IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 001980

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

INQUEST INTO THE PASSING OF SCOTT ALAN MURDOCH

Findings of:	Coroner David Ryan
Delivered on:	14 October 2024
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria
Inquest hearing dates:	11 October 2024
Counsel Assisting the Coroner:	Bemani Abeysinghe Coroners Court of Victoria
Correct Care Australasia:	Jeremy Smith Meridian Lawyers
Forensicare:	Sarah Watson Lander & Rogers
Secretary to the Department of Justice and Community Safety:	Kate Wright Victorian Government Solicitor's Office
Keywords:	Death in custody – medication hoarding – drug toxicity – observation

INTRODUCTION

1. On 19 April 2021, Scott Alan Murdoch was 43 years old when he was located deceased at the Melbourne Assessment Prison (**MAP**). MAP is operated by staff employed by Corrections Victoria (**CV**). Medical services to prisoners at MAP were provided at the time by Correct Care Australasia (**CCA**)[1] and forensic mental health services are provided by Forensicare.[2]

2. Mr Murdoch is survived by his two children and his mother and sister.

BACKGROUND

3. Mr Murdoch's medical history included Type 1 diabetes, chronic pain, hepatitis B & C, hypertension, borderline personality disorder and emotionally unstable personality disorder. He had a long history of illicit drug use and suicidal ideation with self-harm. At the time of his death, Mr Murdoch was being prescribed medication which included amitriptyline,[3] pregabalin,[4] quetiapine[5] and metformin.[6]

4. At the time of his death, Mr Murdoch was serving a term of imprisonment for a series of violent offences including murder. He had been accommodated at MAP since February 2019.

5. Mr Murdoch had a history of engaging in self-harm in prison which included overdosing on what was suspected to be amitriptyline in February and September 2017. The prescribing of amitriptyline was ceased after the overdoses but recommenced in 2019 as it was noted by his clinicians to be helpful for his sleep, mood and general stability. Initially, its administration was subject to enhanced monitoring by staff which included

[1] Medical services at MAP are now provided by GEO Healthcare.
[2] Victorian Institute of Forensic Mental Health.
[3] Amitriptyline is a tricyclic antidepressant that is indicated for major depression, panic disorder, neuropathic pain and enuresis.
[4] Pregabalin is used for treatment of partial seizures and neuropathic pain.
[5] Quetiapine is an antipsychotic medication used to treat schizophrenia, bipolar disorder and depression.
[6] Metformin is an antidiabetic drug used to treat maturity-onset diabetes.

mouth checks, additional drinks, crushing of the dose and observation for 15 minutes post-dose.

6. At the time of his death, Mr Murdoch was allocated a Suicide and Self-harm (**SASH**) risk rating of S4 which indicated a history of attempted suicide and/or self-harm.[7] This was the lowest rating as although he had a history of self-harm, he had not been exhibiting any acute signs of suicidal ideation in the period before his death.

7. Mr Murdoch's history of hoarding medication in the context of his previous overdoses was documented in his prison medical records. The administration of his amitriptyline by CCA and CV staff took place in the evening through the trap in his cell door. The staff would then monitor Mr Murdoch while he consumed the medication and CV staff would conduct a *"mouth check"*. Under *Deputy Commissioner's Instruction 1.05*, a mouth check involves:

    (a) Directing prisoners to open their mouth while a correctional officer visually examines the mouth, instructing the prisoner to lift their tongue; and

    (b) Where there are concerns that prisoners are secreting or attempting to divert medication, a more thorough search may be conducted where prisoners are directed to lift their top lip and lower their bottom lip.

8. Mr Murdoch's cell was also searched on a frequent basis, including on 2 and 16 April 2021.

9. Mr Murdoch received comprehensive support for his mental health while in MAP and he engaged with a nurse practitioner and a psychologist on a fortnightly basis. Clinicians reported that he did not express any suicidal ideation in the lead up to his death and there was no indication from his assessments that he was contemplating or planning suicide.

[7] The S rating is utilised where a prisoner presents a relevant risk of suicide or self-harm due to their clinical presentation or a history of attempting to end their life or of self-harm. The rating ascribed will determine the level of observation required.

10. Mr Murdoch was last reviewed by a psychiatrist on 31 March 2021 and a psychologist on 14 April 2021 and it was documented that he was behaviourally settled and engaged and reporting no significant thoughts of suicide or self-harm.

CORONIAL INVESTIGATION

11. Mr Murdoch's death constitutes a "*reportable death*" under ss 4(1)(b) and 4(2)(c) of the *Coroners Act 2008* (**the Act**), as it occurred in Victoria and immediately before his death, he was a person placed in custody or care. Pursuant to s 52(2)(b) of the Act, an inquest was also required to be held which occurred on 11 October 2024.

12. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

13. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

14. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr Murdoch's death. The Coronial Investigator conducted inquiries on my behalf and prepared a Coronial Brief which included relevant CCTV footage, prison and medical records and statements from the forensic pathologist, treating clinicians and correctional officers. Further evidence was also directly obtained by the Court from Forensicare and the Department of Justice and Community Safety (**DJCS**) and a report was obtained from the Justice Assurance and Review Office (**JARO**).

15. At the inquest, a summary of the evidence was provided to the Court by Counsel Assisting. The individual witnesses who provided statements in the brief were not required to give evidence at the inquest as, after carefully considering all of the material in the brief, I was satisfied that there were no significant factual disputes or controversies

which remained unresolved in order for me to make the findings required under section 67 of the Act. The interested parties were given an opportunity to make submissions.

16. This finding draws on the totality of the coronial investigation into the death of Mr Murdoch including evidence contained in the coronial brief, the submissions made by Counsel Assisting and the interested parties. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[8]

CIRCUMSTANCES IN WHICH DEATH OCCURRED

17. On 18 April 2021 at 4.15pm, Mr Murdoch was placed in his cell at MAP by correctional staff and the door was locked.

18. At around 5.27pm, Mr Murdoch was administered his amitriptyline medication through the trap in the cell door by a CCA staff member with a CV Health Services Officer.

19. In the morning on 19 April 2021, CV Health Services Officer, Samantha Pettigrew and CCA Nurse, Ancilla Zulu attended Mr Murdoch's cell to administer his morning medications. At around 6.05am, they observed him through the window of his cell door, lying on top of his bed coverings with his left leg on the ground. There was blood visible coming from his mouth and he did not appear to be breathing. Ms Pettigrew called a Code Black.[9] The cell door was opened but cardiopulmonary resuscitation (**CPR**) was not commenced as staff observed that Mr Murdoch was clearly deceased.

20. An ambulance was called at 6.15am. Victoria Police and Ambulance Victoria subsequently attended the scene and Mr Murdoch was pronounced deceased at 7.08am.

[8] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[9] A Code Black is an alarm activated to signal a serious medical emergency.

21. Victoria Police did not find any evidence of suspicious circumstances. They located a number of handwritten notes in Mr Murdoch's cell addressed to family members in which he expressed his regret and conveyed an intention to take his life.

IDENTITY OF THE DECEASED

22. On 19 April 2021, Scott Alan Murdoch was visually identified by Health Services Officer, Samantha Pettigrew.

23. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

24. On 22 April 2021, Dr Matthew Lynch, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy and prepared a report of his findings dated 22 July 2021.

25. Dr Lynch did not find any evidence of injuries or natural disease which would have contributed to death.

26. Toxicological analysis of post-mortem samples detected the presence of amitriptyline (and its metabolite), pregabalin, quetiapine, metformin and oxycodone. Over three grams of amitriptyline was located in the stomach contents.

27. Dr Lynch noted that the level of amitriptyline in Mr Murdoch's system was markedly elevated while the other drugs were detected at levels consistent with therapeutic use.

28. Dr Lynch formulated the cause of death as "*1(a) Amitriptyline toxicity*".

29. I accept Dr Lynch's opinion.

OTHER INVESTIGATIONS

JARO review

30. Section 7 of the Act requires the coroner to liaise with other investigative authorities and to not unnecessarily duplicate inquiries and investigations.

31. Mr Murdoch's death was reviewed by JARO which is part of DJCS and reported to the Secretary to the Department (**the Secretary**), who is responsible for the monitoring of all correctional services to achieve the safe custody and welfare of prisoners.[10] JARO's review involved the interviewing of staff at MAP and the review of relevant records, policies and procedures.

32. JARO prepared a report containing its findings and recommendations dated 3 October 2023. The review was conducted in collaboration with Justice Health.[11]

33. In summary, JARO made the following relevant findings:

    (a) Mr Murdoch received extensive support in response to his mental health, and the strategies used by custodial and health staff reflected his SASH history, current presentation, and risks;

    (b) Mr Murdoch's medication, including amitriptyline and pregabalin, were prescribed as clinically indicated noting the risks of addiction, hoarding and diversion;

    (c) In the period preceding his death, Mr Murdoch displayed stable behaviour and neither custodial nor health staff observed any signs to indicate he was an active risk of suicide or self-harm;

    (d) The S4 risk rating was appropriate and consistent with reports from mental health staff about his stable presentation;

[10] Section 7 of the *Corrections Act 1986*.
[11] Justice Health is a part of the Department of Justice and Community Safety and has responsibility for the delivery of health services to Victoria's prisoners.

(e) Mr Murdoch was challenging for health services to manage, dismissive of health expertise and had a history of refusal and non-attendance of health appointments which could have greatly assisted in his health care and management;

(f) Mr Murdoch's history of hoarding medication and using it in attempts at self-harm were well documented. He was able to source approximately 21 days' worth of amitriptyline medication over an unknown period, which he appears to have taken when locked down in his cell on the evening of 18 April and the morning of 19 April 2021, resulting in his death;

(g) The way in which Mr Murdoch acquired 21 days' worth of medication cannot be confirmed. He may have hoarded his own medication or sourced it from other prisoners;

(h) Dispensing medication through the cell trap creates an increased risk of hoarding or diverting medication, particularly for prisoners who have a history of this behaviour and a history of SASH;

(i) Mr Murdoch's cell was searched above the minimum frequency required at the MAP. Despite the best efforts of staff, cell searches cannot eliminate the risk of medication hoarding entirely;

(j) Due to the length of his sentence and the nature of his offending, Mr Murdoch's ongoing classification as a maximum-security prisoner and his placement at the MAP was appropriate; and

(k) The response to Mr Murdoch's death was efficiently coordinated and consistent with established procedures. The decision not to commence CPR on Mr Murdoch was appropriate given the circumstances that staff encountered upon finding him in his cell.

34. I accept these relevant findings identified in the JARO report and they are consistent with my own review of the evidence.

35. JARO made the following recommendation:

> CV, in collaboration with Justice Health and Health Service Providers, identify and, where possible, implement alternative options for administering supervised medication in these circumstances, to enable custodial staff to more closely supervise the process and inspect whether the medication has been consumed. Specific consideration should be given to identifying safe and secure options that avoid administering medication through the cell trap so that custodial staff can closely observe the prisoner consume the medication and conduct a thorough mouth check

36. DJCS advised at the inquest that it had accepted the recommendation made by JARO. In April 2024, CV and Justice Health implemented new training for staff in public prisons to deal specifically with the risks associated with medication hoarding which includes a focus on diversion methods and prevention. The training emphasises that addressing medication diversion requires a multifaced approach that combines staff training, vigilant observation, and the implementation of preventative measures. Further, a pilot program has been commenced at Barwon Prison in relation to the trial of secure medication distribution systems.

Forensicare review

37. Forensicare completed a Serious Incident Review (**SIR**)[12] after Mr Murdoch's death which resulted in the following relevant findings:

    (a) The level and nature of the mental health care and support provided to Mr Murdoch was responsive to his needs, and there was a good level of engagement in his mental health treatment, such that he appeared to be at a stage prior to his death where he could communicate with staff regarding his current mental state and seek additional support when needed;

[12] Forensicare SIRs are internal clinical review working documents. They are not a root cause analysis or a formal review. The purpose of an SIR is to encourage frank and comprehensive internal discussion and reflection, with the intention of identifying and rectifying clinical issues that may arise from or be identified as a result of an incident.

(b) There was no apparent evidence of significant concerns regarding Mr Murdoch's mental state that was inconsistent with his usual presentation (which was known to fluctuate) in the days leading up to his death, and no exacerbation of known psychosocial stressors;

(c) There was evidence that Mr Murdoch received a good level of mental health treatment and support by Forensicare. Additionally, there was close collaboration regarding supporting Mr Murdoch's needs between the various stakeholders including CV, CCA and Forensicare, including via a weekly case conference in times of increased risk which was reduced to monthly in periods when Mr Murdoch's mental health was stable;

(d) Mr Murdoch was offered mental health treatment and support by Forensicare that exceeded what might be expected given his psychiatric rating of P2 immediately prior to his death.[13] This was in response to the complexity of his mental health issues;

(e) There was a lack of documentation prior to 2017 highlighting that consideration had been given to prescribing amitriptyline for Mr Murdoch, explicitly stating concern that the medication could be lethal in overdose, given his history. Mr Murdoch continued to be prescribed amitriptyline from 2015 until 2017 despite many instances of attempted suicide and self-harm and was only finally taken off the medication when he eventually overdosed on it in September 2017 (having previously had a polypharmacy overdose earlier that year);

(f) Mr Murdoch had previously reported that he had found it easy to divert medications despite mouth checks before a previous overdose, in the context of lower staffing levels. Given his history, he was a patient at high risk of future fatal suicide attempt, and it was foreseeable that this could occur without him eliciting any major concerns regarding his mental state

[13] The P rating refers to the assessed need for psychiatric need and follow-up. P2 is ascribed where a prisoner has a significant ongoing condition requiring psychiatric treatment.

from clinicians, as this had been his history. In this context there was a lack of evidence of consideration of any additional precautions needed during the administration and supervision of medications during the Covid pandemic, which may have affected staffing levels and administration/supervision of medication practices. If this was considered, there was lack of evidence it was communicated to CCA and CV; and

(g) There was a lack of evidence of an exhaustive consideration of other medication options associated with lower rates of fatality in overdose, to assist with insomnia and mood disturbance. While he had trialled several medications in the past for his symptoms, the list was not exhaustive.

38. I accept the relevant findings identified in the SIR and they are consistent with my own review of the evidence.

39. The following relevant recommendations were made by Forensicare after the SIR:

(a) Where patients at high risk of overdose/past history of overdose are identified, prescribers could consider alternative medication less likely to be lethal in overdose and only prescribing tricyclic antidepressants in cases where other options have been excluded/dismissed with a clear rationale documented on the file; and

(b) Interagency discussion between Forensicare, CV and CCA regarding reviewing the guidelines for medication supervision in order to decrease the risk of medication diversion. This may include adaptations that could be made to mitigate any increased risk caused by COVID precautions, reviewing and setting of medication for high-risk patients to reduce distraction and maximise visibility, and reviewing the process of supervision itself (for example, increased room searches, or if a period of observation is required after medication administration in a patient at high risk of overdose).

40. Forensicare advised at the inquest that it had accepted the recommendations made in SIR. In response to the SIR, Forensicare have taken the following relevant action:

(a) made refinements to clinical processes and documentation for outpatients at MAP, particularly where there is a need to alert other members of the care team of a history of overdose; and

(b) optimised the practices associated with medication administration and supervision.[14]

FINDINGS AND CONCLUSION

41. Although Mr Murdoch had not displayed any recent indications that he was contemplating or planning suicide, he had experienced chronic suicidal ideation throughout his adult life in the context of a mental health diagnosis and his responsibility for seriously violent and criminal behaviour in the community. In the circumstances, I am satisfied that Mr Murdoch intended to take his life.

42. I am satisfied that the issues relating to the appropriate prescription, administration and supervision of medications to prisoners assessed with a chronic risk of self-harm, and the risk of prisoners stockpiling those medications for potential overdose, have been identified in the JARO and SIR reports with appropriate responding recommendations and action.

43. Having held an inquest into Mr Murdoch's death, I make the following findings, pursuant to section 67(1) of the Act:

(a) the identity of the deceased was Scott Alan Murdoch, born on 24 August 1977;

(b) the death occurred between 18 and 19 April 2021, at the Melbourne Assessment Prison, Spencer Street, West Melbourne, Victoria from amitriptyline toxicity; and

(c) that the death occurred in the circumstances set out above

[14] Statement of Dr Kate Roberts dated 19 January 2024, Director of Clinical Services, Forensicare, CB102.

I convey my condolences to Mr Murdoch's family.

Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Senior Next of Kin

Secretary to the Department of Justice and Community Safety, C/- Victorian Government Solicitor's Office

Correct Care Australasia, C/- Meridian Lawyers

Forensicare, C/- Lander and Rogers

Justice Assurance and Review Office (JARO)

Senior Constable Bede Whitty, Coroner's Investigator

Signature:

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Coroner David Ryan

Date: 14 October 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.