



## **FINDING OF INQUEST**

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adeladie in the State of South Australia, on the 26<sup>th</sup>, 27<sup>th</sup> and 28<sup>th</sup> days of March 2019 and the 23<sup>rd</sup> day of May 2019, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Philip Michael Harris.*

*The said Court finds that Philip Michael Harris aged 30 years, late of Yatala Labour Prison, Peter Brown Drive, Northfield, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 17<sup>th</sup> day of September 2015 as a result of exsanguination due to division of left brachial artery. The said Court finds that the circumstances of his death were as follows:*

### **1. Introduction, cause of death and reason for Inquest**

- 1.1. Philip Michael Harris died on 17 September 2015 at the Royal Adelaide Hospital. He had been brought into the hospital by ambulance from the Yatala Labour Prison. At the time of his death Mr Harris had been on remand in the Yatala Labour Prison for seven days having been admitted on 10 September 2015.
- 1.2. An autopsy was carried out by Dr John Gilbert of Forensic Science South Australia and in his report<sup>1</sup> Dr Gilbert gave the cause of death as exsanguination due to division of left brachial artery, and I so find. Mr Harris had inflicted severe cuts to his left arm using a blade from a disposable razor to make longitudinal cuts on his left arm.
- 1.3. Because his death was a death in custody within the meaning of that expression in the Coroners Act 2003, this inquest was held as required by section 21(1)(a) of that Act.

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<sup>1</sup> Exhibit C2a

## **2. Issues at inquest**

- 2.1. In the course of this inquest two issues of concern were examined. The first matter of concern was that Mr Harris, who had a chronic risk of self-harm as a result of many previous incidents, would have access to a razor issued within Yatala Labour Prison. The second issue was that post-mortem toxicology results indicated that Mr Harris had an unexpectedly high concentration of the anti-epilepsy medication, carbamazepine, in his blood when he died. Both of these issues have been extensively ventilated in the course of the inquest and I am satisfied that the Department for Correctional Services is undertaking an internal review of the issue of razors to prisoners with a view to reaching a satisfactory balance between the obvious need to issue razors to prisoners for the purposes of their daily care needs with the risks involving prisoners at high risk such as Mr Harris. The difficulty for the prison system is clearly that there is a need for razors to be provided to prisoners generally. For the most part these pose no particular risk. Prisoners are in a position to exchange razors within the prison system and it is necessary to devise a system that will offer sufficient protection to prisoners such as Mr Harris. In the circumstances I am content to leave the development of an appropriate policy to the Department for Correctional Services which on the evidence is proposing to undertake that task.
- 2.2. As to the issue of carbamazepine, as will be presently seen, the medical evidence provided cogent explanations for the apparently high concentrations of carbamazepine in Mr Harris' blood. I am satisfied that there was no connection between those high concentrations and his self-harming behaviour. Furthermore, I am persuaded that the high concentrations were not the result of inappropriate prescription either within the prison system or within the community.

## **3. Background**

- 3.1. At the time of the offending which led to his imprisonment, Mr Harris was in a very negative relationship with a woman which was characterised by domestic violence. Mr Harris also had an extensive history of mental health presentations in the public hospital system. There were instances where he was detained pursuant to the Mental Health Act. There were many presentations involving self-harm and threatening and aggressive behaviour. Mr Harris had a pattern of behaviour that led him to react to any emotional disturbance or argument by engaging in volatile and violent acts, particularly

self-harm either by cutting himself or overdosing on drugs. This history is set out in considerable detail in the investigating officer's report<sup>2</sup>.

- 3.2. Upon his admission to Yatala Labour Prison, Mr Harris was immediately identified by staff as being at risk due to his extensive history of mental health concerns and self-harm, including while in custody previously. The prison system had also received information from SAPOL that Mr Harris had deliberately cut his arm a week prior to his arrest. Upon his admission he said that he was experiencing grief and loss as a result of the death of his mother. All of these issues led to correctional officer Maranda raising a notice of concern which meant that Mr Harris was to receive particular attention. He spent the first night in the prison within G Division which affords the highest level of security and observation available in the prison. The next day he was assessed by the High Risk Assessment Team (HRAT). He denied to the assessor that he had any thoughts of self-harm or suicidal ideation. On the second day he was moved to E Division and placed in a cell with two other prisoners. He remained under intensive observation.
- 3.3. At about 10:50am on 17 September 2015 Mr Harris was in the cell when, without warning, he became agitated and aggressive. The evidence did not disclose any specific event that prompted this behaviour. His cellmate, Mr Knotte-Parke, became very concerned and tried to calm Mr Harris down. Mr Harris was saying that he was sick of being told what to do and stated words to the effect '*they will listen to me now*'. He grabbed his disposable razor, threw it on the floor and then crushed it under his shoes. He then retrieved the blade from the crushed plastic. Mr Knotte-Parke said that he would call the guards on the intercom if Mr Harris did not put the blade down but Mr Harris then threatened him by saying '*if you buzz up I'm going to kill you*'. Mr Harris then cut himself from his wrist to his elbow twice in quick succession and without hesitation blood immediately spurted from the wound. Mr Knotte-Parke was in fear and yelled out of the trap in the door to attract the attention of prison officers. At 10:59am a Code Black medical emergency was called.
- 3.4. The effect of the call was for medical and prison officers to attend immediately. Mr Harris remained aggressive and as a result the officers did not enter the cell immediately. Instead they passed a towel through the trap and asked him to put pressure

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<sup>2</sup> Exhibit C33a

on the wound and Mr Harris refused. The officers were splattered with blood during their attempts to persuade him otherwise and were directed by their supervisor to don protective clothing before entering the cell. Mr Harris remained aggressive and continued to wield the razor blade. After a while he became quieter, presumably due to a loss of blood, and the opportunity was taken by officers to open the cell and evacuate Mr Knotte-Parke. At this time Mr Harris became agitated and again sprang at the officers with the razor blade. However he was able to be removed from his cell by his feet so that treatment could be commenced by Prison Health staff. Mr Harris did continue to be aggressive and obstruct treatment.

- 3.5. South Australian Ambulance Service was called by the prison at 11:03am. Ambulance officers arrived at the scene at 11:24am and said that Mr Harris was acting in a combative and confused manner. Mr Harris' condition was deteriorating because of loss of blood and he needed to be taken to the Royal Adelaide Hospital. The ambulance left the prison at 11:51am. On the way to the Royal Adelaide Hospital at 12:02pm Mr Harris lost consciousness and went into cardiac arrest. The ambulance officers commenced CPR which continued as they arrived at the Emergency Department. Despite ongoing resuscitation efforts for 35 minutes, Mr Harris could not be revived and was declared deceased at 12:32pm.

#### **4. Discussion**

- 4.1. Mr Harris had a lengthy mental health history. There were extensive medical records evidencing presentations to Emergency Departments with acute conditions. There is a clearly defined pattern of behaviour of inflicting lacerations to his left forearm as a reaction to emotional turmoil or stress. Indeed this occurred repeatedly in the eight months leading up to the incident in Yatala Labour Prison, but also in preceding years. Many of the previous forearm lacerations were so severe that they required surgery, sometimes the cuts were so deep that they exposed muscle and bone.
- 4.2. Dr Jayakrishnan Nair, consultant psychiatrist at the Lyell McEwin Hospital, had diagnosed Mr Harris with borderline antisocial personality disorder and in May 2015 expressed the opinion that Mr Harris remained at chronically high risk of harm to himself from misadventure and aggression.
- 4.3. Outside hospital Mr Harris failed to engage with suggested community health treatment options.

- 4.4. It would appear that the mental health system had little success in assisting Mr Harris to deal with his condition. Certainly inpatient admissions or detention under the Mental Health Act had been counterproductive, and were avoided if possible.
- 4.5. As I have said, there was no warning sign of the catastrophic behaviour he showed in the prison in the days leading up to his death. There was no apparent precipitating grievance or argument. All witnesses including guards, social workers and cellmates who interacted with Mr Harris believed that he was stable and not exhibiting signs of distress. However, Mr Harris' previous history showed that his volatile behaviour was unpredictable. The prison system properly identified his risks by the raising of notices of concern and his placement on the list of the HRAT.
- 4.6. As I have noted, there was some delay in the prison officers entering Mr Harris' cell once they were alerted to the crisis by Mr Knotte-Parke. I make no criticism of the delay that was required in order to deal with the biological risk created by the presence of a considerable amount of blood and the possible risk of exposure to communicable disease. The use of biohazard suits was necessary once the first attending officers had been splashed with blood, even while trying to push the towel through the trapdoor. Clearly it was necessary to use safety equipment and there was no unnecessary delay in the extraction of Mr Harris from the cell.
- 4.7. As soon as Mr Harris indicated signs of weakness due to loss of blood the doors were opened and assistance was rendered. Even after this Mr Harris continued to physically resist treatment.
- 4.8. Correctional officer Massie stated that he heard Mr Harris say words to the effect '*I didn't mean to go so far, you know*'. This indicates that Mr Harris may not have intended to take his own life and was simply behaving as he had done on many previous occasions, namely cutting himself to relieve psychological distress and seek help. Unfortunately on this occasion his cutting resulted in damage to an artery and rapid blood loss.
- 4.9. I heard evidence from Mr Harris' general practitioner about his prescription of carbamazepine for Mr Harris' epilepsy. The general practitioner saw him on only four occasions in 2015. On the first occasion Mr Harris presented simply to seek his usual prescriptions for his poorly controlled epilepsy. The general practitioner ascertained from Mr Harris what his current medication regime was and simply provided a

prescription in accordance with that regime. The general practitioner merely considered himself to be issuing ongoing prescriptions of a medication in accordance with a long standing prescription history. However he ordered routine therapeutic drug testing to assess blood levels and to test Mr Harris' compliance. Furthermore, it was very clear on the evidence that Mr Harris was prescribed carbamazepine at the same dose and according to the same regime on many occasions prior to the general practitioner seeing him. Furthermore, after the general practitioner last saw Mr Harris and before the day of Mr Harris' death there were multiple hospital admissions in the course of which other medical practitioners prescribed carbamazepine according to the same regime. Furthermore, medical officers within the South Australian prison service followed suit.

- 4.10. In the circumstances I accept the submission of the general practitioner's counsel that the dosage reflected a reasonable regime for a person with long standing epilepsy going back to childhood.
- 4.11. The Court obtained an expert opinion from Dr Robinson, neurologist, regarding the carbamazepine levels. Dr Robinson gave evidence that a dose of 1mg of carbamazepine twice per day was high, but was nevertheless within the therapeutic range of that drug. He said that cannabis smokers such as Mr Harris may need a higher dose and the evidence showed that Mr Harris had regularly smoked cannabis from the age of 13. Dr Robinson said that the therapeutic goal for an epileptic patient was to titrate the amount of medication to achieve a situation where the patient has no seizures at all. It was plain from his evidence that the signs and symptoms of carbamazepine toxicity include nausea, vomiting, double vision, unsteady gait and a general appearance consistent with alcohol intoxication. I accept the submission that during the period in Yatala Labour Prison there was no evidence that Mr Harris displayed any of those symptoms of toxicity.
- 4.12. Dr Robinson acknowledged that Mr Harris did not show any of those signs or symptoms and therefore there was no clinical manifestation that he was suffering carbamazepine toxicity. Dr Robinson said that a person can build up a tolerance to carbamazepine and that the objective signs and symptoms being displayed by the patient were a more important indicator of their reaction to the drug than the concentration of carbamazepine in their blood.

- 4.13. Importantly, Dr Robinson said that carbamazepine does not cause agitation. He gave evidence that he knew of practitioners who had prescribed it to aggressive patients to calm them down. It is clear from his evidence that Mr Harris' erratic, impulsive, violent and agitated behaviour on the day of his death was not consistent with symptoms of carbamazepine toxicity.
- 4.14. The evidence showed that the manufacturer of carbamazepine includes a warning that the drug might result in suicidal thoughts. However Dr Robinson said that the actual proof of such a relationship is very poor<sup>3</sup>. He said there was no conclusive data to link suicidality to carbamazepine and thought that the warning was included on the product warning sheet out of an abundance of caution and perhaps with a view to avoiding litigation. He had never heard of carbamazepine being associated with suicidal behaviour. Furthermore, it is far from clear that Mr Harris was exhibiting suicidal behaviour and indeed his last words to correctional officer Massie indicated precisely the opposite. I am satisfied that the high levels of carbamazepine found in Mr Harris' post-mortem blood played no part in his spontaneous and erratic act of self-cutting exhibited on the day of his death.
- 4.15. I have already referred to the evidence provided on behalf of the Department for Correctional Services that the issue of access to razors requires closer consideration within the prison system and that there will be a review of the relevant standard operating procedure to take into account the circumstances surrounding Mr Harris' tragic death. As a result of this I do not intend to make any recommendations in this case.

*Key Words: Death in Custody; Prison; Suicide*

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

*Seal the 23<sup>rd</sup> day of May, 2019.*

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*State Coroner*