CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of Mark Anthony O'Connor**
Citation:	**[2019] ACTCD 4**
Inquest Dates:	22 & 23 January 2019
Last Submissions:	26 April 2019
Findings Date:	26 June 2019
Before:	**Coroner Theakston**
Decision:	See [34]-[35], [51]-[52]
Catchwords:	**CORONIAL INQUEST** – Death in Custody
Legislation Cited:	*Coroners Act 1997* (ACT) s 13(1)(i)
Parties:	Counsel Assisting the Coroner The Family of Mark O'Connor Australian Capital Territory
Representation:	**Counsel** Mr M Hassall (Counsel Assisting the Coroner) Ms J Dempster (the Family of Mark O'Connor) Mr K Archer (Australian Capital Territory) **Solicitors** Mr M Kamarul (Solicitor Assisting the Coroner) Mr R Montagnino (the Family of Mark O'Connor) Ms C Warden (Australian Capital Territory)
File Number(s):	CD 110 of 2017

CORONER THEAKSTON:

Introduction

1. On the evening of 13 May 2017 a detainee died at the Alexander Maconochie Centre. He was suspected to have suffered a drug overdose. That detainee was Mark Anthony O'Connor. A police investigation commenced immediately and I, as the duty Coroner, attended the scene and received an initial verbal briefing.

2. In this case, because the death occurred in custody, the *Coroners Act 1997* (ACT) mandates that an inquest and hearing be held. Due to the circumstances of the death, I would have been minded to conduct the inquest in any event. This report contains my reasons and findings.

3. It is appropriate that I acknowledge Mr O'Connor's family and fiancée, and express my condolences for their loss. Mr O'Connor was a relatively young man, who had expressed hope for the future. His death would have been a shock to his family, including his son and fiancée. I note that Mr O'Connor's sisters, Natasha O'Connor and Skye McMahon, were present throughout the hearing.

4. For the purpose of facilitating evidence from detainees and to assist with their safety, I made an order prohibiting the publication of the names of detainees, save in relation to that of Mr O'Connor.

5. There was little controversy at the hearing. The only real contest was between the evidence of Mr O'Connor's cellmate, who I will refer to by the pseudonym 'Mr C', and the admissions and events attributed to him by two witnesses.

Background

6. Mr O'Connor grew up in difficult circumstances. He was exposed to family violence. At the age of 12 years, Mr O'Connor commenced using cannabis. He left school after completing Year 8. At the age of 14 years, he commenced using methylamphetamine. By the age of 21 he was using heroin.

Detention

7. Mr O'Connor was a detainee at the AMC between August 2009 and the night of his death on 13 May 2017, save for a few months between late January and early April 2010 and a short period between late January and early February 2014. He had been both a remanded detainee and a sentenced prisoner while at the AMC. Additionally, following a motor vehicle accident in late January 2014 he was detained on remand as an inpatient at hospital. On the day of his death he was serving a term of imprisonment in relation to offences of dishonesty.

8. On 27 April 2017, Mr O'Connor was moved to the Sentence Unit One as a result of disciplinary action. That unit accommodates detainees under management following disciplinary action. Detainees in that unit are locked in their cells for 23 hours a day, and permitted out for the remaining one hour. They spend that time out of their cells split between the common room and the outdoor area. Mr O'Connor was placed in Cell 2 with Mr C.

9. On 13 May 2017, Mr O'Connor and Mr C were in Cell 2, save for their programed time out of the cell between 3:07 and 3:58 pm and a short period to retrieve items from the laundry at 6:11pm. That trip to the laundry was captured on CCTV recording and depicted Mr O'Connor being alert and moving quickly and freely. That was the last time Mr O'Connor was seen by anyone before the emergency, other than by Mr C.

Recent drug use

10. Between April 2010 and July 2015, Mr O'Connor received methadone as part of the ACT Opioid Dependency Treatment Program. This would have occurred while he was at the AMC.

11. Mr O'Connor was subject to a number of disciplinary actions while at the AMC. Between September 2014 and April 2016 he refused on a number of occasions to provide urine samples. He was also disciplined for a variety of infractions, including:

(a) passing an unidentified item to another detainee via an out-of-bounds caged area;

(b) being in possession of steroids, methylamphetamine and substances associated with heroin;

(c) excessive use of medication; and

(d) being in possession of smoking implements, weapons and mobile phone charges.

12. A former cellmate reported that he had used methylamphetamine with Mr O'Connor on an irregular basis, but also that Mr O'Connor had made attempts to 'get clean' from illicit drugs. However those attempts had achieved mixed results.

The emergency

13. At 6:55 pm on 13 May 2017, Mr C pressed the intercom button in his cell and requested assistance for Mr O'Connor. Correctional Officer (CO) Herrick answered that call. By coincidence CO Berenyi was carrying out final observations for the day and was only a short distance outside the cell and heard what Mr C said. Mr C said words to the effect of 'My celly has fainted. Miss, please hurry' or 'My celly's not breathing'. The cell door was unlocked and CO Berenyi immediately entered the cell. CO Herrick ran to the cell.

14. CO Berenyi observed that Mr O'Connor was half on the bed with his head at an odd angle and his feet on the floor. Mr C explained to CO Berenyi 'I got his heart started again and then I "knocked up".' The expression 'knocked up' means press the intercom button. CO Berenyi used his radio to advise of a medical emergency by declaring a 'code pink' and added the additional information 'the prisoner's not breathing'. He then carefully observed Mr O'Connor's breathing and pulse and determined that CPR was necessary. He heard unnatural gurgling sounds and could not hear a heartbeat when he placed his ear to Mr O'Connor's chest. COs Berenyi and Herrick and Mr C moved Mr O'Connor out of the cell and into the common area, a number of metres in front of the open cell door.

15. The events that occurred outside of the cell are captured clearly on CCTV recording. CO Berenyi immediately commences CPR. Other officers arrived very quickly. Between 6:55 and 7:30 pm officers took turns administering CPR to Mr O'Connor. At 6:56 pm a defibrillator was employed and attached to Mr O'Connor. Unfortunately that device did not detect any signs making it appropriate for a shock to be administered. At 6:58 pm Mr C voluntarily administered two breaths to Mr O'Connor. Shortly thereafter and also at 6:58 pm, three members of the on-site ACT Health medical staff attended. They immediately administered air to Mr O'Connor by way of a bag valve mask, also known as an 'ambu bag', which was connected to, and supplied additional oxygen to Mr O'Connor. At that stage, Mr O'Connor was cold and clammy, his pupils were not reacting and his Glasgow Coma Scale was zero.

16. At 7:13 pm ACT Ambulance Services arrived. They inserted a breathing tube and attached their own cardiac monitor, which showed no electrical activity and nothing to defibrillate. They administered five doses of adrenalin, one dose of sodium carbonate and 200-250 ml of saline without response.

17. At 7:30 pm, the ambulance officers recommended the cessation of treatment and the corrections officers ceased CPR.

18. At 9:54 pm, Dr Catherine Brogan attended the scene and examined Mr O'Connor. At 10:27 pm she pronounced life extinct.

19. There are a number of features about the above description that should be commented upon. It is clear that Mr O'Connor received immediate treatment from Corrections Officers as soon as his condition was brought to their attention. CPR was commenced within seconds of CO Berenyi entering the cell. Additional assistance was also requested immediately. That assistance arrived within three minutes when ACT Health staff attended and assisted by the immediate application of the bag valve mask with oxygen. Further assistance arrived 15 minutes later when ACT Ambulance officers attended and assumed the care of Mr O'Connor. Overall, the treatment of Mr O'Connor during the emergency appears to have been professional, comprehensive and appropriate.

Medical Evidence

20. Evidence was received from Prof Johan Duflou in relation to his examination of Mr O'Connor, and his opinion about the cause of death. Prof Duflou's opinion was informed by the results for blood, urine and hair testing.

21. Tests on Mr O'Connor's blood sample indicated the presence of:

    (a) methylamphetamine at the level of 0.31 mg/L;

    (b) buprenorphine at a level of less than 0.005 mg/L;

    (c) norbuprenorphine at a level less than 0.005 mg/L; and

    (d) quetiapine at a level of less than 0.05 mg/L.

22. Tests on Mr O'Connor's pubic hair sample indicated the presence of buprenorphine, methamphetamine and amphetamine.

23. Prof Duflou noted that there were no significant injuries noted on the surface of Mr O'Connor's body, and while there were very limited petechial haemorrhages on the whites of both eyes, there was no evidence of compression on detailed examination of the neck. Mr O'Connor also had scarring on his right antecubital fossa. Additionally, an examination of the organs revealed no significant disease processes. Prof Duflou expressed the following opinions:

    (a) Amphetamine is a metabolite of methylamphetamine, and the presence of the latter but not the former in Mr O'Connor's blood is indicative of the latter drug being consumed less than hours before his death.

    (b) Norbuprenorphine is a metabolite of buprenorphine, and the presence of both drugs is indicative that the latter drug was taken some time before death.

    (c) The presence of methylamphetamine in Mr O'Connor's hair indicated that he had also consumed that drug at a time prior to the day of his death.

    (d) While there is a poor correlation between the level of methylamphetamine in a person's bloodstream and whether the drug causes death or a

different desired result, the level of that drug in Mr O'Connor's blood was capable of causing an overdose.

(e) The level of buprenorphine in Mr O'Connor's blood was described in such a way that it was consistent with it being both within the fatal and therapeutic ranges.

(f) The scarring observed on Mr O'Connor's right antecubital fossa indicated that there had been recurrent intravenous injections into that part of Mr O'Connor's body.

(g) The methylamphetamine in Mr O'Connor's blood was most likely administered by intravenous injection via his right antecubital fossa less than hours before his death.

(h) In the absence of any evidence of traumatic or natural disease causing death, and where the level of methylamphetamine and possibly buprenorphine is such that death could readily be attributed to those drugs, either by the former alone or by both in combination, the cause of death was most likely due to multiple drug toxicity. The most likely mechanism of the death was that the toxicity caused cardiac arrest, which possibly occurred very quickly.

24. This evidence is compelling and I accept the same.

Evidence of cellmate 'Mr C'

25. As indicated above, the only real evidential contest was between the evidence of Mr C, and the admissions and events attributed to him by two witnesses.

26. Mr C gave evidence that neither he nor Mr O'Connor consumed methylamphetamine on 13 May 2017. He was in his cell watching TV and Mr O'Connor was standing in the cell near the door. Mr C heard a thud and saw Mr O'Connor 'laying into the toilet' near the door. Mr C picked Mr O'Connor up and placed him on the bed. He checked for a pulse but only observed two beats in 12 seconds. Mr O'Connor was going blue and Mr C gave him two breaths by way of mouth to mouth. Mr C then pressed the intercom button.

27. Mr C also said that the following day on 14 May 2017, he re-entered cell 2 and grabbed a piece of methylamphetamine off the table. Photographs of that desk depicted seeds where the drug was said to be located. He also said that he used that methylamphetamine that night, but when reminded about the timing of a drug test, adjusted his evidence and said it was used before the test.

28. Independent evidence confirmed that a drug test was administered to Mr C at 3:20 pm on 14 May 2017, and Mr C tested positive to methamphetamine and amphetamine.

29. Ms Sally Fitzmaurice, the Case Management Team Leader employed by ACT Corrective Services for duty at the AMC, told the court that she had met with Mr C on 15 May 2017, two days after Mr O'Connor's death. She did so in order to check on his wellbeing and to provide him with any necessary support following that incident. Mr C told her that he and Mr O'Connor had both used 'ice' on 13 May 2017, and after what may have been a few hours, he saw that Mr O'Connor was not doing okay. He

got Mr O'Connor to lie down and at some point he performed CPR on Mr O'Connor. Mr C denied both making that admission and the truth of the admission.

30. On that same day, CO Jonathon Honchera filed a *Report of a Detainee – Breach of Discipline*. That report recorded him seeing Mr C in his cell at around 10:30pm with a syringe in his arm and later capped in his mouth. The syringe was never recovered. Mr C was reported to have admitted to CO Honchera that he had taken drugs. At the hearing, Mr C denied both the making of that admission and the possession of a syringe as described.

31. Ms Fitzmaurice told the court that on 16 May 2017, three days after Mr O'Connor's death, Mr C told her that the previous day he had injected methylamphetamine left over from the incident with Mr O'Connor. He had retrieved the left over drugs from a desk in Cell 2 on 14 May 2017. He had swallowed the capped syringe used to inject the drugs and later vomited it back up. He had then flushed the syringe down the toilet in Cell 3. At the hearing, Mr C denied that further admission and the truth of the admission.

32. For the purpose of resolving question about whether or not to accept Mr C's version of events, as provided at the hearing, I adopt, with respect, the reasoning of Counsel Assisting at [39] and [40] of his submissions. In short:

    (a) Mr C had a clear motive to distance himself from any events linked to Mr O'Connor's death;

    (b) Considering the significance of Mr O'Connor's death, it is inherently unlikely that Mr C would have no recollection of events in the cell for the 40 minutes or so prior to the emergency;

    (c) The weight of evidence is against Mr C, in that it includes reports by a case worker and corrections officer in relation to three separate events, and contemporaneous notes were made of those events;

    (d) Mr C's assertion that after multiple searches of the cell, he later entered and located crystalline methylamphetamine sitting on a desk in plain sight is inherently implausible and inconsistent with the photographic evidence; and

    (e) The initial claimed timing of Mr C's subsequent use of that crystalline methylamphetamine is inconsistent with the timing of the positive result to a drug test administered to Mr C.

33. I have strong reservations about the evidence of Mr C and prefer the evidence of Ms Fitzmaurice and the report attributed to CO Honchera. Further, my reservations about Mr C's evidence extend to what he described occurring within the cell for the 40 minutes prior to the emergency. I accept the evidence of Ms Fitzmaurice and the report of CO Honchera and make findings accordingly.

Cause of death

34. The evidence at the hearing support a number of conclusions, and I accordingly make the following findings:

    (a) Mr O'Connor commenced use of methylamphetamine intravenously at an early age.

(b) Mr O'Connor was subject to disciplinary action for possession of methylamphetamine while within the AMC.

(c) Mr O'Connor used methylamphetamine while sharing a cell with another detainee before moving to Sentence Unit One.

(d) There were multiple opportunities within the AMC for Mr O'Connor to receive methylamphetamine and buprenorphine in the days and hours leading up to his death.

(e) At 6:11 pm on 13 May 2017 when Mr O'Connor visited the laundry, he was alive and well.

(f) On 13 May 2017, Mr C and Mr O'Connor both used methylamphetamine.

(g) At 6:55 pm on 13 May 2017 Mr O'Connor was removed from his cell unconscious, not breathing and with no detectable pulse.

35. The above medical evidence together with the above findings, lead me to conclude and find without reservation that:

(a) Mr O'Connor died at about 7:00 pm on 13 May 2017 at the Alexander Maconochie Centre; and

(b) Mr O'Connor's death was caused by multiple drug toxicity, being either an overdose due to methylamphetamine alone, or arising from the combination of methylamphetamine and buprenorphine.

(c) It is likely that the methylamphetamine was self-administered between 6:11 pm and 6:55 pm on 13 May 2017 while Mr O'Connor was in his cell.

Matters of public safety

Illicit drugs in the AMC

36. During the hearing it became immediately apparent that illicit drugs were available within the AMC and could be moved easily between detainees. I accept the submission of Mr O'Connor's family that the evidence supports the following conclusions:

(a) Detainees would regularly place towels over the doors of their cell, which obscured the view into the cells by officers.

(b) Detainees passed small items around the closed doors of the cells.

(c) Detainees could pass items through yard fences.

(d) Detainees, at times, moved beyond Sentenced Unit One.

(e) When outside of their cells, detainees could pass items between each other.

(f) Drugs and other items were able to be brought into the AMC, including through contact visits.

37. At the beginning of the hearing I indicated that the inquest would not focus on the general question about drugs entering and circulating within correctional institutions. I did so for two principal reasons.

38. The challenge of keeping illicit drugs and other prohibited items out of correctional institutions appears to be ubiquitous in nature and experienced universally across correctional institutions within Australia and beyond. Therefore any considered assessment or analysis of the problem would look at various centres, at various locations and at various times, including the range of responses employed and contemplated. To conduct an inquiry solely into what may be occurring at the AMC at the material time would at best be myopic.

39. Secondly, the challenge of keeping illicit drugs and other items out of correctional institutions takes place in the setting of ongoing evolutions of techniques to bring those items into the institutions and systems designed to keep them out. Any public inquiry about that challenge would risk publicly disclosing weaknesses in the systems used by institutions and identifying methods of infiltration that are likely to remain or become effective.

40. I note that the submissions made on behalf of the Territory contains an undertaking by the Territory that it would undertake a review into the practice of detainees passing items through cell doors.

41. I also note that the issue of drugs entering and circulating within the AMC has been touched upon by other inquiries. I will therefore only note the issue, and leave it to the Executive to investigate and manage further.

Source of buprenorphine

42. The Territory submitted that I should make the finding that it was unlikely that the buprenorphine found in Mr O'Connor's blood had been diverted from detainees who had been prescribed Suboxone at the AMC. This was on the basis that Suboxone is prescribed at the AMC for opiate replacement therapy and contains naloxone and buprenorphine. Mr O'Connor's blood was tested for naloxone and none was detected.

43. Prof Duflou explained that the half-life of naloxone is given as 30 to 80 minutes, and so it would be entirely possible for Suboxone to have been taken sometime previously, for example a number of hours before, and for no naloxone to be detected, but for both buprenorphine and norbuprenorphine to be detected in Mr O'Connor's blood.

44. While I accept that it remains open on the evidence that Mr O'Connor did not consume Suboxone, in the light of Prof Duflou's evidence, it would not be appropriate for me to make a definitive finding that Mr O'Connor did not consume that medication.

Allocation of cellmate

45. Mr O'Connor's family's final submission expresses concerns about Mr O'Connor being placed in a cell with another drug user, in circumstances where Mr O'Connor himself was trying to minimise his drug use. They suggest that there should have been a considered assessment of Mr O'Connor's situation.

46. Unfortunately, this issue was raised very late and was not explored during the hearing. There is insufficient evidence to allow me to comment about that claim in any meaningful way. For example, we do not know what assessment may have been conducted, what facts were considered and how those facts were individually weighed. I have much sympathy for Mr O'Connor's family and understand their

concerns and hopes for Mr O'Connor. However, I also have difficulty in understanding how the AMC could operate other than, at times, placing detainees with drug histories in cells together. To do otherwise, would involve either detainees not sharing cells or detainees with drug histories only sharing cells with those without drug histories. It is notorious that a significant proportion of the AMC detainee population have a history with drugs. Further, some may argue that a detainee without a drug history would themselves be placed at a heightened risk of commencing drug use when they share a cell with a detainee with a drug history.

47. For those reasons, I am not of the view that this is a matter of sufficient public safety to warrant me inquiring further into the matter and receiving additional evidence.

Securing the scene

48. Due to the nature of the location where Mr O'Connor was moved to and treated, there was clear CCTV footage of the movements and actions of those present. During the time of the emergency up until Mr C was placed in an adjoining cell, Mr C could be observed to move freely around the immediate area of the common room and his cell. On at least three occasions he re-entered Cell 2. He was also observed to hold and place down an item which appears to have been a tobacco pouch of sorts.

49. While in retrospect it may have been better to secure Mr C as soon as possible, and there were sufficient staff to do that, it is difficult to criticise the officers present or the procedures in place at the time. The officers appropriately directed their attention to the immediate treatment of Mr O'Connor. While Mr C was free to move around the immediate area, he was still secured and still monitored to some extent by the officers present.

50. The procedures appropriately prioritise the provision of life saving treatment to detainees over the securing of a potential crime scene.

Quality of care, treatment and supervision

51. In the above circumstances, I make no adverse finding against any individual or the Territory about the quality of care, treatment or supervision of Mr O'Connor.

52. In the above circumstances I make no recommendation in relation to the matters of public safety discussed above.

I certify that the preceding fifty-two [52] numbered paragraphs are a true copy of the Reasons and Findings of his Honour Coroner Theakston

Associate: Priyanka Koci

Date: 26 June 2019