

The Hon. Michael Daley, MP
Attorney General
52 Martin Place
SYDNEY NSW 2000
office@daley.minister.nsw.gov.au

Coronial inquest into the death of KT

Dear Attorney General 

I write in relation to the findings and recommendations made on 23 March 2023 by Deputy State Coroner Elizabeth Ryan regarding the death of KT.

KT was a 27 year old man who died between the night of 8 May 2019 and the following morning, while in lawful custody after overdosing his prescribed medication, clozapine. KT died as a result of mixed drug (methylamphetamine and clozapine) toxicity. The evidence does not establish that KT ingested the medication with the intention of ending his life.

KT was the third of five children, and very close to his younger brother, LT. KT was in juvenile detention for periods of time and this pattern continued in his adult years in correctional centres. He was diagnosed with chronic schizophrenia in December 2016 by Justice Health medical staff, and by January 2018, it was determined most likely treatment resistant. In June 2018, KT commenced on clozapine, an oral antipsychotic medication usually reserved for treatment-resistant schizophrenia.

On 21 April 2019, the family received the terrible news that KT's brother, LT, had died aged 24 years in the Mid North Coast Correctional Centre in Kempsey. On 3 May 2019, KT met with a psychologist who recorded that KT spoke openly about LT's death and his 'grieving' and that 'the boys are supporting him through chats and talks'. KT denied current thoughts of self-harm or suicide.

On 7 May 2019, Corrections staff spoke with KT about how he was feeling since his brother's death and the rejection of his application to attend LT's funeral. Later that day, KT received his evening meal and medication. A Justice Health nurse gave him 3 clozapine tablets and watched KT take them with water. She did not note anything of concern. It was the last time KT was seen alive. KT was found unresponsive at 6.23am the next morning and could not be revived.

The Deputy State Coroner accepted expert evidence that KT's diagnosis of treatment-resistant schizophrenia was appropriate, as was the decision to prescribe clozapine. Further, Magistrate Ryan accepted expert evidence that within the constraints of the custodial environment, the treatment which KT received for his mental illness was generally adequate, except for two aspects. The first related to a plasma test result that should have prompted urgent reassessment, and the second was in relation to KT's paper medication chart. Magistrate Ryan also noted that Justice Health is introducing electronic medical records for all inmate patients.

The Deputy State Coroner directed one recommendation to Justice Health NSW, which is supported.

That consideration be given to providing a copy of the Court's findings in this inquest to the team working on the Pathology Review Project, with a view to informing that Project's consideration of how to regularise the ordering and signing off of clozapine serum level tests.

The A/Director, Clinical and Corporate Governance, Justice Health, discussed KT's coronial findings with the project clinical lead, and provided a copy of the coronial findings report to be shared with the Pathology Review Project team.

The project clinical lead acknowledged receipt of the coronial findings. Further, the project clinical lead also confirmed two improvements in progress for pathology order sets and pathology reports.

I trust that this response confirms NSW Health's commitment to a process of continuous improvement and delivering safe and high-quality care to all patients of the NSW health system.

For more information, please contact Vicki Manning, A/Executive Director, System Management Branch, NSW Ministry of Health at moh-systemmanagementbranch@health.nsw.gov.au.

Yours sincerely



Ryan Park MP
Minister for Health
Minister for Regional Health
Minister for the Illawarra and the South Coast
CC: NSW Coroner's Court
Encl. Coroner's report - *Inquest into the death of KT*