IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 0753

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Findings of:	**DARREN J. BRACKEN, CORONER**
Deceased:	**MARK SKIDMORE**
Delivered on:	29 September 2022
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	7 and 8 July 2021
Counsel assisting the Coroner:	Acting Sergeant Darren Cathie
Appearances:	Mr M. McLay appeared on behalf of St Vincent's Health Mr R. Harper appeared on behalf of G4S Custodial Services Pty Ltd
Catchwords:	"Death in custody", "Port Phillip Prison", "Unascertained Cause of Death", "Opioid Substitution Program", "OSTP", "Methadone"

“Consumption of Prescribed Drugs”, “Consumption of Drugs not Prescribed”.

HIS HONOUR:

BACKGROUND

1. On 14 February 2017 Mr Skidmore was found deceased in his cell in the Charlotte Unit at Port Phillip Prison.[1] Mr Skidmore was last seen when he was spoken to by prison staff on 13 February 2017.

THE PURPOSE OF A CORONIAL INVESTIGATION

2. Mr Skidmore's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**); his death occurred in Victoria and was unexpected or unnatural or both. Further, because Mr Skidmore was a person under the care, control or custody of the Secretary to the Department of Justice[2] and pursuant to section 52(2) of the Act, was 'in custody' when he died, an inquest is mandatory.

3. The Act requires a Coroner to investigate reportable deaths such as Mr Skidmore's and, if possible, to find:

   (a) The identity of the deceased;

   (b) The cause of the death; and

   (c) The circumstances in which the death occurred.[3]

4. For coronial purposes, "*circumstances in which the death occurred*"[4] refers to the context and background of the death including the surrounding circumstances. Rather than being a consideration of all the circumstances which might form part of a narrative, culminating in the death, required findings in relation to circumstances are limited to those circumstances which are sufficiently proximate to be considered relevant to the death.

[1] The Charlotte Unit is a management unit. The cells are single prisoner cells. Prisoners are permitted exercise out of the cells for 1 hour per day.
[2] *Coroners Act 2008* (Vic) s 4.
[3] *Coroners Act 2008* (Vic) preamble; s 67.
[4] *Coroners Act 2008* (Vic) s 67(1)(c).

5. The Coroner's role is to establish facts and not to attribute or apportion blame for the death.[5] Nor is it the coroner's role to determine criminal or civil liability[6] or to determine disciplinary matters.

6. One of the broader purposes of coronial investigations is to reduce the number of preventable deaths in the community and Coroners may:

   (a) Report to the Attorney-General on a death;[7]

   (b) Comment on any matter connected with the death including matters of public health or safety and the administration of justice;[8] and

   (c) Make recommendations to any minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[9]

7. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities applying the principles of such proof set out by the Justice in *Briginshaw v Briginshaw*.[10] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[11] Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the finding, and effect.[12]

8. Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[13] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[14]

---

[5] *Keown v Khan* [1999] 1 VR 16.
[6] *Coroners Act 2008* (Vic) s 69(1).
[7] *Coroners Act 2008* (Vic) s 72(1).
[8] *Coroners Act 2008* (Vic) s 67(3).
[9] *Coroners Act 2008* (Vic) s 72(2).
[10] (1938) 60 CLR 336, pp. 3662-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte; Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 9, 95.
[11] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J by reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings* (1992) 67 ALJR 170 at pl 70-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[12] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.
[13] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[14] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J; *Cuming Smith & Co Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pl 70-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

Such a description should be interpreted in the context of the coronial jurisdiction being inquisitorial and having nothing to do with guilt or innocence.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased - section 67(1)(a) of the *Coroners Act 2008*

9. On 16 February 2017, the Deceased was identified by his fingerprints as Mark Skidmore, born 24 December 1972.

10. Mr Skidmore's identity is not in dispute in this matter and therefore requires no further investigation.

Cause of death - section 67(1)(b) of the *Coroners Act 2008*

11. On 17 February 2017, Dr Essa Saeedi, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr Skidmore's body and in his resultant report dated 18 June 2017 concluded that despite a comprehensive examination, the medical cause of Mr Skidmore's death was '*Unascertained*'.

12. Toxicological analysis of post-mortem blood and urine specimens taken from Mr Skidmore identified the presence of methadone (and its metabolite, EDDP),[15] mirtazapine,[16] clonazepam (and its metabolite, 7-aminoclonazepam),[17] paracetamol,[18] tramadol,[19] and pregabalin.[20]

Circumstances in which the death occurred - section 67(1)(c) of the *Coroners Act 2008*

The Inquest

13. I held an inquest into Mr Skidmore's death over 7 and 8 July 2021 during which three witnesses were called.

[15] Methadone is a synthetic narcotic analgesic available in Australia as Biodone Forte (Oral Liquid), Methadone Syrup or Physeptone (tablets) in 5 mg/mL syrups or 10 mg tablets respectively. Methadone is used for the treatment of opioid dependency (methadone maintenance programmes, MMP) or for the treatment of severe pain.
[16] Mirtazapine is indicated for the treatment of depression.
[17] Clonazepam is a benzodiazepine related to diazepam possessing sedative and anticonvulsant properties.
[18] Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs such as codeine and propoxyphene.
[19] Tramadol is a narcotic analgesic used for the treatment of moderate to severe pain.
[20] Pregabalin, an analogue of the inhibitory neurotransmitter gamma-aminobutyric acid is used clinically as an analgesic, anticonvulsant and anxiolytic agent.

14. Whilst Dr Saeedi determined that even after conducting an autopsy, he was unable to determine the cause of Mr Skidmore's death he made reference to the autopsy revealing:

    (a) Focal myocardial fibrosis.

    (b) Left ventricular hypertrophy.

    (c) Fat infiltration and disarray at the posteroseptal left ventricular wall .

    (d) Mild inflammation with thickening of the airway basement membranes in the lungs.

    (e) Moderate steatosis with mild periportal mixed inflammation.

    (f) Clear cell papillary renal cell carcinoma (with no evidence of metastatic disease).

    (g) Testicular and prostatic atrophy (in keeping with a history of Klinefelter Syndrome) and

    (h) Foreign body giant sells with polarisable crystalloid material in the antecubital fossa skin.[21]

15. Dr Saeedi referred to the 'toxicological analysis' revealing:

    (a) Methadone,

    (b) Mirtazapine,

    (c) 7-aminoclonazepam a metabolite of clonazepam,

    (d) Tramadol,

    (e) Paracetamol and

    (f) Pregabalin.

16. Dr Saeedi referred to Mr Skidmore's heart being larger than is normal for a male of his height but not weight, and to non-specific changes seen in histological examination of samples from the heart showing interstitial fibrosis , myocyte hypertrophy and disarray falling short of "…*the criteria required for a diagnosis for a specific inherited disease entity which may cause death secondary to arrhythmias.*" Dr Saeedi noted no evidence of injury to Mr Skidmore's body which may have caused or contributed to death.

[21] Medical Examiner's Report, Page xxvi Inquest Brief.

Dr Saeedi referred to Mr Skidmore's 'C-reactive protein (a marker of inflammation within the body) being mildly elevated in keeping with the presence of patchy inflammation in his lungs.

17. Dr Saeedi referred to;

> "…*Many of these drugs* [those found by toxicological analysis of samples] *have a central nervous depression effect and are capable of causing respiratory depression and suboptimal protection of the airways. It is certainly possible that methadone may have contributed to his death as deaths related to its use most commonly occur during the induction phase (within days of commencement of dosing) occur with concurrent use of other drugs with central nervous system depressant potential such as clonazepam and tramadol. It appears he was not prescribed clonazepam and tramadol which were detected as metabolites in the blood and urine.*".

18. Dr Saeedi opined that determining the significance of the levels of drugs detected at post mortem was complicated by post mortem redistribution and the development of tolerance to the effect of some of those drugs.

Dr Gerostamoulos

19. At my request Dr D Gerostamoulos, a Toxicologist and Pharmacologist practising at the Victorian Institute of Forensic Medicine provided a report in relation to the drugs detected in the deceased's system and their contribution to death.[22]

20. In his report Dr Gerostamoulos referred to the drugs found in Mr Skidmore's toxicology sample and to the drugs that had been prescribed for him. Dr Gerostamoulos referred to Mr Skidmore's history of 'drug over-doses' and gave evidence that ;

> "…*clinically significant respiratory disease and asthma….clinically significant liver disease….The last urine drug screen that was conducted on Mr Skidmore was 27/01/2017 (page 9/132 medical records and was negative for drugs of abuse….Mr Skidmore was not prescribed clonazepam or tramadol which were detected in Mr Skidmore's post-mortem samples collected at autopsy."*.

21. Dr Gerostamoulos referred to methadone, mirtazapine, clonazepam, tramadol and pregabalin being capable of depressing the central nervous system leading to "… *diminished respiratory function, unconsciousness and death*."

[22] Statement of Dr D Gerostamoulos dated 3 December 2017.

Dr Gerostamoulos canvassed Mr Skidmore's methadone 'dosing regime', his dose being reduced on 13 February 2017 at his request and the medical records showing "…*no indication that Mr Skidmore was suffering any adverse effects to the doses of methadone he was receiving nor in combination with other medication being administered.* Dr Gerostamoulos, like Dr Saeedi referred to blood concentrations of methadone post-mortem being elevated due to redistribution from neighbouring tissue, "…*this increase can be substantial and is likely to be at least a factor of two from peri-mortem concentrations*." Dr Gerostamoulos referred to the dose of unprescribed clonazepam taken by Mr Skidmore being unknown.

22. Dr Gerostamoulos explained that unprescribed use of benzodiazepines by those on opioid substitution programs can result in unwanted side effects adding to the depressant side effects of other drugs acting on the central nervous system. Dr Gerostamoulos referred to Mr Nurse Sharpe examining Mr Skidmore on 13 February 2017 and of her notes recording that Mr Skidmore was alert and orientated with his respiratory rate normal and of him nor reporting any issues of ill effects and indeed, he was reported as engaging appropriately and that his speech was normal.[23] On this basis Dr Gerostamoulos opined that Mr Skidmore most likely consumed clonazepam after that assessment. Dr Gerostamoulos considered it possible that Mr Skidmore also consumed Tramadol, a narcotic analgesic which was not prescribed for him, after this assessment.

23. Dr Gerostamoulos made clear that death can be the result of a person taking clonazepam and tramadol unsupervised with methadone and in summary explains that "…*the combination of methadone, mirtazapine, clonazepam, tramadol and pregabalin may have led to diminished respiratory function, unconsciousness and death*.".

24. Dr Gerostamoulos gave evidence that despite him initially understanding that Mr Skidmore had been given 30mg of methadone daily between 8 and 14 February 2017 that he was in fact given 20mg daily for those days, but that made no difference to the opinions that he expressed in his statement.[24]

25. Dr Gerostamoulos gave evidence that the reason people are put on to methadone programs is to try to deal with their opioid misuse whether that involves a misuse of buprenorphine or another opioid such as heroin.

[23] Dr Gerostamoulos refers to Mr Skidmore's medical notes.
[24] T.19. - 20.

26. Dr Gerostamoulos gave evidence that:

(a) Testing blood or urine of those to be commenced and undertaking opioid substitution programs was difficult and only something that is possible in a 'forensic lab' rather than a pathology service.[25]

(b) Whilst there was a possibility that the combination of methadone, mirtazapine, clonazepam and tramadol resulted in Mr Skidmore's death toxic symptoms aren't always observed and they usually die in their sleep as a result of their shallow breathing.

Dr D Joseph

27. Dr Joseph is the medical director of St.Vincent's Correctional Health Service and made two statements for the Inquest Brief.[26] Dr Joseph also provided written responses to requests for written information and gave *viva voce* evidence that:

(a) Mr Skidmore had told St.Vincent's staff that he had been using Buprenorphine and wanted to 'get onto' the Opioid Substitution Program (OSTP)on a number of occasions.[27]

(b) If a prisoner to seeks to commence on the OSTP at one prison, assessment to consider the appropriateness may begin. If the prisoner is transferred to another prison the assessment process then needs to start again at the second prison, and that there is a 'siloing' difficulty which was still in place as a 7 July 2021.[28]

(c) Assessment for commencement of suitability for the OSTP program needs to begin and conclude at one prison and 'they' want to be certain that assessments are consistent for six weeks and monitored for two weeks afterward.[29] Prisoners on the OSTP program who are found to have taken unprescribed medication are taken off the program and not returned to it for six months.[30]

(d) Those on the OSTP program are not screened to check if they are using other drugs unless there is something that comes to light to suggest that they may be.[31]

[25] T.17.- 19.
[26] Statement of Dr D Joseph dated 10 August 2020, 14 August 2020 (p.29 Inquest Brief) and 20 April 2021 (p.34 Inquest Brief).
[27] T.51-52.
[28] T.53-54.
[29] T.54.
[30] T.67-68.
[31] T.62-63.

(e) Managing prisoners on a OSTP program is a complex process especially if they are discovered using unprescribed medication whilst on the program.[32]

Ms Patricia Sellman

28. Ms Sellman, the General Manager Port Phillip Prison provided a statement for the Inquest Brief dated 17 May 2021 and gave *viva voce* evidence.

29. Ms Sellman gave evidence that:

(a) Up until then recently, only 'general purpose dogs' at the prison were trained to detect buprenorphine but that those which were used to search cells were not. That has since changed and now dogs used to search cells are so trained.[33]

(b) Dogs used in prisons are not trained to detect prescription drugs.[34]

(c) 'ION Scanners' are only used at barrier searches.

(d) Dogs are used to screen staff entering the prison on a randomly selected or targeted basis.[35]

(e) Staff and others entering Charlotte Unit, including visitors are not, as a matter of course again screened for drugs etc.[36]

(f) Empty cells are not routinely searched by dogs before a new occupant arrives. "…*there is a small chance that contraband could be left in the cell*." New prisoners to Charlotte Unit are all 'strip-searched before being housed although dogs and ION scanners are not used.[37]

(g) Because Charlotte is a management unit, prisoners only have an hour out of their cells per day. Some prisoners can select other prisoners to accompany them on their 'run-out'.[38]

(h) Five percent of the prison population, (50-60 prisoners) are randomly selected for drug testing every month.

[32] T.82-84.
[33] T.93-94.
[34] T.94.
[35] T.94-95.
[36] T.95.
[37] T.96-97.
[38] T.98.

(i) The most common route for drugs into Port Phillip prison is visitors.[39]

(j) Even despite not all prisoners in the Charlotte Unit having visitors, and most not having contact visits, the most common route of drugs into Charlotte Unit is visitors. 'Billet' prisoners can pass drugs between cells including in Charlotte Unit.

(k) Mr Skidmore was housed in the Charlotte Unit from 21 December 2016 until his death on or about 14 February 2017. She was surprised that during this period Mr Skidmore made references to health staff about having used buprenorphine, one of which was on his arrival on 21 December 2016. The second reference was on 19 January 2017 when he referred to having been heavily using buprenorphine for six months. Neither of these reports were brought to the attention of correctional staff.[40]

(l) At any one time there are between 200 and 300 prisoners at Port Phillip Prison on the OSTP.[41]

(m) Just because a prisoner says that he has been using illicit drugs in prison and is seeking to get onto the OSTP, prison staff do not simply believe the assertion of illicit drug use. Some prisoners who use illicit drugs before coming into prison maybe motivated to say that they have been using illicit drugs in prison because they are unable to obtain those drugs in prison and see admission to the OSTP as an alternative.

(n) There have been considerable changes at Port Phillip Prison since Mr Skidmore died including:

(i) Previously only one dog was available, now there are two or three on any given day

(ii) Increased CCTV capability by installing "…*hundreds of new cameras all over the site and around the perimeter so that helps in terms of detecting any 'throwovers' and any suspicious activity within units*.

(iii) Increase in resourcing of the prison intelligence unit.

(iv) The rate of 'positives' for drug testing has declined from about 15% to 2.9%.

[39] T.101,104.
[40] T.108-109.
[41] T.121.

CONCLUSIONS AND FINDINGS

Conclusions

30. As at 14 January 2017 Mr Skidmore suffered from a number of comorbidities and had a medical history nominating a number of others. Toxicological analysis revealed that Mr Skidmore had consumed both prescribed and unprescribed drugs which Dr Gerostamoulos and Dr Saeedi described as depressing central nervous system function and in combination potentially causing death. In his report Dr Gerostamoulos referred to the combination of drugs diminishing central nervous system function to the point of unconsciousness and death, a proposition with which Dr Saeedi agreed. Despite extensive investigation but in the context to which I have referred, Dr Saeedi was unable to ascertain a specific cause of Mr Skidmore's death.

31. I have not been able to determine how Mr Skidmore obtained the drugs found in his system which had not been prescribed to him. I have considered Dr Gerostamoulos' opinion that Mr Skidmore consumed unprescribed clonazepam and Tramadol after he was assessed by nurse Sharpe on 13 February 2017. It is at the very least, possible that Mr Skidmore's consumption of drugs not prescribed to him in combination with his prescription medication caused his death. Given the evidence of Dr Saeedi and Dr Gerostamoulos however, I am not prepared to make such a finding.

32. The facts of Mr Skidmore's treatment in prison and his death raise the perennially difficult issue of confidentiality between prisoners and medical staff on the one hand, and on the other, medical staff reporting what prisoners tell them about them obtaining using illicit drugs . There is no simple solution to such a dilemma and each decision made by medical staff to disclose what a prisoner tells them to custodial staff or not, must balance the prisoner's welfare and the safe operation of the prison. The damage done to a particular prisoner by revealing information may reach further than that prisoner and at the very least has the potential to undermine the operation of health services at the prison by seriously discouraging prisoner's from frankly disclosing information about their conduct to those trying to treat them.[42]

[42] T112-115.

33. Commencing prisoners on an opioid substitution program too requires judgement and balancing of a prisoner's real needs and at least potentially a desire to ameliorate the stresses of prison life with some kind of opioid.

34. Both The Justice Assurance and Review Office and Justice Health conducted reviews in relation to the circumstances of Mr Skidmore's death and made no 'causative' recommendations.

35. Despite considering Mr Skidmore's comorbidities and medical history, his use of prescribed drugs together with drugs which he was not prescribed, and the effect of such a drug cocktail including on his central nervous system, no specific cause of his death can be determined. The cause of Mr Skidmore's death is 'unascertained'.

Findings

36. Having held an inquest and investigated the death of Mark Skidmore, pursuant to section 67(1) *Coroners Act* (2008) I find that:

(a) The identity of the deceased was Mark Skidmore, born 24 December 1976.

(b) Mr Skidmore died on or about 14 February 2017, at Port Phillip Prison, 451 Doherty's Road, Truganina, Victoria, from unascertained causes and

(c) his death occurred in the circumstances set out above.

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

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

(a) Mr Keith Skidmore, senior next of kin;

(b) Donna Filippich, St Vincent's Health;

(c) Ingrid Nunnink, Marsh & Maher;

(d) Kelli Dell'Oro, Meridian Lawyers;

(e) Michelle Gavin, Justice Assurance and Review Office; and

(f) Senior Constable David Reynolds, Coroner's Investigator, Victoria Police.

Signature:

_____

DARREN J. BRACKEN

CORONER

Date: 29 September 2022.