, and the nurse is responsible for rebooking those appointments at the receiving prison at the time of transfer. This change is also now reflected in the relevant Local Operating Procedure (**LOP**) for Middleton.

Day 6 of OSTP

73. On 26 May 2018, DJ required an Imprest dose of methadone because he had transferred to Middleton the previous day and no pre-dispensed dose was available for him.

[9] Transcript of evidence, p 260 (Randall).

74. It is clear on the evidence that RN Napier prepared three Imprest doses that day, including one for DJ, and that RN Randall administered a methadone dose to DJ.

75. However, the evidence is unclear as to when DJ's dose was prepared and administered and whether the required processes were undertaken to ensure that DJ was provided with the correct, prescribed dosage.

Circumstances of the administration of methadone doses on 26 May 2018

76. On the morning of 26 May 2018 DJ attended the Middleton Prison Health Centre for his methadone dose. RN Randall and RN Napier were on duty in the OSTP clinic that day.

77. In addition to the statements and oral evidence of the nurses, the Court was provided with the following documents relevant to this issue:

    a. The Schedule 8 Register that recorded methadone doses dispensed in pre-packaged containers;

    b. The Schedule 8 Register that recorded doses of methadone drawn from the on site Imprest stock;

    c. The methadone administration records for DJ and two other prisoners which were filled out and signed by a RN and the prisoner; and

    d. The OSTP Attendance record which is usually filled out by a prison officer.

78. If implemented as intended, the Registers together with the methadone administration records and the OSTP Attendance Record should create a complete picture of precisely what occurred during the OSTP. Each of the documents contains information that, in the normal course of events, can be reconciled or used as a double verification of the identities of recipients, the specific doses that were administered to each prisoner, and a running total of Imprest Stock left after a dose had been drawn down. These documents should also operate as a record of any activity out of the ordinary that has impacted on the available methadone on site, whether it is Imprest stock or pre-packaged doses.

79. The Court heard evidence the process of the OSTP clinic was that prisoners first attended a waiting room then passed through to the dosing area after which they were required to stay in the holding room where prison officers observed them for a period of approximately five minutes.

80. The Court heard that prisoners presented to the OSTP clinic on an ad hoc or first come first served basis. A maximum of five prisoners were permitted in the waiting room at once during the clinic.

81. Prisoners then moved into the dosing area one at a time. They presented to one of the RNs at a window where their identity was verified, and they received and consumed their dose of methadone in the dosing room.

82. The evidence established that a dose of methadone was given either from the pre-packaged bottles, or in circumstances where a pre-packaged dose was not available, the dose was drawn from the Imprest stock held on site. It was then mixed with water for the prisoners to drink.

83. Once the prisoners consumed their methadone, they would proceed to the holding room where they would be observed by prison officers for a minimum of five minutes. The purpose of the holding room was described as a means of ensuring that prisoners did not divert their methadone dose thereby preventing illicit exchanges and ingestion of non-prescribed drugs by other prisoners.

Evidence concerning DJ's methadone dose administration

84. RN Napier had no clear and independent recollection of her actions on 26 May 2018. She gave evidence that her usual process would be as follows:

    a. She would check the prisoner's prescribed dose against a hard copy of their prescription;

    b. She would draw up the relevant dose from the Imprest stock bottle;

    c. She would transfer the dose from a syringe to a medicine cup;

d. She would label the cup with the prisoner's name using a permanent marker; and

e. She would put the labelled medicine cup on top of a hard copy of the relevant prescription and the relevant sign in sheet on the window bench in the dosing room.

85. Similarly, RN Randall had no clear and independent recollection of her actions on 26 May 2018. She gave evidence that her usual process for administering methadone to prisoners was as follows:

a. She would check the prisoner's identification against the relevant Methadone Administration Record and prescription which were contained in a folder located in the dosing area;

b. For prisoners with a pre-packaged dose she would take the relevant bottle from a box with the prisoner's name on it which was kept in a safe. The box was labelled with the relevant name, CRN, dose and date;

c. For prisoners that did not have a pre-packaged dosage she would pick up the pre prepared Imprest dose from the bench in the dosing room;

d. She would check the pre-prepared dose against the prisoner's prescription; and

e. She would pour the dose into a cup of water and hand it to the prisoner.

86. With regard to the administration of methadone to DJ on 26 May 2018, there was a lack of clarity in evidence.

87. RN Napier gave evidence that at some time after she prepared an Imprest dose for DJ, she observed RN Randall check the dose in the cup against the medication chart.[10] RN Napier gave evidence that she did not recall whether she verbally communicated the dose to RN Randall.

88. RN Randall had no specific memory of checking the Imprest doses on 26 May 2018, however she indicated that her usual process was to check the dose drawn in the syringe,

[10] Transcript Napier pp 196-7

not the cup. RN Randall also gave evidence it was not her usual process to check the dose against the prescription at the time. RN Randall said that RN Napier would instead tell RN Randall what the methadone dose was supposed to be in the syringe and RN Randall would examine the syringe to verify that amount was in fact in the syringe.

89. Despite a lack of clear recollection of relevant events on 26 May 2018, both RNs were steadfast in their evidence that DJ received the correct dose of methadone on the day.

Evidence regarding other methadone doses during the OSTP of 26 May 2018

90. Evidence also emerged at the inquest from both RNs Randall and Napier that another prisoner, referred to in these proceedings as XYL, spilled his pre-packaged dose of methadone when he presented to the OSTP clinic on 26 May 2018.

91. RN Napier had a limited recollection of the spill in that she could not remember how or precisely when the spill occurred however, she did recall asking RN Randall to draw up a replacement dose from the Imprest stock.

92. RN Randall also did not have a specific recollection of the circumstances of the spill; however she gave evidence that a prisoner spilled their cup of pre-packaged methadone and it spilled onto her side of the dosing window.

93. The spill is not recorded in either of the Schedule 8 Registers, nor on any other record that was available to the Court.

94. There are four records from the OSTP clinic that refer to inmate XYL:

    a. The Imprest Schedule 8 register which contains an entry for XYL at 8.35 am. Evidence from RN Napier was that she filled out the register at or around the time she administered the dose (by implication this must have occurred after the pre-packaged dose was spilled);

    b. The Methadone Multidose register contains an entry for 8.46 am for a pre-filled methadone bottle. RN Randall gave evidence that her usual practice was to fill out

the Register in the presence of the prisoner, and that she would have filled it out regardless of whether it was consumed or spilled;

c. XYL's Methadone Administration record which contains an entry for 8.45 am signed by both XYL and RN Randall. RN Randall's evidence was her usual practice was to sign and have the prisoner sign this record around the time she got their dose;

d. The OSTP Attendance Record completed by a prison officer which records the time that XYL entered the holding room as 8.48 am.

95. As Counsel Assisting has submitted, the timings in these records present as confusing and seemingly inaccurate. There is no ready explanation as to why RN Napier would have drawn up XYL's Imprest dose at 8:35 am if XYL signed for his pre-packaged methadone dose some ten minutes later at 8:45 am and then entered the holding room at 8:48 am.

96. RN Napier suggested that the variance in the entries may have been the result of a difference in time on her watch as compared to the Clinic clock. However, this does not offer any explanation for why the Imprest Schedule 8 Register also records doses being drawn up for prisoners in a different order than the Methadone Administration Records and OSTP Attendance Records.

97. These inconsistencies in the recorded entries, as well as RN Napier's equivocation about both the timing and the order of her methadone dispensing, made it difficult to accept the accuracy of her recollection and her evidence.

98. Other evidence that bears on the question of the level of DJ's methadone dose from OSTP clinic was contained in the statements of several prisoners who observed DJ after his visit to the OSTP clinic, around midday:

a. In his statement, a prisoner referred to in these proceedings as XZB reported that sometime shortly before the midday muster DJ said to him "*he felt like he had an extra dose on his methadone…"*

b. A prisoner referred to in these proceedings as XZE also stated that DJ told him "*I don't know what they've done with my methadone…I think it was too much*".

99. Whilst these statements were not tested during inquest, I accept the submissions of Counsel Assisting that some weight can and should be afforded to the prisoners' statements on the basis that the statements were made on the day of DJ's death and therefore offer a relatively contemporaneous record of events which was made at a time that neither prisoner could have known that DJ's death was from methadone toxicity.

Conclusion

100. As discussed above, I consider that there is sufficient evidence to conclude that DJ suffered from methadone toxicity because he ingested *more than 10mg* of methadone on the day of his death. This finding raises two possible propositions:

a. That DJ was administered the correct dosage of 10 mg of methadone at the OSTP clinic and he ingested more methadone from another source on the morning of 26 May 2018; or

b. That DJ was administered more than 10 mg of methadone at the OSTP Clinic.

101. It is necessary to consider the relative strength of each propositions, taking into account all available evidence.

102. In support of the first proposition the Court heard from Ms Fuller that methadone dose diversion was a recognised problem at Middleton in 2018 as it was across the prison system generally. As pointed out in submissions, the OSTP LOP in force at the time contained specific instructions on the various ways methadone doses could be diverted. Furthermore, Ms Fuller also acknowledged that methadone could be obtained illegally through means other than dose diversion at both Middleton and in prisons more generally. In relation to this proposition, I accept that although I have no direct evidence upon which to make a finding that DJ obtained an additional dose of methadone either as a diverted dose or through other illicit means, the possibility of this occurring cannot be

excluded. I therefore do not accept the submission put on behalf of DJ's family that "*Medication error is the only cogent explanation…*"

103. As to the second proposition, despite the unsatisfactory state of record keeping and the equivocal evidence about crucial details such as the timing and order of the methadone dosing in the OSTP Clinic on 26 May 2018, I agree with the submissions of Counsel Assisting that the available evidence is not sufficient to support a finding that DJ was provided an incorrect or higher dose of methadone by Correct Care nursing staff.

104. I find that RN Randall and RN Napier did not adequately or accurately record entries relating to methadone dose administration on 26 May 2018 and further that this failure occurred in breach of relevant policies and procedures.

105. I further find that deficiencies in record keeping by Correct Care staff presented an impediment to the investigation into the circumstances of DJ's passing.

ADEQUACY OF THE EMERGENCY RESPONSE

106. During the inquest there was contradictory evidence given by the POs as to whether the POs commenced CPR. PO Garsed recalled compressions having commenced before the medical staff arrived however his contemporaneous notes stated that "Medical started CPR".

107. As conceded by DJCS, I find that the POs did not commence CPR on DJ, and that CPR was commenced by RN Napier and RN Randall once they arrived to assess and attend to DJ. However I agree with submissions by DJCS that it would not be appropriate to draw any adverse finding from this fact. The actions of the POs in responding to DJ's presentation were timely and appropriate in the circumstances, and the evidence suggests that DJ could not have been saved had CPR been commenced immediately upon discovery. This is because there was evidence that DJ was already in cardiac arrest at that time and that his condition was irretrievable at this point.

108. Similarly, although the delay in opening the prison gates was unfortunate, I am satisfied that the delay did not cause or contribute to DJ's death.

109. Overall, I am satisfied that the POs and medical staff undertook a timely and appropriate response to the Code Black and I find that none of the actions of prison officers, medical staff or Ambulance Victoria caused or contributed to DJ's death.

REMEDIAL MEASURES IMPLEMENTED SINCE DJ'S DEATH

110. Since DJ's death Correct Care has implemented a number of changes concerning OSTP:

    a. The Court heard evidence that ambiguous language regarding the monitoring and observation schedule for the induction phase of OSTP has now been clarified to make the precise duration of the observation period more clear;

    b. A new LOP has been implemented at Middleton Prison that requires any scheduled review or monitoring appointments of OSTP prisoners who are to be transferred to be rebooked at the time of transfer, and health care staff are responsible to take active steps to follow up prisoners who miss a scheduled observation. The LOP also requires that prisoners' methadone dose is not administered until the scheduled observation has been completed.

111. In relation to the gate system at Middleton, the prison has:

    a. conducted training sessions for gatehouse and control room staff;

    b. upgraded software used in the Security Management System;

    c. posted signage outlining instructions about accessing the manual override key in case of a system failure during an emergency; and

    d. incorporated a weekly gate override training and testing exercise.

112. The Department also outlined changes that it had implemented since DJ's death, including:

    a. The introduction of long acting injectable buprenorphine in Victorian prisons, which is administered once per week or once per month, with benefits including that there is less risk of diversion and non-medical use of the medication; and

b. A full review of the Department of Justice & Regulation – Victorian Opioid Substitution Therapy Program Guidelines 2015 which was due by June 2023.

FINDINGS AND CONCLUSION

113. Having held an inquest into the death of Darren Fielding, I make the following findings pursuant to section 67 (1) of the Act:

    a. The identity of the deceased was Darren James Fielding, born on 2 October 1988;

    b. The death occurred on 26 May 2018 at Middleton Prison;

    c. As a result of methadone toxicity; and

    d. The death occurred in the circumstances set out above.

COMMENTS

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

114. The inconsistencies and discrepancies between the documents that variously purported to record the preparation and administration of methadone at the OSTP clinic on 26 May 2018 have impeded my ability to make findings as to the circumstances in which DJ received a methadone dose that morning.

115. Consideration of the relevant records has revealed clear inadequacies in recordkeeping on 26 May 2018, noting that:

    a. Despite giving clear evidence that a spill occurred, RN Randall did not make any record of a spill in the Schedule 8 Methadone Multidose Register; and

    b. RN Napier crossed through an entry in the Imprest Schedule 8 Register (the column titled "Methadone' in respect of the dose of another prisoner known in these proceedings as XYG) rendering the number underneath largely illegible.

116. This was despite requirements in the 2017 Correct Care Controlled Substances Policy that:

a. if discarding a part of a controlled substance when preparing a dose this should be recorded in the register;

b. the register must show the signature of a person making the entry (including when discarding); and

c. records in the register must be made contemporaneously.

117. The above policy requirements reflected the requirements of Part 13 of the DPCS Regulations force at the time, which required that "discarded" methadone doses be recorded in Schedule 8 Registers as soon as practicable.

118. As a result of these inadequacies, it is not possible to positively exclude that an incorrect and higher dose was given to DJ on the morning of 26 May 2018 by Correct Care nursing staff which was higher than his prescribed dose.

119. Given this possibility cannot be positively excluded, it is open to me to make comments and recommendations in respect of the delivery of the OSTP program by Correct Care at Middleton.

120. On this basis, I find that there is scope for improvement in Correct Care nurses' understanding of Schedule 8 administration and record-keeping requirements and have made relevant recommendations below.

RECOMMENDATIONS

I make the following recommendations connected with the death under section 72(2) of the Act:

(i) That Correct Care Australasia review its Controlled Substances Management Policy and ensure that the policy provides a clearly articulated procedure for the preparation, labelling and storage of Imprest stock, including in particular, a direction that the Imprest stock bottle should be weighed and the details of the running weight recorded between each dose being drawn from the Imprest stock bottle.

(ii) That Correct Care Australasia provide instruction to relevant staff of the importance of maintaining accurate records in relation to Schedule 8 medications and, specifically, that any spill must be contemporaneously recorded, that times entered in relevant registers must be accurate, and that any errors made must be amended in compliance with policy requirements.

I order that this finding is to be published on the Internet.

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

Cheyne Hetherington, Senior Next of Kin
Keith and Helen Fielding, Parents
Correct Care Australasia
The Department of Justice and Community Safety
Scott Swanwick, Justice Health
Michelle Gavin, Justice Assurance and Review Office
Amie Herdman, Ambulance Victoria

Signature:

CORONER Leveasque Peterson

Date: 9 November 2023

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 inquest. 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 Act.