Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 37/15

I, Barry Paul King, Coroner, having investigated the death of ***Axel Josef Cremer*** *with an inquest held at the* ***Perth Coroner's Court*** *on* ***5 October 2015****, find that the identity of the deceased person was* ***Axel Josef Cremer*** *and that death occurred on or about* ***5 January 2014*** *at* ***Karnet Prison Farm*** *from* ***methiocarb toxicity*** in *the following circumstances:*

Counsel Appearing:

Sergeant L Housiaux assisting the Coroner
Ms D M Underwood (State Solicitor's Office) appearing on behalf of the Department of Corrective Services

Table of Contents

INTRODUCTION

1. Axel Josef (the deceased) died at Karnet Prison Farm (**Karnet**) from methiocarb toxicity after intentionally consuming a fatal quantity of that pesticide.

2. At the time of his death,[1] the deceased was a sentenced prisoner. Under s 16 of the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services (**DCS**) and was thereby a 'person held in care' under s 3 of the *Coroners Act 1996* (**the Act**). His death was therefore a 'reportable death' under the Act.[2]

3. Under s 19 of the Act, a coroner has jurisdiction to investigate a death if it appears that the death is or may be a reportable death. Section 22(1)(a) of the Act requires a coroner who has jurisdiction to investigate a death to hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death a person held in care. An inquest into the death of the deceased was therefore required under the Act.

4. Under s 25(2) of the Act, where the death is of a person held in care, the coroner investigating the death must comment on the quality of the supervision, treatment and care of the person while in that care.

5. I held an inquest into the deceased's death on 5 October 2015.

6. The evidence adduced at the inquest comprised two comprehensive reports into the circumstances of the deceased's death and of his treatment while in custody: one report was prepared by Detective Senior Constable Luke Elsbury of the Coronial Investigation Unit of the Western Australian Police;[3] the other was prepared by

[1] Or 'immediately before death' as provided in s 22(a) *Coroners Act 1996*.
[2] Section 3 *Coroners Act 1996*
[3] Exhibit 1, Volume 1

Richard Mudford of the DCS.[4] Mr Mudford provided oral testimony relating to his report.[5]

THE DECEASED

7. The following information was obtained primarily from a pre-sentence report dated 19 January 2012.[6]

8. The deceased was born on 26 September 1955 in Cologne in Germany and he grew up there.

9. He had a happy childhood and a relatively positive experience in school, both academically and socially. He completed the equivalent of Year 12 and went on to complete an economics degree at Cologne University.

10. When the deceased was 21 years old his father died, which affected him significantly and left him wanting to travel. During the time he was 23 to 26 years old he worked in an insurance company and travelled on and off depending on his financial situation.

11. While the deceased was travelling he spent 18 months in Israel, where he met his first wife. In 1984 he followed his future wife to Perth, her hometown. When he first came to Perth he spoke little English and underwent a period of feeling isolated.

12. The deceased and his first wife stayed together for about 15 years and had two daughters together. He had little contact with those daughters later in his life.

13. The deceased worked as a financial advisor and then a commodities broker in the mid-eighties but found this work stressful. He worked for a time as a retail clothing sales assistant and eventually became involved in irrigation installation and supply. He had his own

[4] Exhibit 1, Volume 2
[5] ts 4-10
[6] Exhibit 1, Volume 2, Tab 2

irrigation business from about 1988 until he was incarcerated in July 2011.

14. At some time prior to 2000 the deceased converted to Islam.

15. In about 2000 the deceased commenced a second relationship with a woman who was his wife at the time of his death. His wife and her two young daughters were Indonesian. The deceased's wife's children became his step-daughters.

THE DECEASED'S INCARCERATION

16. On 21 January 2012 the deceased pleaded guilty to 16 counts of offences involving sexual abuse of his step-daughters between December 2004 and June 2011. He had been on remand in Hakea Prison from July 2011. He was sentenced to nine years imprisonment and was made eligible for parole.[7]

17. The deceased was in Hakea Prison from July 2011 until May 2012 when he was transferred to Casuarina Prison, where he completed a 'food safe' course over about two months. On 25 July 2012 he was transferred as a minimum security prisoner to Karnet, and he remained there until his death.

18. Karnet Prison Farm is a working farm at which food is grown to supply other prisons in the State.[8]

19. While in prison the deceased did not display any mental health or self-harm issues. Routine pathology testing revealed abnormal cholesterol levels and hypertension, for both of which he initially declined medication. He later agreed to be treated for hypertension, but refused an increase in the prescribed medication, ramipril, when testing showed that his blood pressure was still high.

---

[7] Exhibit 1, Volume 1, Tab 40
[8] http://www.correctiveservices.wa.gov.au/prisons/prison-locations/karnet.aspx

20. While at Karnet the deceased was employed in garden production. He was considered to be self-sufficient, industrious and trustworthy. He was respectful to staff and was keen to improve his knowledge, including by enrolling in an occupational safety and health course.

21. As with other prisoners at Karnet, the deceased underwent induction training and was provided with protective personal equipment for the use of chemicals associated with horticulture. This accorded with the DCS *Hazardous Substances and Dangerous Goods Procedure.*[9] There was a locked chemical store at Karnet and a system of recording the use of chemicals kept in it.

22. Until about June 2012 the deceased received fairly regular visits from his wife and friends. Between June 2012 and February 2013 he had no visitors. His last telephone contact with his wife was in October 2012 though she visited him once in March 2013 and once in June 2013.[10]

23. On 2 January 2014 the deceased was served with divorce documents by his wife. He told prison staff that he had previously seen the documents, and he did not appear upset or concerned at the time.[11]

EVENTS LEADING UP TO DEATH

24. The deceased was seen at dinner time at about 5.00 pm on 4 January 2014.[12] There would have been a lockup muster for lights out at 10.30 pm, at which time the deceased would have been seen in his cell, though there is no direct evidence of this. There were also to be two muster checks conducted by Karnet staff overnight, but the nature and timing of those overnight checks was not the subject of evidence either.[13]

---

[9] Exhibit 1, Volume 2, Death in Custody Review, p.11
[10] Exhibit 1, Volume 2, Tabs 13 and 14
[11] Exhibit 1, Volume 2, Death in Custody Review, p.8
[12] Exhibit 1, Volume 1, Tab 3
[13] Exhibit 1, Volume 2, Death in Custody Review, p.13

25. At about 6.45 am on Sunday 5 January 2014 an informal muster was conducted at Karnet. A prison officer saw the deceased apparently sleeping in his cell.[14]

26. At 11.00 am on 5 January 2014 a formal muster parade was conducted at Karnet. This procedure required prisoners to stand by their cell doors while prison officers checked their names against a bed placement list. The prison officer conducting the muster parade in the deceased's unit noted that the deceased was still in his bed, so he tried to rouse the deceased by tapping the deceased's door with his foot. When the deceased did not respond, prison officers, including one who had been an ambulance officer for many years, entered his cell and determined that he was dead.[15]

27. Ambulance officers attended and noted that the deceased was cold and stiff, with obvious signs of lividity and rigor mortis. At 12.56 pm a volunteer ambulance officer certified that the deceased's life was extinct.[16]

28. Police detectives from the Major Crime Squad and the Coronial Investigations Unit attended and examined the deceased and his cell. They found no evidence of criminality, so they handed the investigation over to the Coronial Investigations Unit.[17]

29. On 8 January 2014 prison staff opened the deceased's cell in order to clean it. They found a bundle of documents belonging to the deceased, among which was a note in which the deceased expressed to prison authorities his intention to end his life. The note was dated Saturday 4 January 2014.[18]

30. Other documents in the bundle included messages to his wife and step-daughters in which he indicated his

[14] Exhibit 1, Volume 2, Tab 15
[15] Exhibit 1, Volume 2, Tab 15
[16] Exhibit 1, Volume 2, Tab 7
[17] Exhibit 1, Volume 1, Tab 3
[18] Exhibit 1, Volume 1, Tab 39

intention to end his life due his despair at losing them because of his criminal acts. These messages were also dated 4 January 2014.[19]

31. Police investigators from the Coronial Investigations Unit attended Karnet on 8 January 2014 and seized the documents found by prison staff. They re-entered the deceased's cell and found three drink containers containing liquid and two spray bottles also containing liquid. The police investigators took samples from each container for analysis.[20]

32. Toxicological analysis of the liquids found in the containers in the deceased's cell detected the pesticide methiocarb in two drink containers and two other pesticides, piperonyl butoxide and permethrin, in one of the spray bottles.[21]

33. Police investigators concluded that there was no criminality associated with the death.[22]

CAUSE OF DEATH AND HOW DEATH OCCURRED

34. Forensic pathologist Dr D M Moss conducted a post mortem examination on 8 January 2014 and found coronary artery atherosclerosis and pulmonary oedema and congestion. There were also small nodules in the kidneys.[23]

35. Microscopic examination of tissues showed mild patchy scarring within the heart muscle, significant atherosclerosis within the coronary arteries and small focal areas of tumour in the kidney.[24]

36. Toxicological analysis showed the presence of methiocarb artefact within the blood and urine and

[19] Exhibit 1, Volume 1, Tabs 26 and 38
[20] Exhibit 1, Volume 1, Tab 5
[21] Exhibit 1, Volume 1, Tab 9
[22] Exhibit 1, Volume 1, Tab 2
[23] Exhibit 1, Volume 1, Tab 8
[24] Exhibit 1, Volume 1, Tab 8

a significant level of methiocarb, 1100 mg, within the stomach. The other two pesticides were not detected.[25]

37. Dr Moss formed the opinion that the cause of death was consistent with methiocarb toxicity.[26]

38. Having regard to the circumstances of the deceased's death and to Dr Moss' opinion, I find that the cause of death was methiocarb toxicity.

39. It is apparent that, with an intention to end his life, at some time after 10.30 pm on 4 October 2014 the deceased ingested a toxic quantity of the pesticide methiocarb, which caused his death some time later.

40. I find that death occurred by way of suicide

CHANGES TO PROCEDURES FOLLOWING THE DEATH

41. Following the deceased's death, the DCS made no significant changes to the *Hazardous Substances and Dangerous Goods Procedure*.[27] However in relation to the storage and issue of chemicals from the chemical store at Karnet, an upgrade of the store was undertaken to allow for a centralised chemical store, which is expected to increase the control of chemicals at the prison farm.[28]

42. In response to the potential for prisoners to keep hazardous substances in their cells in cleaning product containers, on 12 August 2014 the DCS Adult Custodial Division issued a priority Broadcast Directive to all prison superintendents directing that cleaning chemicals of any description were not to be stored in cells.[29]

---

[25] Exhibit 1, Volume 1, Tab 9
[26] Exhibit 1, Volume 1, Tab 8
[27] Exhibit 1, Volume 2, Death in Custody Review, p.11
[28] Exhibit 1, Volume 2, Death in Custody Review, p.11
[29] Exhibit 1, Volume 2, Tab 25

43. On 16 September 2014 the DCS Adult Custodial Division issued an Assistant Commissioner Custodial Operations Notice directing superintendents that all prisoners leaving work locations were to be inspected and searched if necessary, that cell inspections were to include the checking of containers for contraband, and that dangerous goods were to be handled in accordance with the *Hazardous Substances and Dangerous Goods Procedure.*[30]

COMMENT ON THE SUPERVISON, TREATMENT AND CARE OF THE DECEASED WHILE IN CUSTODY

44. I find that the medical treatment and care of the deceased was of a satisfactory standard. His age-typical medical conditions were detected and treated accordingly to the extent that the deceased consented.

45. The existence of the focal areas of tumour in the kidney was not mentioned in Mr Mudford's report, and the evidence before me does not address what investigations had been undertaken that may have led to possible treatment of that condition. However, the circumstances of the deceased's death made clear that a medical condition was not related to the cause or manner of death.

46. As to the issue of supervision, the deceased had access to potentially fatal chemicals and, once such chemicals were issued from the secure store, it would have been difficult if not impossible for Karnet staff to control entirely what happened to them.[31] As a result, the deceased was able to secret a quantity of methiocarb back to his cell where he could store it in drinks containers and use it at a time when he was unlikely to be monitored.

[30] Exhibit 1, Volume 2, Death in Custody Review, p.13
[31] Exhibit 1, Volume 2, Death in Custody Review, p.12

47. I infer that this would have been particularly easy for the deceased given his standing as a self-sufficient, industrious and trusted worker.

48. It may be argued that more stringent control of potentially fatal chemicals should have been in place at Karnet to ensure that the chemicals were not misused, including for the purpose of suicides. However, Karnet was a working farm in which minimum security prisoners were expected to work unsupervised.[32]

49. I assume that at least one purpose of the trust afforded to prisoners to work unsupervised was to assist in the process of rehabilitating them for eventual release by engendering responsibility and self-esteem. No doubt the process involved a balance between ensuring prisoners' safety and the prison's security on one side and furthering the prisoners' rehabilitation on the other.

50. In these circumstances, the control of chemicals at the relevant time was not unreasonable.

51. As to considerations of whether Karnet staff should have put in place steps to prevent the deceased from ending his life, he gave no indication of an intention or plan to do so, and he did not appear to suffer from a mental illness that may have predisposed him to be at risk of suicide.

52. In such circumstances, it was reasonable for Karnet staff not to check on the deceased more frequently overnight or to place him in a cell with another prisoner, as examples.

53. It is relevant that the deceased did not appear to be suffering from a mental illness that predisposed him to suicide. Rather, the deceased made a conscious, rational decision to end his life, which he then planned and carried out secretly. In such a case, he could not be treated for the cause of his suicidality.

[32] Exhibit 1, Volume 2, Death in Custody Review, p.12

54. In addition, the deceased did not impulsively use a means of suicide that happened to be close at hand. Other means of ending his life were available to the deceased if a toxic substance had not been; for example, photographs of the deceased's cell show electrical cords and ligature points that the deceased could have used to hang himself.[33]

55. The deceased could have ended his life at any time of his choosing.

56. In such circumstances, it is difficult to see how Karnet staff could have prevented the deceased from committing suicide.

57. On the basis of the foregoing, I am satisfied that the DCS provided a satisfactory level of supervision of the deceased while he was held at Karnet.

CONCLUSION

58. The deceased chose to end his life due to circumstances that, as he recognised in notes left to his wife and step-daughters, were of his own making.[34]

59. I am satisfied that the circumstances of the deceased's death were causally unrelated to the supervision, treatment and care he received while in the custody of the CEO of the DCS.

B P King
Coroner
30 October 2015

[33] Exhibit 1, Volume 1, Tab 38
[34] Exhibit 1, Volume 1, Tab, 26 and 38