CORONERS ACT, 1975 AS AMENDED

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Whyalla and Adelaide in the State of South Australia, on the 9th, 10th and 11th days of December 2002, the 12th, 13th and 24th days of February 2003 and the 28th day of March 2003, before Anthony Ernest Schapel, a Coroner for the said State, concerning the death of Justin Malcolm Rogers.

I, the said Coroner, find that, Justin Malcolm Rogers aged 27 years, late of 3 Mepstead Street, Whyalla, South Australia died at Whyalla, South Australia on the 29th day of June 2000 as a result of Propoxyphene toxicity.

1. Introduction

1.1. Justin Malcolm Rogers, the deceased, was 27 years of age when he died in police custody in the early hours of the morning of 29 June 2000. He lived at 3 Mepstead Street, Whyalla. These were premises of which he was the usual occupant. In the weeks preceding his death, the deceased had befriended a woman by the name of Margaret Rogan. She and her son, Rex, aged 13 at the time, were living at the Mepstead Street address at the time of the deceased's death. In the days preceding his death, the deceased had befriended one Andre Connell, his association with whom led to the deceased acquiring a large amount of Propoxyphene, commercially known as Doloxene, the ingestion of which caused the deceased's death. It will be understood in these findings that a reference to Propoxyphene or Doloxene is a reference to the same substance.

1.2. The deceased suffered from chronic paranoid schizophrenia. It is thought that he developed this as a result of an industrial accident in 1992. At the time of his death, the deceased had been prescribed Zuclopenthixol in relation to his schizophrenia.

This drug was administered by injection on a regular basis by staff of the Whyalla Mental Health Team. The last time the drug was administered before his death was at 1pm on 28 June 2000. I received in evidence a statement verified by affidavit of Gary Dugan, the Team Leader of the Whyalla Mental Health Team (Exhibit C15, C15a). His statement describes a pattern of drug abuse on the part of the deceased. It mentions a number of medications in this regard and suggests that the deceased had been exhibiting drug seeking behaviour in the months preceding his death. In particular, the statement suggests that the deceased 'would also engage other people to assist him in these goals through manipulation'. As far as the deceased's behaviour was concerned, it was the experience of the Whyalla Mental Health Team that the deceased was generally unmanageable with traits such as pacing, agitation and irritability. He was noted to become more verbally aggressive when under the influence of drugs of abuse and would engage in loud shouting. Mr Dugan had never seen the deceased be physically violent towards any person.

1.3. On 27 June 2000 at about 12:30pm, some 39 hours prior to his death, the deceased and Andre Connell presented at the rooms of the Playford Clinic in Whyalla and there consulted Dr Gerhard Rossouw, a medical practitioner who emigrated from South Africa in April 2000. Dr Rossouw was under the supervision of local medical practitioners, pending the recognition of his South African medical qualifications. Dr Rossouw was nevertheless permitted to consult with patients. One of those patients was Andre Connell who had been consulting Dr Rossouw in relation to a personality disorder problem. Connell, current whereabouts unknown, was a self-confessed drug abuser. I received in evidence a written statement made by Connell (Exhibit C23a) in which that is patently clear. Dr Rossouw knew that he was a drug abuser as Connell had told him that when he first started treating him. Connell had consulted Dr Rossouw, inter alia, to receive anti-inflammatory injections, sleeping tablets and pain killers for back pain. The pain killers were Doloxene for which Dr Rossouw issued prescriptions to be filled on a daily basis pursuant to an arrangement made with the Monarch Pharmacy at the Westlands Shopping Centre in Whyalla. This arrangement, according to Dr Rossouw, was made because of Connell's known history of drug abuse.

1.4. Doloxene is a pain killing drug. I heard evidence from Dr Harold Lane, an experienced general practitioner in the mid-north of the State, about the nature and

effects of Doloxene. I deal in more depth with his experience, expertise and qualifications later in these findings in another context, but he described in his evidence the circumstances in which this drug might be prescribed. Dr Lane told me that for moderate to severe pain he would normally prescribe Panadeine Forte and would reserve Doloxene for people who were not obtaining pain relief from Panadeine Forte. Doloxene is perhaps slightly stronger than Panadeine Forte. In his view Panadeine Forte is a safer drug than Doloxene as the latter presents a more serious dependency problem. To his knowledge, Doloxene is taken as a substance of abuse, the perception being that it gives the abuser 'a high', to make them hallucinate or achieve a feeling of greater well-being. An extract from MIMS Annual produced in evidence (Exhibit C22b) refers to possible reactions of euphoria and hallucination. It states that contraindications to its usage include concomitant use of alcohol in patients with abuse potential or a history of alcohol or substance abuse. MIMS suggests that it should not be prescribed for patients who are suicidal or prone to drug dependency. It also states that excessive doses of the drug are a major cause of drug related deaths, suggesting also that its judicious prescribing is essential to its safe use and that it should not be taken in doses higher than those recommended by a doctor. The usual adult does is 100mg, four hourly as needed. MIMS also refers to the drug's potential to induce dependence. The most commonly reported adverse reactions to the drug are dizziness, sedation, nausea and vomiting. Professor Byard who conducted the post-mortem examination of the deceased's body also gave evidence of its potentially fatal effects. I deal with this evidence when I come to discuss the deceased's cause of death.

1.5. The deceased's attendance on the afternoon of 27 June was the first occasion Dr Rossouw had met the deceased. He saw both Connell and the deceased together. Dr Rossouw was later to tell the police that the deceased complained of chronic headaches and that the only thing that worked was Doloxene, the very pain killer Dr Rossouw had been prescribing for Connell. In circumstances that give rise to a number of issues in this inquest, Dr Rossouw gave the deceased a prescription for 100 Doloxene capsules.

1.6. Later that day, the deceased attended with Connell at another Monarch Pharmacy, situated in Playford Avenue, Whyalla. He asked for the prescription to be filled. At that time, only 50 capsules were in stock. They were supplied to the deceased. On

the following day, the deceased re-attended at the same pharmacy and was able to purchase the remaining 50 Doloxene capsules.

1.7. The deceased died in police custody in the early hours of 29 June. Incidents involving the deceased which took place at his house and at the home of an estranged female partner had occurred earlier during the night. I will describe the circumstances of these incidents and the precise cause of the deceased's death presently, but it is as well to observe that a post-mortem examination conducted with respect to the deceased's body revealed a fatal concentration of propoxyphene in his bloodstream. An issue canvassed during the course of the inquest was whether this fatal toxicity had led directly to the deceased's death or rather, whether the presence of the drug had, by various mechanisms, led to the deceased dying as the result of the aspiration of his stomach contents. I will deal with that issue as well, but it is clear that by whatever mechanism the deceased died, it was as the result of the ingestion of an excessive amount of the Doloxene that had been prescribed for him by Dr Rossouw on 27 June and which had been acquired by the deceased on that day and on the following day from the Monarch Pharmacy in Playford Avenue, Whyalla.

1.8. It is against that background that the events of the early hours of the morning of 29 June 2000 have to be examined.

1.9. In the evening of 28 June 2000 an incident occurred at the Mepstead Street premises occupied by the deceased. During this incident, the deceased had evidently been suffering from delusions that he was talking to God and the Devil. He had been drinking and smoking marijuana and he started to talk about death and dying. At one point he threatened to kill both himself and Ms Rogan if she would not marry him. He was seen to swallow some pills by Ms Rogan. He obtained a knife and cut his wrist. He left the house holding the knife. Ms Rogan's young son went to Westlands where he rang 000.

1.10. The deceased had at one time maintained a relationship with a woman by the name of Kerrilyn Francis. She had borne a son to him. The deceased had failed to come to terms with the fact that this relationship was long over. As it so happened, Ms Francis lived in the next street to the deceased. That was Phillips Street in Whyalla. She lived with her children at number 9.

1.11. The deceased proceeded in his agitated state to Ms Francis' premises. He took the knife with him. The time was by now something after 2am. Ms Francis was asleep on a mattress on the floor of one of the bedrooms of the premises. The deceased broke into her house by smashing the front door and he proceeded to the bedroom occupied by Ms Francis. He there attacked Ms Francis with the knife but fortunately inflicted only superficial injuries. The deceased told her that he loved her and that he wanted her to come with him. One possible interpretation is that he wanted to kill her as well as himself. Meanwhile the SA Ambulance Service and the police had been called as a result of Ms Rogan's son's 000 call. Two uniform mobile police patrols responded to the tasking. Both patrols had been in the near vicinity. They both went to the Mepstead Street address first. The deceased had left, but the officers of one of the patrols then proceeded into Phillips Street where they saw the deceased breaking the door to Ms Francis' house. The other patrol arrived on foot, having left their vehicle in Mepstead Street. All officers entered the premises. The two male officers rescued Ms Francis from the attack, but not before one of the male officers had attempted to subdue the deceased with OC spray and the other male officer had struck him in the face. The deceased was ultimately subdued and after a struggle in the premises he was handcuffed behind his back, removed from the house and placed on the ground in the front yard. The deceased continued to struggle on the ground, but in due course quietened down. An ambulance crew arrived after a number of minutes. When they examined the deceased lying on the ground they discovered he had suffered a cardiac arrest. The two ambulance officers applied resuscitative measures but to no avail. The deceased had died, very likely as he lay on the ground in the front yard of the premises.

1.12. The fact that the deceased had gone into cardiac and respiratory arrest had not been observed by any of the police officers into whose custody the deceased had been taken. This inquest was mandatory pursuant to the provisions of the Coroners Act 1975 because the deceased died while in lawful custody. However, a number of issues arose in the course of the inquest which required particular scrutiny. I investigated whether any act or omission on the part of any police officer or officers could have contributed to the deceased's death. In particular, I examined whether any measures could have been taken to detect the fact of the cardiac and respiratory arrest and whether anything could have been done to commence effective resuscitative measures before the arrival of the SA Ambulance Service. I also examined the issue

as to whether any relevant SAPOL protocols or operational guidelines had been observed in relation to the welfare of persons in police custody. Another issue examined at the inquest was whether it had been appropriate for Dr Rossouw in all of the circumstances to have prescribed the quantity of Doloxene capsules that he did.

2. The cause of death

2.1. A post-mortem examination of the deceased was performed. I have already referred to the fatal concentration of propoxyphene in the deceased's bloodstream. He also had a blood alcohol concentration of 0.02%, a not significantly high reading. The post-mortem examination itself was conducted by Professor Roger Byard who gave evidence before me. Professor Byard's post-mortem report was also produced in evidence (Exhibit C47). Before dealing with Professor Byard's evidence, which contained a significant modification of his original opinion as to the cause of death, it is important to examine Professor Byard's opinion as to the cause of death as expressed in his report in conjunction with the objective evidence of the circumstances of the deceased's death.

2.2. Professor Byard expressed the view in his report that death was due to aspiration of vomitus with filling of upper and lower airways with gastric contents. Professor Byard had observed aspirated food within the upper airways and lungs and he had noted that there was documentation of vomiting made by ambulance personnel at the scene. One of the more frequently recognised adverse effects of propoxyphene is nausea and vomiting. Professor Byard also made the observation that the amount of material in the airways, observed both at the time of autopsy and in microscopic slides, was far in excess of that normally seen after resuscitation or from terminal vomiting. In Professor Byard's view, as expressed in his report, the role played by the ingestion of propoxyphene was to initiate the vomiting. In his view 'death did not result directly from propoxyphene toxicity as the manifestations of this are coma and respiratory depression'.

2.3. The issue as to whether death was caused by aspiration of vomitus, induced by propoxyphene toxicity, or by propoxyphene toxicity itself was an important issue in this inquest. The ambulance personnel told me in evidence that the deceased was already in cardiac arrest at the time they first examined him. He was not to be revived. If Professor Byard's opinion that this cardiac arrest and its inevitable

consequence of death was caused by aspiration of vomitus, some evidence of vomiting probably would have been noticed by the police at a time before the arrival of the ambulance. Such vomiting would no doubt have given them reason for concern in relation to the deceased's well-being.

2.4. However, there was no evidence of vomiting before the deceased was observed to be in cardiac arrest. I heard from the two ambulance officers who attended the scene and treated the deceased. They were a Mr Scott Crockett and a Mr Philip Gloede. Mr Crockett was the first paramedic to examine the deceased. At that time, there was no pulse, respiratory movement or response to painful stimulus and he was obviously unconscious. In truth, there were no signs of life whatsoever. The deceased was in cardiac arrest at that point and so CPR was administered which involved the management and suction of the deceased's airway. His cardiac arrest was not treatable by electric defibrillation and so CPR continued until his arrival at hospital. Mr Crockett said that there was no indication of the deceased having vomited prior to his arrival. He did vomit, however, when the bag and mask was administered. In Mr Crockett's experience, this can happen even where a patient is in cardiac arrest. Professor Byard was to confirm this possibility in his evidence. Whilst Mr Crockett conceded that he might have vomited before he started treating the deceased, there was no vomit in the vicinity and no odour of vomit at that time. Mr Crockett said that he vomited a number of times during treatment. Mr Crockett said that there was no sign of the deceased having choked or that he was choking. Mr Crockett gave this evidence in cross-examination by Mr Brenton Illingworth who appeared as counsel for the Commissioner of Police:

> 'Q. Indeed using the bag could actually draw vomit into the oesophagus and trachea and the airways as part of that resuscitation. Is that correct.
>
> A. Yes, that's correct.
>
> Q. So it's possible that at the time you arrived, and I put this as a general hypothesis not as an actuality, that at the time that you arrived and you started working on the patient, that there may have been no vomit in the airways and the oesophagus. But by bagging him, that very action caused the involuntary reaction through the stomach, bringing the vomit into the system and into the airways and the mouth. Is that correct.
>
> A. That's correct.
>
> Q. That is a common event during that sort of resuscitation process.
>
> A. Yes.

CORONER

Q. When you bagged him, did you have to open his mouth.

A. I use a jaw thrust, hold a jaw thrust and a guedels airway.

Q. So before you put the guedels airway in, you've got to open his mouth. Do you look for airway obstructions before you put the -

A. Had a quick feel at that point and there was nothing.

Q. Nothing there.

A. Nothing that I could feel.

MR ILLINGWORTH

Q. So it was only after you'd started the process and were going through the bagging procedures then, that the involuntary vomiting occurred.

A. That's correct.

Q. There was nothing unusual about that from your observations, in the normal manner you go about dealing with a cardiac arrest fashion.

A. No.' (T301)

Mr Gloede, the other ambulance officer, was also asked about the issue of vomiting. This passage of evidence was given:

'Q. Was there any sign that the patient had vomited before you and Mr Crockett started treating him.

A. I can't recollect because Scott was doing the airway, where I was doing the other things.' (T317)

I also add that there is no evidence that any of the police officers had observed the deceased vomiting at a time before the arrival of the ambulance. The four officers gave evidence before me. I will return to their evidence later.

2.5. It is reasonably clear, therefore, that one of the primary bases for Professor Byard's opinion that death was caused by aspiration of stomach contents has been largely undermined. I think it is plain from the evidence as a whole that the deceased vomited as a result of resuscitative measures, measures that were only instituted at a time after ambulance personnel had found no signs of life. To my mind, the deceased had probably died before the ambulance officers commenced administering treatment and before the deceased regurgitated his stomach contents consequent upon that treatment. Therefore, another more probable explanation for that death has to be sought.

2.6. Professor Byard, in his evidence, recognised the difficulty occasioned by the evidence of lack of vomiting at a time before the deceased's vital signs became extinguished.

Professor Byard acknowledged that vomiting can be induced agonally with resuscitation. One of the significant factors underlying his opinion that the deceased died from aspiration of stomach contents was that there was a considerable amount of vomitus in the airways, 'much more than you normally see just with resuscitation induced aspiration or with movement' (T470). However, Professor Byard said that it was possible that the stomach contents had entered the airways as a result of resuscitative action. He acknowledged this possibility because of the evidence that had been given by the ambulance officers to which I have referred. Nevertheless, he also made the observation that if vomiting had been the cause of death, 'you would expect there to be a lot observed before the resuscitation' (T471). There had not been.

2.7. Professor Byard stated that the level of propoxyphene detected in the deceased's bloodstream was a significant level. He said:

> '… people have actually died from levels less than half what Mr Rogers had.' (T472)

He also said:

> 'I think that it's a very unusual scenario. Normally when people die from Propoxyphene they become sleepy, they lapse into a coma and their respiration just dwindles off and they die because it's a respiratory depressant. Obviously this didn't happen in this case and I think that it illustrates the difficulties in cases where you've got a person who is very agitated who is moving around because they respond differently to other people. So we haven't got the classical respiratory depressant effect of Doloxene. What we do have though is a high level, we have somebody who is running around who then suddenly stops and I think there are several or two possibilities. One is that once Justin stopped moving then the high level of Propoxyphene did what it normally does and that is that it depressed respiration and stopped him breathing. The other possibility is that he may have had an arrhythmia of his heart because Doloxene is an irritant to the heart so that is another distinct possibility and that would fit in with what the ambulance officers observed. I think there are two further features about the toxicity to the heart. One is that because he was running around so frantically he would have a lot of adrenaline on board so his adrenaline levels would be up. That is also an irritant to the heart so that may have had an effect. The other feature is that in his running around he would be getting a lot of oxygen and so this may have been compensated for the respiratory depressant effect of the Doloxene. Once he stopped running around he wasn't overbreathing any more and then he had respiratory depression and this then precipitated the arrhythmia. So I think it's a whole combination of various factors. That each could have played a role or played a role in unison.' (T472-473)

2.8. Professor Byard expressed a view that the toxic effects of the propoxyphene, in relation to both its possible effects on heart function or respiration, and also in relation

to the induction of vomiting, may all have contributed to the deceased's death. This was a significant modification of his original opinion that aspiration of vomit was the cause of death. For my part, given the evidence of the ambulance officers to which I have referred, in particular Mr Crockett's evidence that there was no evidence of vomit near the deceased nor any obstruction to his airway when resuscitative measures were initiated, and that there had undoubtedly been copious vomiting induced by those measures, I think it is unlikely that vomiting did play a role in the deceased's death. Professor Byard effectively acknowledged this when told that resuscitative measures could not restart the deceased's heart. He said:

> 'I think usually if an arrest occurs because of blocking of the upper airway and somebody is fit once you unblock the airway and get oxygen my experience has been that you can resuscitate them. That's an interesting observation it does suggest that there is a problem with the heart that is not related to say the airways. So I think that again would push me more towards a toxic effect on the heart from the Propoxyphene.' (T479)

The more probable cause of his death, in my opinion, was the direct effect of propoxyphene toxicity on the function of the deceased's heart or on his respiratory processes or both. He had a fatal concentration of the substance in his bloodstream, after all.

2.9. Professor Byard discounted the possibility that the deceased had died from asphyxiation either caused by the manner in which he was restrained by the police, either by the use of OC spray or by handcuffing. He agreed that there was nothing that the police officers did that contributed to the death of the deceased. I accept his evidence on this issue.

2.10. I therefore find that the cause of the deceased's death was propoxyphene toxicity.

2.11. I have considered whether there is any proper basis to determine whether the deceased had intended to take his own life. He had slashed his wrist. He had made comments about death and dying and on one interpretation of the events at Phillips Street, wanted to kill himself and take Ms Francis with him. He had taken a lethal dosage of Doloxene. On the other hand, there was no doubt that he was suffering from paranoid schizophrenia and there is evidence to suggest that he was deluded on the evening of his death in so far as he exhibited a belief that he was talking to God and the Devil. In addition, there is nothing to suggest that the deceased would have had any knowledge that the amount of Doloxene he consumed was likely to kill him. The slashing of the

wrist did not cause a life-threatening injury. In all of those circumstances, it is difficult to determine what the deceased's intentions were as far as his will to continue living was concerned. In the event, I make no finding as to whether the deceased, on the evening of his death, intended to take his own life, or indeed the life of any other person.

3. <u>Was there any act or omission on the part of the police which contributed to the deceased's death?</u>

3.1. The police officers apprehended the deceased in the course of his assaulting Ms Francis. They were plainly lawfully entitled to do so. He continued to struggle and attempted to get back into Ms Francis' bedroom. The application of handcuffs was therefore called for and was reasonable in the circumstances. OC spray had been sprayed in close proximity to the deceased but with little or no effect on his behaviour. In my opinion, Constable Humphrys in striking the deceased to the head area, was doing no more than was reasonably necessary to prevent injury to Ms Francis and to effect an arrest.

3.2. I find that the deceased was at all material times in lawful custody, and this includes the period of time the deceased was situated on the ground in the front yard of the premises.

3.3. I have already observed that the application of OC spray and handcuffing in no sense contributed to his death. The deceased died from the effects of propoxyphene toxicity. There was, in any event, no reason for the police officers to believe that he had consumed a lethal dosage of that drug, or a lethal dosage of any other substance for that matter.

3.4. I did examine, however, whether there was any action that the officers could have taken either to have prevented the deceased from suffering a cardiac arrest, or to have taken resuscitative measures before the ambulance arrived.

3.5. Some of the evidence before me suggested that after the deceased was removed from the premises, and was placed on the lawn in the front yard, he was motionless and silent for a period of time before the arrival of the ambulance. The deceased's lack of movement and his silence may for some of that time be explained by him being resigned to his state of custody. However, it is very possible that it is explicable, at

least for part of that time, by the deceased's cardiac and respiratory arrest. As observed, by the time the ambulance officers commenced their treatment, all vital signs of life had been extinguished.

3.6. The four police officers had made various notations as to times and I received in evidence a communication log which was complied by an Officer Wasilenia who was that morning responsible for communications at the local police station. It was universally accepted by counsel in this inquest that the evidence concerning these times, including records compiled within the local police communications centre, was less than reliable. I need say no more about this than that I agree. It surprised me that SAPOL were not able to produce a tape of relevant SA Ambulance Service communications that had been made, together with evidence of objectively verifiable times of those communications. The SA Ambulance Service on the other hand, were able to produce such evidence. I received in evidence an audio-tape recording of the various relevant communications made on the night in question (Exhibit C25a). Superimposed over the voices of the participants is the time recorded by voice at 10 second intervals. I also received in evidence the affidavit of Philip John Lawson (Exhibit C25) in which the procedure as to how the times are checked and superimposed on the communications tape is explained. The synchrony of the imposition of the recorded time voice and the contents of communications is regularly checked and found to be accurate to within 60 seconds or much less than that and I am satisfied that the tape constitutes reliable evidence, indeed the only reliable evidence, as to time.

3.7. I do not have the benefit of a transcript of the SA Ambulance Service tape, but the tape was played in open court during the course of the inquest and the times and the subject matter of the communications on it were noted.

3.8. Certain matters can be inferred from these communications as to the sequence of events, the timing of those events and the duration of time between those events, the purpose of the exercise being to try and reconstruct the duration of the period during which the deceased was lying on the ground at the front of the premises before the arrival of the ambulance.

3.9. There is no doubt that the first agency to be informed of the deceased's difficulties on the night in question was the police. Ms Rogan's son, Rex, initiated that from a

payphone at the Westlands Shopping Centre. This is confirmed by the statement verified by affidavit of Rex Hammond (Exhibit C8a) and by a SAPOL operational log (Exhibit C22b). It is evident from the SAPOL log that the ambulance service were notified almost immediately and as well, the two mobile police patrols were dispatched. Even if this was not recorded in this way, I would have inferred that the dispatching of the police patrols and the notification of SA Ambulance Service would, in the nature of things, have occurred promptly. The ambulance service tape reveals that the service was notified by the local police communications at 2:32am. The two police patrols, who as I say, were both only a matter of a few streets away from Mepstead Street were notified just prior to that time according to the police log. The police log states the times of these events. However, I am satisfied that the SA Ambulance tape time of 2:32am as to when that agency was notified is intrinsically more accurate. The SA Ambulance tape does not, of course, contain internal police communications, but it does reveal that the ambulance manned by Mr Crockett and Mr Gloede arrived at the Phillips Street address at 2:41am. The whole of the events following the dispatch of the two police patrols occurred between about 2:31am and 2:41am.

3.10. In this time, a number of things occurred. The two patrols proceeded immediately after their dispatch to the Mepstead Street address. The first patrol, consisting of Senior Constable Humphrys and a WPC Norris, arrived at the premises and spoke at the front of it with Ms Rogan. Humphrys and Norris then proceeded on foot to try and locate the deceased. Humphrys conducted a search of a school oval at the end of Mepstead Street by flashlight. He then proceeded on foot towards Phillips Street which was the next street parallel to Mepstead Street. Meanwhile, the other patrol, consisting of Constable Bonython and a Probationary Constable by the name of Bianca Scott, entered Phillips Street in their vehicle. They saw the deceased break the door of Ms Francis' premises and then enter. Constable Bonython went in to the bedroom first. Senior Constable Humphrys, who had been on foot, entered a short time later. The efforts to subdue the deceased, including the use of OC spray and physical restraint, then took place. A struggle then took place in which the deceased was endeavouring to get back into Ms Francis' bedroom. He had to be handcuffed, and at one point, the deceased head-butted the wall. At another point he appeared to have been subdued, but then struggled again. He was taken outside still struggling and was placed on the ground. All of those events in my view must have taken a

number of minutes. The incident in the house took time and the extracting of the deceased from the house sounded like a slow process.

3.11. The entire period of time during which the deceased was outside on the ground cannot be determined with precision. It appears, however, that for some of the time when the deceased was outside and on the ground, he continued to struggle and tried to get up. Senior Constable Humphrys had to place his knee in the middle of the deceased's back. Senior Constable Humphrys said that the time from the deceased being placed on the ground until the arrival of the ambulance was about two minutes.

3.12. WPC Norris confirmed that the deceased continued to struggle whilst on the ground for a period of time. WPC Norris re-entered the premises with Ms Francis at one point and later noticed that the deceased was no longer struggling on the ground. When asked about the length of time the deceased was lying on the ground before the ambulance arrived she said that she could only say minutes. She thought that the deceased had given up fighting and was being compliant.

3.13. Constable Bonython also said that the deceased continued to struggle for some time after he was placed on the ground outside. He stated in a record of interview taken from him on 30 June 2000 the following:-

> 'I said: How long did Senior Constable Humphrys restrain the man in that position?
>
> He said: Ah I would say virtually anywhere between from a minute to two minutes at the, two minutes at the absolute outside because what's happened is as we've got him down on the ground, Senior Constable Humphrys is trying to hold him down because he is still struggling around. I've, when we initially got this call to attend in Mepstead Street the office man has called up on the radio and asked Senior Constable Humphrys whether it would be a good idea to get an ambulance rolling considering that we are looking for someone that had taken a large, or taken drugs and attempted to slit their wrist. So Senior Constable Humphrys had told him to get the ambulance rolling and then when we've got out here and he's been placed on the ground, I had a radio on with a bungee strap and I've stood back watching what was going on and requested that an ambulance be diverted to this address. Now the bloke was still struggling on the ground with Senior Constable Humphrys on top of him and the ambulance was here virtually within one to two minutes. On our running sheet when I had a look at it later it was showing virtually a minute.
>
> …
>
> I said: While he was being restrained on the ground, were his feet tied at any time?
>
> He said: No they definitely were not.

I said: Were his feet ever restrained or tied to his hands.

He said: No.'

(Exhibit C40, p12)

He later said in the same interview that the deceased stopped struggling virtually as the ambulance arrived. He remained alongside the deceased for the whole of the time the deceased lay on the ground. The following questions and answers appear in his interview:

'I said What happened when the Ambulance arrived?

He said: When the ambulance arrived the gentleman had stopped struggling, like virtually stopped struggling as the ambulance had come from this direction, virtually as the ambulance pulled up he then only stopped struggling. Pat said.

I said: Just, sorry to interrupt, was there any other behaviour that accompanied that, was there an exhale of breath or did you notice him choking?

He said: No, no I didn't notice any.

I said: He just simply stopped struggling?

He said: Yeah, his struggling had yeah stopped and Senior Constable Humphrys said to me "can you look after him, I'll go tell the boys what we've got then I will go and tell the ambulance crew what we've got here, what the situation is", so I then leant down and grabbed the gentleman's arm and Senior Constable Humphrys has started to walk over to the ambulance and the ambulance at that stage pulled up and starting to get out and they are going towards each other to meet each other. Because it is general practice with me, once someone stops struggling I put them onto their side for comfort reasons because they are handcuffed etc, and I've moved him onto his side, rolled him onto his right side and I've said to him, I'm actually at this stage down on my knees, and I've said to him something similar to "that's better, stay calm mate", to which he's actually like, he hasn't said anything to me but he's sort of tilted his head a bit and looked up at me, but didn't say anything to me.

…

I said: What happened after you told the man to calm down and he looked at you?

He said: Okay, the ambulance crew come into the yard, they took hold of the gentleman and laid him on his back and I saw one of them, had a small pen like type torch looking into his eyes and I said to them do you want me to remove the cuffs because at this stage he's not struggling and they obviously want to treat him. I asked them if they wanted me to remove the cuffs and they said no they didn't want to have them removed. They continued treating him. At this stage one of the girls had got me a spray bottle of water and I was squirting that on my face and drinking a bit of it trying to get rid of the burning etc from the capsicum spray. '

(Exhibit C40, p13-14)

Constable Bonython told me that his impression was that when the ambulance officers rolled the deceased onto his back to examine him, the deceased was still conscious and breathing. He told me that the time from his being placed on the ground until the arrival of the ambulance was two minutes at the outside. He also said:

> 'A. No. As far as I'm concerned in the time frame from when he was taken outside and from the time he stopped struggling to the time that the ambulance got there there was no time to even consider first aid' (T234)

3.14. The fourth officer, Probationary Constable Scott, said that after the deceased was taken outside and placed on the ground he might have been yelling. She was then in the main, attempting to locate water so that the two male officers could decontaminate themselves from the effects of the OC spray. She did not know what the deceased was doing at that stage. She said she did not recall looking at him and seeing what state he was in. During the period from the time the deceased was removed from the house until the ambulance arrival, she had gone back into the house to look for the knife. Around about one or two minutes had transpired in that period. In addition, she said that after the arrival of the ambulance she had shone her torch at the deceased and had noticed his eyes had rolled back. She estimated that a 'couple of minutes' had elapsed from the time he had been removed from the house.

3.15. There were observations made by neighbours. The evidence of Jane Hallam, who lived at 13 Phillips Street, suggested that the deceased had been lying on the ground very still and silent at a time before the arrival of the ambulance. She had been awoken by the commotion coming from number 9. She said that she went outside, waited for about a minute observing the activities, then went to number 9, collected Ms Francis' children and took them back to her residence. The ambulance had not arrived by that time. She estimated that period of time to be about two minutes, if that. The deceased had been motionless and silent during that entire time. She said that the two male officers were both spraying themselves with water, and that no officer was immediately near the deceased or appearing to attend to him. She disagreed with the suggestion that one of the officers was with the deceased, leaning over him and holding onto him.

3.16. Kerrilyn Francis, the deceased's former partner, also gave evidence before me. She was obviously traumatised by events, and was affected by OC spray, but did appear to have a good recollection of what happened both inside and outside the house. I do

bear in mind, however, that she was present while much of the evidence in this inquest was given. She said that while the deceased was lying on the ground a male police officer had been squatting beside him, 'just keeping an eye on him I guess' (T449). The officer was endeavouring to reassure the deceased. She said that the officer was Constable Bonython. That evidence supports the account given by Constable Bonython, except that she did say that for the whole time she was in the front yard, the deceased remained motionless and silent, although he did not appear to be distressed. She said in both her witness statement (Exhibit C14a) and her evidence-in-chief before me that about five minutes elapsed between the time she was brought out of the house and the time of the arrival of the ambulance. In cross-examination, she conceded that it was possible that the period of time described above was as little as two minutes.

3.17. Another witness, a Mr Raymond Marshall, who was related to the deceased and lived across the road from him, had been awoken by noises in Mepstead Street. He went outside to investigate. Much of Mr Marshall's evidence was irreconcilably inconsistent with his witness statement on material issues (Exhibit C1a). I found Mr Marshall to be a generally unreliable witness for this reason. However, he did confirm the evidence of the other witnesses that for much of the time the deceased was lying on the ground in the front yard of the Phillips Street premises he was motionless and silent. Indeed, Mr Marshall claims to have said to an unidentified person at the scene that the deceased was not breathing. He also said that the deceased was 'like really white'. This was at a time prior to the arrival of the ambulance. In his witness statement, he only mentions the deceased's non-breathing in the context of the ambulance officer's treatment. He also mentions vomiting, but in the same context. Mr Marshall said it was about five minutes between the deceased being brought out of the house, which he claims he witnessed, and the arrival of the ambulance.

3.18. The whole incident from the time the police were tasked until the arrival of the ambulance, as I say, took approximately 10 minutes. I do not think that the deceased lay on the ground for as much as 5 minutes. In my judgement, more time than 5 minutes must have elapsed between the police tasking and the deceased being placed on the ground, bearing in mind the nature of the intervening events. In all probability, the deceased lay on the ground for about 2 or 3 minutes before the arrival of the

ambulance. For part of that time, at least, he continued to struggle. I accept Constable Bonython's suggestion that he remained at the deceased's side until the arrival of the ambulance. He is supported in this regard by Ms Francis, who in spite of everything, was in my view a reliable witness. However, I am unable to accept Constable Bonython's suggestion that the deceased continued to struggle virtually until the arrival of the ambulance. I think he is mistaken on this. The evidence overwhelmingly, in my view, points to the fact that for some period of time, the deceased lay motionless and silent on the ground in the front yard of the premises. It is difficult to judge for how long this state of affairs existed, but it was less than the possible 2 or 3 minutes that the deceased lay on the ground in total.

3.19. I find that the deceased exhibited no sign that he was in difficulty, other than that he was motionless and silent. Not one witness, other than Mr Marshall, said that he appeared to be in difficulty. Mr Marshall's observations about his not breathing in my view are unreliable. He was an inconsistent witness on many issues and he may well have been transposing his observation of the deceased not breathing at the time the ambulance officers were treating him to a time before their arrival. There is no evidence to suggest that it was obvious to anyone there that the deceased had gone into cardiac and respiratory arrest before the arrival of the ambulance. No-one saw him vomit, for instance, and the evidence of the ambulance officers, to which I have already referred, leads me to conclude that he probably did not vomit until resuscitative measures were undertaken by those officers. He had a fatal concentration of propoxyphene in his bloodstream and I think that the reality of the situation was that as he lay on the ground he passed away painlessly and silently from the effects of that drug.

3.20. Mr Illingworth, for the Commissioner of Police, tendered to the inquest a document entitled 'Positional Asphyxia' (Exhibit C54). This was in force at the time of these events. The contents of this document leads me to conclude that in the circumstances there was a duty on the police officers, in whose custody the deceased was situated, to inter alia:

> 'Closely monitor and assess the person's breathing if you use high-level restrain techniques or rely on officers using their weight to restrain and subdue a person who is resisting violently. Immediately abandon or alter the restraining technique if there is any sign of breathing difficulties or lack of pulse.'

Constable Bonython was with the deceased as he lay on the ground. I find that for a period of time the deceased was motionless and silent in his presence. Some might argue that a closer eye should have been kept on the deceased to ensure that he continued to breathe. There were, however, circumstances that ameliorate any criticism that might be directed towards those officers. Both male officers were affected by OC spray. They were to a degree, distracted by its effects. In addition, as I have already observed, there was no reason for the officers to believe that the deceased had taken a lethal dose of a drug. Indeed, his behaviour in the house, and for a time outside, belied any suggestion other than that the deceased was a physically healthy and able-bodied young man. To that extent, the fact that the deceased would suffer a cardiac and respiratory arrest was wholly unpredictable. His motionless and silent behaviour was very much to be objectively interpreted as a reflection of his resignation to his current custodial circumstances.

3.21. Neither the effects of the OC spray, the physical efforts of the police to subdue the deceased, his handcuffing nor the position in which he was placed on the ground contributed to the deceased's death. Most importantly, I accept the following evidence of Professor Byard:-

'Q. And finally, if one were to be present when a person suffered this condition, such as police officers standing or being close by, would it be obvious to a person that the deceased is going into this state of arrest, respiratory arrest.

A. Not at all. Unless you're actually monitoring the person at the time. If you just take the respiratory arrest, basically a person would go quiet and appear to have gone to sleep, and with a cardiac arrhythmia, basically people can just die without moving. Obviously sometimes people will have convulsions but other people can just slip away and there's no pain, no suffering, they just go.

CORONER

Q. Given the scenario that Mr Illingworth has described to you and just also going on from the question I asked you a moment ago, if the police officers had identified a cardiac arrest at a time prior to the ambulance attending, and the cardiac arrest was consequent upon - toxicity, was there anything that they could have done which may have brought about a happier outcome than what happened here do you think.

A. You can always say that the earlier you start cardiac resuscitation the better the chances you have, but I think given the high levels of Propoxyphene and the effect it was having on the breathing and or the heart, I would doubt that they would be able to have to changed the outcome.

Q. Yes all they could have done I suppose was perform CPR in those circumstances, there's nothing else they could have done.

A. That's correct. They could have maintained him until the ambulance arrived and then the ambulance would have tried do the electric resuscitation but that didn't seem to have worked.' (T483-484)

It will be remembered that the ambulance officers could not use their defibrillation equipment to reverse the deceased's cardiac arrest. They performed CPR until the deceased's arrival at hospital and further resuscitation measures there proved fruitless. No amount of CPR had any resuscitative effect. The ambulance officers had attended as fast as they could and did all they could. On Professor Byard's evidence I do not think that the police officers could have done anything for the deceased even if they had noticed the deceased's respiratory arrest. Indeed, there was insufficient evidence from which the time after he stopped breathing could properly be estimated. The deceased's motionless and silent state, is not necessarily wholly referable to his cessation of heart function or respiration. It is possible that he stopped breathing just before the arrival of the ambulance. This would have given the police even less time to detect that something was seriously wrong with the deceased and to have acted upon that.

4. The prescription of 100 Doloxene capsules

4.1. As a result of Dr Rossouw's prescription of 27 June 2000, the deceased acquired 50 Doloxene capsules that day and another 50 the next. It is to be remembered that Andre Connell had also been prescribed Doloxene by Dr Rossouw. Dr Rossouw gave evidence before me. According to Dr Rossouw, Connell's own prescriptions had been rationed, as it were, on a daily basis. This was a reflection of Dr Rossouw's unease about placing large quantities of the drug in the hands of a self-confessed drug abuser. He had made an arrangement with the Monarch Pharmacy at Westlands that Connell could only be provided with 8 Doloxene capsules per day, although the prescription was for more. I had no evidence before me that confirmed the existence of this arrangement. Connell's statement, not under oath, and not subject to cross examination, states:

'Dr Roussow would prescribe to me as many of these tablets as I wanted. The last time I saw him was Tuesday 20th June, 2000 when he prescribed 100 100mg Doloxene tablets to me. I would take 5 of these tablets a day to keep me calm.'

He makes no mention in his statement of the rationing arrangement that Dr Rossouw said existed. I proceed with caution in relation to the contents of Connell's statement

and for the purposes of these findings I act on the basis that the rationing arrangements, as far as Connell was concerned, were in place.

4.2. Connell says in his statement that the deceased had asked him if he could take some of his Doloxene tablets. Connell would not allow that, but he agreed to take him to see Dr Rossouw. I can well believe those assertions.

4.3. Connell in his statement explains what transpired:

> 'I took Justin to the surgery at Playford Avenue and I went into the Drs rooms with Justin when he saw the Doctor. During the appointment Justin asked about Doloxene and Rossourw (sic) explained to him about what the drug is and what it is taken for. Rossouw then prescribed Justin with 100 100mg Doloxene tablets. To my knowledge Justin had never seen Rossourw (sic) before this date. I remember Rossouw told Justin to take 5 of these tablets every day the same as I was on. This happened on Tuesday 27th June, 2000.
>
> As soon as we left the surgery Justin took 5 of the tablets all at once and he gave me 5 and I took them all at once too. After going to the surgery on Playford Avenue we had gone to Monarch Pharmacy and that is where Justin had used the prescription to get the Doloxene.
>
> After this we went back to 3 Mepstead and Justin took another 45 of the tablets. Justin only had 50 tablets because when we went to the chemist they only had 50 of the tablets in stock and they asked Justin to come back the next day and get the other 50. Justin took the last 45 all at once.
>
> After Justin took the last 45 tablets he was as high as a kite. He was pacing up and down and saying that he was tripping out and seeing ghosts and demons.
>
> I stayed with Justin all of that evening until I went to be at about 11:30pm to midnight. Justin was still awake, pacing around and talking to himself when I went to bed.'
>
> (Exhibit C23a, p4-5)

4.4. Connell states that on the following day the deceased said he was going to obtain the remaining 50 tablets and he asked Connell to go with him. Connell refused. Connell did not see the deceased again.

4.5. The deceased did in fact return to the Monarch Pharmacy in Playford Avenue and acquire the other 50 tablets.

4.6. I have no reason to doubt Connell's account of the deceased's Doloxene consumption on 27 June. It appears from the statement verified by affidavit of Stuart John Birch (Exhibits C19 and C19a), a crime scene examiner, that 5 empty boxes of Doloxene capsules were located in and around the Mepstead Street premises. The 5 boxes

would originally have contained 50 capsules. He found 18 Doloxene capsules in the house in their plastic strips. The other 5 boxes, originally containing the other 50 capsules were located by Mr Marshall in the Mepstead Street house. He handed them to the police. They were empty.

4.7. In keeping with the pattern of consumption on 27 June as described by Connell, it is highly likely that the deceased consumed most of the 50 capsules he acquired on 28 June. In any event, it is obvious from his post-mortem toxicology that by the time of his death he had consumed a fatal dose. I infer from all of this that since the deceased saw Dr Rossouw on 27 June, and received from him a prescription for 100 tablets, he consumed enough of them over the ensuing 39 hours to account for a fatal concentration of propoxyphene in his bloodstream. Given that only 18 were found on the premises, it is more likely than not that he consumed just over 80 capsules in that time.

4.8. I examined how it could have come to pass that a person previously unknown to Dr Rossouw could have inveigled Dr Rossouw into prescribing what was a potentially lethal quantity of Doloxene.

4.9. Dr Rossouw was interviewed by the police about this matter on 21 July 2000. The interview was taped and a transcript of the recording became Exhibit C48. In that interview, Dr Rossouw made the following statements:

(a) that Andre Connell introduced the deceased to him as a friend who had brain problems, could not speak for himself and had a long suffering ailment;

(b) that this was the first and last time he had seen the deceased;

(c) that the deceased was not consistent with what he was saying and was eager to get out and eager to get something from him;

(d) that the deceased said that he suffered from headaches and that the only thing that really worked was Doloxene;

(e) that the deceased told him he was schizophrenic and that is why he needed Connell to be with him and speak for him in case he got mixed up;

(f) that he prescribed 100mg Doloxene tablets, two to be taken three times a day; he admitted that he prescribed 100;

(g) he identified the prescription recovered from the Monarch Pharmacy, Playford Avenue, as that he had given to the deceased.

He was asked these questions and gave these answers to the interviewing police officer:

'Q35 Were you concerned of prescribing him that quantity of those tablets?

A Not at that stage because I didn't know him at the time that they would be anything different because what I actually had in the, idea I had was that Andrew he would go to a Pharmacy and sort of be in the same sort of arrangement with Pharmacy where they give tablets on a daily basis.

Q36 Was that arrangement made in relation to Mr Rogers?

A No, not it was not because Mr Connell at that time he think it would be better if they go to the same Pharmacy and have their medicines at the same time.

Q37 Given that Andre Connell was an abuser of drugs and had to have his tablets prescribed on a daily basis, were you concerned of issuing Mr Rogers with the 100 in one hit?

A Nnn, I think it crossed my mind, but I was not worried because me and Andre Connell has had a sort of a thing going, he listened to me and I would help him through this whole thing as long as he stick to the policy we had over him and since he verbalised that he would see that this guy take them the right way and going to the same Pharmacy and arrange, I was sort of happy with the arrangement made and he would have them at the same times and date as Andre.

Q38 But no, no arrangements were made where he was bound to take his tablets in that way?

A No, not with me, but between me and the Pharmacist.'

(Exhibit C48, p4-5)

4.10. Dr Rossouw gave evidence before me. He identified Exhibit C48 as being an accurate transcript of the interview he had with police.

4.11. Dr Rossouw explained the arrangement that was in place for the dispensation of Doloxene to Connell. He said that in accordance with his usual practice he would have written on Connell's prescriptions the need for Connell to be dispensed with Doloxene daily, in his case 8 a day. The pharmacist would then phone him to confirm the arrangement. He said that he had a 'contract' with Connell that if Connell stuck to the rules and guidelines Dr Rossouw laid down for him in terms of taking his prescribed medications in the prescribed quantities, then Dr Rossouw would help him

get off all other types of drugs. He prescribed the Doloxene as a pain killer for long standing back problems. He had known Connell for about 6 to 8 weeks.

4.12. When examined by Ms Hodder, Counsel Assisting the Coroner, he was shown the prescription for 100 Doloxene capsules that he had given to the deceased. This was the same prescription that he had identified in his interview without comment. When he was shown the prescription in evidence he said:

> 'Yes, but this isn't the complete document.' (T503)

4.13. Dr Rossouw went on to explain that the prescription (Exhibit C49) was originally part of a larger A4 size document which consisted of the prescription, the patient's copy of the prescription and a blank area of paper at the foot of the sheet. He produced a sample of such a document (Exhibit C49c). The blank part of the document, which can be used for other computerised instructions, not applicable in this instance, is separated from the rest of the document by a perforated line. The blank section can be torn from the prescription proper along that perforated line. Dr Rossouw told me that he had written on the blank section of the document an instruction to the pharmacist that the deceased's prescription should be dispensed daily. The prescription proper was for 100 capsules, two capsules to be taken three times a day which would mean that the pharmacist would understand from the written instruction that a maximum of six capsules could be dispensed per day. This was a similar arrangement to that which applied to Connell. Dr Rossouw said that he gave the whole of the sheet to the deceased in a folded state. He did not put it in an envelope. He said that he could have given the deceased the following instruction:

> '… and I say you just give that to the chemist and you will see that you get your medication at the right time at the right quantities.' (T506)

4.14. Dr Rossouw acknowledged that the deceased could easily have unfolded the script and seen what was written on it. In addition, he accepted that if the deceased or Connell had been minded, they could easily have torn off the written instruction concerning daily distribution. He said that possibility did not cross his mind at that stage. This was because of the nature of the agreement he had reached with the deceased, that if either he or Connell broke the rules, they would be discharged from the practice. For the same reason, he had not written the instruction for daily distribution on the prescription proper.

4.15. Dr Rossouw's prescription was not addressed to any particular pharmacist. Thus it was that the deceased could have had the prescription filled at any pharmacy. However, Dr Rossouw expected that the prescription would be filled at the same pharmacy with which Connell had his daily distribution arrangement, namely the Monarch Pharmacy at Westlands. Indeed, although he acknowledged that the script could have been taken to any pharmacist, he was quite clear that there had been some discussion to the effect that they would go the Monarch Pharmacy at Westlands. He said he would have expected the pharmacy to have retained the portion of the document that bore the written instruction. He said:

> 'If he received it definitely, he must have it.' (T511)

He said that in accordance with the usual practice, his expectation was that the pharmacy would contact him. He did not telephone the pharmacist to explain the arrangement and he did not receive any communication from a pharmacist in relation to the deceased's prescription.

4.16. In the event, the prescription was not filled at the Monarch Pharmacy at Westlands. It was filled at the Monarch Pharmacy in Playford Avenue, Whyalla. I have already referred to the fact that 50 capsules were given to the deceased on 27 June and the remaining 50 were given to him the following day. This distribution would have been contrary to the written instruction Dr Rossouw said he had placed on the blank section of the document.

4.17. The manager of the Playford Avenue pharmacy, Glenys Thompson, was called to give evidence at the inquest. She provided the prescription (Exhibit C49) to the police during the course of their investigation. The prescription does not have the blank section of the original A4 document attached and so it does not bear the instruction as to daily dispensation that Dr Rossouw claims the whole document originally bore. Ms Thompson remembered the deceased. From time to time the deceased had brought in prescriptions from his general practitioner, a Dr Connelly. I gained the impression that Ms Thompson was a responsible pharmacist. She told me, and I have no reason to disbelieve her, of her having contacted Dr Connelly and having told him that the arrangement by which the deceased had been collecting his medication for schizophrenia had broken down because of the deceased's lack of cooperation. This had resulted in the deceased not having visited that pharmacy since July of 2000. Ms

Thompson knew of Dr Rossouw as she had dispensed some of his prescriptions in the past. She believed that there were no special arrangements concerning the distribution of medication in relation to any of Dr Rossouw's patients, remembering of course that Connell's arrangement was with the Westlands Pharmacy. She recalls the deceased presenting at her pharmacy with another man on 27 June and dispensing the first 50 capsules on that occasion. She had not been on duty on the following day. Another employee had dispensed the second lot of capsules. Ms Thompson told me the following:

(a) there was no instruction accompanying the actual prescription;

(b) she would have remembered if there had been any special instruction and she would have dispensed the Doloxene as instructed;

(c) she would have noted any instruction written on the blank part of the document;

(d) she would have understood an instruction to dispense daily to mean, in this instance, that she was required to distribute no more than 6 capsules daily;

(e) she would have kept any such instruction in her records and made a note of the frequency of distribution;

(f) she would have handed the instruction to the police at the same time she handed the prescription proper, had she still had it in her possession;

(g) she probably would have communicated with the doctor to establish what was to happen on Sundays and to ascertain whether the doctor was happy for a double issue to be distributed on Saturday.

4.18. I bear the following matters in mind when assessing the credibility of Ms Thompson. There is the largely unspoken suggestion that Ms Thompson and her staff had placed a potentially lethal quantity of Doloxene into the hands of the deceased. Secondly, if Ms Thompson did receive the written instruction from Dr Rossouw she would have an undoubted motive to now conceal that fact in the light of the tragic use to which the Doloxene was put. Thirdly, Ms Thompson was unable to explain what had happened to the customer's copy of the prescription. Somewhat surprisingly, she told me that the customer's copy was generally retained unless there was a repeat prescription. I don't know why a customer's copy would not be given to the customer in all cases. The fact that Ms Thompson could not account for a part of the document,

that is the customer's copy, might reflect on her reliability when she said that no written instruction on the blank portion was retained. Fourthly, she was not cross-examined by anyone representing Dr Rossouw, although I must observe that she was thoroughly questioned by counsel who did appear before me.

4.19. However, I found Ms Thompson to be a witness of truth. There was nothing in her demeanour that suggested she was attempting to conceal the truth from me. It is highly unlikely that Ms Thompson would have ignored a written instruction of the nature that Dr Rossouw claims he entered on the blank portion of the document. It is highly unlikely that she would have discarded such an instruction and not retained it in her records. All of that is highly unlikely, especially in circumstances where another practitioner, Dr Connelly, had a distribution arrangement with her in respect of the dispensing of the deceased's medication for schizophrenia. In the end, I am satisfied beyond reasonable doubt that Ms Thompson did not receive any written instruction to dispense the deceased's Doloxene on a daily basis.

4.20. There are two competing possibilities to explain why Ms Thompson did not receive the written instruction to dispense the Doloxene on a daily basis. Either Dr Rossouw did not write anything on the blank portion of the prescription form, or the blank portion had been removed before it was presented to Ms Thompson by the deceased. There is nothing inherently unlikely about the second of those scenarios. The deceased had exhibited drug seeking behaviour recently and there is reason to believe that either he, or perhaps Connell, would have found a direction that the Doloxene be distributed by as little as six capsules per day not to their liking. On the other hand, I have absolutely no confidence in the evidence of Dr Rossouw that he did in fact write the instruction on the blank portion of the prescription form. I say so for the following reasons:

(a) Dr Rossouw said nothing of the kind in his interview with the police when he had every opportunity to do so. When shown the prescription in the interview, he identified it without comment. Indeed, he agreed that the prescription allowed the deceased to obtain 100 capsules. He did not add that another part of the document spoke of them being rationed on a daily basis.

(b) Dr Rossouw admitted that before giving evidence in the inquest he had received a copy of the report of Dr Harold Lane who had expressed criticism of Dr Rossouw's having prescribed this quantity of Doloxene tablets all at once.

(c) In Dr Rossouw's interview with the police he spoke more of a hope than of an actual arrangement that the deceased would have his Doloxene capsules rationed on the same basis as Connell. He said 'the idea I had was that Andre and he would go to a pharmacy and sort of be in the same sort of arrangement with pharmacy where they give tablets on a daily basis' (Q&A 35). In fact by his answers in Q&A 36 and 37 it is plain to me that what he was telling Detective McIntyre was that no actual arrangement as to the distribution of the deceased's Doloxene was put in place because he had faith in Connell that Connell would in some way ensure that the deceased 'would have them at the same times and date as Andre'. Question and Answer 38 reads as follows:

> Q38 But no, no arrangements were made where he was issued to take his tablets in that way?
>
> A No, not with me, between me and the pharmacist.

Dr Rossouw seized on this answer as demonstrating that he had made an arrangement with pharmacist. He maintained that the word 'but' can be implied between 'me' and 'between'. This is certainly one available interpretation. The other interpretation is that he was saying that there was no arrangement between him and the pharmacist. However, the context in which this answer was made, a context in which Dr Rossouw had failed to mention anything about the written addendum to the script and had given every impression from his previous answers that no such arrangement with a pharmacist had been made, leads me to conclude that the interpretation Dr Rossouw places on this answer is incorrect. The existence of any such arrangement with a pharmacist is belied by the fact that no pharmacist telephoned him to confirm the arrangement as he would have expected and he himself did not telephone a pharmacist.

(d) Dr Rossouw's insistence that there was discussion about the prescription being filled at the Monarch Pharmacy in Whyalla is sharply contradicted by the following question answer in his police interview:

> 'Q28 Did you speak to him or did he say where he was going to obtain these capsules?

A No, no I don't know what Pharmacy they went to.' (Exhibit C48)

(e) Dr Rossouw's assertion that he wrote the direction for daily dispensation on the blank portion of the document to my mind is intrinsically unbelievable when he acknowledges that the direction could have been written on the prescription proper. His explanation that it never crossed his mind that someone would tear it off and break the rules of the agreement that he believed he had with Connell and the deceased, which would lead to them being discharged from the practice, to my mind is equally unbelievable (T506).

4.21. That Dr Rossouw should have maintained confidence in the actions of a man whom he had never seen before, and who had sought out, or had sought out on his behalf, the drug Doloxene, the very drug which he had prescribed for Connell in limited qualities because he knew Connell had been a drug abuser, is extremely difficult to accept. Dr Rossouw rejected the suggestion that the deceased's desire to obtain Doloxene was in any sense coincidental bearing in mind the fact that Connell, a man with a history of drug abuse, was being prescribed the same drug in limited quantities. He said the coincidence did not strike him. He said that he didn't see any evil in it (T514). I also find this hard to accept.

4.22. I have considered carefully the competing possibilities referred to above, namely that Dr Rossouw wrote the direction about daily dispensation and someone tore it off, or that Dr Rossouw simply did not write it. I do not accept Dr Rossouw's evidence that he wrote this instruction on the blank portion of the document for the reasons mentioned above. I think it is so intrinsically unlikely that a doctor would write such an important instruction, not on the prescription proper, but on a section of the document that could easily be torn off, that such a scenario defies belief. I think this so improbable that it removes any doubt that I might otherwise have entertained as to the possibility that Connell or the deceased tore off the instruction. So it is that I find beyond reasonable doubt that Dr Rossouw did not write any instruction as to daily dispensing on the deceased's prescription.

4.23. Dr Harold Lane was called to give evidence at the inquest. I have already referred to the fact that in a report he provided for the purposes of this matter he was critical of Dr Rossouw's actions. The report became Exhibit C50. Dr Lane is an experienced rural general practitioner. He has worked as a general practitioner in Balaklava in this

state for nearly 40 years. He has fellowships of the Royal Australian College of General Practitioners and of the Royal Australian College of Rural and Remote Medicine. He has prescribed the drug Doloxene on a number of occasions. The assumed facts underlying Dr Lane's opinions were that Dr Rossouw had prescribed 100 Doloxene capsules without any daily dispensation restriction. He had read Dr Rossouw's interview with the police and had seen a copy of the relevant prescription. Much of what Dr Lane said, both in his report (Exhibit C50) and in his evidence, were matters of common sense. Dr Lane's opinions are summarised in this way:

> 'In conclusion I believe that the prescription of Doloxene in a quantity of 100 capsules to Mr Rogers by Dr Rossouw at the consultation on the 27 June would not be generally accepted as good practice for a GP in that situation. I consider that in retrospect I believe Dr Rossouw should have been far more cautious prescribing Doloxene in a quantity of 100 capsules, to a person whom he has never seen professionally before, and who was accompanied by a known Doloxene dependent person, for whom he had authorized limited dispensing of this drug.'
>
> (Exhibit C50)

4.24. Dr Lane assumes, I think, that Connell had a Doloxene dependence. I do not think there is any evidence that Connell was Doloxene dependant, or if he was, Dr Rossouw knew that. Dr Rossouw did know, however, that Connell had been a drug abuser, that Doloxene was a drug of abuse and that the daily dispensing of the drug in Connell's case had been arranged for those reasons. The foundation for Dr Lane's opinion is thus still valid, in my view.

4.25. Dr Lane was critical in a number of specific respects. This included the following:

(a) He felt that Dr Rossouw should have been more suspicious of the deceased in seeking a prescription for the very drug he had prescribed Connell in limited quantities. Dr Lane referred to Dr Rossouw's statement to Detective McIntyre that the deceased was not consistent in what he had said and had been eager to get something from him and all this suggested to Dr Lane that he was a drug seeker. That something, of course, was not any old thing, but specifically Doloxene. Dr Rossouw, in his evidence, admitted to an element of naiveté in his thinking. He also endeavoured to explain this statement away by saying that the deceased's drug seeking was possibility in relation to harder drugs. I was not convinced by this explanation. To my mind, Dr Lane's comments are valid and simply reflect common sense. There is no evidence to suggest that Dr Rossouw

deliberately placed an excessive amount of a drug of abuse into the hands of the deceased. However in my view, his actions were reckless. He knew that Connell had a substance abuse problem. He was asked to prescribe Doloxene when he knew that Connell had been allowed only a restricted supply. The deceased said inconsistent things and was eager to obtain Doloxene and if it did not occur to Dr Rossouw that all of this was but a device to secure a large quantity of a drug abuse, then it should have in the circumstances I have described. It was also extremely naïve for Dr Rossouw to have thought that the same arrangement of dispensing that existed for Connell would somehow be put in place for the deceased. He should have specifically prescribed a daily limit for the deceased by writing the words 'please dispense daily' on the prescription proper, if it was indeed proper for him to have prescribed Doloxene at all. I have already observed that Dr Rossouw, in my judgement, did not in fact write these words anywhere on the document. Placing a large quantity of the drug in the hands of the deceased was, bearing in mind his obvious relationship with Connell, virtually placing them into Connell's hands as well. Dr Rossouw claimed that it did not occur to him that the approach by Connell and the deceased may have been an attempt by Connell to circumvent his own restrictions as far as the supply of Doloxene was concerned (T530). I am not certain whether I accept Dr Rossouw on that, but in any event this was certainly a possible scenario that he should have considered.

(b) Dr Lane was also critical of Dr Rossouw's acceptance of the deceased's assertions to him that his schizophrenia had stabilised in that schizophrenics are well known to be non-compliant with drug therapy and that Connell would not be an appropriate person to monitor the deceased. Dr Rossouw attempted to field this criticism by referring to his six to eight week old relationship of trust with Connell (T536). I was not persuaded that this was a satisfactory answer to Dr Lane's criticism. The whole scenario before Dr Rossouw carried an air of suspicion such that Connell's motives and those of the deceased were manifestly questionable.

(c) There were other criticisms which I do not need specifically to deal with. Dr Rossouw dealt with some of them by pointing to the fact that he had instructed the pharmacist to dispense daily, thereby limiting the daily dosage to a maximum

of six. If this was correct, it would meet many if not all of Dr Lane's criticisms, but for the reasons I have mentioned, I am unable to accept that this was the case.

4.26. In the final analysis, Dr Rossouw did accept that he probably should have prescribed a much less number of Doloxene capsules, say 20, and then seen how he progressed. He also thought that he possibly should have prescribed another analgesic such as paracetamol or aspirin (T539-540). I agree with Dr Rossouw as to this.

5. The actions of the pharmacist

5.1. Dr Lane also directed criticism towards the pharmacist who filled the prescription. It was Ms Thompson who supplied the first 50 capsules to the deceased. Another employee supplied the remainder. I took Dr Lane's criticism to be directed in the main towards the person who first agreed to fill the prescription. Dr Lane was concerned that a pharmacist would dispense 50 Doloxene capsules to a person who was accompanied by a known abuser of the drug, Connell, who was on a limited daily supply of it. However, it will be remembered that the arrangement that involved Connell was with the Monarch Pharmacy at Westlands. Ms Thompson's pharmacy was at Playford Avenue. Ms Thompson told me that she knew Connell by reputation as someone who had caused trouble at the Westlands Pharmacy at one time. She had inferred that Connell may have had a propensity to abuse medication, but she had no idea of the drugs that may have been involved. The manager at Westlands Pharmacy had told her to exercise caution in accepting Connell as a customer. I had no direct evidence about the nature of any incident that had given rise to the Westlands manager's concerns. Dr Rossouw knew something of it, but I did not fully understand what the incident was about. Nevertheless, the Westlands manager had not told Ms Thompson anything about the nature of drugs with which Connell had been supplied.

5.2. Ms Thompson knew at the time that Doloxene had potential for abuse. She appreciated that there would be some people who would try to obtain it in whatever way they could. However, she had not encountered anyone who had abused it.

5.3. As mentioned earlier, Ms Thompson had filled the deceased's schizophrenia medication prescriptions in the past. They had been prescribed by Dr Connelly. She did not know whether or not the deceased had ever seen Dr Rossouw other than on the occasion when he had prescribed the Doloxene. She had no concerns about

authorising the dispensing of the Doloxene tablets to the deceased. She had no information that he had ever been an addict of prescription drugs. In addition, 100 Doloxene capsules was not an unusual amount because it is often legitimately prescribed in large quantities for chronic pain.

5.4. It is to be observed also that I have found that there was no daily limit stipulated as part of the prescription.

5.5. I was concerned about the fact that Ms Thompson was aware that the deceased had come in to the pharmacy with Connell and what that association might have signified in her mind. Not only had she heard about Connell from the manager at Westlands, but he had been in her pharmacy on the previous day and had acted oddly, although he had not attempted to acquire anything. I asked her:

> 'Q. Did you associate in your mind Andre Connell's behaviour the day before and his presence on the following day, the Tuesday, with a possible attempt by him to secure a drug that he might abuse.
>
> A. I was not aware of drugs that - whatever drugs he had been taking. Had the description been for Andre I may possibly have reacted differently to what I had but it was clearly for Justin and Justin was the person that I dealt with. ' (T655)

5.6. I was satisfied that Ms Thompson told me the truth about these matters. Thus it is that much of the platform for Dr Lane's criticism falls to the ground. Ms Thompson did not know about any specific addiction that Connell may have had. She did not know, for instance, of any particular arrangement that Connell had at Westlands concerning Doloxene. Hers was a vastly different situation to that which had presented itself to Dr Rossouw. Dr Rossouw knew much about Connell's past and was aware chapter and verse about Connell's Doloxene consumption and how his supply was limited.

5.7. Having considered the matter carefully, I do not think any criticism can be directed towards Ms Thompson for filling a prescription that she was legally entitled to fill. In reality, there was no reason for Ms Thompson to suppose that Connell was party to an attempt to acquire a large quantity of a drug that can potentially be abused. Some people in her position, even with the limited knowledge that she did have, might have been suspicious. However, I am by no means convinced that everyone would have been. In the event, I find that there was no sufficient reason for Ms Thompson to believe that the deceased would take the Doloxene other than as prescribed.

6. Conclusions

6.1. The deceased was lawfully arrested by officers Humphrys and Bonython, (a) for having assaulted Kerrylin Francis and (b) in order to prevent a further assault upon her. I find that the use of OC spray was appropriate in the circumstances. I find that he was appropriately handcuffed in order to prevent the deceased from returning to the bedroom where the assault had taken place.

6.2. The deceased was still struggling after having been removed from the premises. I find therefore that it was appropriate for the deceased to be placed on the ground in a handcuffed state.

6.3. I find that there was no reason for any of the four police officers to suppose that the deceased had taken a fatal dose of propoxyphene, or a fatal dose of any other drug. His actions in the house and his aggressive physical behaviour pointed in the opposite direction.

6.4. I find that the deceased lay on the ground at the front of the premises for about two or three minutes before the arrival of the ambulance. I find that Constable Bonython remained at the side of the deceased for the whole of that period.

6.5. I find that nothing done by the officers, including the use of OC spray, and the manner of the deceased's restraint, contributed to the deceased's death.

6.6. I find that for a period of time while the deceased was lying on the ground at the front of the premises he was motionless and silent. I find that for a period of time, that cannot precisely be determined, the deceased remained in that state until the arrival of the ambulance.

6.7. I find that at some point prior to the examination of the deceased by SA Ambulance officers Crockett and Gloede the deceased went into cardiac and respiratory arrest.

6.8. I find that the deceased did not vomit until resuscitative measures were applied by the ambulance officers.

6.9. I find that there was no reason for the officers to believe that the deceased had suffered a cardiac and respiratory arrest.

6.10. I find that the cause of the deceased's death was propoxyphene toxicity.

6.11. I find that appropriate resuscitative measures were taken in the unsuccessful attempt by ambulance officers to revive the deceased.

6.12. I find that at the time the deceased died he was in lawful custody.

6.13. I find that the deceased had taken a quantity of Doloxene capsules at a time prior to his death sufficient to result in there having been a fatal concentration of propoxyphene in his body. I find that the Doloxene capsules that he consumed had been supplied to him by employees of the Monarch Pharmacy, Playford Avenue, Whyalla on 27 and 28 June 2000.

6.14. I find that the Doloxene capsules referred to above had been prescribed for the deceased by Dr Gerhard Rossouw on 27 June 2000. I find that Dr Rossouw had prescribed 100 Doloxene capsules, two to be taken three times a day as required. I find that Dr Rossouw did not write either on the prescription proper nor on any other part of the original A4 size document anything to the effect that the capsules should be dispensed daily.

6.15. I find that the deceased sought the supply of Doloxene capsules not for any therapeutic purposes. I find that the statements made to the effect that he suffered from headaches and that Doloxene was the only drug that would be of therapeutic benefit was a device calculated by the deceased, with the connivance of Andre Connell, to enable the deceased to acquire Doloxene for the purposes of abuse.

6.16. I find that Dr Rossouw should in the circumstances have questioned the legitimacy of the deceased's request for Doloxene for the reasons I have explained in these findings. At the very least, Dr Rossouw should have taken appropriate steps to ensure that a total of 100 Doloxene capsules was rationed on a daily basis by including such a direction on the prescription, or have prescribed a much lesser quantity. I find that Dr Rossouw should have considered prescribing a different, less dangerous analgesic and not taken at face value the assertion that Doloxene was the only analgesic that worked for the deceased.

6.17. I find that there was no reason for the pharmacist Ms Thompson not to fill the prescription or to otherwise question the legitimacy of the deceased's desire to acquire Doloxene.

7. Recommendations

7.1. I am empowered pursuant to Section 25(2) of the Coroner's Act to make recommendations that might, in my opinion, prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest.

7.2. I do not think that the police officers could have done anything to prevent the deceased's death. Their actions did not cause nor contribute to it. I see no need for the making of any recommendation in relation to future police behaviour

7.3. I see no need to make a recommendation in relation to any other issues.

Key Words: *Death in Custody; Drug Overdose; Medication; Medical Treatment - Medical Practitioner, Inadequate Examination; Inadvertence*

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 28th day of March, 2003.

Coroner