



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 30th day of April and the 28th day of May 2020, by the Coroner's Court of the said State, constituted of Simon James Smart, Deputy State Coroner, into the death of Jeffrey Thomas White.

The said Court finds that Jeffrey Thomas White aged 35 years, late of 8 Leadenhall Road, Port Adelaide, South Australia died at Port Adelaide, South Australia on the 28th day of July 2016 as a result of heroin toxicity. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

- 1.1. Jeffrey Thomas White was born on 15 June 1981 and died on 28 July 2016 aged 35 years at his home address of 8 Leadenhall Road, Port Adelaide. Mr White's body was identified by his partner Ms Jessica Williamson¹.
- 1.2. A post mortem examination of Mr White's remains was undertaken by forensic pathologist Dr Karen Heath at Forensic Science South Australia. In her report of that examination Dr Heath provides the cause of death as heroin toxicity², and I so find.
- 1.3. A toxicological analysis of Mr White's post mortem blood revealed that morphine, codeine, methylamphetamine, amphetamine and other drugs were in his system at the time of death³.

¹ Exhibit C1a

² Exhibit C2

³ Exhibit C3

2. Reason for Inquest

- 2.1. Mr White's death was the subject of a mandatory inquest pursuant to section 21(1)(a) of the Coroners Act 2003 as Mr White was subject to home detention bail at the time of his death.
- 2.2. On 8 April 2016 Mr White appeared before the Adelaide Magistrates Court on charges of serious criminal trespass non-residential and theft. He was released on home detention bail on the same day. Full details of his bail are to be found in the statement of Ms Debra James, home detention case manager, for the Department for Correctional Services (DCS)⁴. Mr White lived alone and was placed on home detention at 8 Leadenhall Road, Port Adelaide.
- 2.3. Mr White breached his home detention bail on one occasion when he failed to provide for a random drug test on 10 May 2016. On 14 May 2016 Mr White was arrested for that breach, but was released on the same day back on home detention bail.
- 2.4. Overall, it was reported that Mr White was polite, respectful and always engaged well with his home detention case manager. Apart from the one breach, he complied with his conditions of bail. He was however warned about not answering the phone to the monitoring unit and not charging electronics. Mr White remained on home detention bail until his death on 28 July 2016, a total of 78 days.

3. Background

- 3.1. I turn to Mr White's background which has been obtained from the statements of his mother Ms Georgia White⁵, his partner Ms Jessica Williamson⁶, police statements and documents tendered to the Court.
- 3.2. Mr White was an only child. His father Dennis White was absent at birth and not involved in his upbringing. Mr White's mother states his father contacted him in 2005, but she provided no further details.
- 3.3. Ms White states that her son did not have any qualifications. He had various jobs, with the longest employment being for three years as a concrete worker. Ms White was

⁴ Exhibit C7

⁵ Exhibit C4

⁶ Exhibit C1b

acutely aware of her son's drug use. She states that he started with cannabis at the age of 15 years and moved onto harder drugs.

3.4. Ms White states her son never attempted suicide, she said:

'I don't believe he would ever take his own life, he had everything to live for and was besotted by his son. '

3.5. As far she was aware he was never diagnosed with any mental health issues, but she does state that he seemed depressed, especially on the last few occasions she spoke to him. The last time she saw him was on 16 June 2016. She noted that he seemed withdrawn and was not talkative. He was always bubbly with his son Jacob, but on that occasion he appeared depressed.

3.6. Ms White regularly talked to her son on the telephone. She states that in the last few months of his life while on home detention he was physically and mentally affected by the restrictions. She believed his health issues were also affected due to not having enough of the drugs he required.

3.7. Mr Whites' partner, Ms Williamson⁷, states she met him when she was 19 years old. He is the father of their son Jacob, who was two years old at the time she gave her statement to police. Ms Williamson was also aware that Mr White was taking heroin and 'gear' in her words. She also knew that he was on a program for his drug issues.

4. Involvement with Drug & Alcohol Services SA

4.1. Mr White had an extensive history of drug use. Full details of his contact with Drug and Alcohol Services South Australia (DASSA) are set out in the statement of Toni Hendry⁸ who is the regional manager. Mr White first contacted DASSA in December 2002 aged 21 years having been referred by the Police Drug Diversion Line. He had been found in possession of a bag containing traces of amphetamine.

4.2. Mr White provided a history of occasional amphetamine use from the age of 19 years. He stated he had been a regular user of cannabis from the age of 17. He was provided advice and given material on harm reduction strategies.

⁷ Exhibit C1b

⁸ Exhibit C6

- 4.3. In August 2012 at the age of 31 years he presented to DASSA requesting assistance for heroin withdrawal. He had an extensive drug problem and was seen by a psychologist. He continued to be offered counselling until a detox service could be arranged. Mr White was referred to his general practitioner and Salvation Army for support whilst waiting for admission to a withdrawal service. Mr White failed to attend further appointments and told the psychologist he was no longer interested in the detox service.
- 4.4. In January 2013 Mr White presented again seeking assistance. On this occasion he commenced an outpatient detox program that was completed on 19 February 2013. On 28 February 2013 he attended DASSA and requested the Suboxone program to assist him as he had recommenced intravenous heroin use. He was offered a medical appointment and was commenced on an initial dose of 6mg Suboxone daily.
- 4.5. Mr White's Suboxone was adjusted and he continued to receive a dose until he failed to attend two appointments. Mr White ceased his involvement with DASSA on 19 September 2014, at which time he was transferred to a private prescriber, Dr Patrick O'Leary.
- 4.6. Mr White contacted DASSA on 25 July 2016, just three days prior to his death. He contacted the Alcohol Drug Information Service and stated he was injecting \$100 to \$150 of heroin per week and taking methadone which he obtained illegally. He stated he was unable to function and was offered an appointment on 4 August 2016 at 2pm.
- 4.7. Dr Patrick O'Leary
Dr Patrick O'Leary was general practitioner at the Morphettsville Medical Centre. He states that he first saw Mr White in September 2014 and subsequently prescribed him Suboxone⁹. Dr O'Leary states that Mr White suffered from opiate and polysubstance abuse. The doctor saw no signs of depression or psychosis.
- 4.8. Dr O'Leary last saw Mr White was on 6 March 2016. He observed no issues and Mr White appeared stable. Dr O'Leary noted that Mr White was impeccably behaved throughout his dealings with him.

⁹ Exhibit C5

5. Circumstances on the day of death

- 5.1. On 27 July 2016, the day prior to Mr White's death, Ms Williamson decided she would visit Mr White at his home detention address in Port Adelaide. She finished work and arrived at the address at about 5pm. Mr White appeared unwell and in pain. He was repeatedly calling the same number and was becoming increasingly angry at getting voicemail. Ms Williamson gave him \$100 and left. She called him at about 10.30pm and he sounded sick. She asked him if he wanted a doctor, but he said he had to go.
- 5.2. The following day, 28 July 2016, Ms Williamson received a call from DCS stating that they were unable to contact Mr White. Ms Williamson attended at Mr White's house at approximately 2pm. She knocked at the front and back doors but got no response. She contacted Mr White's mother who in turn contacted police.
- 5.3. Senior Constable Anthony Laing¹⁰ stated that he was tasked to attend Mr White's address following welfare concerns raised by his mother. When Senior Constable Laing arrived at Mr White's premises a DCS Community Corrections officer was in attendance with the South Australian Ambulance Service.
- 5.4. Senior Constable Laing states that paramedics had forced entry and found Mr White deceased in the kitchen. A police investigation commenced and police located a syringe, a spoon with residue marks, a lighter and a small piece of paper with no substance present in it on the kitchen bench.
- 5.5. Crime Scene Examiner, Brevet Sergeant Steven Gresch, attended the premises. His observations are detailed in his statement that was tendered to the Court¹¹.

6. Coronial investigation

- 6.1. Detective Brevet Sergeant Neil Dunne was appointed to investigate Mr White's death in custody and a report of his investigation was tendered to the Court¹². In that report he sets out the thorough investigation undertaken by South Australia Police.
- 6.2. Detective Dunne's investigation found that Mr White was lawfully placed on home detention bail and that there were no suspicious circumstances surrounding his death,

¹⁰ Exhibit C9

¹¹ Exhibit C10

¹² Exhibit C12

nor anything to indicate any third-party involvement. I agree with the conclusion of Detective Dunne on these matters.

- 6.3. Mr White's mobile phone and movements were analysed¹³. SAPOL were unable to determine the source of the drugs. Mr White was a known illicit drug user and by his own admission stated he needed assistance with his illicit drug use three days prior to his death. The cause of death and toxicological analysis clearly establish that Mr White consumed a lethal cocktail of illicit drugs. There is no evidence to suggest this was a suicide. No suicide note or other indicators of suicide were found.
- 6.4. It was also drawn to the Court's attention that shortly after Mr White's death the Minister for Health and Substance Abuse issued a public health warning following a spate of heroin related deaths¹⁴.

7. **Recommendations**

- 7.1. I make no recommendations pursuant to section 25(2) of the Coroners Act 2003.

Key Words: Death in Custody; Home Detention; Drug Overdose

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

Seal the 28th day of May, 2020.

Deputy State Coroner

Inquest Number 31/2019 (1423/2016)

¹³ Statement of Stephen Dean, Exhibit C8a and Michael Wood, Exhibit C11

¹⁴ Exhibit C12c