



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 26th day of March 2008, the 12th day of September 2008 and the 18th day of March 2009, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of John Frederick Wanganeen.

The said Court finds that John Frederick Wanganeen aged 29 years, late of 1 Narunga Avenue, Maitland, South Australia died at the Lyell McEwin Hospital, Haydown Road, Elizabeth Vale, South Australia on the 24th day of August 2005 as a result of multiple drug toxicity. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

- 1.1. John Frederick Wanganeen died on 24 August 2005. He was 29 years of age at the time of his death. A post-mortem examination was conducted upon him by Forensic Pathologist, Dr Allan Cala, who gave the cause of death as multiple drug toxicity and I so find. Toxicological analysis of Mr Wanganeen's blood indicated the presence of buprenorphine, oxazepam, diazepam, alprazolam and methylamphetamines in his system at the time of death.
- 1.2. Mr Wanganeen was on home detention bail to reside at an address at Maitland on the Yorke Peninsula.
- 1.3. On the morning of the day prior to his death, Mr Wanganeen breached his bail by leaving that address. The evidence showed that he travelled to Adelaide that day with

his defacto spouse, Ms Cherie Sansbury. They spent the day at the home of a friend, Ms Melissa Weetra. They obtained amphetamines which they injected intravenously. They spent the night at the home of Ms Weetra and the following morning they consumed five Serepax and three Valium tablets each. Sometime that afternoon they were travelling in a white Ford Laser being driven by Ms Anne Wills. Another person, Mr Stephen Thomas, was also present. Earlier that day Ms Wills had obtained buprenorphine from the Brahma Lodge Pharmacy. She had taken one dose of buprenorphine at the pharmacy and taken away four doses for the ensuing four days.

- 1.4. Mr Wanganeen, Ms Sansbury, Ms Wills and Mr Thomas each injected a mixture of the crushed buprenorphine tablets and water in the car in a car park near Centrelink at Salisbury. For some time after this, Mr Wanganeen was left unaccompanied in the vehicle while the other three went their separate ways. Mr Wanganeen appeared to be sleeping. It appears that the other three went in search of further illicit drugs.
- 1.5. Upon their return to the vehicle, Mr Thomas and Ms Sansbury were unable to rouse Mr Wanganeen. Mr Thomas and Ms Sansbury each ran off to obtain assistance, the latter approaching the attendant at a nearby Subway store.
- 1.6. The South Australian Ambulance Service received a tasking at 3:36pm and an ambulance arrived at the scene at 3:41pm. The ambulance officers cleared Mr Wanganeen's airway and CPR was commenced. Narcan, an opioid antagonist, and intravenous adrenaline were administered with no apparent effect. The ambulance departed the scene at 4pm, arriving at the Lyell McEwin Hospital at 4:05pm. Mr Wanganeen was declared deceased at the hospital.

2. **Mr Wanganeen is granted home detention bail**

- 2.1. During the period between 19 June 2005 and the date of his death on 24 August 2005 Mr Wanganeen was either in custody or on home detention bail. The periods of custody were a result of breaches of his conditions of home detention bail. For much of the period I have referred to Mr Wanganeen was at large, having breached his home detention bail and not yet having been arrested. The following is a brief synopsis of his home detention bail status during this period.

- 1) On 19 June 2005 Mr Wanganeen was released on home detention bail to live at Maitland. Prior to this he had been on remand at Yatala Labour Prison.
- 2) On 29 June 2005 at 0150 hours an officer of the Department for Correctional Services reported Mr Wanganeen for being in breach of his home detention bail conditions by being absent without authority.
- 3) Sometime after 29 June 2005 Mr Wanganeen was arrested and remanded in custody. On 19 July 2005 he was again released on home detention bail to live at Maitland.
- 4) On 24 July 2005 a report was made by an officer of the Department for Correctional Services that Mr Wanganeen was in breach of his home detention bail conditions by being absent without authorisation. Mr Wanganeen had stated that he was going to attend at the Maitland Hospital to visit a sick relative. However, a check was made at the hospital and it was established that Mr Wanganeen had never attended there.
- 5) Sometime between 24 July 2005 and 15 August 2005 Mr Wanganeen was arrested for breach of bail and held in custody. On 15 August 2005 Mr Wanganeen was again released on home detention bail to live at the address in Maitland.
- 6) On 19 August 2005, while on an approved pass from home detention, Mr Wanganeen was arrested on another breach of bail and taken to the Elizabeth Police cells to face Court the following day.
- 7) On 20 August 2005 Mr Wanganeen was released from police custody and was due to return to home detention bail at the Maitland address.
- 8) On 22 August 2005 an employee of the Department for Correctional Services contacted Mr Wanganeen and advised him that he was in breach of his bail conditions for having failed to return to the Maitland address.

- 9) On 23 August 2005 at 0847 hours Mr Wanganeen was noted by his Department for Correctional Services supervisor to be absent from his home without authorisation. As I have said, this was the day before Mr Wanganeen's death¹.
- 2.2. From the above summary it can be seen that Mr Wanganeen was continually breaching his conditions of home detention bail. As Mr Wanganeen was absent from the place of his required detention at the time of his death, his death was not a death in custody within the meaning of that expression in the Coroners Act 2003.
- 2.3. Mr Wanganeen's home detention supervisor was an employee of the Department for Correctional Services based at the Elizabeth Community Corrections Centre. He was required to monitor Mr Wanganeen remotely from that metropolitan location while Mr Wanganeen was resident at the address in Maitland. Mr Wanganeen had an electronic monitoring device locked to his ankle. This transmitted a signal to another device connected to Mr Wanganeen's home telephone. That device would automatically alert a computer situated in the metropolitan area when Mr Wanganeen was out of range of his place of residence. The device attached to the telephone would register that Mr Wanganeen was out of range when his range from the telephone exceeded a distance of 25 metres.
- 2.4. Apart from the obligation to reside at the address at Maitland and not leave it without authority, Mr Wanganeen's bail was also subject to the condition that he not consume alcohol or any drug that was not medically prescribed or otherwise legally available.
- 2.5. Mr Wanganeen's medical records clearly indicate that he was a drug user. In particular, the clinical admission records of the South Australian Prison Health Service indicate that on an assessment made on 27 July 2005 Mr Wanganeen reported using \$200 worth of intravenous heroin or morphine per week, \$200 worth of intravenous amphetamines per week and smoking \$100 worth of cannabis per week, and also taking two to three 5mg tablets of benzodiazepine per day². Mr Wanganeen's medical records at the Lyell McEwin Health Service also show a prior history of drug taking behaviour³.

¹ The above summary is taken from Exhibit C22g

² Exhibit C16f

³ Exhibit C16e

- 2.6. Mr Wanganeen was referred to the South Australian Prison Health Service infirmary on 27 July 2005 because he had symptoms of drug withdrawal. While on remand he was treated with oxazepam, diazepam and buprenorphine. In short, Mr Wanganeen was a long-term drug user.
- 2.7. Surprisingly, Mr Artis, who was Mr Wanganeen's home detention supervisor, and who gave evidence at the Inquest, said that he did not consider Mr Wanganeen to be a drug user⁴.
- 2.8. It is obvious that the information which was clearly known to the South Australian Prison Health Service that Mr Wanganeen was a long-term drug user, and in particular withdrawing from illicit drugs in the period of his home detention bail on 27 July 2005, was not made known to the Community Corrections staff who were responsible for his supervision. In short, there was a total lack of proper sharing of information.
- 2.9. Mr Lange Powell was the Director of Community Corrections for the Department for Correctional Services in 2005. In a statement he said that there were no formal policies or protocols in place in 2005 for systemic exchange of information between the South Australian Prison Health Service and Community Corrections⁵. He said that the lack of policies for the sharing of information between those two entities has been acknowledged by both of them. He said that the agencies have attempted to formulate a response to the issue following previous recommendations made by this Court.
- 2.10. In my finding in the matter of an Inquest into the death of Neil James Brooks⁶ in the Adelaide Remand Centre in 2003, I said that the exchange of information between the custodial system and the Prison Health Service was restricted. It was restricted in the same way, and apparently for the same reasons, that exchange of information between medical advisers and persons other than their patients is restricted in the general community. I said then and repeat now that more than this is required of the Prison Health Service and the custodial system.

⁴ Transcript, pages 52-53

⁵ Exhibit C22k

⁶ Inquest 23/2006

- 2.11. The Prison Health Service is not the subject of specific statutory recognition. In my view, some advantage would be obtained by a statutory codification of the existence and role of the Prison Health Service. By this means it would be possible to obtain some relaxation of the ordinary obligations of confidentiality imposed upon a medical practitioner where the provision of information was in the best interests of the prisoner. A statutory codification of the Prison Health Service might also provide an opportunity to modify the relationship of the health service to the prisoner in a way better designed to recognise the realities of the prison system.
- 2.12. In the present case, it seems to me that it would have been in Mr Wanganeen's interests for the Prison Health Service to have known that it was a condition of his home detention bail that he not consume illicit, non prescription drugs. Furthermore, it would have been in his interests for the Prison Health Service to be required to inform the supervisors of his home detention bail that he was clearly in breach of that condition. Neither of these things occurred.
- 2.13. In the present case, the problem was exacerbated by the logistical difficulty associated with the supervision of persons on home detention in country locations when the supervisors are located in the city. It may well be that the difficulty presented by this separation meant that there was less opportunity to make physical checks upon Mr Wanganeen, thus providing him with a greater opportunity than would otherwise be the case to engage in drug abuse.
- 2.14. Ms Carmen Bryan, Manager of Case Management at the Elizabeth Community Corrections Centre, gave a record of interview which was admitted as Exhibit C22b. She said, referring to 2005 when Mr Wanganeen was on home detention bail:

'In those days it was impossible for us to supervise non metro it's like Yalata you know the courts gave people the home detention we were not able to fully meet the conditions because of the distance.'⁷

⁷ Exhibit C22b, page 12

3. **Recommendations**

3.1. I make the following recommendations pursuant to section 25 of the Coroners Act 2003:

- 1) That the Department for Correctional Services review the system of home detention bail with particular attention to the logistical difficulties imposed in ensuring proper supervision of bailees in regional areas.
- 2) That the Department for Correctional Services and the Department for Health review the sharing of information between the two entities. In my view, their review should give particular consideration to the creation of a statutory codification of the duties of clinicians in the Prison Health Service to recognise that there is a need to modify the ordinary obligations of confidence of medical practitioners when working with persons who are in custody, or on home detention bail.

Key Words: Home Detention; Drug Overdose

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

Seal the 18th day of March, 2009.

State Coroner