JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	10 OCTOBER 2023
DELIVERED	**:**	29 NOVEMBER 2023
FILE NO/S	**:**	CORC 395 of 2021
DECEASED	**:**	ASHBY, SAMUEL EDWARD

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Sergeant A. Becker assisted the coroner.

Ms J. Kasbergen (State Solicitor's Office) appeared for the Department of Justice and the North Metropolitan Health Service.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Samuel Edward ASHBY*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 10 October 2023, find that the identity of the deceased person was* ***Samuel Edward ASHBY*** *and that death occurred on 9 February 2021 at St John of God Midland Public Hospital , 1 Clayton Street, Midland, from aspiration pneumonia in an obese man with a history of diabetes mellitus, obstructive sleep apnoea, recent right ankle fracture and clozapine effect in the following circumstances:*

Table of Contents

INTRODUCTION **3**
MR ASHBY **4**
Background 4
Offending history 4
Prison history 5
Medical history 6
Management of medical issues 7
EVENTS LEADING TO MR ASHBY'S DEATH **11**
Admission to SJOG 11
Management at SJOG 11
CAUSE AND MANNER OF DEATH **12**
Possible role of clozapine in Mr Ashby's death 12
Cause and manner of death 18
Clozapine prescription following Mr Ashby's death 19
OTHER ISSUES ARISING FROM THE EVIDENCE **20**
CPAP Machine 20
Failure to advise NOK about admission 24
QUALITY OF SUPERVISION, TREATMENT AND CARE **25**
CONCLUSION **27**

INTRODUCTION

1. Mr Samuel Edward Ashby (Mr Ashby) was 46 years of age when he died at St John of God Midland Public Hospital (SJOG) on 9 February 2021, from aspiration pneumonia. At that time, Mr Ashby was a sentenced prisoner at Acacia Prison (Acacia) and was thereby in the custody of the Chief Executive Officer of the Department of Justice (DOJ).[1,2,3,4,5,6,7]

2. Accordingly, immediately before his death, Mr Ashby was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*". In such circumstances, a coronial inquest is mandatory. Further, where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received whilst in that care.[8]

3. On 10 October 2023, I held an inquest into Mr Ashby's death. The documentary evidence adduced at the inquest comprised one volume, and the following witnesses gave evidence:

a. Dr Natalia Bilyk (Mr Ashby's Consultant Treating Psychiatrist);

b. Ms Pansey Stewart (Health Services Manager, Acacia Prison)

c. Dr Joy Rowland, CSM (Medical Director, DOJ); and

d. Ms Storm Duval, (Review Officer, DOJ).

4. The inquest focused on the supervision, treatment and care provided to Mr Ashby while he was in custody, and the circumstances of his death.

[1] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (24.04.22)
[2] Exhibit 1, Vol. 1, Tab 2, Report - Sen. Const. L Riley (24.07.22)
[3] Exhibit 1, Vol. 1, Tab 3, Memorandum - Sen. Const. N Dempsey(10.02.21)
[4] Exhibit 1, Vol. 1, Tab 4, Death in Hospital form (09.02.21)
[5] Exhibit 1, Vol. 1, Tab 5, P92 - Identification of Deceased by Visual Means (11.02.21)
[6] Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (24.01.22)
[7] Section 16, *Prisons Act 1981* (WA)
[8] Sections 22(1)(a) & 25, *Coroners Act 1996* (WA)

MR ASHBY

Background[9,10,11]

5. Mr Ashby was born in Adelaide on 12 December 1974. He was raised on a farm in Esperance and had two siblings. After attending high school as a boarder, Mr Ashby completed a pre-apprenticeship course in light automotive mechanics, before returning to the family farm. Mr Ashby was reported to struggle with complex tasks, and he was later assessed as having "*low average intellectual functioning*".[12]

6. Mr Ashby had a history of polysubstance use, and disclosed using alcohol from 13 years of age, and cannabis from 16 years of age. In his early twenties, Mr Ashby reportedly experimented with MDMA[13] (commonly known as Ecstasy), and he was also a heavy smoker of tobacco cigarettes.

7. In 2007, Mr Ashby relocated to Tasmania where he married. He and his wife had a child, but they separated, and in 2010 Mr Ashby returned to Western Australia.

Offending history[14,15,16,17,18]

8. On 1 June 2014, Mr Ashby was arrested by police and charged with murder. He was assessed as fit to stand trial and on 20 November 2015, in the Supreme Court of Western Australia, Mr Ashby was convicted of murder.

9. Mr Ashby was sentenced to life imprisonment with a minimum term of 17 years' imprisonment, and made eligible for parole. His earliest eligibility date for release was calculated as 31 May 2031.

---

[9] Exhibit 1, Vol. 1, Tab 2, Report - Sen. Const. L Riley (24.07.22), p2
[10] Exhibit 1, Vol. 1, Tab 10.2, Supreme Court of WA, Transcript of Sentencing Remarks, Justice B Fiannaca, pp5-11
[11] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (25.08.23), pp4-5 & 8
[12] Exhibit 1, Vol. 1, Tab 10.2, Supreme Court of WA, Transcript of Sentencing Remarks, Justice B Fiannaca, p5
[13] MDMA is the abbreviation for 3,4-Methylenedioxymethamphetamine, also known as Ecstasy
[14] Exhibit 1, Vol. 1, Tab 9, Warrant of Commitment (20.11.15)
[15] Exhibit 1, Vol. 1, Tab 10.2, Transcript of Sentencing Remarks (20.11.15) per Fiannaca J, p49
[16] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (25.08.23), pp9-10
[17] Exhibit 1, Vol. 1, Tab 15.1, [2015] WASCSR 251, per Fiannaca J, delivered 20.11.15
[18] Exhibit 1, Vol. 1, Tab 15.4, Mr S Ashby: History for Court - Criminal & Traffic

Prison history[19]

10. After Mr Ashby was remanded to Hakea Prison (Hakea) on 1 June 2014, he was transferred to the Frankland Centre (Frankland) on 3 June 2014. He was transferred back to Hakea on 23 March 2015, before being moved to Casuarina Prison on 30 March 2015. Mr Ashby was transferred to Acacia Prison (Acacia) on 30 May 2016, and he remained there until his death.

11. Between June 2016 and January 2021, Mr Ashby was intermittently managed on DOJ's Support and Management System (SAMS) in view of his mental illness, serious offending behaviour, and cognitive issues. SAMS is designed to provide support to prisoners who, whilst not assessed as being at acute risk of self-harm or suicide, nevertheless require additional support, intervention or monitoring.[20,21]

12. Due to his psychotic behaviour and following several self-harm incidents, Mr Ashby was also managed at various times on the At Risk Management System (ARMS) from 3 April 2019 to 9 June 2020. An example of a self-harm incident occurred on 9 May 2020, when Mr Ashby cut his wrist with a plastic knife.[22,23,24,25]

13. ARMS is DOJ's primary suicide prevention strategy and aims to provide staff with clear guidelines to assist with the identification and management of prisoners at risk of self-harm and/or suicide. An interim management plan is prepared for a prisoner placed on ARMS, and the prisoner is subjected to observation at high (one-hourly), moderate (2-hourly) or low (3 or 4-hourly) levels.[26]

14. Mr Ashby's observation regimes on ARMS varied depending on his perceived risk, and after being removed from ARMS on 9 June 2020, he was managed on SAMS.

[19] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (25.08.23), pp4-7 & 9-17 and ts 10.10.23 (Duval), pp54-56
[20] Exhibit 1, Vol. 1, Tab 15.5, SAMS Module Reports (Jun 2016 - Jan 2021)
[21] SAMS Manual (2009), pp2-5 and ts 10.10.23 (Duval), pp55-56
[22] Exhibit 1, Vol. 1, Tab 15.9, Incident Summary Report (09.05.20)
[23] Exhibit 1, Vol. 1, Tab 15.6, ARMS Interim Management Plan (03.04.19)
[24] Exhibit 1, Vol. 1, Tabs 15.7-15.8 & 15.10-15.13, PRAG Minutes (10.09.19 - 8.06.20)
[25] ARMS Manual (2019), pp2-12
[26] ARMS Manual (2019), p16

15. Mr Ashby was never employed during his incarceration, and records show he received 223 social visits, and eight official visits. Mr Ashby sent two items of mail whilst in prison, and was the subject of several random cell searches and substance use tests, all of which returned negative results.[27,28,29,30,31]

16. Mr Ashby was convicted of seven prison offences during his incarceration, namely: four counts of assaulting other prisoners, one count of assaulting a custodial officer, one count of misconduct for setting fire to his cell, and one count of being in possession of a lighter whilst confined in the detention unit. Mr Ashby was variously punished with reprimands, and confinement to a punishment cell.[32]

Medical history[33,34,35,36,37,38,39]

17. Mr Ashby's medical history included high blood pressure, high cholesterol, type-1 diabetes, substance use disorder (including cannabis and alcohol), and intellectual impairment. Mr Ashby was also diagnosed with paranoid schizophrenia, and he had obstructive sleep apnoea, for which he used a continuous positive airway pressure machine (CPAP).

18. Before he entered prison Mr Ashby had been under the care of community mental health services for many years, and at various times he was treated as an inpatient and an outpatient on an involuntary basis. By the time he was transferred back to Hakea on 23 March 2015, Mr Ashby's schizophrenia was assessed as being in "*partial remission*", but he was still experiencing psychotic symptoms despite taking three antipsychotic medications.

[27] Exhibit 1, Vol. 1, Tab 15.21, Visits History
[28] Exhibit 1, Vol. 1, Tab 15.22, Prisoner Mail - Offender
[29] Exhibit 1, Vol. 1, Tab 15.23, Work History - Offender
[30] Exhibit 1, Vol. 1, Tab 15.24, Substance Use Tests Results
[31] Exhibit 1, Vol. 1, Tab 15.25, Cell searches
[32] Exhibit 1, Vol. 1, Tab 15.26, Charge History - Prisoner
[33] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23) and ts 10.10.23 (Bilyk), pp7-9
[34] Exhibit 1, Vol. 1, Tab 17, Health Services Summary (15.08.23), pp3-4
[35] ts 10.10.23 (Stewart), pp28-37
[36] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (25.08.23), p9
[37] Exhibit 1, Vol. 1, Tab 8, Statement - Mr B Ashby (29.03.21)
[38] Exhibit 1, Vol. 1, Tab 12, EcHO medical records
[39] Exhibit 1, Vol. 1, Tab 15.3, Graylands Hospital Discharge Summary (23.03.15)

19. In her report to the Court, Mr Ashby's treating psychiatrist from 2016 until his death (Dr Natalia Bilyk) noted that Mr Ashby's schizophrenia was "*treatment resistant*", which refers to schizophrenia where there is:

> [T]he persistence of psychotic symptoms despite two or more trials of antipsychotic medications of adequate dose and duration with documented adherence.[40]

Management of medical issues[41,42,43]

20. Whilst he was incarcerated, Mr Ashby attended prison medical centres and received treatment for various medical issues. His blood sugar levels and blood pressure were routinely checked, and he had regular consultations with mental health staff, including Dr Bilyk. Records show Mr Ashby was counselled about his heavy smoking, and although he periodically indicated a desire to quit smoking, this never occurred.

21. Mr Ashby was managed on a diabetic care plan, and he attended the diabetic clinic at SJOG. It was noted that Mr Ashby was sometimes non-compliant with his oral medication, and he received regular "*depot*" injections of the antipsychotic medication, zuclopenthixol.

22. Mr Ashby is reported to have experienced auditory hallucinations (AH) which fluctuated in frequency and intensity. Mr Ashby usually reported that his AH were general in nature (e.g.: brush your teeth, etc). However, at times his AH were noted to be "*accusatory of others*", and as noted, Mr Ashby was the perpetrator of a number of unprovoked assaults on other prisoners.[44]

23. Dr Bilyk said she first considered prescribing clozapine (regarded as the "*first-line treatment*" for treatment resistant schizophrenia) to Mr Ashby in June 2017. By that time, Mr Ashby's psychotic symptoms had begun to include "*misidentification delusions*" involving prison staff, and this was regarded as "*a red flag symptom for increased violence to others*".[45]

---

[40] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), p2
[41] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (25.08.23), pp4-7 & 9-17
[42] Exhibit 1, Vol. 1, Tab 17, Health Services Summary (15.08.23), pp5-77
[43] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), pp2-6 and ts 10.10.23 (Bilyk), pp9-15 & 26-27
[44] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), pp3-4
[45] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), p3

24. Following a brief admission to Frankland which began on 17 July 2017, Mr Ashby was started on a trial of clozapine, and he remained on this medication until his death.[46] I will have more to say about the relevance of Mr Ashby's smoking to his clozapine levels later in this finding. For now, I merely want to acknowledge that because Mr Ashby's mental illness "*made him a chronic risk to others in prison*", the decision to start him on clozapine was clearly appropriate.[47]

25. Dr Bilyk said that after a period of "*slow upward titration*", Mr Ashby's daily clozapine dose settled at 500 mg. Although this is regarded as a "*reasonable dose*", Mr Ashby's clozapine serum levels (i.e.: the levels of clozapine in his blood) remained low. This was thought to be related to Mr Ashby's heavy smoking, and he reportedly smoked 30 - 40 rolled cigarettes per day. Cigarette smoke contains compounds which reduce clozapine levels by inducing the production of the primary liver enzyme which metabolises clozapine.[48,49,50]

26. Before and after he was started on clozapine Mr Ashby periodically complained of "*oversedation*", and at times he was seen falling asleep during the day while sitting in a chair. Although a pharmacological cause for his sleepiness was considered, it was also noted that during periods when he used his CPAP machine regularly, Mr Ashby's daytime sleepiness reduced, and he also reported experiencing fewer AH.

27. Unfortunately, even after he was well-established on clozapine, Mr Ashby's mental state remained problematic, and he was involved in several unprovoked assaults on other prisoners. By March 2020, Dr Bilyk had decided to trial Mr Ashby on fluvoxamine, an antidepressant known to increase clozapine levels by inhibiting the liver enzyme referred to earlier. However, despite this new medication regime, Mr Ashby's mental state remained unsettled, and he assaulted another prisoner on 7 April 2020 and then set fire to his own cell.

[46] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), p3
[47] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), pp3-4
[48] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), p2
[49] Exhibit 1, Vol. 1, Tab 16.4, Graylands Hospital Drug Bulletin: Interpretation of Clozapine levels (Apr 2017)
[50] Exhibit 1, Vol. 1, Tab 16.5, Lucas L & Martin J, Smoking and drug interactions, (2013, Vol. 36:3) *Australian Prescriber*, p102

28. Following this latest assault, Mr Ashby was managed in the medical centre at Acacia until he could be transferred to Frankland for assessment on 14 April 2020. Mr Ashby was returned to Acacia on 23 April 2020, and although his mental state remained unsettled, after several weeks he reported a lessening of his AH.

29. When she reviewed him, Dr Bilyk noted Mr Ashby was "*more agitated due to experiencing constipation for the first time on clozapine*". Dr Bilyk also noted Mr Ashby had swallowed plastic food wrap in a misguided attempt to improve his symptoms. By June 2020, Dr Bilyk decided to cease Mr Ashby's fluvoxamine, theorising he was probably experiencing "*cognitive side-effects at therapeutic levels of clozapine*".[51]

30. On 24 August 2020, Mr Ashby's electronic medical record (EcHO) states that he told a mental health nurse he wanted to stop smoking, and asked if he could be admitted to Frankland for this purpose. Mr Ashby was told this was not something Frankland could assist him with, and after a long discussion with the mental health nurse, Mr Ashby decided "*to try to cut down gradually each week*".[52,53]

31. Towards the end of 2020, Mr Ashby was struggling with an exacerbation of his auditory hallucinations, and although his clozapine dose was moved to lunchtime this had "*minimal effect*". Medical staff noted a deterioration in Mr Ashby's condition, and he was described as having a "*chronically dishevelled appearance with stains and cigarette burns on his clothing*".[54]

32. When Dr Bilyk reviewed Mr Ashby on 22 January 2021, she noted he was still experiencing distress from his AH, and after discussion, it was decided to restart his fluvoxamine.[55] The following day, Mr Ashby was reviewed by a prison nurse after he was found asleep in a chair. He was initially unrousable and had considerable "*drool*" down the front of his shirt, but he woke up when custodial staff lifted him, and was then described as orientated and alert.

[51] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), pp5-6
[52] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (25.08.23), p13
[53] Dr Bilyk said Mr Ashby often made the same request to her and received the same reply: ts 10.10.23 (Bilyk), p19
[54] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (25.08.23), p13 and ts 10.10.23 (Bilyk), pp26-27
[55] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), pp5-6

33. At the time he was found, Mr Ashby had not had his daily dose of clozapine, and his newly reinstated fluvoxamine medication had not been given either. Although Mr Ashby claimed he had been using his CPAP machine, his deep sleep was thought to be related to his obstructive sleep apnoea.[56]

34. On 5 February 2021, Mr Ashby was noted to be disorientated. He was also walking with an unsteady gait and was snoring when awake and asleep. When Dr Bilyk reviewed Mr Ashby at about 4.00 pm, she was concerned that his fluvoxamine dose had increased his clozapine levels resulting in excessive sedation, and/or that he was not using his CPAP machine appropriately. Dr Bilyk ordered Mr Ashby's fluvoxamine be ceased, and she and a mental health nurse went to Acacia's pharmacy and removed fluvoxamine from Mr Ashby's medication packs.[57]

35. Mr Ashby was kept in the medical centre for observation and on 6 February 2021, he was noted to be snoring loudly and drooling when asleep. After breakfast, he was returned to his block at his request,[58] but at about 11.15 am on 7 February 2021, a "*code blue*" medical emergency was called when Mr Ashby collapsed in his block. Although Mr Ashby was conscious and breathing, he could not recall why he had fallen. He was taken to the medical centre where he denied any loss of consciousness or head strike, but he was unable to weight bear and complained of pain in his right ankle. Although no visible deformity was noted, Mr Ashby was kept in the medical centre for observation.[59]

36. On 8 February 2021, Mr Ashby was still unable to walk, and he told clinical staff he had experienced difficulties since rolling his ankle a few days earlier. Mr Ashby was reviewed by a prison medical officer, and referred to SJOG for an x-ray to determine if (as was suspected), Mr Ashby had fractured his ankle. It was also noted Mr Ashby's CPAP machine mask was "*very dirty*" and "*likely had not been cleaned for a long time*".[60]

[56] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), p6
[57] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), p8 and ts 10.10.23 (Bilyk), pp14-15
[58] Exhibit 1, Vol. 1, Tab 17, Health Services Summary (15.08.23), pp72-73
[59] Exhibit 1, Vol. 1, Tab 14, Incident Description Reports (07.02.21)
[60] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (25.08.23), p14

EVENTS LEADING TO MR ASHBY'S DEATH[61,62,63,64,65]

Admission to SJOG[66,67]

37. On 9 February 2021, Mr Ashby was taken to SJOG for an x-ray of his ankle, and to investigate his recent episodes of postural syncope (transitory loss of consciousness, typically precipitated by standing). In accordance with departmental policy, Mr Ashby was transported to SJOG in handcuffs, leg irons, link chains and flexicuffs.[68]

38. An x-ray confirmed Mr Ashby had fractured his right ankle, and he was admitted for surgical repair. Whilst he was at SJOG, Mr Ashby's custodial supervision was the responsibility of staff from a company called Broadspectrum, which contracts with the Department to provide this service. Following a restraints risk assessment, Mr Ashby was restrained to his hospital bed using only a single restraint on his left leg.

Management at SJOG[69,70,71,72]

39. After his admission to SJOG on 9 February 2021, Mr Ashby's condition deteriorated. At about 10.20 pm, an attempt was made to transfer Mr Ashby to the intensive care unit, but he experienced an episode of "*acute respiratory distress*". Although Mr Ashby was intubated, he continued to "*desaturate*" with what was suspected to be a "*massive aspiration*".[73]

40. At 10.30 pm, SJOG staff asked Broadspectrum officers to remove Mr Ashby's restraints, which they did. Mr Ashby went into cardiac arrest at about 10.37 pm and although CPR was started, and he was given adrenalin, Mr Ashby could not be revived. He was declared deceased at 10.54 pm.[74]

---

[61] Exhibit 1, Vol. 1, Tab 2, Report - Sen. Const. L Riley (24.07.22), pp3-5
[62] Exhibit 1, Vol. 1, Tab 3, Memorandum - Sen. Const. N Dempsey(10.02.21)
[63] Exhibit 1, Vol. 1, Tab 17, Health Services Summary (15.08.23), pp73-75
[64] Exhibit 1, Vol. 1, Tab 15.14, External Movement Risk Assessment (08.02.21)
[65] Exhibit 1, Vol. 1, Tab 15.15, Hospital Admittance Advice - Prisoner (09.02.21)
[66] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (25.08.23), pp 6 & 14-15
[67] Exhibit 1, Vol. 1, Tab 15.16, Broadspectrum PIC Escort Record
[68] ts 10.10.23 (Duval), pp54-55
[69] Exhibit 1, Vol. 1, Tab 16.6, SJOG Discharge Summary (10.02.21)
[70] Exhibit 1, Vol. 1, Tab 11, SJOG Progress notes (09.02.21)
[71] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (25.08.23), p6 & 14-15
[72] Exhibit 1, Vol. 1, Tab 15.16, Broadspectrum PIC Escort Record
[73] Exhibit 1, Vol. 1, Tab 11, SJOG Discharge Summary (10.02.21), p3
[74] Exhibit 1, Vol. 1, Tab 4, Death in Hospital Form (09.02.21)

CAUSE AND MANNER OF DEATH[75,76]

41. A forensic pathologist (Dr Dan Moss) conducted a post mortem examination and noted Mr Ashby's heart was enlarged (cardiomegaly), and that his right ankle was fractured. Microscopic examination of lung tissues showed bronchopneumonia in Mr Ashby's right lung, but his internal organs were otherwise unremarkable.

42. Specialist examination of Mr Ashby's brain showed malrotation of his left hippocampus, but Dr Moss stated that: "*in the absence of a history of epilepsy (this) was felt to be an incidental finding of no clinical significance*". Dr Moss noted no other significant abnormalities.

Possible role of clozapine in Mr Ashby's death[77,78]

43. Toxicological analysis found medications in Mr Ashby's system which were consistent with his medical history and recent care. His levels of citalopram, paracetamol, codeine and morphine were "*unremarkable*", and the levels of his depot medication, zuclopenthixol, were within the expected range.[79,80,81]

44. However, due to concerns about the levels of clozapine detected in Mr Ashby's system, an expert opinion was obtained from Professor David Joyce, who is an experienced physician, pharmacologist and toxicologist.[82]

45. I will address Professor Joyce's findings shortly, but first I will make some brief comments about clozapine. As noted, clozapine is regarded as the "*first-line treatment*" for treatment resistant schizophrenia,[83] and has been shown to produce very good results in some patients. Because of potentially dangerous side-effects, clozapine serum levels are tested weekly for the first 18 weeks, with monthly blood tests thereafter.[84]

---

75 Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (24.01.22)
76 Exhibit 1, Vol. 1, Tab 6.2, Post Mortem Report (19.02.21)
77 Exhibit 1, Vol. 1, Tab 13, Report - Prof. D Joyce (19.12.22)
78 Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), pp6-7 and ts 10.10.23 (Bilyk), pp17-23
79 Exhibit 1, Vol. 1, Tab 7.2, Final Toxicology Report (15.03.21)
80 Exhibit 1, Vol. 1, Tab 13, Report - Prof. D Joyce (19.12.22), pp7-8
81 Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), pp6-7
82 Exhibit 1, Vol. 1, Tab 13, Report - Prof. D Joyce (19.12.22)
83 Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), p3
84 Exhibit 1, Vol. 1, Tab 16.7, Medication: Clozapine Prescribing and Monitoring, pp6-9 & 16-17

46. Clozapine's potential side-effects vary in frequency, but may include: myocarditis, cardiomyopathy, tachycardia, seizures, sedation, postural hypotension, hypersalivation, constipation, nausea, weight gain, agranulocytosis, and low white blood cell count (neutropenia) which can increase a patient's susceptibility to infection.[85,86,87]

47. In Mr Ashby's case, his use of clozapine was complicated by his documented heavy smoking. As Dr Bilyk noted, smokers taking clozapine have been found to have lower serum levels, and an article attached to her report (the Article) notes:

> A 50% difference in the mean daily dose of clozapine needed by smokers and non-smokers to reach a given blood concentration has been reported.[88]

48. The Article also notes that: "*clearance of clozapine has been shown to decrease when smoking is ceased, with a mean increase of 72% in plasma clozapine concentrations*". As for changes in the dose of clozapine for patients who cease smoking, the Article's authors state:

> It is suggested that daily dose reductions (of approximately 10% until the fourth day after smoking cessation) should be made whenever patients cease smoking during treatment with clozapine.[89]

49. An entry in Mr Ashby's SJOG medical notes on 9 February 2021, made by the emergency department intern, states that Mr Ashby had advised that he had: "*Quit smoking 2 weeks ago, reports used to smoke 40 cigarettes/day now none*".[90]

50. I am cautious about accepting Mr Ashby's assertion at face value, particularly as it is self-reported. I note that at the inquest, Ms Pansey Stewart (Acacia's Health Manager) confirmed that prisoners admitted to the health centre at Acacia are not permitted to smoke.[91]

---

[85] See: https://www.nps.org.au/australian-prescriber/articles/clozapine-in-primary-care
[86] Exhibit 1, Vol. 1, Tab 16.3, Side-effects associated with clozapine therapy
[87] Exhibit 1, Vol. 1, Tab 16.7, Medication: Clozapine Prescribing and Monitoring, p2
[88] Exhibit 1, Vol. 1, Tab 16.5, Lucas L & Martin J, Smoking and drug interactions, (2013, Vol. 36:3) *Australian Prescriber*, p103
[89] Exhibit 1, Vol. 1, Tab 16.5, Lucas L & Martin J, Smoking and drug interactions, (2013, Vol. 36:3) *Australian Prescriber*, p103
[90] Exhibit 1, Vol. 1, Tab 11, SJOG Progress Notes (12.55 pm, 09.02.21)
[91] ts 10.10.23 (Stewart), pp34-35

51. Further, Dr Bilyk noted in her report that she had been unaware of the suggestion that Mr Ashby had stopped smoking two weeks earlier, and in her report, she said she would:

> [Q]uestion the veracity of that report, as Mr Ashby always struggled to cease smoking unless he could not physically access tobacco. More certain is that Mr Ashby did not smoke, or smoked very little, for four days, from the night of 5/2/2021 to his death, given that Mr Ashby spent most of his time in the Acacia Prison medical centre before he was transported to hospital on 9/2/2021. If smoking cessation is expected to be longer than two days, the recommendation is to decrease the dose of clozapine by 20% to 40% after 4 days.[92]

52. Given Mr Ashby's long-term and very heavy smoking habit, it seems more likely that he stopped smoking when he was admitted to the health centre on 5 February 2021, rather than some weeks before. It appears that the impact on Mr Ashby's clozapine levels of him having ceased smoking (even for the four days he was in the medical centre) was not appreciated at the relevant time, although health centre staff are now more aware of this issue.[93]

53. In his report, Professor Joyce noted that clozapine is subject to "*post mortem redistribution*" meaning that after death, levels can rise or fall (but more typically rise) "*as a result of the drug moving between tissue and blood*". As to Mr Ashby's post mortem clozapine levels, Professor Joyce stated:

> The post mortem levels of clozapine in this case seem to be higher than expected from the concentration measured in life two weeks earlier, even after making an allowance for post mortem redistribution.[94]

54. Professor Joyce also noted that Mr Ashby's hospital notes and the post mortem findings pointed to "*aspiration of gastric contents, of a magnitude sufficient to asphyxiate*".[95]

---

[92] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), p7
[93] ts 10.10.23 (Stewart), p35
[94] Exhibit 1, Vol. 1, Tab 13, Report - Prof. D Joyce (19.12.22), p8
[95] Exhibit 1, Vol. 1, Tab 13, Report - Prof. D Joyce (19.12.22), p10

55. Professor Joyce also noted that although aspiration pneumonia is a known (albeit rare) complication of clozapine therapy, the mechanism is not well understood. However, it appears that hypersalivation, gastro-intestinal hypomobility (including disordered stomach emptying), and sedation (all of which are known side-effects of clozapine therapy) were potentially implicated.[96]

56. Professor Joyce noted that aspiration pneumonia does not occur in middle-aged men in the absence of impaired consciousness or major upper gastrointestinal tract disease, so that in Mr Ashby's case clozapine intoxication was "*the most likely explanation for aspiration and death*".[97]

57. However, Professor Joyce noted that clozapine does have "*a broad range of other toxicities including a few that might manifest as unexpected death on a background of unexplained collapses*". As noted, clozapine can cause cardiomyopathy and myocarditis, even at serum levels "*within the conventional treatment range*". However, although the post mortem noted Mr Ashby's heart was enlarged, there was no evidence of cardiomyopathy or myocarditis and as Professor Joyce observed, "*it seems safe to dismiss the possibility*" in this case.[98]

58. Clozapine can also cause a "*lethal disturbance of the heart rhythm*" (cardiac arrythmia) without leaving behind any abnormality which could be identified during a post mortem examination.[99]

59. However, Professor Joyce noted that when he was admitted to SJOG, Mr Ashby had an electrocardiogram which "*showed nothing that predicted an arrythmia*", and pulse and blood pressure readings were obtained during the early stages of the resuscitation efforts following Mr Ashby's collapse. Thus, in Mr Ashby's case, it was "*safe to dismiss the possibility of clozapine-induced arrythmia as a cause of death*".[100]

[96] Exhibit 1, Vol. 1, Tab 13, Report - Prof. D Joyce (19.12.22), p10
[97] Exhibit 1, Vol. 1, Tab 13, Report - Prof. D Joyce (19.12.22), p10
[98] Exhibit 1, Vol. 1, Tab 13, Report - Prof. D Joyce (19.12.22), p10
[99] Exhibit 1, Vol. 1, Tab 13, Report - Prof. D Joyce (19.12.22), p10
[100] Exhibit 1, Vol. 1, Tab 13, Report - Prof. D Joyce (19.12.22), p10

60. Another possibility was that Mr Ashby's clozapine levels had induced an epileptic seizure event. However, although Mr Ashby reported a three-day history of "*twitching episodes*" in his right arm,[101] no evidence of seizure activity was observed and he had no previous history of epileptic fits "*while on therapy*". Further, there were no post mortem findings of tongue biting or other signs of an epileptic seizure, and in relation to a fatal epileptic seizure event, Professor Joyce said: "*the possibility therefore is unsupported in this case*".[102]

61. After considering the available evidence, Professor Joyce stated:

> Overall, therefore, the evidence points strongly towards a role for clozapine in causing death through aspiration pneumonia, but does not give support for other recognised causes of sudden death in patients taking clozapine.[103]

62. Professor Joyce also expressed the following conclusions:

> Notwithstanding the possible effects of post mortem distribution, there was an apparent recent increase in clozapine concentration, which would explain the increased sedation and hypersalivation. The most (likely) cause was cessation of smoking;
>
> Sedation from clozapine and/or impaired postural blood pressure control caused by diabetic autonomic neuropathy and clozapine may have explained the fall on 8th February and the presyncopal events over the preceding days; and
>
> The circumstances of (Mr Ashby's) death, involving large aspiration and aspiration pneumonia, are likely to have some explanation in clozapine toxicity, possibly in the context of diabetic gastropathy.[104]

[101] Exhibit 1, Vol. 1, Tab 11, SJOG Progress notes (12.55 pm, 09.02.21)
[102] Exhibit 1, Vol. 1, Tab 13, Report - Prof. D Joyce (19.12.22), p11
[103] Exhibit 1, Vol. 1, Tab 13, Report - Prof. D Joyce (19.12.22), p11
[104] Exhibit 1, Vol. 1, Tab 13, Report - Prof. D Joyce (19.12.22), pp11-12

63. In her report, Dr Bilyk provided some helpful observations about the factors she believed may have affected Mr Ashby's clozapine levels. Dr Bilyk referred to Mr Ashby's smoking (which would lower clozapine levels) and his use of fluvoxamine (which would increase clozapine levels). Dr Bilyk also noted that Mr Ashby's post mortem clozapine level was probably a "*peak level*", given that clozapine levels usually peak 1.5 - 2 hours after ingestion.[105]

64. Dr Bilyk said clozapine had a "half-life" of 10 - 12 hours and that she would have expected Mr Ashby's peak level to have decreased by up to 50% by the following morning. However, although Mr Ashby was usually given his clozapine dose at 8.00 pm, Dr Bilyk acknowledged that the timing of Mr Ashby's last dose was unclear.

65. When Mr Ashby was admitted to SJOG, his C-reactive protein levels (CRP) were elevated at 99.7 mg per litre. CRP is an inflammatory marker, and Dr Bilyk said that a level of 100 mg per litre is regarded as "*significant*" and suggests bacterial infection. However, Mr Ashby was afebrile, his blood count was normal, and the chest x-ray he had in the emergency department was "*unremarkable*" and "*consistent with the absence of lung infection at least*".[106]

66. Although the extent of Mr Ashby's pneumonia prior to his aspiration event is unclear, Dr Bilyk noted that recent World Health Organisation data on clozapine-related deaths "*indicates a significant rate of mortality in patients on clozapine with pneumonia*". Dr Bilyk also noted that:

> No matter the cause of the raised CRP, the medical literature clearly identified the risk of clozapine toxicity during inflammation. The (NMHS) clozapine guidelines indicate that a raised CRP of 50 - 100 mg/L should be monitored with ECG and daily blood tests. A CRP >100 mg/L should result in cessation of clozapine and a physician assessment.[107]

[105] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), pp6-7
[106] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), p7
[107] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), p7

67. At the inquest, Dr Bilyk said she had never previously had a patient experience an aspiration event due to clozapine-induced sedation.[108] Further, in her report Dr Bilyk said that in her clinical opinion there had been "*a complex set of interactions that have (led) to the possibility of clozapine toxicity as a contributor to the death of Mr Ashby*".[109] In summary, the interactions identified by Dr Bilyk were:

> Oversedation caused by increased clozapine levels and/or untreated sleep apnoea, which together with hypersalivation can increase the risk of aspiration and pneumonia;
>
> Mr Ashby's fluvoxamine was ceased on 5 February 2021, and he had stopped smoking for the four days he was in the health centre;
> When admitted to SJOG Mr Ashby had raised CRP levels suggesting significant infection. However, his clozapine levels were not assessed to confirm/exclude any increase above a therapeutic level;
>
> Mr Ashby's catastrophic aspiration event was associated with sedation, which could have been related either to his clozapine levels and/or untreated sleep apnoea. An EcHO entry on 8 February 2021, noted Mr Ashby was not using his CPAP machine consistently that night, and this would have caused oversedation the following day.[110]

Cause and manner of death

68. At the conclusion of his post mortem examination, Dr Moss initially expressed the opinion that the cause of Mr Ashby's death was:

> [A]spiration pneumonia in an obese man with a history of diabetes mellitus, obstructive sleep apnoea and recent right ankle fracture.[111]

69. However, after receiving Professor Joyce's report, Dr Moss amended his opinion and expressed the view that the cause of Mr Ashby's death was:

> [A]spiration pneumonia in an obese man with a history of diabetes mellitus, obstructive sleep apnoea, recent right ankle fracture and clozapine effect.[112]

[108] ts 10.10.23 (Bilyk), p23
[109] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), p8
[110] Exhibit 1, Vol. 1, Tab 16, Report - Dr N Bilyk (18.09.23), p8
[111] Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (24.01.22)

70. I respectfully accept and adopt Dr Moss' updated opinion as my finding in relation to the cause of Mr Ashby's death.

71. Further, on the basis of the evidence of Professor Joyce and Dr Bilyk, it seems likely that the aspiration event which led to Mr Ashby's death was related to sedation caused by his elevated clozapine levels and/or his obstructive sleep apnoea.

72. However, I have been unable to establish the precise role clozapine played in Mr Ashby's death, meaning it is unclear whether his death occurred by way of natural causes, or by accident. I therefore make an open finding as to the manner of Mr Ashby's death.

Clozapine prescription following Mr Ashby's death

73. At the inquest, Dr Bilyk and Ms Stewart agreed that it would be appropriate for an alert to be placed on the EcHO records of prisoners who are prescribed clozapine. This would ensure that health centre staff were aware of the prescription and could monitor the prisoner if they suddenly stopped smoking.[113]

74. In her evidence at the inquest, DOJ's Medical Director Dr Joy Rowland (Dr Rowland), explained that the blood count form used for prisoners being treated with clozapine was amended earlier this year to record the date the prisoner was advised about the potential side-effects of caffeine and smoking on their clozapine levels.[114,115]

75. Dr Rowland also noted that health staff have received education about the issues relating to clozapine, and that prisoners taking clozapine are asked to advise health staff if their intake of caffeine and/or use of cigarettes changes. This information is also captured by means of alerts and service codes in the prisoner's electronic record.[116,117,118]

---

[112] Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (17.05.23)
[113] ts 10.10.23 (Bilyk), p25 and ts 10.10.23 (Stewart), p35
[114] ts 10.10.23 (Rowland), p39-45
[115] Exhibit 1, Vol. 1, Tab 19.1, Clozapine blood count record form
[116] Exhibit 1, Vol. 1, Tab 19.2, TOMS Clozapine Alert
[117] Exhibit 1, Vol. 1, Tab 19.3, TOMS Active problem List
[118] Exhibit 1, Vol. 1, Tab 19.4, TOMS Clozapine Service Code

76. At the inquest, Ms Stewart confirmed that mental health staff at Acacia are now more aware of the effects of smoking cessation on clozapine serum levels, and that:

> [S]ince this (case we) have learnt a lot around Clozapine and if somebody is a smoker, and the impacts on that. So, at the time, for me, I wasn't totally across…the effects. But since this case it has been advised to the health care team. We've liaised with mental health services to raise awareness within the health centre regarding patients who are on Clozapine. If they've been transferred to hospital what we need to do. If they're on Clozapine and placed in the health centre, to be aware of that, as well.[119]

OTHER ISSUES ARISING FROM THE EVIDENCE

CPAP Machine[120,121,122]

77. As noted, Mr Ashby used a CPAP machine to treat his obstructive sleep apnoea, and the Mayo Clinic's website makes the following comment about CPAP machines:

> Continuous positive airway pressure (CPAP) therapy is a common treatment for obstructive sleep apnoea. A CPAP machine uses a hose connected to a mask or nosepiece to deliver constant and steady air pressure to help (the patient) breathe while (they) sleep.[123]

78. Mr Ashby was issued with a new CPAP machine on 15 January 2019, and his EcHO record states he was "*educated on the importance of looking after the CPAP machine, and* (the importance of) *keeping it clean was reinforced*".[124] Although on at least one occasion medical centre staff were aware that Mr Ashby's CPAP machine "*was dirty*", there is no evidence of any system of routinely checking the device to ensure it was working and/or was being maintained in a clean and hygienic manner.[125]

---

[119] ts 10.10.23 (Stewart), p35
[120] Exhibit 1, Vol. 1, Tab 17, Health Services Summary (15.08.23), p77 and ts 10.10.23 (Stewart), pp29-34 & 36-37
[121] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (25.08.23), pp 7 & 16 and ts 10.10.23 (Duval), pp53-54
[122] ts 10.10.23 (Bilyk), pp15-17 and ts 10.10.23 (Rowland), pp46-51
[123] See: www.mayoclinic.org/diseases-conditions/sleep-apnea/in-depth/cpap/
[124] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (25.08.23), p10
[125] ts 10.10.23 (Stewart), p31

79. During 2020, Mr Ashby told medical staff he was using his CPAP machine periodically, and that he was sleeping well. However, these claims conflict with other evidence that during the same period, Mr Ashby was complaining of daytime sleepiness. Either way, according to departmental records, at times when Mr Ashby said he was not using his CPAP machine, he was encouraged to do so.

80. However, as Photos 1 and 2 (below) show, at the time of his death, Mr Ashby's CPAP machine and mask were in a **deplorable** condition. It seems obvious that the amount of dirt and mould inside Mr Ashby's CPAP mask must have taken some considerable time to accumulate, and in any case, would have been patently obvious to even the most casual observer.

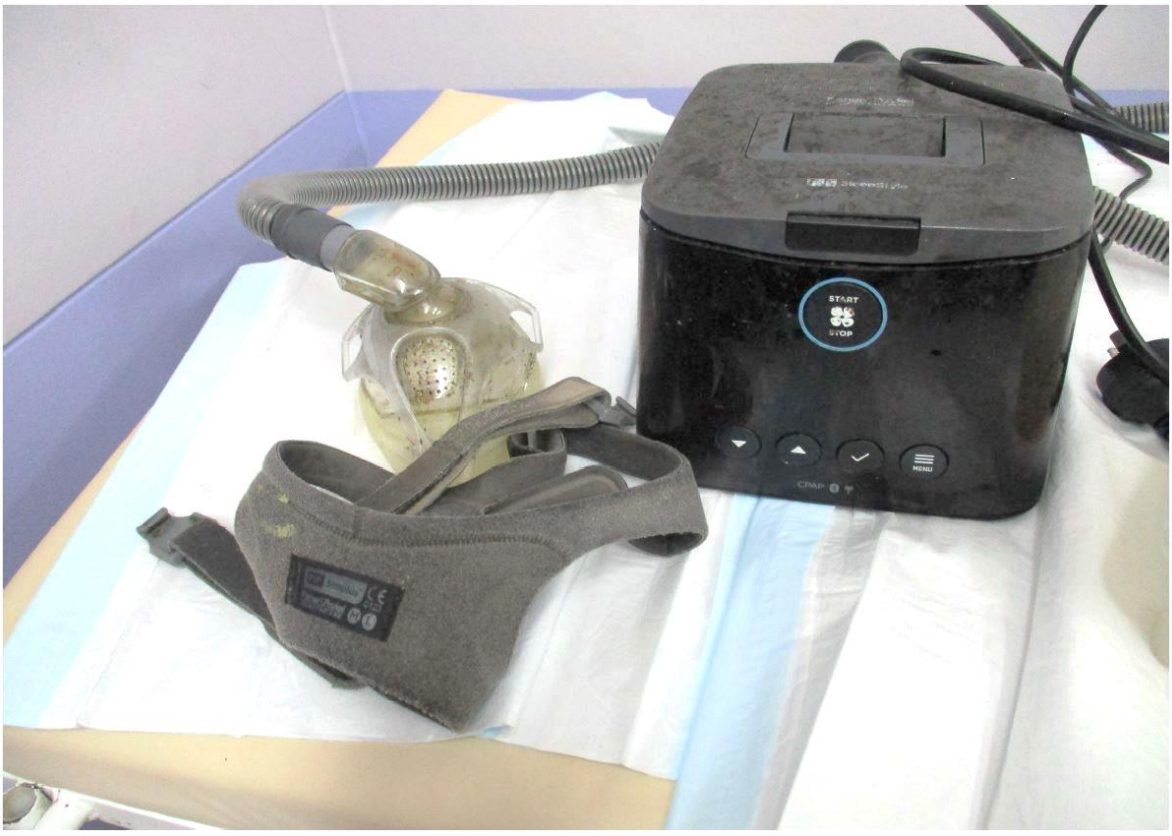

Photo 1: Mr Ashby's CPAP machine[126]

[126] Exhibit 1, Vol. 1, Tab 15.7, Photographs of Mr Ashby's CPAP machine

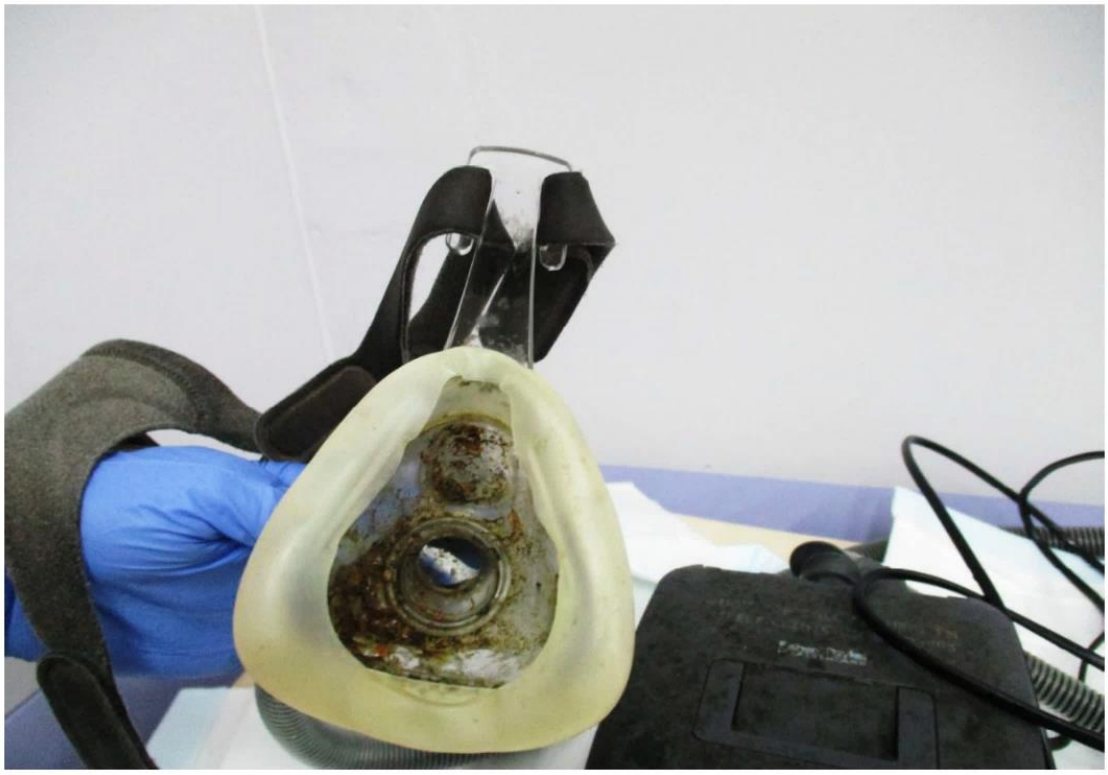

Photo 2: Mask attached to Mr Ashby's CPAP machine[127]

81. It sems clear that Mr Ashby's mental illness and his intellectual issues meant he was simply unable to maintain his CPAP machine and mask in an appropriate condition. Further, Mr Ashby was obviously someone who needed reminders to clean his CPAP mask daily, and guidance and support to do so correctly.

82. Following Mr Ashby's death, his clinical care was reviewed by Acacia (Health Review), which made the following comment about the state of Mr Ashby's CPAP machine:

> An inspection of Mr Ashby's CPAP machine was conducted following his death and the machine was found to be dirty and mouldy. The Acacia Prison Health Services Team has since developed and implemented a work instruction regarding the cleaning of CPAP machines as it is believed this should be a shared responsibility with those prisoners requiring support to maintain the cleanliness of CPAP machines.[128]

[127] Exhibit 1, Vol. 1, Tab 15.7, Photographs of Mr Ashby's CPAP machine
[128] Exhibit 1, Vol. 1, Tab 17, Health Services Summary (15.08.23), p77

83. In an email dated 10 November 2021, Ms Stewart stated:

> Based on this incident, we changed our practice to ensure that patients with CPAP machines are regularly reviewed to provide education on usage and ensure machine(s) are in good working order.[129]

84. The work instruction referred to in the Health Review is entitled "*Acacia Prison Work Instruction - Health Centre: Cleaning of CPAP machines*" (Instruction), and it was introduced on 3 August 2023. The Work Instruction provides that prisoners at Acacia issued with CPAP machines may keep the devices in their cells but "*are expected to complete regular cleaning and maintenance of the device*".[130]

85. The Instruction also provides that where nursing, medical, or custodial staff believe that a prisoner's CPAP machine is "*dirty or not being sufficiently maintained*" the device must be taken to the health centre for inspection. Where the CPAP machine is found to be in an unsafe condition that "*could potentially cause harm to the prisoner*", the relevant prisoner:

> [M]ust be re-educated on both how to clean and maintain the device, as well as the adverse health effects associated with using a dirty CPAP machine.[131]

86. The Instruction mandates that "*as a minimum*" there be 12-monthly reviews of all CPAP machines issued to prisoners. The outcome of these reviews is to be recorded, and subject to the assessing nurse's discretion and depending on the prisoner and the state of the relevant device, "*the frequency of such reviews can be increased*".[132]

87. The Instruction provides cleaning instructions for the CPAP mask (daily with soap and warm water),[133] tubing (weekly with mild soap and warm water) and humidifier tub (daily with soap and water, and weekly soaking in vinegar and water).[134]

---

[129] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (25.08.23), p16
[130] Exhibit 1, Vol. 1, Tab 15.19, Acacia Prison Work Instruction - Health Centre: Cleaning of CPAP machines, p3
[131] Exhibit 1, Vol. 1, Tab 15.19, Acacia Prison Work Instruction - Health Centre: Cleaning of CPAP machines, p3
[132] Exhibit 1, Vol. 1, Tab 15.19, Acacia Prison Work Instruction - Health Centre: Cleaning of CPAP machines, p3
[133] The Instruction contains an unfortunate typo and suggests using "soup" instead of "soap" and warm water
[134] Exhibit 1, Vol. 1, Tab 15.19, Acacia Prison Work Instruction - Health Centre: Cleaning of CPAP machines, pp3-4

88. At the inquest, Ms Stewart referred to Mr Ashby's mental health issues, and in relation to the support he was given to keep his CPAP machine clean, Ms Stewart said she believed "*we could have done that a bit more*". She also said that because of his cognitive impairment, Mr Ashby: "*would need more support to ensure that what was said in the health centre had been carried out in the block*", and this would entail:

> [S]ighting the actual CPAP machine, making sure that it is clean to a good standard, and also supporting the patient in cleaning his machine.[135]

89. At the inquest, Dr Rowland confirmed that in December 2021, a CPAP template was added to EcHO to assist health staff in providing information to prisoners about the correct use and maintenance of their devices. In August 2023, the Department also introduced a policy entitled "*Medical Equipment and Functional Aids PM 15 Policy and Procedure*" (the Policy).[136]

90. The Policy requires CPAP machines to be checked every three months, and an alert is now placed on the relevant prisoner's electronic record to ensure health staff are aware of the need to check the prisoner's CPAP machine. Cleaning instructions for CPAP machines (similar to those in the Instruction) are also set out in the Policy.[137]

Failure to advise NOK about admission

91. In a post incident review dated 18 June 2021 (Review), Acacia determined that Mr Ashby's next-of-kin (NOK) had not been informed of his admission to SJOG on 9 June 2021. In terms of remedial action, the following recommendation was made in the Review:

> Next of kin notification for prisoners admitted to hospitals to be reviewed.[138]

[135] ts 10.10.23 (Stewart), p31 & 32-33
[136] Exhibit 1, Vol. 1, Tab 18, Medical Equipment and Functional Aids PM 15 Policy and Procedure (29.08.23)
[137] Exhibit 1, Vol. 1, Tab 18, Medical Equipment and Functional Aids PM 15 Policy and Procedure (29.08.23), pp5-6 and 9-10
[138] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (25.08.23), p16

92. Following Mr Ashby's death, DOJ investigated his management and supervision whilst he was incarcerated. The results of that review were published in a document entitled "*Death in Custody Review*" (DIC Review) which made the following comment about the failure to advise Mr Ashby's NOK about his admission to SJOG:

> The Commissioner's Operating Policy and Procedure (COPP) 6.1 Section 8.1.2 required that the NOK is advised of the removal of the prisoner to a hospital or other place of assessment/treatment as a result of serious injury or illness. This PAR death in custody review noted that Mr Ashby was initially admitted to SJOG for a suspected fractured ankle, and consequently, his NOK was not advised of his hospital admission as it was not deemed serious at the time of admission.[139]

QUALITY OF SUPERVISION, TREATMENT AND CARE

93. In assessing the quality of the supervision, treatment and care that Mr Ashby received whilst he was incarcerated, I have applied the standard of proof set out in the High Court's decision in the case of ***Briginshaw v Briginshaw***.[140] This requires a consideration of the nature and gravity of the conduct when deciding whether a finding adverse in nature has been proven on the balance of probabilities.

94. I have also been mindful not to insert hindsight bias into my assessment of Mr Ashby's supervision, treatment and care. Hindsight bias is the tendency, after an event, to assume the event is more predictable or foreseeable than it actually was at the time.[141]

95. I note that the DIC Review made the following comments about Mr Ashby's management whilst he was in custody:

> The review found that Mr Ashby's custodial management, supervision and care were generally in accordance with the Department's policy and procedures…

[139] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (25.08.23), p16
[140] (1938) 60 CLR 336, per Dixon J at pp361-362
[141] Dillon H and Hadley M, *The Australasian Coroner's Manual (2015)*, p10

> However, this review found that photographs of Mr Ashby's CPAP machine showed the presence of mould on both the face mask and the body of the machine. The Acacia Health Service Manager has recently developed and implemented a work instruction regarding the cleaning of CPAP machines, where it identified the shared responsibility between prisoners and medical staff to maintain the cleanliness of CPAP equipment.[142]

96. The Health Review made this comment about Mr Ashby's clinical care:

> Mr Sam Ashby was placed in Acacia Prison from 30th May 2016 until his death on 9th February 2021. During those 5 years, Mr Ashby attended the medical centre for blood pressure checks, general health conditions/ailments, blood tests, mental health reviews, including depots, and external health appointments at sleep clinics. Mr Ashby used his CPAP machine regularly and when he was not using his CPAP machine he was advised and encouraged to use his machine.[143]

97. On various occasions while he was incarcerated, Mr Ashby told staff, including Dr Bilyk, that he wanted to stop smoking, and he was told that his clozapine levels would need to be adjusted if he did so. It may be that Mr Ashby's mental health and cognitive issues were barriers to him ceasing smoking. In any case, although his desire to give up smoking was no doubt genuine, he was never able to do so, except for those periods when he was admitted to the medical centre.[144]

98. Having carefully assessed the available evidence, I am satisfied that in general terms, the standard of supervision, treatment and care Mr Ashby was provided whilst he was incarcerated was reasonable.

99. However, in my view, Acacia's failure to regularly monitor the cleanliness of Mr Ashby's CPAP machine, and its failure to provide Mr Ashby with ongoing support to maintain the device in a clean and hygienic state, was poor.

---

[142] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (25.08.23), p7 and ts 10.10.23 (Duval), p55
[143] Exhibit 1, Vol. 1, Tab 17, Health Services Summary (15.08.23), p77
[144] ts 10.10.23 (Bilyk), pp20-21

CONCLUSION

100. Mr Ashby was 46 years of age when he died at SJOG from bronchopneumonia on 9 February 2021. After carefully considering the available evidence, I made an open finding as to the manner of his death.

101. After assessing the available evidence, I found that the standard of supervision, treatment and care that Mr Ashby received whilst he was incarcerated was reasonable.

102. I was critical of Acacia's failure to monitor the cleanliness of Mr Ashby's CPAP machine and provide him with support to maintain it. However, as that issue has been addressed by changes to policies and procedures, I have concluded that it was not necessary for me to make any recommendations in this case.

103. As I did at the conclusion of the inquest, I wish to again convey to Mr Ashby's family and loved ones, on behalf of the Court, my very sincere condolences for their loss.

MAG Jenkin
Coroner
29 November 2023