**CORONER'S COURT**

| | |
|---|---|
| **Inquest:** | Inquest into the death of Tracylee BRANNIGAN |
| **Hearing dates:** | 10-11 June 2014 |
| **Date of findings:** | 16 June 2014 |
| **Place of findings:** | Coroner's Court,<br>Level 5, Downing Centre<br>143-147 Liverpool Street,<br>Sydney NSW 2000 |
| **Findings of:** | Paul MacMahon<br>Deputy State Coroner |
| **Catchwords:** | CORONIAL LAW – Death in Custody, Mandatory Inquest, Drug use in Correctional Centres |
| **File number:** | 2013/59259 |
| **Representation:** | Mr P Bush – Coronial Advocate<br>Ms J Leibowitz – Family of Ms Brannigan<br>Mr S Griffiths – Corrective Services<br>Ms R Mathur – Justice Health |

**Non-publication order made pursuant to Section 74(1)(b) Coroners Act 2009:**

1. The names of the children of the deceased.
2. The photographs of the deceased at Tab 2 of Exhibit 2, and
3. Exhibit 13.

***Findings made in accordance with Section 81(1) Coroners Act 2009****:*

Tracylee Brannigan (born 3 March 1971) died between 24 February 2013 and 25 February 2013 at the Dillwynia Correctional Centre, Berkshire Park in the State of New South Wales. The cause of her death was Heroin Toxicity which was self administered. There was no evidence to suggest that in administering the drug the deceased intended to end her life. The manner of her death is therefore misadventure.

**Recommendations made in accordance with Section 82 (1) Coroners Act 2009:**

To: The Commissioner of Corrective Services:

That consideration should be given to the implementation of random searches of cells at, or shortly after, the afternoon lockdown with particular attention being given to cells occupied by inmates that are known, or reasonably suspected, to be users of illicit substances whilst in custody.

Paul MacMahon
Deputy State Coroner
16 June 2014

**Reasons for Findings:**

Tracylee Brannigan (who I will refer to as 'Tracylee') was born on 3 March 1971. Her parents separated when she was a baby. Her mother worked very hard to provide her with loving care and a good education. Unfortunately as a teenager she became involved in the illicit drug culture. This resulted in her becoming drug addicted and involved in criminal activities.

Notwithstanding her problems Tracylee's mother continued to provide her support and encouragement as did her partner and other friends. Tracylee had two children.

Tracylee was convicted of various drug related offences on 27 May 2009 and was sentenced to imprisonment for a period of six years with a non- parole period of four years. She was eligible for parole 26 May 2013.

In December 2012 Tracylee was transferred to the Dillwynia Correctional Centre at Berkshire Park in western Sydney. On 25 February 2013 at about 5:00am Tracylee's cellmate raised the alarm and correctional officers on entering her cell found Tracylee to be deceased. Her death was reported to the Office of the State Coroner that day.

**Jurisdiction of the Coroner:**

Section 18, Coroners Act 2009 (the Act) gives a coroner jurisdiction to hold an inquest where the death or suspected death of an individual occurred within New South Wales or the person who has died or is suspected to have died was ordinarily a resident of New South Wales.

Section 27 of the Act sets out the circumstances in which the holding of an inquest is mandatory. One such circumstance is where a death occurs in circumstances covered by Section 23 of the Act. Section 23(d) refers to a person who dies in a correctional centre. As Tracylee's death occurred in a correctional centre an inquest

into her death is mandatory. Section 23 of the Act also requires that such an inquest be conducted by either the State Coroner or a Deputy State Coroner.

The primary function of a coroner at an inquest is to be found in Section 81(1) of the Act. That section provides that at the conclusion of the inquest the coroner is to establish, should sufficient evidence be available, the fact that a person has died, the identity of that person, the date and place of their death and the cause and manner thereof.

Section 82 (1) of the Act provides that a coroner conducting an inquest may also make such recommendations, as he or she considers necessary or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations are discretionary and relate usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths.

**Identity, Date and Place of Death:**

Tracylee' body was identified by Ms Leanne O'Toole on 25 February 2013. Ms O'Toole was, at the time, the Acting General Manager of the Dillwynia Correctional Centre and had known Tracylee since her arrival at that Centre.

The date of her death was also not a matter of contention. Tracylee was observed to be alive when placed in her cell at Dillwynia Correctional Centre at about 3:30pm on 24 February 2013 and was subsequently found deceased at about 5:00am on 25 February 2013. She therefore died in her cell at Dillwynia Correctional Centre at some time between those two events.

**Cause of death:**

The cause of Tracylee's death was also not contentious. Following her death an autopsy was performed by Dr Kendal Bailey a forensic pathologist. Based on her findings at autopsy, and taking into account the toxicology and serology reports she received, Dr Bailey concluded that the cause of death was due to Heroin Toxicity. It was found that in Tracylee's blood there was a potentially fatal level of morphine and metabolites specific to heroin. I accept Dr Bailey's conclusion as to the cause of Tracylee's death.

**Issues of Inquest:**

The primary issue for inquest was to inquire into the manner, or circumstances, of Tracylee's death.

There was also a need to investigate the circumstance of Tracylee's incarceration in order to ensure that there were no systemic failures that led to, or contributed to, her death. This examination arose from the fact that Tracylee had been deprived of her freedom. The former State Coroner Kevin Waller described the reasons why such examination is mandatory in the following terms:

> *The answer must be that society, having affected the arrest and incarceration of persons who have seriously breached its laws, owes a duty to those persons, of ensuring that their punishment is restricted to this loss of liberty, and is not exacerbated by ill-treatment or privation while waiting trial or serving sentences. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the government provides a positive incentive to custodians to treat prisoners in a humane fashion, and satisfies the community that deaths in such places are properly investigated.*

In the case of Tracylee's death there was a serious allegation made that Tracylee was not properly cared for by corrective services officers prior to her being placed in

her cell at 3:30pm on 24 February 2013 and, by implication, this contributed to her death. That allegation needed to be examined in detail.

Kat Armstrong was a friend of Tracylee's. She is also the director of an organisation known as WIPAN. That organisation was established in 2008 and was designed to advance the wellbeing and prospects of women in the criminal justice system. Ms Armstrong visited Tracylee on 24 February 2013. She arrived at about 2:00pm. There was some delay in getting Tracylee to the visitors section however after she arrived they spent about 20 minutes together.

Ms Armstrong made a statement to police on 4 March 2013. In that statement she asserted that at the time of her visit she formed the opinion that Tracylee was under the influence of some form of opiate or some pill of some sort. She said that she asked her what she had taken however Tracylee denied that she had taken any drugs. She said that because of her state Tracylee was not in a position to contribute very much to their conversation.

Ms Armstrong said that she did not specifically tell any corrective services staff of her concern because she believed that Tracylee's condition was obvious to them. She said that she engaged in some loud conversation with Tracylee that she expected would draw attention to Tracylee's condition. She did not see it as being her role to 'dob' on her friend so did not specifically tell any corrective services staff of her concerns. Ms Armstrong subsequently repeated her assertion on national television.

Ms Armstrong gave evidence at inquest. In her evidence she said that there was no doubt in her mind that at the time of her visit Tracylee was seriously affected by drugs specifically some form of opiate. In addition to the matters she referred to in her statement in her evidence she said that she had also indirectly raised her concerns with a male corrections officer on her way out after the visit. Once again she did not directly say that she thought Tracylee was under the influence of drugs but believed her comments to the officer would have implied that was the case.

When she was asked why she had not mentioned this in her statement in March 2013 she said that she had told the police officer who had take her statement however he had not recorded that fact.

Lauren Ironside was Tracylee's cellmate at the time of her death. Ms Ironside found her deceased and called for assistance on the morning of 25 February 2013. An electronic interview of some 666 questions was conducted with Ms Ironside on 25 February 2013.

Ms Ironside also gave evidence at the inquest. In her evidence at the inquest Ms Ironside said that at the time of Tracylee's return to the cell following her visit with Ms Armstrong she formed the opinion that Tracylee was under the influence of drugs. This suggestion was new evidence and contradicted the statement that she made in her interview on 25 March 2013 at answer 291 when she said that Tracylee, on her return from the visit, was not 'stoned.'

The allegations made by Ms Armstrong and Ms Ironside are very serious. If, at the time of her return from her visit with Ms Armstrong she was under the influence of drugs it would not have been appropriate for her to be locked in the cell for the night. It would have been necessary, in accordance with corrective services procedure, for her to be taken to the clinic and examined by a Justice Health nurse and, if it was found that she was so affected, placed in an observation cell until the effects of the drug had dissipated.

If it was the case that Tracylee was so affected, and corrections officers knowingly failed to take her for assessment an observation, it would be necessary for me to consider making recommendations that disciplinary action be commenced against such corrections officers.

To determine what occurred on 24 February 2013 evidence was received at inquest from corrections officers Kerri Pedley and Dimity Geddes, who were officers supervising Tracylee during the course of the visit, and corrections officers Westleigh Giles, Steven Vella and Robert Eastwood who undertook muster prior to Tracylee being locked in her cell for the night. Each of these officers said that their training and experience allowed them to identify when an inmate was affected by drugs. Each of the officers said that at the time they observed Tracylee on 24 February 2013 she was not affected by drugs.

In questioning the corrections officers the representative of the family implied that the various officers may not have been able to identify subtle changes that might have been present if Tracylee was in fact affected by drugs but was trying to hide that fact. Because of this Dr Judith Perl a forensic pharmacologist was asked to examine the CCTV recording of Tracylee during the course of the visit and provide an expert opinion as to whether or not Tracylee was affected by drugs. Dr Perl, as a consequence of her training and experience, is an expert in the effects of various drugs on the person and is, as such, able to identify the more subtle changes that such drugs have on individuals. Having examined the CCTV of the visit Dr Perl was strongly of the opinion that Tracylee was not drug affected at the time of the visit.

I accept the evidence of Dr Perl and the five corrections officers. I reject the evidence of Ms Armstrong on this point. In addition I am satisfied that as a friend of Tracylee had Ms Armstrong really thought she was under the influence of a drug at the time of the visit she would have mentioned that fact to a corrections officer out of concern for her friend. The fact that she did not do so supports the contention that that was not a concern that she held at the time but a reconstruction of events that was developed following Tracylee's death.

Why she made the assertions that she made in her statement, during the course of the inquest and when commenting on the matter on national television can only be a matter for speculation however it may be that she was acting out of some misguided agenda of trying to improve the lot of females in custody.

In the case of Ms Ironside I found her to be a most unsatisfactory witness. Why she stated at the inquest that Tracylee was under the influence of drugs at the time of her return from the visit would also be the matter of speculation. She was, however, clearly wrong.

**What happened after 3:30pm?**

The only direct evidence available as to what happened after Tracylee and Ms Ironside were locked in at 3:30pm was what Ms Ironside told the police in her interview on 25 February 2013. In summary she said that Tracylee gave her a Rivotril tablet and after that Ms Ironside went to sleep. Ms Ironside also said that before she fell asleep she also saw Tracylee take some tablets as well. In her statement Ms Ironside said that this occurred after lockdown however in her evidence she said that the tablets were consumed prior to lockdown and not afterwards.

I have already found Ms Ironside's evidence to be questionable. I found that her evidence on this matter is also unsatisfactory. I do not accept that Tracylee consumed Rivotril tablets as asserted when Ms Ironside said she did. In this regard I had the benefit of the evidence of Dr Judith Perl.

Dr Perl gave evidence that Rivotril is a commercial name of a drug known as Clonazepam. That drug was found in Tracylee's blood at autopsy however Dr Perl's evidence was that it was in such low quantities that it must have been consumed at a time well before that suggested by Ms Ironside. I accept this evidence and conclude that I cannot place any reliability on Ms Ironside's evidence as to what happened in the cell after she and Tracylee were locked in at 3:30pm on 24 February 2013 unless such evidence were supported by other credible evidence.

Dr Perl confirmed in her evidence that the level metabolites of the heroin found in Tracylee's blood at autopsy was potentially fatal. Dr Bailey's examination of her body

at autopsy did not find any evidence to suggest that the administration was other than voluntary. At autopsy fresh injection marks on her body found. There was a great deal of evidence available to suggest that Tracylee continued to use illicit substances whilst in custody and was known for her drug seeking behaviour. Heroin was her drug of choice. I am satisfied that it is more likely than not that sometime after she and Ms Ironside were locked in their cell on 24 February 2013 Tracylee administered heroin to herself and that administration resulted in her death.

Tracylee's family have suggested that her death was preventable and that 'the system' let her down. They have asserted, in general terms, that had she been given better educational and rehabilitation opportunities and had, as a known drug user, her cell been searched prior to her being locked up at 3:30pm, and her cell been monitored during the course of the night she may not have overdosed. They have suggested that I make various recommendations in accordance with Section 82 in order to remedy these perceived deficiencies.

Dealing with the issue of searches first the evidence was that about 75% of women inmates in NSW correctional facilities had drug addiction issues. The availability of illicit substances in correctional facilities is an endemic problem. Some inmates will go to considerable lengths to obtain drugs. The evidence available to me was that the problem was recognised and various actions were taken to try and mitigate the problem. I had available to me an outline of such action. For my purposes I do not need to set such action out in detail.

Part of that action however includes searching cells. The evidence was that 5 or 6 cells a day are searched on a random basis and if information becomes available to suggest that an inmate might have contraband then targeted searches are also undertaken. Tracylee's cell was in fact the subject of a random search on the morning of 24 February 2013.

The family was critical of the policy of not searching cells prior to lockdown. Their hypothesis was that as Tracylee was a known user her cell should have been searched before she was locked in and if this had been done the drugs she used would have possibly been found and she would not have died.

Similarly the family suggest that drug users were more likely to use drugs in their cell after lock down and as Tracylee was a known drug user her cell should have been monitored in some way to ensure that she did not use drugs or, if she did, identify when she had overdosed and be able to provide assistance at a time when she might have been able to be revived.

Finally the family had concerns that because Tracylee arrived at Dillwynia in December 2012 and was on sanctions because of breached of prison rules she was precluded from engaging in educational and rehabilitative programs that might have encouraged her to not use the illicit substances that resulted in her death.

Dealing with the last matter first it is trite to say that before a drug addict can begin the journey to overcoming the addiction they have to want to do so. The evidence was overwhelming that Tracylee did not want to abandon her addiction. The records of Tracylee's interaction with Justice Health staff on 21 September 2010, 29 June 2011, 23 August 2011, 25 May 2012, 25 August 2012, 22 October 2012, 21 October 2012, 16 January 2013 and 21 February 2013 was consistent in her refusal to accept any assistance that was offered to help her with her addiction. She simply did not want to, or was unable to, deal with her drug problem at the time.

I do not accept that the absence of any available programs during her time at Dillwynia contributed in any way to Tracylee's death. I do not consider that the circumstance of Tracylee's death give rise to my needing to make recommendations as to the timing, or availability, of educational or rehabilitative programs for inmates.

The monitoring of inmate cells is a difficult issue. Certainly there are cells available for short term occupancy of inmates that are suicidal and have other problems that require close observation. Inmates who are found to be drug affected are monitored to ensure their safety until that crisis passes. Random monitoring of inmates in ordinary cells would however raise significant privacy issues for the occupants. Inmates are entitled to be treated with dignity and respect. Observing them in their cells would counter that obligation particularly in an environment where inmates are being prepared for release into the community. I am not prepared to recommend that such monitoring occur.

The regime of searching cells is part of a considered approach to preventing contraband being available to inmates. The evidence was that such searches have been successful in identifying the existence of contraband. This is to be commended. The evidence of corrective service officer Giles that most drug taking will occur after inmates are locked in does, however, suggest that the searching of cells on a random basis at, or shortly after, lockdown would possibly identify additional contraband that had been secreted outside the cell during the day. I propose to recommend to the Commissioner of Corrective Services that consideration be given to the conduct of searches of cells on a random basis at that time in addition to the current searching regime.

The representatives of the family have also suggested that I should make recommendations as to the training of corrective service officers concerning the identification of inmates affected by drugs and alcohol. There is nothing in the evidence available to me in this inquest to suggest that there is a need for such training. I do not therefore propose to adopt that suggestion.

It has also been suggested that Corrective Services assess the viability of the implementation of a full body scanner at Dillwynia as a pilot project. The purpose of such a scanner would be to identify contraband on the person of inmates that cannot be located by currently approved searching techniques. This suggestion may be a good one however there was no evidence before me as to the costs of the

implementation of such equipment and the suitability of use of such equipment in a correctional centre such as Dillwynia that is preparing inmates for release into the community. Indeed comments during the course of giving her evidence by Leanne O'Toole, the acting general manager of Dillwynia at the time of Teacylee's death, suggest that it may not be appropriate. I do not therefore believe it is appropriate for me to make such a recommendation.

**Media attention:**

The nature of coronial proceedings is such that it inevitably attracts media attention. The inquest into Tracylee's death was no different. On Monday 9 June 2014, the evening before the inquest commenced, Tracylee's death was the subject of extensive coverage on the ABC's program '7:30'. No criticism of the producers is made for them bringing these issues to the attention of the public. It is important that it occur and coroners welcome it occurring.

During the '7:30' coverage Ms Armstrong was interviewed. She repeated the allegations that she made in her statement and again during the course of the inquest. As mentioned above those allegations were found to be not credible. The rejection of the evidence of a witness in an inquest or other legal proceedings is not unusual. That is what occurred in this case.

One of the reasons why it is mandatory for an inquest to be conducted in the case of a death in custody is to ensure that persons responsible for the care and treatment of persons who have been deprived of their liberty have been appropriate. Coroners have quite rightly been quick to point out when such care has been less than appropriate. Equally coroners should not be restrained in acknowledging when, as in this case, the officers responsible for the care of inmates have acted appropriately. Indeed where, as in this case, such officers are the subject of serious allegations of dereliction of duty that are not supported by the evidence this fact should be acknowledged.

The difficulty that arose in this case appears to have occurred as a result of the ‘7:30’ program being shown prior to the commencement of the inquest. This meant that the producers did not having access to all the evidence surrounding Tracylee’s death. This resulted in them broadcasting to the public allegations that were subsequently found not to be credible. This could have had a negative effect on the perception of the public as to the competency and commitment of the various corrective service officers involved in the care of inmates. This is a most unfortunate outcome.

Paul MacMahon
Deputy State Coroner
16 June 2014