CORONERS COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of Reuben Button
Hearing dates:	12 – 15 December 2022 (Coroners Court at Lidcombe)
Date of findings:	21 July 2023
Place of findings:	NSW Coroners Court (sitting at Parramatta Court Complex)
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Death in custody; Death of ATSI man; ischaemic heart disease; Buvidal; Aboriginal Health Workers at Junee Correctional Centre
File Number:	2020/00257665
Representation:	Dr Peggy Dwyer, Counsel Assisting, instructed by Ms Clara Potocki (Crown Solicitor's Office) Ms Gemma Campagna for Amber Brown (Reuben's sister) Ms Teni Berberian, instructed by Sparke Helmore for The GEO Group Pty Ltd Mr Jake Harris, instructed by Hicksons for Justice Health and Forensic Mental Health Network Mr Alexander Jobe, instructed by the Department of Communities and Justice for the Commissioner of Corrective Services Ms Lorna McPhee, instructed by MDA National for Dr Matthew Jones Mr Tim Saunders, instructed by Meridian Lawyers for Dr Nachaat Wahba

Non publication orders:	Non-publication orders made on 6 October 2022; 28 October 2022; and 8 December 2022 prohibit the publication of various persons personal information and particular evidence in the brief of evidence. The orders can be obtained on application to the Coroners Court registry.
Findings	**Identity** The person who died was Reuben Clarke Button **Date of death** Reuben died on 3 September 2020 **Place of death** Reuben died at Junee Correctional Centre, Junee NSW **Cause of death** Reuben died of ischaemic heart disease secondary to coronary atherosclerosis as an antecedent cause. Other significant conditions contributing to his death were diabetes mellitus, hypertension, obesity, and cardiomegaly **Manner of death** Reuben died in custody. The health care he received in the period before his death was hampered by significant resourcing issues at Junee Correctional Centre and systemic factors including long wait periods for specialist appointments, lack of access to an Aboriginal Liaison Officer and/or Aboriginal Health worker, lack of access to specialist health services, and the impact of COVID-19 lockdowns on inmate transfers between correctional centres

Table of Contents

Introduction

1. This inquest concerns the death of Reuben Clarke Button. Reuben was born on 10 November 1985 at the Royal Women's Hospital in Victoria. He died in Cell 6, B Pod, at Junee Correctional Centre on 3 September 2020. He was only 34 years of age. At the time of his death Reuben was looking forward to and planning for his imminent release. Reuben's premature death has devastated his family and they continue to miss him greatly.

2. Reuben was a proud Kamilaroi man who grew up with his sister and mother predominantly on Dharug land. Reuben's family moved around when he was young, for a time settling in the Central West of NSW. For about two years Reuben came under the care of the Department of Community Services.

3. In the late 1990s, Reuben returned to the Lalor Park area of Western Sydney to live with his mother, Ms Edna "Jenny" Brown. He went to school until he completed year 8, and then worked intermittently as a butcher. He called himself a "Blacktown boy".

4. On 6 October 2007, when Reuben was 22 years of age, he suffered a huge blow when he woke up to find his mother had passed away during the night. He attempted to wake her without success. Despite Reuben quickly commencing CPR, his mother could not be revived.[1] Understandably, her death was extremely painful for Reuben.[2] He lost contact with his sister for a period of time, and it appears that he sought escape from his pain and trauma through drug taking.[3]

5. Reuben's sister, Amber Brown shared with the court a little of Reuben's personality. Although there had been periods where they were out of contact, they had reconnected since his mental health and drug use had stabilized in custody. Amber described him as affectionate, happy, and fun loving. He liked to joke and make those around him smile. He gave himself the nickname of "*Big Sexy*" and was quick to laugh. He had recently shown some insight into his past trauma and his complex battles with mental health and substance use and he appeared oriented to the future.

6. Reuben was a well-loved brother, son, nephew, uncle, stepfather, and mate to many others, including the inmates he shared the last years of his life with. Reuben was compliant with his psychiatric medication in custody, and Amber told us that he was more like the brother that she remembered – loving, fun and "a glass half full" character. Both Amber and Reuben believed that things were going to turn around for Reuben upon his release. It was bittersweet for Amber to hear that during his psychiatry sessions with Dr Jones, Reuben had shown insight into some of his past decisions and that he was oriented towards his

[1] Exhibit 1: Tab 8, Statement of DSC McFarland at [25] - [27].
[2] Exhibit 1: Tab 92, Case Notes Report, p.76.
[3] Exhibit 1: Tab 8, Statement of DSC McFarland at [15].

goals for the future, including wanting to "give back" and contribute positively to his family and community.

7. While Reuben appeared to be looking forward to his release, it was obvious that he needed significant health support. His weight had almost doubled while he was in custody. The dangerous effects of obesity are well known. One nurse described him as a "*metabolic ticking timebomb.*"[4] Understandably his family wanted to know why more was not done to minimize this obvious health risk.

8. I record my utmost respect for Amber Brown. I acknowledge her profound sorrow and send my sincere condolences to her and her family. Ms Brown showed fortitude, enormous grace and great dignity and I thank her for her generous participation in these proceedings. I understand she wanted to understand the full circumstances of Reuben's death, but she also wanted to be part of any positive change that could arise from the investigation.

The role of the coroner and the scope of the inquest

9. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[5] A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[6]

10. Reuben had a number of underlying health issues at the time of his death. He had also only recently commenced on an Opiate Treatment Program in custody. For these reasons it was necessary to carefully examine all the available records to establish the exact medical cause of his death and to understand the adequacy of the care he had received.

11. It should be noted that in any event, when a person dies in custody it is mandatory that an inquest is held.[7] The inquest must be conducted by a senior coroner.[8] When a person is detained in custody in NSW the State is responsible for his or her safety and medical treatment. Given that inmates are not free to seek out and obtain the medical treatment of their choice or have their families directly assist them in this task, it is especially important that the care they are offered is of an appropriate standard and is culturally appropriate.

The evidence

12. The court took evidence over four hearing days. The court also received extensive documentary material in eight volumes. This material included witness statements, medical

[4] Exhibit 1: Tab 72, Statement of RN Amanda Shepherd at [26].
[5] Section 81 *Coroners Act 2009* (NSW).
[6] Section 82 *Coroners Act 2009* (NSW).
[7] Section 27 *Coroners Act* 2009 (NSW).
[8] Section 24 *Coroners Act* 2009 (NSW).

records, policies and procedures, and expert reports. The court heard oral evidence from those involved in Reuben's medical care. Oral evidence was also received from four doctors of different specialties: Associate Professor John Basson, psychiatrist; Dr Hester Wilson, addiction medicine specialist; Dr Simon Quilty, general physician; and Professor Alison Jones, forensic toxicologist, during a multidisciplinary expert conclave.

13. While I am unable to refer specifically to all the available material in detail in my reasons, it has been comprehensively reviewed and assessed.

14. A list of issues was prepared before the proceedings commenced[9]. These issues guided the investigation and focused on the medical care Reuben received in the lead up to his death.

Fact finding and chronology

15. Counsel assisting summarised much of the tendered material in her comprehensive closing submissions. I regard her submissions as accurate and, as will be evident, rely heavily on that document to set out a chronology and to summarise certain aspects of the expert evidence. Where appropriate, I have incorporated her words, taking into account the submissions made by each of the interested parties.

[9] (1) Determination of the statutory findings required under s. 81 of the *Coroners Act 2009*, including manner and cause of death; (2) The adequacy of the medical care and treatment provided by GEO treating staff at Junee Correctional Centre to Mr Button to address his chronic health issues including: (a) whether there was appropriate mental health care and treatment provided to Mr Button, particularly with regard to the frequency Mr Button was seen by a psychiatrist, consideration given to any changes to his medication, and any associated record-keeping; (b) whether there was appropriate management of Mr Button's weight in custody, given his co-morbidities; (c) whether there was an appropriate response to Mr Button's cardiac health risk factors, including family history of poor cardiac health, the combination of medications he had been prescribed, and whether he should have been reviewed by a specialist; (d) whether given Mr Button's complaints of daytime fatigue, obesity and other risk factors, and Dr Nachaat Wahba's referral for sleep studies on 4 March 2020, more should have been done to diagnose and treat Mr Button for sleep apnoea; and (e) whether anything further could or should have been done to assist Mr Button in understanding his health issues and treatment, given he may have also had an intellectual disability. (3) The adequacy of the consultations and assessments conducted by Dr Nachaat Wahba on 4 March 2020 and 26 August 2020 in particular: (a) whether Mr Button's reported shortness of breath warranted further investigation of respiratory and cardiac function to determine if there was other pathology to explain this symptom; and (b) whether Mr Button's rapid weight gain required consideration of the possibility of cardiac failure and subsequent interstitial fluid build-up in the legs and gravity-dependent areas of the body. (4) Whether the administration of Buprenorphine (Buvidal) to Mr Button on 2 September 2020 was appropriate in circumstances where: (a) Mr Button did not appear to have a proven current opiate addiction at the time of prescription; (b) Mr Button was prescribed multiple other medications including anti-psychotics; (c) Mr Button was morbidly obese; (d) Mr Button was likely suffering undiagnosed sleep apnoea and sourcing unprescribed medication to assist his difficulty with sleeping; (e) NSW Health guidelines suggest a minimum of 7 days on Suboxone before Buvidal is administered; and (f) Any other relevant circumstances. (5) Whether there were specific risks associated with the administration of Buvidal on 2 September 2020 that required close monitoring of Mr Button, or other steps to be taken by health professionals to ensure Mr Button's safety? (6) What contribution, if any, did the administration of Buvidal play in Mr Button's death, noting that the current toxicological analysis indicated no detection of Buvidal in Mr Button's blood? (7) What contribution, if any, did the combination of medications Mr Button had been prescribed play in his death? (8) Are any recommendations necessary or desirable arising from any matter connected with Mr Button's death pursuant to s.82 of the *Coroners Act 2009*, including the recommendations proposed in the expert reports of Dr Simon Quilty, Associate Professor John Basson and Dr Hester Wilson.

The context of Reuben's incarceration and death

16. It is necessary to place Reuben's health issues in custody in their wider social context prior to examining the particular facts of his death. This court has been advised on previous occasions that in NSW Aboriginal and Torres Strait Islander people make up around 25% of the adult prison population compared to around 3% of the general population.[10]

17. The over-representation of Aboriginal and Torres Strait Islander (ATSI) people is hardly a recently discovered phenomenon. As far back as 1991 the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) publicised the fact that Aboriginal people were grossly over-represented in custody. Further, the Commission explained that this over-representation provides the immediate explanation for the disturbing number of Aboriginal *deaths* in custody. More recently, statistics collected by this court highlight the fact that the majority of Aboriginal deaths in custody are the direct result of what are described as "natural" or medical causes rather than being caused accidently or in suspicious circumstances. However, while these deaths may be recorded as "natural deaths", it is clear that many occur in situations where prior medical treatment in custody or in the community has been lacking or at times inappropriate.[11] The deficiencies of care in custody that have been recorded in a number of recent inquest findings reflect many of the same medical issues that ATSI citizens face in the community.[12] There can be no argument that First Nations people continue to experience significant disadvantage and poorer health outcomes across the board.

18. In examining Reuben's death the court was advised that his status as an indigenous man was *in itself* a known risk factor for coronary artery disease[13]. This risk was exacerbated by factors such as his obesity, his diabetes and his drug use. Dr Simon Quilty told the court that management of these complex issues required attention be given to the provision of care which was culturally safe. In custody there is limited access to Aboriginal Controlled Health Services, however the need to create a safe environment for patient inmates remains essential. Dr Quilty stated: "*Aboriginal Liaison Officers (ALO) and Aboriginal Health Practitioners (AHPs) are specialists and vital in providing culturally safe environments for indigenous patients*." He noted that their participation in health care had the capacity to improve: "*clinician relationships and communication, patient understanding and*

[10] Evidence of Matthew Trindal, Director of Aboriginal Strategy and Culture for Justice Health and Forensic Mental Health Network (JHFMHN) given in the Inquest into the Death of Kevin Francis Bugmy (6 July 2022).
[11] Each year the State Coroner publishes a report to NSW Parliament outlining the deaths in custody and deaths in police operations which have occurred. See for example "Deaths in Custody/Police Operations Report 2022.
[12] Numerous recent inquests have examined including: Inquest into the death of Mootijah Douglas Andrew Shillingsworth (2018/0054603); Inquest into the death of Kevin Francis Bugmy (2019/00120612).
[13] Exhibit 1: Tab 152, Report of Dr Quilty, p. 8.

engagement…and subsequent health outcomes."[14] This view was endorsed by Reuben's family in their submissions and is an issue to which I will return.

Reuben enters custody

19. On 2 May 2015, Reuben was arrested and charged with several offences, including house breaking, committed under the influence of methylamphetamine or ice. The offending was uncharacteristically serious for Reuben and was clearly related to his escalating drug use. At the time of his arrest, Reuben was noted to be incoherent.

20. On 27 March 2017, Reuben was convicted of aggravated break and enter, commit serious indictable offence armed, use of an offensive weapon, assault occasioning actual bodily harm, and steal property in dwelling house. He was sentenced in the Paramatta District Court to a prison term of nine years and eight months imprisonment, with a non-parole period of five years and four months, backdated to 2 May 2015. Reuben's non-parole period was due to expire on 1 November 2020.[15] It was the most significant sentence he had ever received.

21. On remand, Reuben was initially held at Amber Laurel Correctional Centre, the Metropolitan Remand and Reception Centre (MRRC) and Dawn de Loas Correctional Centre. After sentence he was placed at South Coast Correctional Centre.[16]

22. It is important to note that when Reuben first entered Amber Laurel Correctional Centre in May 2015, his weight was recorded as 86-88 kg.[17]

23. On 8 July 2019, approval was granted for Reuben to be transferred from South Coast Correctional Centre. Sadly, it appears that some inmates had "*refused to allow [him] to live in their accommodation*" and there were concerns for his safety.[18] On 28 July 2019, Reuben was transferred to Junee Correctional Centre, via Dawn de Loas and Bathurst Correctional Centres.[19] He was placed in B Unit and, in late October 2019, moved to the minimum-security C Unit where he was assigned work in the kitchen.[20] Reuben requested to be returned to Unit B4 on 14 April 2020, as "*his head was just not in the right space*".[21] He felt that, as his maternal uncle Edward Button was in Unit B4, he would be able "*to get his head right".*[22]

[14] Exhibit 1: Tab 152, Report of Dr Quilty, p. 3.
[15] Exhibit 1: Tab 8, Statement of DSC McFarland at [36]-[37].
[16] Supra at [37].
[17] Supra at [38]-[39].
[18] Supra at [37]; Tab 85: Serious Incident report; Tab 92: Case Notes Report, pp. 105, 111,114; Tab 90: Case Management File.
[19] Exhibit 1: Tab 92, Case Notes Report, pp. 105, 111, 114; Tab 90: Case Management File.
[20] Supra.
[21] Exhibit 1: Tab 8, Statement of DSC McFarland at [43].
[22] Supra.

Events leading up to Reuben's death

24. By 3 December 2015, Reuben weighed 116kg. On this day, he reported to the health staff that he had a heart problem.[23] Consequently, an ECG was done, and a report was created which noted "*consider left atrial enlargement*".[24]

25. By January 2020, after Reuben's transfer to Junee Correctional Centre, Reuben was morbidly obese (now weighing 150kg) and at the baseline for a Chronic Disease/Aboriginal Chronic Care Screen. Employment Officer Janelle Philpott observed Reuben to be breathless and sweating after scaling a flight of stairs, and raised concern about Reuben's weight gain and breathlessness.[25] After he composed himself, Reuben told her that he had also been experiencing hand tremors, weight gain and "*mouth drops for no reason*". On 4 March 2020, Reuben weighed 162kg, and a referral was made for sleep apnoea studies, which did not take place before his death.[26]

26. By August 2020, informed of the possibility that he might be released on parole later that year, Reuben disclosed a history of heroin, cocaine, amphetamines and oxycontin use and requested an assessment for Buvidal as he thought that it might assist his efforts to resist using drugs when he was released from custody on parole.[27] General Practitioner at the Junee Correctional Centre Dr Nachaat Wahba considered him to be "*Suitable for [the] Opioid Treatment Program (OTP)".*[28]

27. There are some unanswered questions about the way Reuben received his first dose. Dr Wahba proposed a dose of Suboxone sublingual film, followed by weekly 8mg Buvidal injections, to commence on 17 September 2020. This was to be administered after a satisfactory ECG on 8 September 2020. However, it appears that the proposed start dates recorded in the original documentation were later changed and the handwriting does not appear to have been Dr Wahba's.

28. In any event an application to prescribe buprenorphine was submitted to NSW Health citing Reuben's primary opioid drug of dependence as heroin, oxycodone, and codeine with other drugs of concern being cannabinoids and methamphetamine.[29]

29. On 31 August 2020, Dr Wahba received authorisation from NSW Health to prescribe Reuben buprenorphine under the NSW Opioid Treatment Program (OTP) for the treatment of Opioid Dependence.[30] On 1 September 2020, Reuben was given Suboxone strips by

[23] Exhibit 1: Tab 119, Justice Health Records, pp.233, 238-242.
[24] Exhibit 1: Tab 119, Justice Health Records, pp.233, 238-242.
[25] Exhibit 1: Tab 63, Statement of Janelle Philpott, Employment Officer, p.1.
[26] Exhibit 1: Tab 119, Justice Health Records, p. 559.
[27] Tab 119: Justice Health Records, p.600-603.
[28] Tab 119: Justice Health Records, p.608-613, 618-619.
[29] Tab 119: Justice Health Records, p.608-613, 618-619.
[30] Tab 119: Justice Health Records, p.620.

Registered Nurse Jennifer Duddy.[31] This occurred prior to Buvidal commencing in case of any adverse reaction. Reuben was hoping that the drug treatment therapy would alleviate any further stress around drug use in the community. He was reported to have been feeling stressed about his parole because he had been moved from C unit to B4 and didn't want the State Parole Authority to form the view that this indicated behavioural breaches. He admitted to being stood over by other inmates to bring drugs back into the centre and he said that he didn't want to do that.

30. Despite NSW Health guidelines suggesting a minimum of seven days on Suboxone before Buvidal is administered[32], the very next day (2 September 2020), at around 10:50am, Reuben was taken to the medical unit, and he received an injection of Buvidal in his right abdomen administered by Registered Nurse Duddy. She was assisted by Administration Support Officer Charmaine Brodin who verified the dosage that Reuben was to receive. Registered Nurse Duddy made various notes of the consultation.[33] She recorded:

    i. Reuben's oxygen saturation as 94%;

    ii. his blood pressure as high at 137/82;

    iii. his heart rate as 103; his respiratory rate at 16; and

    iv. his temperature at 37.2.[34]

31. Thereafter, Registered Nurse Duddy discussed diet and exercise with Reuben, noting he was very obese and displayed shortness of breath on minimal exertion.

32. Reuben left the treatment room at 10.52am and remained in the medical unit until 11:08am.[35] He was then released from the medical wing and made his way back to the B4 unit. From this point, Reuben was under constant view from CCTV.[36] The CCTV shows that Reuben did not appear to be in distress or upset at any time that day. The footage does not indicate any immediate adverse reaction to the injection.

33. At 5:38pm on 2 September 2020, during lock-in, Reuben appeared to be in good spirits when he shared a joke with correctional officer Christopher Lewis about his cellmate keeping him up at night. The joke was that Reuben was in a one out cell.[37] On 3 September 2020, at 6:50am, during headcount, correctional officers (CO) Kylie Alexander and Hayley Clark sighted Reuben asleep in his cell, on his right side facing the wall, snoring. CO Alexander called his name twice and on the second occasion louder, at which point she

[31] Tab 68: Officer Report of Nurse Duddy; Tab 8: Statement of DSC McFarland at [65].
[32] Tab 144: Policy 1.040 – Drug and Alcohol Services.
[33] Tab 68: Officer Report of Nurse Duddy; Tab 8: Statement of DSC McFarland at [65].
[34] Supra; Tab 119: Justice Health Records, p.629.
[35] Tab 68: Officer Report of Nurse Duddy; Tab 8: Statement of DSC McFarland at [65].
[36] Exhibit 1.
[37] Tab 68: Officer Report of Nurse Duddy; Tab 119: Justice Health Records, p.629; Tab 8: Statement of DSC McFarland at [65]-[68].

said he grunted and gave a thumbs up. CCTV records indicate that the 14 seconds that CO Alexander spent checking on Reuben was more than twice as long as most of her other checks that morning.[38] These security checks of B Pod were repeated at 7:14am and 9:00am: CCTV records indicate CO Clark opened Reuben's (B06) cell and observed him in his bed.[39] No concerns were raised at this time.

34. At about 9:15am on 3 September 2020, CO Bethany Wilson attempted to call Reuben over the intercom for a dental appointment. When Reuben did not present himself at the door to be let out of the Pod, three inmates; Jake McEwan, Kevin Galbraith and Reuben's maternal uncle Edward Button; attended his cell to wake him, shortly followed by CO Wilson.

35. At 9:23am CO Wilson located Mr Galbraith and Edward who were attempting to rouse Reuben in his bed. Edward was shaking Reuben and repeating, "*please no*".[40] CO Wilson then called for assistance from other staff, including B4 Correctional Supervisor Russell Mellor, and told the inmates to return to their cells for emergency lock-in.[41]

36. At 9:24am, further The GEO Group Pty Ltd (GEO Group) staff attended Reuben's cell, including CO Pafalani, CO Bradley, and Correctional Supervisor Russell Mellor (wearing a body worn camera). Upon entering Reuben's cell, Correctional Supervisor Mellor activated the Centre Emergency Response Team (CERT) for a CERT 1 Code White medical emergency and noticed Reuben was very cold to the touch.[42] CO Pafalani and Correctional Supervisor Mellor then lifted Reuben to the floor and commenced CPR.[43]

37. In response to the CERT call, a number of officers attended Reuben's cell, including CO Garry Carpenter who recorded the incident with a handheld video camera. At 9:28am, registered nurses Erin Murphy, Peter Cook and Amanda Shepherd attended Reuben's cell, connected Reuben to oxygen via a resuscitation mask and rotated with GEO Group staff in performing CPR.[44] The nurses confirmed that an ambulance had been called and placed a blanket under Reuben so he could be moved to the day area.

38. At 9:33am, the NSW Ambulance Service contacted main control requesting information.[45] After the call was transferred to the nurses on the scene, Registered Nurse Shepherd spoke to '000' dispatch and was advised to call for a defibrillator. The phone was then handed to Registered Nurse Kathryn Shaw to provide an ongoing account of events. As no local

[38] Tab 43: Officer report of Kylie Alexander; Tab 8: Statement of DSC McFarland at [70].
[39] Tab 8: Statement of DSC McFarland at [69]-[70]; Tab 49: Officer Report of Shawn-Ray Pafalani.
[40] Tab 8: Statement of DSC McFarland at [72]-[73]; Tab 47: Officer Report of Bethany Wilson.
[41] Tab 47: Officer Report of Bethany Wilson.
[42] Tab 49: Officer Report of Shawn-Ray Pafalani; Tab 16: Statement of Russell Mellor at [13]-[14].
[43] Supra.
[44] Tab 8: Statement of DSC McFarland at [78]; Tab 119: Justice Health Records, p.640.
[45] Tab 8: Statement of DSC McFarland at [52].

ambulance was available to be dispatched, NSW Ambulances were dispatched from Coolamon and Wagga Wagga.[46]

39. Registered Nurse Shepherd then asked the nearby correctional officers to call Centre Medical Officer Dr Darren Corbett because the ambulance was going to take too long. An automatic defibrillator was brought down from the Medical Unit by CO Christopher Carr, but there was no detectable rhythm, and no shocks were delivered.

40. Dr Corbett arrived on the scene at 9:56 am and performed a number of checks.[47] As Reuben was unresponsive, he then declared Reuben deceased at 9.59am. This was four minutes before NSW Ambulance officers arrived on the scene.[48]

Cause of Death

41. An autopsy was conducted by Dr Benjamin Robert Harding at the Department of Forensic Medicine, Newcastle commencing at 08:45am on 9 September 2020. He was supervised by Dr Hannah Elstub, Staff Specialist in Forensic Pathology.[49]

42. Reuben's autopsy report (dated 1 December 2020) and amended autopsy report and supplementary certificate of analysis (dated 23 June 2022) were prepared by Dr Harding.[50]

43. Dr Harding recorded that the direct cause of Reuben's death was ischaemic heart disease secondary to coronary atherosclerosis.[51] Other significant conditions contributing to the death were diabetes mellitus, hypertension, obesity, and cardiomegaly. Reuben had a body mass index [BMI] of 43.7 kilograms and was classified as morbidly obese [class III].[52] Dr Harding noted that morbid obesity creates a very high relative disease risk. Sudden and unexpected cardiac death in morbid obesity presents at a rate 40 times greater than that of age controlled lean persons with an increased risk of sudden death and dysrhythmias.[53]

44. Reuben's toxicology results showed the presence of two antidepressant medications, Escitalopram and Mirtazapine, as well as the antipsychotic Paliperidone, and the diabetes drug Metformin.[54] It did not show any evidence of the Buvidal injection.[55] Reuben had not been prescribed Mirtazapine and one may assume it had been obtained illegally.

45. The Court was keen to understand why the toxicological results did not show evidence of the recent injection and expert opinion was sought. Professor Alison Jones, forensic

[46] Supra at [80]; Tab 119: Justice Health Records, p.640.
[47] Exhibit 1: Tab 8, Statement of DSC McFarland at [82]-[83].
[48] Supra McFarland at [82]-[84].
[49] Supra.
[50] Tab 7, Autopsy Report, p.1; Tab 7A, Amended autopsy report and supplementary certificate of analysis, p.1.
[51] Tab 7, Autopsy report, p 2.
[52] Supra at p.3.
[53] Supra at p.4.
[54] Supra at p.3.
[55] Supra.

toxicologist, gave evidence at the inquest as to Reuben's cause of death. She stated that: "*the fact that we could not detect the buprenorphine in the post-mortem blood, tells me that the buprenorphine, this opioid drug, is not responsible for Reuben's death, in my opinion."*[56] However, Professor Jones agreed that it was *possible* the buprenorphine could have interacted with the factors that contributed to Reuben's death.[57]

46. Dr Simon Quilty, general health physician, also provided evidence at the inquest. He noted in his statement that: "*The absence of buprenorphine in the autopsy makes it less likely that administration of buprenorphine directly contributed to the death, but it doesn't discount its contribution."*[58]

47. Dr Quilty said in oral evidence that he thinks it is definitely *possible* that the buprenorphine contributed to Reuben's death, and that:

> "*If you have a young and fit body that is capable of respiratory depression, which means that you breathe less, so you just take less breaths, and you'll sleep deeper, then you would be fine, because your heart and lungs would be capable of absorbing enough oxygen. However, the autopsy demonstrated that Mr Button had not just only a weak heart, but he also had fluid in his lungs, and so he wasn't absorbing oxygen at baseline, and the day that he had the injection administered, it would seem that he had an oxygen saturation of 94%, which is right on the cut off of lower end, and for a 35 year old man, even if he was a large man, it's still really very low, and the way that buprenorphine impairs your respiratory drive, that means impairing the number of breaths you take per minute, it blocks some receptors in your brain then to reduce that respiratory drive, and so the buprenorphine itself wouldn't have caused, or would've been very unlikely to have caused, a fit and well man to pass away, but somebody with very severe underlying health problems is much more frail, and much more vulnerable*."[59]

48. At the conclusion of evidence, I was satisfied on the balance of probabilities that Reuben's cause of death should be recorded as having had a cardiac cause.

[56] T4.11.20 (15 December 2022).
[57] T4.12.50 (15 December 2022).
[58] Tab 152: Expert Report of Dr Simon Quilty, General Health Physician, p.12.

Discussion of Issues

Adequacy of the medical care and treatment provided by GEO treating staff at Junee Correctional Centre

49. Reuben had a complex medical presentation and clearly required wholistic management. While his cause of death was identified at autopsy as ischaemic heart disease caused by coronary atherosclerosis, there were other significant health issues including diabetes mellitus, hypertension, obesity, and cardiomegaly. He had a family history of heart disease and had experienced breathlessness in recent times. His mental health issues required medication which can cause side effects including weight gain. He may have been experiencing sleep apnoea. His history of trauma drove his polysubstance abuse and may even have been implicated in his rapid weight gain. The need for opiate replacement therapy needs to be understood in this context. Against this complex background it was necessary for the court to have some understanding of his overall medical management to properly understand all the circumstances of his untimely death.

Psychiatric treatment

50. Reuben had a significant history of mental illness. On 13 June 2005, Reuben attempted to take his own life in the backyard of his family home in Lalor Park, by hanging himself using an electrical cord.[60] Police were called, and they conveyed him to Blacktown Hospital where he was admitted to Bungarribee House, a specialist mental health unit as an involuntary patient.[61]

51. On discharge, Reuben's psychiatric diagnosis was recorded as: "*impulsivity leading to suicide attempts and cannabis abuse"*.[62] Available police records indicate that Reuben may have been admitted to Bungarribee House on other occasions, as well presenting voluntarily for treatment on at least two occasions and being turned away. [63]

52. On 27 April 2015, Reuben was admitted to the Mental Health Unit at Blacktown Hospital.[64] It was noted at the time that he was drug affected and aggressive, and he was diagnosed by the treating doctor with schizophrenia and polysubstance disorder. On his very first entry into custody in September 2013, Reuben self-reported as having been diagnosed with paranoid schizophrenia.[65]

[60] Tab 8: Statement of DSC McFarland at [18].
[61] Supra.
[62] Exhibit 1: Tab 119, Justice Health Records, p. 3.
[63] Exhibit 1: Tab 92, Case Notes Report, pp. 56, 60.
[64] Exhibit 1: Tab 119, Justice Health Records, pp. 164-165.
[65] Exhibit 1: Tab 119, Justice Health Records, p. 57.

Frequency of psychiatrist consultations and management of symptoms

53. Dr Matthew Jones, visiting psychiatrist at Junee Correctional Centre, contracted by GEO Group, gave evidence at the inquest. He saw Reuben on three occasions: 15 January 2020, 27 February 2020, and 28 August 2020.[66]

54. Dr Jones impressed the Court as a caring and able practitioner doing his best in the difficult conditions that currently exist in providing psychiatric care in custodial settings and which were exacerbated at that time by the extra restrictions brought on by the COVID-19 pandemic. At that time, Dr Jones was the only psychiatrist attending Junee Correctional Centre and he was only rostered two days per fortnight. Restrictions introduced during the COVID-19 period meant that consultations took place by AVL.[67] He did not control the waitlist or the patient schedule, attending on each occasion and commencing to see the list of patients he was given.

55. Dr Jones gave evidence at the inquest that the six-month delay between Reuben's entry to Junee Correctional Centre and his first psychiatric consultation on 15 January 2020 was not unusual. He stated: "*it doesn't surprise me that it took six months. It may have been because he was moderately well-managed or coping with his circumstances, some people don't make a lot of noise unfortunately, and not everybody can be seen immediately.*"[68] While not surprising to Dr Jones, to an outsider the delay appears lengthy and concerning.

56. Dr Jones stated that he was under the impression that Reuben self-referred to see a psychiatrist, and was placed on a waitlist by a Mental Health Nurse.[69] At the first consultation on 15 January 2020, Dr Jones discussed Reuben's side effects from Abilify, his antipsychotic medication, which included a tremor and involuntary mouth movements.[70] Dr Jones agreed to switch Reuben from depot injections of Abilify to a trial of Paliperidone, beginning initially with six milligrams orally at night, with a review in four weeks.[71]

57. Dr Jones stated that although Reuben was put on a waitlist, it was six weeks before he saw him again on 27 February 2020. He stated: "*He is automatically put on the appointment schedule system, so as the mental health nurse prepares the list for my clinic, it will come up as an appointment due. The list unfortunately has to be made up of appointments due and crises that have appeared in the last week or two, and so four weeks was my intention, six weeks was the reality which I think is pretty fair in the circumstance*."[72]

[66] Exhibit 1: Tab 76, Statement of Dr Matthew Jones, psychiatrist, p. 1.
[67] T1.47.15 (12 December 2022).
[68] T1.53.5 (12 December 2022).
[69] T1.34.15 (12 December 2022).
[70] Exhibit 1: Tab 76, Statement of Dr Matthew Jones, psychiatrist, pp. 1, 2.
[71] Supra.
[72] T1.37.45 (12 December 2022).

58. When asked if the lack of three-month review after commencing the anti-psychotic Paliperidone could impact Reuben's treatment, Dr Jones stated: "*I was happy with the results at the last review [on 27 February 2020], and he's seen mental health nurses or primary nurses at least monthly, if not more often. And as there are some people that you are more comfortable in leaving them be aware of themselves, and I think Reuben was one of those fellows, that if there was a major problem he would let us know*."[73]

59. Dr Jones sought to review Reuben three months after seeing him on 27 February 2020, but Reuben's appointment was ultimately scheduled for 28 August 2020, five months after that date.[74] At that appointment, Dr Jones' statement indicates that Reuben showed further improvement in his mental state with reduced side effects, and was future-focussed and grateful for the improvement in his mental state.[75]

60. There are significant challenges with the provision of psychiatric care in NSW prisons, but there are also shortages within the broader public health system. Patients in prison should receive at least the same level of care they might expect in the public sector outside prison. Associate Professor John Vincent Basson, Forensic Psychiatrist at Cumberland Hospital Western Sydney, gave evidence to the inquest on the issue of the frequency of Reuben's psychiatrist appointments. He stated that Reuben should have been seen at least once a month by a psychiatrist to manage his mental health issues. To justify this, he stated:

> *"He has a long history of really quite complex problems with regard to his mental health, never mind his physical health, and also that he was of Indigenous background, I think the argument is made that he needs to be seen regularly, and that is to establish a relationship to be able to gauge his understanding of his mental health issues, and as we've just been discussing in some depth, his drug and alcohol issues, and his physical health, and to assist him with that, and to look for resources which will assist, and if I was the psychiatrist, me as a practitioner, in managing him better, to cooperate with the team that is responsible for him."*[76]

61. I accept Associate Professor Basson's opinion on this matter and am comfortable finding that Reuben should have been seen more regularly. It implies no criticism of Dr Jones whatsoever, as the frequency of appointments was a resourcing issue well beyond his control. Those doing their best to work within the custodial system may be unaware of how an outsider views the constraints that become habitual to them. Just because the frequency of appointments seemed fair to Dr Jones, who I recognise as a capable psychiatrist, does

[73] T1.39.50; T1.40.5 (12 December 2022).
[74] Exhibit 1: Tab 76, Statement of Dr Matthew Jones, psychiatrist, p. 1.
[75] Supra, at p. 4.
[76] T4.26.15 (15 December 2022).

not mean that I accept the appointment schedule was "*fair*" after taking into account the independent expert's advice.

62. At the time of Reuben's death, he was prescribed a number of medications including Paliperidone, Perindopril, Metformin, Hyoscine, Quetiapine, Fenofibrate, Simvastatin, and Vitamin D.[77]

63. As I have noted, Reuben ceased taking Abilify and commenced a trial of Paliperidone under Dr Jones' supervision in January and February 2020. This was intended to reduce side effects being experienced by Reuben, which included involuntary movements of his mouth and a tremor in his hand.[78] Reuben had previously switched to Abilify from Olanzapine, also an antipsychotic, in August 2016, in order to reduce these kinds of troubling side effects.

64. When asked about why he selected an oral trial of Paliperidone, Dr Jones stated:

> *"General protocol I guess for switching a medication is that if someone hasn't had it before you'd try it to see if there are any adverse effects. In this case trying an oral medication for those reasons I said before about the quickness of onset, and the quickness of offset of symptoms or side effects or effects, it's a good way to see if someone's allergic to something or if it's going to cause problems with their blood pressure or – there's a whole manner of generalistic [sic] side effects that can occur and aren't expected to occur but this is a good way of trying it. The alternative would be to start someone on an injection, they have a side effects and then the injection takes a couple of weeks to wear off and that's not very fun."*[79]

65. Associate Professor Basson agreed that Abilify and Paliperidone were appropriate options for Reuben in the circumstances, given that he was not tolerating the side effects from Olanzapine, which included weight gain. He affirmed that the introduction of oral Paliperidone was acceptable practice, stating:

> "*If the aripiprazole [Abilify] was coming to an end, and it's once a month, and the starting of the Paliperidone, first of all, you don't want a gap, so the addition of oral helps to make sure, because paliperidone doesn't just come on immediately you get the injection, it takes time, and don't want to have that gap, and the other aspect is that if there's a bit of a delay of giving the oral before the injection, it also helps to check, as you've said, to make sure that there isn't an adverse reaction to the paliperidone. It's very brief, in terms of six days, because transfer of depots is difficult, in a prison context, even more so, because people are not under observation, they're locked away in a cell for most of the day, and so therefore, from that perspective, one*

[77] Exhibit 1: Tab 7, Autopsy Report, p. 2.
[78] Exhibit 1: Tab 76, Statement of Dr Matthew Jones, psychiatrist, p. 2.
[79] T1.37.25—35 (12 December 2022).

would have some concerns about the situation, but those are not something which Dr Jones, himself, could in any way influence or change."[80]

66. I accept his view on this matter.

67. Dr Jones' notes from his final consultation with Reuben on 27 August 2020 indicate that Reuben expressed he was happy and grateful to be on medication, could think more clearly, and see a brighter future.[81]

68. Dr Jones told the court that he was unable to access patient electronic files while conducting audio-visual consults remotely during the COVID-19 lockdown period. He stated that he was able to request records, but was largely reliant on staff at Junee Correctional Centre to provide information about a patient's presentation.[82] Dr Jones was not sure about the reason he did not have access from offsite but thought it was for security or IT reasons. He also stated that he did not think it made a "*massive difference*" to his patient management and that he obtained "*pretty good information from the mental health nurses, what's current, what's recent, and also we try very hard to get what we call a release of information, which is when someone comes into custody we access their primary health care GP or mental health team if there is one and sometimes we get very good information from that."*[83] GEO Group submitted that it should be remembered that it was only the last of Dr Jones' consultations which occurred via AVL. Nevertheless, the court was troubled by this apparent lack of access.

69. By the conclusion of evidence, this matter had been cleared up to some degree. It appears that all private operator medical staff can be provided with access to the electronic medical record, Justice Health Electronic Health System (JHeHS) and the Patient Administration System (PAS) even when they are offsite.[84] To get access, they are required to complete training and submit "on-boarding" paperwork seeking access. It appears that although Dr Jones had access at one point, his account was de-activated. It is open for him to request access and GEO Group have been alerted to the issue.

70. In my view, Dr Jones managed Reuben's mental health issues appropriately within the confines of the system. It appears that the issue with access to patient records has been solved. Nevertheless, I remain concerned about the resourcing of psychiatric and other medical services at Junee Correctional Centre. It is an issue to which I shall return.

[80] T4.38.40—50 (15 December 2022).
[81] Exhibit 1: Tab 76, Statement of Dr Matthew Jones, psychiatrist, p. 4.
[82] T1.56.10 (12 December 2022).
[83] T1.49.24-29 (12 December 2022).
[84] Exhibit 6.

Weight management

71. The court heard evidence that, during his time in custody from May 2015 until his final weigh-in in July 2020, Reuben's weight increased from 86 – 88 kilograms to 162.6 kilograms.[85] The risks that flow from obesity are well known and his weight gain clearly called for urgent strategic intervention.

72. Registered Nurse Shepherd, then a nurse at Junee Correctional Centre, gave evidence on the management of Reuben's weight at Junee Correctional Centre. She noted that there is a clear link between antipsychotic medications and weight gain, and for this reason Reuben was placed on the metabolic monitoring list.[86]

73. Efforts to manage Reuben's weight gain in custody had previously included being placed on an *ad hoc* diet and exercise program in August 2017, referral to an endocrinologist to investigate any relationship between Reuben's hormones and his weight gain – which Reuben declined to attend, and a prescription for Trulicity, a drug for patients with diabetes which aims to assist with weight loss and sugar control.[87] Notwithstanding these measures his weight continued to rise.

74. General Practitioner, Dr Wahba was well aware of Reuben's problematic weight gain. He told the court that there was no access to a dietitian at Junee Correctional Centre. He stated: *"In the absence of an allied health team, including a dietician, I thought that his efforts with controlling food intake, including the quality of food he used to buy in buyups, provision of a low-calorie drink replacement of a meal, and the increase in exercise, and - with the help of a diabetic educator, would spark the start of weight reduction."*[88]

75. When asked about the role of dietitians, Dr Jones noted the difficulties in providing lifestyle support to inmates in correctional centres. He stated:

> "*I think there's good evidence to suggest that lifestyle modification programs, dietetics, exercise physiology, all these things have actual evidence to say that they are helpful, but these are controlled groups that are not necessarily inmates, they're happy campers in a mental health rehab facility where they've got a lot of fresh air and outdoors. I think, you know, a dietician might be helpful, but then you need to have options of diet, and I think that the gaol offers a number of options but they can't offer necessarily an individualised meal package or everybody, just like they can't necessarily organise an individualised exercise and lifestyle package for everybody. I think even the facility, all the powers that be, all the officers, all the inmates would*

[85] Exhibit 1: Tab 8, Statement of DSC McFarland at [38]-[39]; T1.20.15 (12 December 2022).
[86] T2.76.30 (13 December 2022).
[87] T1.8.35 (12 December 2022); Exhibit 1: Tab 119, Justice Health Records, pp. 461, 466, 483; T3.49.35 (14 December 2022).
[88] Exhibit 1: Tab 77, Statement of Dr Nachaat Anwar Wahba, p. 2.

say if we could organise something that was, you know, if we were able to give them more time exercising, or if we could allow them to cook their own food, or you know, all these things that are - I think they're utilised as much as they can be.[89]

76. Once again, I have no specific criticism of the individual doctors in relation to this issue. However, the system does not allow for the provision of wholistic or appropriate care. Not only should Reuben have seen a dietician, he should also have had the opportunity to speak with an Aboriginal Health Worker about weight reduction and fitness strategies in a culturally safe environment.

Cardiac management and sleep issues

77. Reuben is reported to have had a family history of cardiac issues. Given the context of Reuben's rapid weight gain in custody, the prescribed medications he was taking, and his symptoms of breathlessness, Professor Alison Jones was of the view that further investigation of his cardiac health was warranted. Professor Jones stated: "*Reasonable practice, in my view, would be an examination of the cardiovascular or respiratory system, and relevant investigations for shortness of breath that comes off the back of taking a really good history, examining cardiovascular, respiratory system, and linking on with referral if things don't look good*."[90]

78. Dr Wahba noted the difficulties in sending inmates at Junee Correctional Centre for specialist appointments, including in cardiology, which were exacerbated by COVID-19 restrictions. He stated that patients are required to be referred to Long Bay Hospital for non-emergency cardiology investigations. He asserted that many patients do not want to leave Junee Correctional Centre due to the risk of being transferred to another correctional centre permanently.[91] In addition, Dr Corbett, also a General Practitioner at Junee Correctional Centre, noted the lengthy wait times for inmates seeking cardiology appointments with specialists, pointing to a recent case where a patient at Junee Correctional Centre, with ECG abnormalities, has been waiting for a transfer for over eight months.[92]

79. When asked if Reuben was ever referred to a cardiologist in August 2020, Dr Wahba stated: "*No, because at August, already, there was a complete block… no-one can go outside [because of COVID-19*].[93] Similarly, it appears any further investigations of his possible sleep apnoea could not be progressed at that time because of "*panic about COVID*." Dr Corbett told the court that the issue was not just felt during the COVID-19 lockdown period. He said the time frame for a transfer to Long Bay Correctional Centre for sleep

[89] T1.59.50; T1.60.5—15 (12 December 2022).
[90] T4.19.20—25 (15 December 2022).
[91] T2.59.15—25 (13 December 2022).
[92] T3.60.10 (14 December 2022).
[93] T2.55.15—30 (13 December 2022).

apnoea studies is at least two years, not accounting for delays arising during COVID-19 lockdowns.[94] This is clearly unsatisfactory.

80. I accept Professor Jones' view that best practice would suggest that Reuben had sufficient symptoms to require further cardiac assessment. His sleep issues also required investigation.

Lack of contact with an Aboriginal Health Worker or Aboriginal Liaison Officer

81. In my view, the quality of Reuben's care could have been enhanced at Junee Correctional Centre if he had the benefit of contact with an Aboriginal health worker[95]. However, it appears he did not see one at Junee Correctional Centre, although he had been in contact with Aboriginal health workers while under the care of Justice Health and Forensic Mental Health Network (Justice Health) at the South Coast Correctional Centre.

82. The court heard evidence from Reuben's medical team at Junee Correctional Centre that Reuben was proactive about his health management and appeared invested in his own health.[96] It follows that it is likely that he would have benefitted from exploring health strategies with an Aboriginal health worker in a trusting and culturally safe environment as he prepared for release to parole. It is also recorded that Reuben may have had an intellectual disability, although there does not appear to have been any particular recognition of this in his health planning. It is another issue which could have been sensitively explored with a suitably qualified Aboriginal health worker. In court Dr Wahba agreed, for example, that it might be helpful for patients with intellectual difficulties to clearly indicate which "buy-ups" are healthy and unhealthy on menus.[97]

83. Dr Corbett, the most experienced general practitioner at Junee Correctional Centre stated that Aboriginal Liaison Officers in clinical health settings within correctional centres are "*invaluable*". He stated: "*they are the first port of call for a lot of the First Nations people, and they develop rapport a lot quicker than I can, and they are a great source of information.*"[98] He agreed that an Aboriginal Liaison Officer might have been helpful for Reuben, in the context of his co-morbidities and intellectual difficulties.[99]

84. Dr Quilty also emphasised the important role that Aboriginal Liaison staff can play in collaborating with patients and their medical teams in correctional centres to achieve positive outcomes. He stated: "*I would also suggest that having access to somebody whom he trusted within the health system, would've also enabled the opportunity for his shortness*

[94] T3.76.15-25 (14 December 2022).
[95] In the evidence the term Aboriginal Health Worker and Aboriginal Liaison Officer were used somewhat synonymously by different witnesses. The lack of clarity is unfortunate.
[96] T1.36.30 (12 December 2022).
[97] T2.28.40 (13 December 2022).
[98] T3.67.5 (14 December 2022).
[99] T3.67.10 (14 December 2022).

of breath, which was quite clearly very severe and progressive, to have been recognised. It's very hard to form relationships with people who have a natural, and understandable, mistrust of Western institutions and Western health care, and I have seen many times where Aboriginal Liaison Officers have really helped articulate what's going on with an individual so that Western practitioners can appreciate what was actually occurring for that person."[100]

85. In written submissions on behalf of Reuben's sister, Amber Brown, it was submitted that had there been Aboriginal Liaison Officer assisting Reuben, better health outcomes could have been achieved and it would have allowed for a greater, more effective, and holistic wrap-around approach to Reuben's health. Counsel for Ms Brown drew the court's attention to the fact that several witnesses Dr Corbett, Dr Quilty, Dr Wilson, and Associate Professor Basson each gave evidence about the benefit of Aboriginal Liaison Officers when treating Aboriginal patients. It was further submitted that an Aboriginal Liaison Officer could have assisted to encourage, mentor, and advocate for Reuben in the custodial setting and to bridge the gap that very often exists between Aboriginal patients and treating practitioners. Further, it was submitted that Aboriginal Liaison Officers, where appropriate, may act as a conduit between inmates and their loved ones on the outside. The court was informed that Ms Brown and Reuben's family were heartened to know that there was, at the time of the inquest at least, an Aboriginal Liaison Officer at Junee Correctional Centre and that there is, at present, a current job being advertised for an Aboriginal Liaison Officer at Junee Correctional Centre. Nevertheless, the court remains extremely concerned about the staffing of these positions.

86. Ms Brown, in submissions prepared by her counsel, espoused that she: *"strongly believes that more could have been done to facilitate better health and the overall well-being of Reuben, particularly with respect to his diet and exercise*" and that "*Reuben would have benefited from better education regarding healthy diet options*" which is something "*an ALO could be integral in developing and coordinating to ensure that the delivery of such education and programs is culturally appropriate and well-received and engaged in by Aboriginal inmate*".

87. In written submissions on behalf of the GEO Group, it was submitted that GEO Group notes and entirely accepts the Family's Submissions in relation to the important role of an Aboriginal Liaison Officer. It was submitted that GEO Group is committed to having two full time Aboriginal Liaison Officers which it considers to be an invaluable resource for the inmates and the delivery of health services at the Junee Correctional Centre.

88. The evidence established that there were significant deficiencies in the organisation and coordination of Reuben's health care. In particular, I am critical of the frequency of

[100] T4.15.15—20 (15 December 2022).

psychiatric appointments offered and the fact that important specialist services such as sleep apnoea and further cardiac investigations were not offered or available in a timely manner. The lack of input from an Aboriginal health worker or Aboriginal Liaison Officer further compromised the care given. These are systemic rather than personal criticisms of the practitioners involved.

89. I note that GEO Group alerted the court to the difficulties it faces in filling medical positions and Aboriginal Liaison Officer positions. While I accept that regional centres can experience difficulties attracting staff, I do not accept this as an excuse for sub-optimal care. If GEO Group cannot recruit and retain adequate health staff, then steps must be taken to alter the contractual arrangements in place. I intend to send a copy of these Findings to the Commissioner of Corrective Services for his information and review.

Adequacy of the consultations and assessments conducted by Dr Nachaat Wahba on 4 March 2020 and 26 August 2020

Consultation on 4 March 2020

90. Dr Nachaat Wahba, General Practitioner first reviewed Reuben on 4 March 2020. It was Dr Wahba's evidence that Reuben initially sought medical advice for an itchy patch on his back.[101] Throughout the course of the consultation, Reuben mentioned his weight and shortness of breath to Dr Wahba, although Dr Wahba said that Reuben did not express any particular concern about those symptoms.[102]

91. At the inquest, Dr Wahba recalled: "*I asked about his weight and shortness of breath that he mentioned, and, while I'm reviewing his patch, I just put the stethoscope to make sure that he is not congested… He's not congested, not oedema, not in failure…"*[103]

92. Dr Wahba recorded the following in his consultation notes: "*Sleep also during the day. Some tiredness, as well. Not nodding or falling asleep during the day. SOB, shortness of breath, due to weight and low exercise capacity. May be home on 1 November 2020. Exercise, walking an hour, slow walk, walking every day. Was 158 kilograms a few weeks ago. Today, weighs 162.1."*[104]

93. It is apparent that Dr Wahba then discussed Reuben's diet with him. Dr Wahba noted that Reuben was consuming foods such as noodles, pasta, potato chips, four slices of bread per day, a tub of butter every two to three weeks and sweet foods, including chocolate, caramel slices, and sugar.[105] The corresponding note on Reuben's medical file reads:

[101] T2.10.45 (13 December 2022).
[102] T2.11.10 (13 December 2022).
[103] T2.11.10-15 (13 December 2022).
[104] T2.10.25 (13 December 2022).
[105] T2.11.40-T12.5 (13 December 2022).

"*Bloods. Increase the exercise and decreased fat. [Carbohydrates] buyup*,"[106] indicating that Reuben was using his buyups to purchase foods that were high in carbohydrates.

94. As such, Dr Wahba formed a treatment plan that reads as follows: "*Plan. Increase exercise. Decrease carbohydrate and fats. Bloods. ECG handed to [the] nurse…Referral to sleep apnoea. ? medication side effects. ? shakes*."[107]

95. At the inquest, Dr Wahba elaborated upon his notes relating to Reuben's electrocardiogram (ECG), which was conducted the day prior to the consultation (being 3 March 2020). Dr Wahba said: "*I remember, a nurse handed to me - "this is his ECG". I see 5 - I said, "Okay, repeat this ECG because it is a bit high QTc". It's mild, yes, but high. And I told her, "Please, can you redo it?" She said to me, "Can you please sign it, to put it in the" - I said, "Yeah, I'll sign", I give it to her*."[108]

96. Dr Wahba then clarified that Reuben's ECT showed a "*longer QT*," which measures the contraction and relaxation of the heart muscle. He explained:

> "*So we usually find, in gaol, these findings, especially in gaol, because most of them are put on either antidepressants, antipsychotics - and, plus, most of them - or part of them, not most of them, use drugs. So this can prolong this electricity period in the heart electricity, and, this period, it is - if it is long, it make - and this is a conduction between the heart, when it - electricity, when it contract - and, after that, it relax - and this period, if it is long, it gives a chance to any focus of the heart muscle to put impulse and to get right off the control of the heart. So we want it to be less than 450, to be able to not have this risk."*[109]

97. It was put to Dr Wahba at the inquest that Reuben's follow-up ECG on 11 March 2020 also showed signs of prolongation of the QTc. Dr Wahba suggested that, if he had been the doctor to sight the follow-up ECG results, he would have re-called Reuben for a further appointment to discuss treatment options.[110] Unfortunately, Dr Wahba did not review Reuben again until August 2020. Instead, Reuben's second ECG result was reviewed by Dr Wahba's colleague at Junee Correctional Centre, Dr Darren Corbett. Dr Wahba and Dr Corbett did not discuss the results of Reuben's follow-up ECG.

98. At the inquest, Dr Wahba reviewed Reuben's second ECG (dated 11 March 2020) and expressed the view that there was a "*slightly mild, early moderate" elevation of the QT*".[111] He considered that had he seen Reuben for a consultation following the second ECG, he might have suspected that the cause was Reuben's antipsychotic medication, and taken

[106] T2.11.25 (13 December 2022).
[107] T2.12.10-15 (13 December 2022).
[108] T2.13.5 (13 December 2022).
[109] T2.13.35 (13 December 2022).
[110] T2.14.50-15.30; T2.17.10-20 (13 December 2022).
[111] T2.22.10-15 (13 December 2022).

steps to reduce the dosage. He may also have suspected that Reuben was taking non-prescribed medication of which Dr Wahba was not aware.[112]

99. When asked whether he believed it was important for patients to receive continuity of care, Dr Wahba responded:

> "*Continuity is there but, in the gaol system, you cannot have this. We have, like, 200 or 300 on the booking and we have - we're being allowed by 20 hours or so per week, me and my colleague, to finish this size. I don't think we'll have - as a GP outside, "Please come next week", or "Go this-and come to me". It is not easy…I usually have the habit to sit with my colleague, I believe, every Friday, for an hour, to get exchange of what's happening, because some patients work me against him and work him against me, regarding medication addition - this is one. Some patients are not favouring me or not favouring him. Some patients wanted to see him but not wanted to see him, and vice-versa; some don't like to see me. So we decide, "Okay, so you get this patient. Make sure that you are on the top of it." "Yes." "And I will do this patient if he speak" - because I speak some language, so, if patient is speaking this language and he feel not able to express himself, he insist to see Dr Wahba, for example - and this the same; if someone come to me and doesn't like to see me, just go - this is what happen, usually."*[113]

100. When asked whether Reuben's results warranted referral to a cardiologist, Dr Wahba said that the process usually takes about six months (at least) for this to occur. He did not believe that it was possible to use telehealth for a specialist consultation, such as with a cardiologist, even after the COVID-19 pandemic.[114] It seems extraordinary that telehealth consultations are not used in these situations, at least to provide an initial review with a specialist.

Consultation on 26 August 2020

101. On 26 August 2020, Reuben was referred to Dr Wahba after a drug and alcohol nursing assessment. He was referred to Dr Wahba for assistance regarding his issues with multi-drug use, namely, heroin. Dr Wahba told the court that the focus of the consultation was Reuben's potential entry into an opioid treatment program, and he: "*didn't think that there [was] any change of weight, or any change of anything regarding him - as a general health…*"[115]

[112] T2.20.5-15 (13 December 2022).
[113] T2.16.20-25 (13 December 2022).
[114] T2.18.5; T2.18.40 (13 December 2022).
[115] T2.29.5 (13 December 2022).

Adequacy of Dr Wahba's care

102. When asked for his opinion as to the management of Reuben's shortness of breath, Dr Quilty, General Specialist Physician, said:

> "*At that stage his management could entirely be kept to general practitioner, and it would be examining the systems one at a time, so an ECG would be the first thing, and it is common knowledge that an ECG doesn't exclude potential cardiac disease. I would've thought that it would be reasonable, at that stage, to get an echocardiogram, which is an ultrasound of the heart, and the ultrasound of the heart would've shown three of the four pathologies immediately, and a chest x-ray. A chest x-ray would've also demonstrated the large heart, and given that he was very obese, I think overnight sleep studies and pulse oximetry's for measuring how much oxygen was going into his blood overnight. When you are very overweight, the chest has to compete against gravity to open and close, and that weight can pressure your lungs, and reduce the effectiveness of your lungs to absorb oxygen. And I think with a 35 year old man who has such severe shortness of breath on exertion, further investigations should be warranted."*[116]

103. Dr Hester Wilson, Addiction Medicine Specialist, similarly noted in her evidence:

> "*That's a massive weight increase in a short period of time, and in someone that's complaining that they're very short of breath. Yes, people get short of breath when they're overweight, but this is a change, and certainly my first thought would be what is happening here, I need to look further. Is he actually going into heart failure? It's just the time there is so short, for that huge change in weight, and you know, potentially, it could be that he's just eating heaps more, but you've really got to think, "What else is going on here?", and look further. And I absolutely agree with the need to do further investigations. Not a cardiologist at this point, but investigations to work out what's going on, so that you can actually manage it."*[117]

104. Professor Alison Jones, Forensic Toxicologist told the court:

> "*Reasonable practice, in my view, would be an examination of the cardiovascular or respiratory system, and relevant investigations for shortness of breath that comes off the back of taking a really good history, examining cardiovascular, respiratory system, and linking on with referral if things don't look good*."[118]

105. Dr Quilty gave evidence that an ECG would not necessarily have indicated the extent of Reuben's heart condition; specifically, it might not have shown that Reuben's heart was

[116] T4.17.10-20 (15 December 2022).
[117] T4.19.20-25 (15 December 2022).
[118] T4.19.35 (15 December 2022).

dilated, that the heart muscle had become thick, and that one of the pipes to his heart was almost completely blocked. He said: *"…the problem is ECGs are not particularly good at making subtle diagnoses, and not that what Reuben had was subtle, it was actually very quite advanced heart disease, but an ECG is a rough tool, and it often misses these kinds of conditions".*[119]

106. In relation to Reuben's diet and apparent weight gain, Dr Wahba gave evidence that there is no dietician available to inmates at Junee Correctional Centre, nor is there an exercise physiologist. There are nurses and a diabetes educator, although it was noted that a diabetes educator would not consult an overweight person who was not clinically diabetic.[120]

107. Dr Wahba noted in his first statement: "*In the absence of an allied health team, including a dietician, I thought that his efforts with controlling food intake, including the quality of food he used to buy in buyups, provision of a low-calorie drink replacement of a meal, and the increase in exercise, and with the help of a diabetic educator, would spark the start of weight reduction."*[121]

108. Once again, it is clear that the level of care Dr Wahba was able to give was impacted by the resourcing of medical services at Junee Correctional Centre. He was aware of the issues Reuben faced and attempted to manage them with little support. The experts called for greater curiosity about what was actually going on for Reuben and suggested further investigations that could have taken place. Unfortunately, Dr Wahba was working within a framework where he was under continual pressure to cope with the patient load.

109. The court received correspondence from GEO Group's legal representatives which addressed some of the concerns raised about the general resourcing issue.[122] It is concerning that it appears that the rise in average inmate numbers which has occurred at Junee Correctional Centre since the time of Reuben's death has not resulted in any obvious improvement in medical coverage. Information received recorded that the current wait time to see a general practitioner at Junee Correctional Centre is approximately 100 days, and while GEO Group was attempting to remedy the situation, it continues to experience difficulties recruiting and retaining medical staff. I accept that difficulties in recruiting and retaining medical staff in a country gaol exist, nevertheless more must be done to attract staff if an adequate service is to be provided. If an adequate service cannot be provided, then contractual changes must be made.

110. The court was informed that Junee Correctional Centre still does not have a formal telehealth service that is used to consult specialists. GEO Group told the court that it was

[119] T4.10.40 (15 December 2022).
[120] T2.27.30 (13 December 2022).
[121] Exhibit 1: Tab 77, Statement of Dr Nachaat Anwar Wahba, p. 2.
[122] Correspondence from Sparke Helmore dated 30 January 2023.

"*currently in discussions with Wagga Wagga Base Hospital regarding a telehealth service and the scope of specialist consultant service that will be covered. The interface will need to be the subject of consultation with Justice Health. Nevertheless GEO hopes to have the specialist service in place as soon as practicable, noting there are a number of stakeholders to be consulted."*[123] This appears to be a positive step but one that must be approached with some urgency. Inmates at privately run prisons should not receive second rate medical care.

Whether the administration of Buprenorphine (Buvidal) to Reuben on 2 September 2020 was appropriate in the circumstances and whether there were specific risks associated with the administration of Buvidal on 2 September 2022 that required close monitoring of Reuben, or other steps to taken by health professionals to ensure his safety

111. The importance of Opiate Replacement Treatment in custody cannot be under-estimated. The program has the capacity to significantly reduce harm in the custodial environment and can also stabilise inmates ready for release. Both Dr Corbett and Registered Nurse Neucom acknowledged that unprescribed use of buprenorphine is prevalent in Junee Correctional Centre and has serious impacts for users including transmission of Hepatitis C from shared use of needles. Dr Corbett stated: "*In the last two years, we've had three spinal abscess, two endocarditis cases and two lung collapses all from dangerous drug injecting practices."*[124]

112. Nevertheless, given Reuben's complex medical presentation, including respiratory issues and morbid obesity, it was necessary to closely examine the decision to place him on the program in September 2020.

113. On 20 August 2020, Reuben disclosed a history of heroin, cocaine, amphetamine, and OxyContin use and he requested an assessment for Buvidal as he thought it would help him to resist drug use when he was released from custody on parole.

114. Although Reuben had reported use of up to 80 to 100 milligrams of Oxycontin as a substitute for heroin *before* entering custody, medical and nursing staff at Junee Correctional Centre held varying opinions as to whether Reuben had a proven *current* opiate addiction at the time he was placed on the program.

115. Registered Nurse Neucom explained in her statement that on 23 April 2020, she was working a morning shift from 6.30am to 2.30pm in the medical clinic, and saw Reuben at about 12.51pm because he wanted to go on the wait list to be seen for a drug and alcohol comprehensive medical assessment to see if he was suitable to be placed on the Opioid Substitute Treatment Program. During this consultation, she observed fresh track marks on

[123] Correspondence from Sparke Helmore dated 30 January 2023.
[124] T3.70.25 (14 December 2022).

his arms. When asked about Reuben's response to her questions about the source of the track marks, Registered Nurse Neucom stated: "*He told me that he was using 'bup' which was Buprenorphine, and that he had been injecting down in the unit".*[125]

116. However, some months later when reviewed by Dr Wahba on 26 August 2020, Dr Wahba recalled that Reuben was not able to easily quantify his current use of Buprenorphine. Reuben allegedly stated to Dr Wahba that he was injecting eight milligrams of Buprenorphine weekly. However, Dr Wahba noted that at the time of that appointment, during COVID-19 related restrictions on visitors to correctional centres, an eight milligram strip of suboxone was greatly inflated in price, retailing for around $1,200. Dr Wilson stated a higher figure of $2,000 for the same quantity. Ultimately, Dr Wahba formed a view that Reuben was unlikely to be able to afford unprescribed suboxone.

117. Dr Wahba acknowledged that as a result of the high costs and supply shortages arising from COVID-19 restrictions, Reuben may have been using lesser or unknown quantities of unprescribed opiates. He stated:

> "*So I usually go to him again, about what "you use", again, and he state that - he was not able to quantify, because - what happens usually, they use in groups or individual, and it's not every time once a day; could be twice a day. What I understand from what he say, is about one to four. This is what his level - and he take two - one strip of eight. If available more, he will take, but, is not available, he - little - to take 8 milligram per week. And he cannot give details because - I get from every place - like, I get information - I cannot get him to be clear - every injection, maybe one but it could be four* ."[126]

118. At the time of Reuben's prescription, Registered Nurse Neucom acknowledged that there was no policy requirement for drug and alcohol assessments to include a urine sample. Dr Wahba agreed that he was prepared to refer Reuben to the Opioid Substitute Treatment Program without a urine sample. He alerted the court to the inherent danger of mandating a dirty urine. He suggested that requiring a positive urine sample was inviting patients in custody to use unprescribed drugs specifically to test positive and be considered eligible for the program. When asked about referral without a positive urine sample for opiates, he stated:

> *"Yes, because, if I asked him [for] urine at any stage, he… a person can go and use [opiates] and [say]- "look, positive. I'm eligible [for the Opioid Substitute Treatment Program]". We can't [with] argue that."*[127]

[125] T3.70.18-19 (14 December 2022).
[126] T2.31.30 – 50 (13 December 2022).
[127] T3.38.37-38 (13 December 2022).

119. In July 2020, Reuben weighed 162.6 kilograms and was categorised as morbidly obese. Dr Wahba agreed that the risk involved in prescribing Buvidal to Reuben was increased by his weight, but stated that he calculated the risk as less than the risk of unprescribed use of suboxone.[128]

120. The court heard a variety of views on the decision to start Reuben on the program. When asked what he might have done in the circumstances, Dr Corbett said, "*on balance I think I would have started him on Buvidal as well."*[129]

121. Dr Quilty was less convinced, stating:

> "*The decision to commence opioid substitution treatment program seems to have been based on minimal evidence of opioid dependence, and was dangerous in the light of Reuben's significant chronic respiratory compromise, morbid obesity, and suspected obstructive sleep apnoea, unknown but potential cardiac disease, and prescription with sedating antipsychotics, and the fact that his oxygen saturations were low, 94%, on the day that the first and final dose of Buvidal was administered.*[130]

122. Professor Alison Jones also expressed some reservations stating: "*given [Reuben's] morbid obesity and likely risk of sleep apnoea and respiratory compromise, I would have been hesitant to prescribe Buprenorphine to him, albeit in the small dose, 4 milligrams, on which he was commenced*."[131]

123. Dr Wilson also assessed the decision in the light of information that Reuben had been sourcing sleeping pills and that there were unconfirmed accounts that he may have been suffering sleep apnoea, although there had been no conclusive diagnosis of the condition.[132] In this context, she noted that Buprenorphine is a safer alternative to methadone in people with co-occurring sleep apnoea and opioid dependence, and is preferred in people with a history of or risk of sleep apnoea.[133] Dr Wilson also stated that: "*I just want to correct that there was a 4mg sublingual dose given, not subcutaneous, sublingual, so it was in the mouth, and that was the first one on day one of his treatment, and then on day two he was given a subcutaneous, or injection, under the skin of 8mg of buprenorphine*."[134]

124. Having considered all the evidence it appears that while Reuben's medical history was complex, it was at least open to medical staff at Junee Correctional Centre to prescribe

[128] T2.47.30 (13 December 2022).
[129] T3.62.35 (14 December 2022).
[130] Exhibit 1: Tab 152, Expert Report of Dr Simon Quilty, General Health Physician, p. 2.
[131] Exhibit 1: Tab 149, Expert Report of Professor Alison Jones, Toxicologist, p. 8; T2.47.30 (13 December 2022).
[132] T3.36.20 (14 December 2022).
[133] T3.65.40 (14 December 2022).
[134] T4.11.32-35 (15 December 2022).

Buprenorphine. In prescribing Reuben with Buvidal, Dr Wahba prioritised risks associated with the use of unprescribed opioid substitutes in Junee Correctional Centre, and the risk of future relapse upon his re-entry into the community during parole. Dr Wahba considered Reuben's medications and co-morbidities, but ultimately, he felt the risks to Reuben's health were better managed by entry onto a program than by leaving him unmedicated in the uncontrolled environment of the cells or the community. I understand the decisions he made and accept that different minds may give different weight to the complex factors involved.

125. Nevertheless, I remain somewhat concerned about the way the drug was administered, noting NSW Health guidelines which suggest a minimum of seven days on Suboxone. On 1 September 2020, Reuben was given suboxone ahead of commencing Buvidal, which ultimately occurred on 2 September 2020. When asked about the contravention of the NSW Health guidelines, Dr Wahba stated that he believed any reaction or response to the Suboxone will be on the spot, within half an hour/an hour, it will show what will happen [135].

126. With the benefit of hindsight, given Reuben's comorbidities and use of multiple prescription drugs, the risk of respiratory distress caused by Buvidal should perhaps have been more closely monitored. I accept the evidence of Dr Wilson in this regard. In her expert report, she found:

> "*In normal circumstances Mr Button's induction to OAT was within guidelines and appropriate. The issue that remains unresolved is the level of Mr Button's neuroadaptation to opioids. The NSW guidelines suggest that assessing for intoxication and withdrawal is part of the comprehensive assessment prior to deciding to commence OAT. This assessment is important as intoxication is associated with increased overdose risk and withdrawal severity measures the severity of dependence allowing an estimation of the correct starting dose. I suggest that assessment of intoxication and withdrawal could have assisted with safe induction for Mr Button to OAT, and it is not clear if this was undertaken. I suggest, given Mr Button's comorbidities, a longer period of lower dose sublingual buprenorphine may have been appropriate. In the prison setting it may have been appropriate to manage this as a hospital inpatient."*[136]

127. The real life difficulties of monitoring a patient in the custodial setting were addressed by Dr Corbett. He said that it would have been difficult or impossible to undertake close monitoring of Reuben after commencing Buvidal. Prison authorities are always concerned about drug diversion and appropriate facilities to monitor patients did not exist at Junee Correctional Centre. He told the court that monitoring Reuben would have been difficult:

[135] T2.62.25—30 (13 December 2022).
[136] Exhibit 1: Tab 151, Expert Report of Dr Hester Wilson, Addiction Medicine Specialist, p. 28.

"*That means we would have to put him in what we call a RIT cell, which are really the suicide-watch cells up in the medical unit. And then someone would have had to walk by and check him. …Walk by the cell and check him, and do his pulse oximetry… continuously. …We have never done it for anyone we've started on methadone or buprenorphine. I've prescribed opioid substitute therapy on the outside. We never do that.*[137]

What contribution, if any, did the administration of Buvidal play in Reuben's death, noting that the toxicological analysis indicated no detection of Buvidal in his blood at autopsy

128. As noted above, Reuben's toxicology results did not show the presence of the Buvidal injection from 2 September 2020. This remains somewhat of a mystery. It is possible that the drug was still present in very small quantity, below the reporting levels but the court had no evidence of this. Professor Alison Jones, an experienced medical practitioner and forensic toxicologist, gave evidence at the inquest in relation to Reuben's cause of death. She stated that: "*the fact that we could not detect the buprenorphine in the post-mortem blood, tells me that the Buprenorphine, this opioid drug, is not responsible for Reuben's death, in my opinion."*[138] I accept her opinion in this matter.

129. However, Professor Jones also agreed that it was *possible* the Buprenorphine could have interacted with the factors that contributed to Reuben's death. Dr Simon Quilty also noted in his report: "*The absence of Buprenorphine in the autopsy makes it less likely that administration of buprenorphine directly contributed to the death, but it doesn't discount its contribution.*[139]

130. In my view, it is very difficult to determine exactly what impact Buvidal had on Reuben's health. Reuben had used drugs, both prescribed and unprescribed over many years. There is no doubt that drug use may have impacted his cardiac health in some way over the years. However, it has not been established that Buvidal was a causative factor in his death. Similarly, while other medications were present in his post mortem drug toxicology, including unprescribed mirtazapine, it is not possible to assess the real effect these other drugs had on his health. It has certainly not been established that these other drugs caused his death.

131. I accept that Reuben's death is correctly recorded as ischaemic heart disease secondary to coronary atherosclerosis. I note the complicated background factors set out in the post mortem report.

[137] T3.61.20—35 (14 December 2022).
[138] T4.11.20—25 (15 December 2022).
[139] Exhibit 1: Tab 152, Expert Report of Dr Simon Quilty, General Health Physician, p. 12.

The need for recommendations

132. Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the circumstances of each death.

133. Counsel assisting put forward a number of recommendations arising out of the evidence for the court's consideration. I will deal with each in turn. The first three were directed to Justice Health and Forensic Mental Health Network (Justice Health).

That Justice Health implement a procedure for Aboriginal Health Liaison staff to explain the risks of any new therapy or medication to Aboriginal patients receiving care in corrective services

134. This recommendation grew out of the expert recognition that Aboriginal Health Workers or Aboriginal Health Liaison Officers can be game changers when they are involved in the medical management of First Nation patients in the custodial environment. I accept that best practice would mandate the kind of involvement contemplated by counsel assisting.

135. The independent experts and general practitioners contracted to GEO Group all spoke of the way in which Aboriginal Health Workers' (AHWs) ability to build rapport and trust with ATSI patients has the capacity to improve health outcomes. It follows that high quality care would see them involved when new therapies and treatments are contemplated. Counsel for Reuben's family, Dr Wahba, and Dr Jones were supportive of the recommendation.

136. Unfortunately while Reuben had previously seen AHWs while under the care of Justice Health, he did not see one at Junee Correctional Centre.

137. I note that Justice Health opposed the making of the recommendation. While the recommendation was directed to Justice Health, the court is aware and understands that Justice Health does not provide health staff or supervise the provision of health services at Junee Correctional Centre which were the subject of review in this inquest.

138. I also accept that the inquest did not hear detailed evidence about the current availability of AHWs or the policy describing how they are deployed within Justice Health. Justice Health informed the court that it is committed to growing Aboriginal staff representation and currently has funding for seven AHWs across the state.[140] Nevertheless, it was submitted that the proposed recommendation, which would require an AHW to explain the risks of

[140] Final Submissions provided to the Court by Justice Health.

"*any new therapy or medication*" to Aboriginal patients was so broad as to require AHWs to be present at "*almost all health events"*. Justice Health explained that the recommendation is currently impractical as there are insufficient AHWs to allow this to occur. It was submitted that these scarce resources must be directed to those most in need.

139. Given the way the recommendation was framed in counsel assisting's submissions, GEO Group did not comment directly on the recommendation. However, it informed the court that while Reuben did not see an AHW, there are now two full time Aboriginal Liaison Officer positions at Junee Correctional Centre.[141] Given the number of inmates currently held at Junee Correctional Centre, it seems to follow that it is likely that there are insufficient AHWs or Aboriginal Liaison Officers for them to be involved in explaining the risks of all new therapies and medications.

140. I have no hesitation in accepting the importance of having AHWs involved in consultations where risks need to be explained. However, I accept the submission that Justice Health has no direct control over this issue at Junee Correctional Centre and I have for this reason decided not to make the recommendation as drafted. However, as previously stated I remain very concerned about the apparent lack of availability of AHWs at Junee Correctional Centre. While I was informed that two Aboriginal Liaison Officer positions existed, I remain unsure about whether they need to have any particular health training. I was informed that at least one position was vacant for a period of time. Once again, I suggest that if GEO Group cannot provide this essential resource, immediate steps should be taken to review and enforce its contractual obligations to provide appropriate medical care to the First Nations prisoners in its care. It is a matter I intend to bring to the attention of the Commissioner of Corrective Services.

That Justice Health implement a policy mandating regular multidisciplinary care meetings to discuss management of patients with complex histories and multiple comorbidities

141. Justice Health opposed the making of this recommendation. In short, it was submitted that Justice Health already has adequate policy in place to manage patients with chronic conditions such as Reuben. The process commences with a Reception Screening Assessment (RSA) which is completed on entry into custody. From there a Chronic Disease Screen (CDS) is conducted for all patients with a confirmed condition, as well as ATSI inmates over 35 and other patients over 55 years of age. The findings of the CDS will inform the clinical pathways then provided. A Multidisciplinary Care Plan (MCP) is completed when called for.

142. Counsel for Justice Health summarised the way in which this process played out for Reuben. Some of it occurring while he was cared for by Justice Health staff and some while

[141] Final Submissions provided to the Court by GEO Group.

he was at Junee Correctional Centre and cared for by GEO Group staff. His initial RSA was performed on 6 May 2015.[142] He was identified as an Aboriginal man with schizophrenia. A CDS was completed on 3 December 2015.[143] A multidisciplinary consultation was not considered necessary at that stage, but records indicate he saw an AHW employed by Justice Health at South Coast Correctional Centre on at least twenty-one occasions across a two year period.[144] The CDS was reviewed and updated on 24 July 2017.[145] An MCP was created for Reuben, with the most recent version being updated in March 2020[146].

143. Counsel for Justice Health submitted that the question of whether an earlier multidisciplinary consultation should have taken place was not squarely considered on the evidence. Nor was the policy relating to the procedure examined in any detail during the inquest. I accept that submission.

144. However, the evidence establishes that Reuben's health issues were not approached in a wholistic manner, particularly in the period before his death. It is clear that during his time at Junee Correctional Centre he would have benefitted from working with a dietician, AHW and exercise coach. Further cardiac and sleep investigations appear to have been warranted. There appears to have been little *coordination* of his psychiatric care, substance use care, and general medical care.

145. In all the circumstances, while I accept that it is not necessary to make this recommendation to Justice Health, it is apparent that prior to Reuben's death his medical care was not approached in a wholistic manner. It is clearly a matter for GEO Group to review and I intend to send a copy of these findings to the GEO Group Board of Directors.

That Justice Health require consultation with an addiction specialist prior to prescription of opioid substitutes

146. Reuben's family supported this recommendation and in submissions Amber Brown urged Justice Health "*to take greater care when prescribing opioid substitutes*".

147. Justice Health opposed this recommendation and drew the court's attention to relevant policy, including *"OAT no 1: Assessment and Commencement for Opioid Agonist Treatment (OAT)*"[147] and the publicly available policy "*NSW Clinical Guidelines: Treatment of Opioid Dependence – 2018.*" Justice Health submitted that these policies already ensure that the prescribing of a treatment such as Buvidal is managed by appropriately trained staff. According to policy, there must be an assessment by a Medical Officer or Nurse Practitioner who is appropriately qualified to prescribe OAT. Additionally, it was submitted that within

[142] Exhibit 1: Tab 119, Justice Health Records, p. 185.
[143] Exhibit 1: Tab 119, Justice Health Records, pp. 233 -238.
[144] Exhibit 1: Tab 119, Justice Health Records.
[145] Exhibit 1: Tab 119, Justice Health Records, pp. 306 and 310.
[146] Exhibit 1: Tab 119, Justice Health Records, p. 574.
[147] Exhibit 4.

Justice Health NSW there are at least five staff Specialists, including the Clinical Director, Drug and Alcohol, who are Fellows of Addiction Medicine. Further there are at least three psychiatrists with a subspecialty in Addiction Psychiatry. These practitioners may be called upon for advice with complex patients. Following assessment there is the final approval process with the Pharmaceutical Regulator Unit at the Ministry of Health.

148. I accept the matters put and remind GEO Group that expertise from Justice Health can be drawn upon when necessary.

That the GEO Group supports medical and nursing staff to ensure any issues with access to medical records are speedily resolved

149. The court was concerned during Dr Jones' evidence to hear of his limited access to medical records. I note that this appears to have occurred while he was consulting and using audio visual link during the COVID-19 period.

150. GEO Group informed the court that consultations have now reverted to in person consultations and that all staff should have access to both the JHESS and PAS system. Moreover, the court was informed that all medical and nursing staff have now been reminded of the issue. Justice Health in a letter to the court advised that in June 2022 the Justice Health Commissioning Unit conducted an onboarding process meeting which provided refresher training to Private Operators in relation to the processes for onboarding staff and access to Justice Health electronic medical records.[148]

151. In all the circumstances, I am persuaded that this issue has been resolved and that a recommendation is not required.

That GEO Group prioritises improvement of the staffing ratios of doctors and nurses to inmates at Junee Correctional Centre to reduce waitlists and accommodate the increasing numbers of inmates at the centre

152. GEO Group stated that it had no "*in principle objection*" to the proposed recommendation. However, it drew the court's attention to the very real recruitment issues it has experienced. The court was informed that GEO Group was hopeful that a new relationship with a large Wagga Wagga general medical practice *might* solve some of the difficulties. In my view, it is far too early to tell.

153. The evidence establishes that Junee Correctional Centre continues to have long waiting lists, well after the particular difficulties caused by the COVID-19 lockdown crisis.

[148] Exhibit 6.

154. The State must accept responsibility for the care of prisoners it outsources to private providers. If private providers cannot recruit sufficient and appropriate medical staff, contracts should be re-considered.

155. It appears that Junee Correctional Centre also need to prioritise the staffing ratios of AHWs. The court was informed that their two Aboriginal Liaison Officer positions were recruited, one commencing in January 2021, but resigning in November 2022 and one commencing in June 2022. GEO Group informed the court that it considers these positions are invaluable but has had difficulty in recruiting a suitable person for the second position.

156. In my view, the provision of culturally appropriate care at Junee Correctional Centre is severely compromised by having only one active Aboriginal Liaison Officer position. While GEO Group stated they are committed to having two full time staff, this is also likely to be inadequate given the numbers at the gaol and the matters disclosed in these proceedings.

157. Reuben's sister, Amber Brown is convinced that the provision of an Aboriginal Liaison Officer or AHW would have assisted Reuben. She spoke powerfully to the court on this issue as follows: *"…the importance of an Aboriginal Liaison Officer to connect with the families because you have medication to help people … but we actually heal the heart. We heal your head [emphasis added]. The family will help you … let the families do that, take the pressure off the doctors, take the pressure of the psychologists, and let us do our job, let us be there for our people, and our brothers, and our sisters, because that's effortless for us. We don't need a degree in that."*[149]

158. In my view, it is both necessary and desirable to make this recommendation. While the draft recommendation did not include AHWs, in my view they should be included. I am satisfied that there is no particular unfairness to do so given that the importance of these workers was well canvassed at the hearing and GEO Group had the opportunity to provide information about the staff they had and the difficulties they experienced in recruitment.

That Justice Health continue to advocate for a trial for access to Medicare for Aboriginal inmates

159. Counsel assisting reminded the court of evidence recorded in the *inquest into the death of Kevin Francis Bugmy* which disclosed that that access to Medicare would greatly improve the holistic provision of health care to prisoners during their time in custody and improve continuity of care after they are released. During those proceedings Dr Gary Nicolls, Clinical Director, primary Care Medicine within Justice Health, among others outlined the benefits which would accrue to inmates if Medicare could be accessed in custody. The services available would increase and could include allied services such as psychology. Access to Medicare would also assist the continuity of care for people as they move between gaol and

[149] T4.41.11—18 (15 December 2022).

living in the community. For example, it would be possible to refer inmates to Aboriginal medical services or their local doctor and there would be reviews on discharge or release from prison and access to the electronic health records. The issue has also been raised in other inquests.[150]

160. Reuben would have benefitted from having had access to a number of allied services that may have been available through contact with a local Aboriginal controlled medical service.

161. Justice Health submitted that it is unnecessary to make the recommendation in circumstances where Justice Health will continue to advocate for Medicare access to be expanded for Aboriginal inmates and where the former NSW Minister for Health, Mr Brad Hazzard has raised the issue with the Federal Minister for Health and Aged Care.

162. While I accept that Justice Health will continue to advocate for a Medicare trial for Aboriginal and Torres Strait Islander prisoners, I do consider it necessary to repeat the formal recommendation when the issue remains urgent and unsolved. I intend to make the recommendations and to send a copy of these findings to the current NSW Minister for Health and Minister for Regional Health, the Federal Minister for Health and Aged Care, the NSW Minister for Aboriginal Affairs and Treaty, and the Federal Minister for Indigenous Australians for their consideration of this important issue.

Findings

163. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The person who died was Reuben Clarke Button.

Date of death

Reuben died on 3 September 2020.

Place of death

Reuben died at Junee Correctional Centre, Junee NSW.

Cause of death

Reuben died of ischaemic heart disease secondary to coronary atherosclerosis as an antecedent cause. Other significant conditions contributing to his death were diabetes mellitus, hypertension, obesity, and cardiomegaly.

[150] See for example Inquest into the death of Mootijah Douglas Andrew Shillingsworth (2018/0054603).

Manner of death

Reuben died in custody. The health care he received in the period before his death was hampered by significant resourcing issues at Junee Correctional Centre and systemic factors including long wait periods for specialist appointments, lack of access to an Aboriginal Liaison Officer and/or Aboriginal Health worker, lack access to specialist health services, and the impact of COVID-19 lockdowns on inmate transfers between correctional centres.

Recommendations pursuant to section 82 *Coroners Act 2009*

164. For the reasons stated above, I recommend:

To the GEO Group Board of Directors

> **That GEO Group prioritises improvement of the staffing ratios of doctors, Aboriginal health workers and nurses to inmates at Junee Correctional Centre to reduce waitlists and to provide culturally appropriate care for the increasing numbers of inmates at the centre**

To Justice Health and Forensic Mental Health Network

> **That, consistent with the recommendation in the Inquest into the death of *Kevin Francis Bugmy*, JHFMHN should continue its work advocating for a trial for access to Medicare for Aboriginal inmates. In this context, JHFMHN should consider liaising with its equivalent or counterpart bodies in other States to coordinate and advocate for a trial process involving Medicare being made available by the Commonwealth to Aboriginal inmates**

165. A copy of these findings should be provided to the NSW Commissioner of Corrective Services, the GEO Group Board of Directors, the NSW Minister for Corrections, the NSW Minister for Health and Minister for Regional Health, the Federal Minister for Health and Aged Care, the NSW Minister for Aboriginal Affairs and Treaty, and the Federal Minister for Indigenous Australians.

Conclusion

166. I offer my sincere thanks to counsel assisting, Dr Peggy Dwyer and her instructing solicitor Clara Potocki for their hard work and enormous commitment in the preparation of this matter and in drafting these findings. I also thank Nicolle Lowe, ACISP worker at this court for her enormous contribution.

167. Finally, once again I offer my sincere condolences to Reuben's family, especially Amber Brown.

168. I greatly respect Ms Brown's decision to participate in the coronial investigation and inquest. She has shown enormous grace and fortitude. As her counsel noted in submissions, her participation was always "*within the spirit of the jurisdiction and the outcomes it sets to achieve*". I acknowledge her family's ongoing sorrow, grief, profound loss, and the continuing anguish of Reuben's death.

169. As set out by counsel assisting in her submissions, "*nearing the end of his non-parole period in custody, Reuben saw a bright future for himself. It is a tragedy that he passed away so shortly before he would have been released into the community. He is remembered affectionately for his great sense of humour, ability to cheer people up, and willingness to have a joke with everyone he encountered*."

170. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner, NSW State Coroner's Court, Lidcombe
21 July 2023