IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 002787

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008
Amended pursuant to s76 of the *Coroners Act 2008*
on 11 January 2017[1]

Deceased:	CAIN DOUGLAS ERNEST HUTCHINSON
Hearing date:	15 December 2016
Findings of:	CORONER CAITLIN ENGLISH
Counsel assisting the Coroner:	Ms Evelyn Shaw
Representation:	Ms Ingrid Nunnink, G4S Custodial Services Pty Ltd

[1] Two typographical errors (on pages 2 and 16) where the date of death was incorrectly noted as 6 June 2015, have been changed to the correct date of 7 June 2015.

I, CAITLIN ENGLISH, Coroner having investigated the death of Cain Hutchinson

AND having held an inquest in relation to this death on 15 December 2016

at Melbourne

find that the identity of the deceased was Cain Douglas Ernest Hutchinson

born on 16 April 1994

and the death occurred 7 June 2015

at Port Philip Prison, 280 Palmers Road, Truganina

from:

1 (a) METHYLAMPHETAMINE TOXICITY

in the following circumstances:

Introduction

1. Cain Hutchinson was a 21 year old man who died whilst on remand at Port Philip Prison (PPP). He is survived by his partner, Jaymi Lee Parsons, his daughter Jaylee and his stepson Tyler.

2. At 8am on 7 June 2015, Mr Hutchinson complained to his cellmate of feeling unwell. Over the subsequent hours, Mr Hutchinson's condition deteriorated before he went into cardiac arrest and was unable to resuscitated. He was declared deceased by paramedics at 11.40am.

The coronial investigation

3. Mr Hutchinson's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act* (2008) (the Act).

4. Pursuant to section 4 of the Act, his death was unexpected and unnatural. Further, his death was also reportable as Mr Hutchinson was a serving prisoner who immediately before death was *a person placed in custody or care*.[2]

5. In such a case, where a person immediately before death was placed in custody or care, a coronial inquest is mandatory pursuant to section 52(2) of the Act. The evident intention of the legislation is to recognise the vulnerability of people placed in the care or custody of the State or its instruments, and to accord to prisoners in particular, the protection afforded by

[2] ss 3 and 4(2)(c) of the Act.

independent scrutiny of the circumstances in which they died, and to promote accountability on the part of the state or its instruments.[2]

6. 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.

7. I have based this finding on the evidence contained in the coronial brief and other sources of evidence outlined below. In the coronial jurisdiction facts must be established to the standard of proof which is the balance of probabilities. [3]

8. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[4]

Investigation – Sources of Evidence

9. This finding is based on the materials obtained by the coronial investigation into Mr Hutchinson's death. This includes the brief of evidence compiled by Coroner's Investigator Detective Senior Constable Karina Prodan, the additional statements and reports obtained from various witnesses and the sworn evidence of the Coroner's Investigator at inquest.

10. In addition to the coronial brief, there were three reviews conducted regarding Mr Hutchinson's death:

- "Review of the Death of Cain Hutchinson on 7 June 2015" conducted by the Office of Correctional Services Review (OCSR) dated 16 December 2015;[5]

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[2] Whereas a coroner has a discretion to hold an inquest into any death they are investigating, a coroner *must* hold an inquest into a death which the deceased was immediately before death, a person placed in custody or care: s52 of the Act.

[3] This is 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.

[4] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions *if the coroner believes an indictable offence may have been committed in connection with the death.* See sections 69(2) and 49 (1).

[5] A redacted version of this document is found at pp160-172 of the Coronial Brief (Volume 1).

- "Report into Death in Custody Mr Cain Hutchinson CRN 201121" conducted by Justice Health dated 18 June 2015 (which appears as Appendix 1 to the OCSR report); and

- "Internal Management Review – Death in Custody – Prisoner Cain Hutchinson CRN 201121" conducted by G4S Custodial Services (the private operators of Port Phillip Prison) dated 29 June 2015[6]

11. At inquest, coroner's investigator DSC Prodan was called to give evidence. She outlined the course of the investigation and noted that she attended the scene of Mr Hutchinson's death at Port Phillip Prison as well as the autopsy with Dr Bouwer on 8 June 2015.

12. At inquest, Mr Hutchinson's father asked for clarification about two matters. The first was whether his son had been hand cuffed when taken to St Thomas, the hospital unit at the prison. DSC Prodan confirmed her understanding that he was cuffed with his hands in front of him as he was thrashing around due to his agitated state. The footage recorded by a body camera on one of the correctional officers taken when Mr Hutchinson was transported down the stairs from his cell recorded between 10.29.06 and 10.30.18 is unfortunately obscured and of limited value.

13. Secondly, Mr Hutchinson's father asked if it was possible to ascertain how the balloon in which the drugs were wrapped managed to come undone. I made inquiries with Forensic Pathologist, Dr Bouwer, who indicated:

'It would appear that the knot came partly undone causing the drugs that were contained in a small clear ziplock bag to leak out into the gut.' [7]

14. I have based this finding on all of the available the evidence. In the coronial jurisdiction facts must be established to the standard of proof which is the balance of probabilities. [8]

Background and personal circumstances

15. Mr Hutchinson grew up around Camperdown, Colac and Norlane. He was the eldest of four children, with siblings Darcie, Ethan and Ashley. His mother, Jo-Ann Payne described him

[6] A redacted version of this document is found at page 15*ff* of the Coronial Brief (Volume 2).
[7] Email from Dr H Bouwer dated 14/12/2016.
[8] This is 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.

as 'happy go lucky' growing up in Camperdown. In his early teens, he began smoking marijuana and drinking alcohol. He was expelled from school for disruptive behaviour and began committing offences. He left his mother's home and moved in with his grandmother. He started a different secondary school but left when he was in year 9.[9]

16. He lived between his mother's home in Colac, his grandmother and father in Norlane and relatives in Camperdown. Over time, his drinking and drug use escalated, as did his criminal involvement. [10]

17. In May 2011, he was sentenced to ten months detention in a youth justice centre.

18. In 2012, Mr Hutchinson commenced a relationship with Jaymi Lee Parsons.

19. In September 2013, he was sentenced to six months imprisonment in adult custody and spent time at Barwon Prison. During his time as a prisoner in Barwon, Ms Parsons had visited Mr Hutchinson. In December 2013, Barwon Prison staff created an alert regarding Ms Parsons on the Prisoner Information Management System ('PIMS'). Barwon Prison staff created a number of information reports suggesting Ms Parsons was attempting to introduce drugs into the prison in 2013 and 2014.[11] Reflecting the prison's concerns at this time, Mr Hutchinson was restricted to non-contact visits from December 2013 until February 2014, when he was released. [12]

20. In February 2015 Mr Hutchinson and Ms Parsons had a daughter together named Jaylee. Ms Parsons also had a son, Tyler, from a previous relationship. Mr Hutchinson considered Tyler as his own. His mother, Ms Payne, described him as happy being a dad.

Circumstances of incarceration

21. On 1 May 2015, Mr Hutchinson was arrested on old warrants, which related to criminal activity in 2013-2014. He was initially remanded at the MAP before transferring to PPP on 13 May 2015.

22. Additional charges were served upon him whilst he was in custody; he had an impending committal mention date of 26 June 2015.

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[9] Statement of Jo-Anne Payne dated 16 September 2015; Coronial Brief pp24-27.
[10] *Ibid.*
[11] Coronial Brief pp158-159 (Volume 1).
[12] OCSR report, page 7; Coronial Brief p166 (Volume 1).

23. He had two registered visitors, one of which was Ms Parsons. He received five contact visits at PPP during the five weeks of his remand before death. On two occasions, Ms Parsons brought Jaylee or both children with her.

Circumstances of death

24. Ms Parsons visited Mr Hutchinson with their four month old daughter, Jaylee, on the afternoon of 6 June 2015.

25. On 5 June 2015, Mr Hutchinson spoke on the telephone with Ms Parsons, arranging for her to bring drugs into the prison the following day. Although the telephone call was recorded,[13] the contents of the call were only reviewed after Mr Hutchinson passed away.

26. Mr Hutchinson telephoned Ms Parsons again, twice, on the afternoon of 6 June 2015, asking whether she was coming. She confirmed she would definitely make it in before 5pm.

27. At 5.15pm, Ms Parsons and Jaylee arrived at the prisoner visitor area of PPP.

28. She had her contact visit with Mr Huchinson in the visitor centre. After ten minutes, Ms Parsons purchased some pretzels and a drink from the vending machine. At 5.28pm, she took Jaylee to the bathroom to change her nappy. Whilst in the bathroom Ms Parsons removed a balloon containing a small bag of methylamphetamine from where it had been concealed on her person. She kept it in her hand as she returned to the visitor area.

29. Upon her return, Ms Parsons handed Jaylee to Mr Hutchinson. Then, she took some pretzels from the bag and in so doing deposited the balloon into the pretzel packet. In turn, Mr Hutchinson took some pretzels and in so doing moved the balloon to his mouth and swallowed. He had a drink. Ms Parsons was alarmed at the amount of orange juice he drank as she had understood he would keep the balloon at the back of his throat so it could be easily retrieved once he returned to his cell. [14]

30. Following the visit, Mr Hutchinson told his cellmate that the visit went well. [15] As he had missed the usual dinner time (5pm), Mr Hutchinson brought a pasty and some salad on a plate to his cell for dinner.

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[13] Exhibit 7 of the Coronial Brief.
[14] Coronial Brief Record of Interview p 90.
[15] Statement of [redacted], Coronial Brief p28ff (Volume 1).

31. At 8am on 7 June 2015, Mr Hutchinson's cell mate, [redacted], awoke to find Mr Hutchinson shivering and reporting that he did not feel well.[16] Mr [redacted] went downstairs to make Mr Hutchinson some breakfast and returned with porridge. Mr Hutchinson had locked himself in the cell. He said he was on the toilet. Mr [redacted] left the porridge outside the door and went to see some prisoners in the next door cell.

32. Some other prisoners gathered around Mr Hutchinson's cell, knocking on the door and telling him to open up.

33. At approximately ten past ten that morning, one of the prisoners of the unit, [redacted] advised Correctional Officer [redacted] that Mr Hutchinson was unwell, with suspected food poisoning and required medical attention.

34. CO [redacted] went to Mr Hutchinson's cell where he was found to be shaking, vomiting, rolling around on his bed and saying he was 'boiling hot.' CO [redacted] called a 'code black', requesting medical response. The other prisoners of the unit were locked down in their cells, by other Correction Officers.

35. Correction Officers spoke to Mr [redacted] in an attempt to understand what was happening to Mr Hutchinson. He reported the Mr Hutchinson had been feeling unwell earlier in the day. He stated Mr Hutchinson had not mentioned anything about drugs, and he thought Mr Hutchinson had food poisoning.

36. In response to the code black, St Vincent's Correctional Health Service (SVCHS) staff arrived at the unit. Medical staff transferred Mr Hutchinson to St Thomas's Unit at PPP before an ambulance arrived.

37. Mr Hutchinson's condition continued to deteriorate.

38. Paramedics transferred Mr Hutchinson to the ambulance but as he was being loaded, he went into cardiac arrest. Resuscitation was attempted but was ultimately unsuccessful. He was pronounced deceased by paramedics at approximately 11.40am, when attempts to revive him were ceased.

39. Approximately an hour later, at 12.45pm, Mr Hutchinson's cell was cordoned off as a crime scene. Prior to this, the cell had been locked as a biohazard, however Mr [redacted] had been permitted to reach in, observed by a correctional officer, to retrieve a few personal items.

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[16] Ibid, p29.

40. I attended the scene in company with Dr Heinrich Bouwer, forensic pathologist from the Victorian Institute of Forensic Medicine (VIFM). We arrived at approximately 2.30pm. We were briefed by the Coroner's Investigator DSC Karina Prodan before viewing Mr Hutchinson in situ in the back of the ambulance. I also observed Mr Hutchinson's cell. The cell was cordoned and in disarray. As at that point food poisoning was a possibility, I directed food receptacles in the cell be seized. I noted the wall next to the lower bunk occupied by Mr Hutchinson was adorned with family photos.

The medical cause of death

41. On 8 June 2015, Dr Bouwer at VIFM, conducted a post mortem examination and autopsy. Dr Bouwer completed a report, dated 11 September 2015 in which he formulated the cause of death as 1(a) Methylamphetamine Toxicity. I accept Dr Bouwer's opinion as to the medical cause of death.

42. At autopsy, a foreign body, namely an orange balloon which contained a small clear plastic bag, was located in the bowel. The balloon was perforated and the contents of the bag had spilled out into the gut.

43. Toxicological analysis of post mortem fluid specimens taken from Mr Hutchinson identified markedly elevated concentration of methylamphetamine in the blood (~7.6mg/L). Methylamphetamine was also detected in the urine as well as the contents of the plastic bag located in the small bowel. Amphetamines were detected in blood and urine and methcaninone[17] was detected in the urine.

44. Amphetamines is a collective word to describe central nervous system stimulants structurally related to dexamphetamine. One of these, methylamphetamine, is often known as 'speed' or 'ice'. Methylamphetamine is a strong stimulant drug that acts like the neurotransmitter noradrenaline and the hormone adrenaline.

45. Toxicity associated with amphetamine use includes agitation, hyperthermia, and hallucinations leading to convulsions, unconsciousness and respiratory and or cardiac failure.

46. Dr Bouwer commented that the cause of death was due to the toxic effect of methylamphetamine.

[17] Methcaninone is a derivative of cathinone. Cathinone is a beta-keto phenylethylamine, is one of the active constituents of the khat plant, first identified in the plant in the 1970s. The pharmacological effects of cathinones are considered to be the same as amphetamine; however, the potency of cathinone is about one half of that of amphetamine.

47. A neuropathological examination was conducted on 8 June 2015 by Dr Linda Iles, on referral from Dr Bouwer. In her report dated 25 August 2015, Dr Iles did not identify any macroscopic abnormality.

Mr Hutchinson's assessment at PPP

48. Mr Huthinson was not targeted for any urine testing during his time on remand nor was he identified to be urine tested within Corrections Victoria's random urine screening program.[18]

49. At Inquest, Ms Nunnink was asked how Mr Hutchinson's risk of drug use was categorised or managed within PPP.

50. Ms Nunnink advised: [19]

'Mr Hutchinson's positive drug test was from an earlier sentence at a different prison.

We are unable to confirm whether this positive test resulted in Mr Hutchinson being established by that prison with an 'Identified Drug User Status' ("IDU") under the Victorian Prison Drug Strategy - Identified Drug User Program.

Nevertheless, we understand that under the Victorian Prison Drug Strategy - Identified Drug User Program a prisoner's IDU is cancelled upon the end of their imprisonment.

The Victorian Prison Drug Strategy - Identified Drug User Program is comprehensive and detailed.

The Victorian Prison Drug Strategy - Identified Drug User Program runs across the correctional system and is applied at Port Phillip Prison. It relates to the management of IDU status prisoners and covers a range of restrictions, interventions and initiatives to reduce the incidence of drug use in prisons.

A prisoner's IDU is recorded on the relevant pages of the State-wide electronic databases and the level of monitoring and restriction of that prisoner as a result of their IDU status is implemented at Port Phillip Prison according to the requirements of the program. Compliance audits of the IDU program is part of the standard compliance program at Port Phillip Prison, which is also subject to compliance review by the OCSR and/or Contract Management Branch of Corrections Victoria.'

51. I note the Justice Health Review on the coronial brief indicates that when Mr Hutchinson entered the Melbourne Assessment Prison on 6 May 2015 a mental health intake assessment was conducted. This assessment noted that Mr Hutchinson: [20]

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[18] Coronial Brief OCSR Report p 170.
[19] Email from Ingrid Nunnink to CCOV dated 19 December 2016
[20] Coronial Brief p 175.

'...self-reported a history of poly-substance use, including amphetamines, cannabis and other substances as well as smoking.'

52. The report also noted that Melbourne Assessment Prison was in receipt of collateral information from Barwon Health that Mr Hutchinson had a provisional diagnosis of a spasm of the mesenteric artery, *'...secondary to the use of amphetamines.'* [21]

53. When Mr Hutchinson was transferred to PPP on 13 May 2015, a further health assessment was completed by St Vincent's Correctional health Service *'...that did not identify any new health issues.'* [22]

54. This suggests that given Mr Hutchinson's disclosures about his prior drug use on admission to Melbourne Assessment Prison, PPP was aware of his history. It does not appear that he was given an Identified Drug User Status.

55. Mr Hutchinson's telephone calls were not targeted. At Inquest, Ms Nunnink indicated a multi-factorial approach is taken when determining whether calls will be targeted, such as intelligence from Victoria Police or within the prison, none of which applied to Mr Hutchinson. She indicated with 1000 inmates at PPP the volume of calls creates a significant amount of data on a daily basis.

Ms Parsons' assistance

56. On Tuesday 9 June 2015, Ms Parsons telephoned the Coroner's Investigator's police station, Wyndham Criminal Investigation Unit and spoke with one of her police colleagues. She confessed tearfully that she had supplied the balloon containing methyl amphetamine to Mr Hutchinson during her visit to the prison. She knew that this might result in criminal charges for her. She made arrangements to be interviewed the following day.

57. On Wednesday 10 June 2015, Ms Parsons attended Geelong Police Station. She was interviewed by the Coroner's Investigator and a second police member. She provide full and frank admissions and explained exactly how she had been able to bring the drug into the prison and transfer it to Mr Hutchinson.

58. Ms Parsons was charged and on 15 September 2015, pleaded guilty at the Geelong Magistrates' Court to two criminal charges (possess methamphetamine and introduce contraband to a prison). She was fined without conviction.

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[21] Coronial Brief p 175.
[22] Coronial Brief p 175.

G4S Internal Management Review

59. G4S is a private company which is contracted by the state to manage and operate PPP. G4S is obliged to comply with Commissioners Requirements which are issued by the Commissioner, Corrections Victoria. PPP operates according to Operational Instructions (OIs) which are approved and endorsed by Corrections Victoria.

60. In the days following Mr Hutchinson's death, G4S staff member [redacted] conducted an Internal Management Review which identified that Ms Parsons had used the bathroom to change baby Jaylee's nappy in the course of her contact visit with Mr Hutchinson on 6 June 2015.

61. The CCTV footage of the visit, as well as recordings of telephone conversations were obtained and reviewed. A possible method by which Ms Parsons had transferred drugs to Mr Hutchinson was identified. At the time of conducting these investigations, G4S staff were unaware of Ms Parsons' admissions to police.[23]

62. After the death of Mr Hutchinson, G4S implemented a change in policy in relation to visits conducted at PPP. An immediate change to the relevant Operating Instruction number 78 was implemented in relation to the process for visits after visitor access to the toilet or baby changing facilities. A copy of the amended policy is included in the coronial brief and dated 9 June 2015. [24]

63. The amended Operating Instruction now requires that when a visitor uses the bathroom or changes a baby in the course of a contact visit, following this, the visit will proceed as a non-contact visit.[25]

64. Changes were also made to the Commissioners Requirement 3.2.1 *Management of Visits to Prisoners* following Mr Hutchinson's death. The version of this requirement in place at the date of Mr Hutchinson's death did not refer to the use of the bathroom or baby changing facilities during a contact visit. The current version of this requirement, updated in December 2015, now states that if a visitor requests the use of toilet or baby change facilities during a contact visit, the officer-in-charge will then assess whether the visit should resume, resume as a non-contact visit or be terminated.

65. The Finding of the Internal Management Review stated: [26]

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[23] Statement of Ian Pugh Thomas dated 6 June 2016 p4; Coronial Brief p4 (Volume 2).
[24] Coronial Brief volume 2 pp 115-125
[25] Ibid. See also Operational Instructions No 78: *The Visits Centre* dated 9 June 2015.

'Nil systemic issues were identified by this review; however there is some scope to review and enhance the contact visit procedures in the event that the continuity of the visit is broken in any way. [redacted]

OCSR Report

66. A summary of the findings of the OCSR review noted that although PPP had improved a number of elements within the contact visits process since Mr Hutchinson's death, there were remaining risks in PPP's management of intelligence and visits. The report noted that Ms Parsons had a prior history of attempting to introduce contraband into prison. Further, that there were inadequate policies and processes in place at PPP to ensure visitor intelligence alerts were consistently assessed.

67. The OCSR report made three recommendations:

    1) Corrections Victoria amend relevant policies to clarify required processes and records for assessing nominated visitors with PIMS visits alerts;

    2) Corrections Victoria seek assurance from PPP that barrier control infrastructure and processes in the prison reception reflect the required standard; and

    3) Corrections Victoria seek assurance from PPP that supervision and monitoring in the prison's visits centre achieve the required standard.

68. Corrections Victoria accepted recommendation (1) in principle and indicated it was currently being implemented.

69. As indicated above, Commissioners Requirement 3.2.1 *Management of Visits to Prisoners* has been amended, updated in December 2015, and now states that if a visitor requests the use of toilet or baby change facilities during a contact visit, the officer-in-charge will then assess whether the visit should resume, resume as a non-contact visit or be terminated.

70. Further, Commissioners Requirement 3.2.1 *Management of Visits to Prisoners* updated in December 2015, now contains an addition that:

[26] Coronial Brief volume 2 p 21.

5.1.14 Where a visitor has a flag in PIMS, staff processing the visit on the PIMS Visits module, will record the manner in which a PIMS flag has been actioned, for example, 'Visitor offered non-contact visit.'

71. Corrections Victoria accepted recommendation (3). This is considered this to have been achieved by the actions undertaken by G4S in the immediate period following Mr Hutchinson's death. This included a new staff console [redacted]

72. In response to recommendation (2), Corrections Victoria was, at the time of publication of the OCSR report, in the process of reviewing the processes and practices at PPP's reception to assess the level of compliance.

73. Since publication of the OCSR report, Corrections Victoria determined not to accept recommendation (2). This was because Corrections Victoria was satisfied that PPP staff acted appropriately in relation to the 'intelligence alert' on PIMS in this case. The flag was specific to Barwon Prison, and was related to intelligence gathered during Mr Hutchinson's previous term of imprisonment, almost eighteen months earlier. There was no intelligence current at the time of Mr Hutchinson's death to suggest that Ms Parsons would attempt to introduce contraband. She had been subject to searches on previous visits. This indicated that the 'random' nature of visitor searches appeared to capture a broad cross-section of visitors attending PPP. [27] Corrections Victoria also noted that PPP arguably had the strictest barrier controls of all maximum security prisons.

74. The OCSR report also identified two matters for the attention and consideration of the General Manager of PPP:

1) That PPP update relevant policies to include the requirement that reception staff forward all applications from visitors with intelligence alerts to the Prison Intelligence Unit, to be further assessed.

2) That PPP consider developing policies to initiate crime scene procedures when prisoners present as unwell in suspicious circumstances.

75. PPP accepted in principle matter (1). To that end, General Manager Ian Thomas has advised:

[27] Statement of Ian Pugh Thomas dated 6 June 2016, p8; Coronial Brief, Volume 2, p 8.

'G4S is submitting an amended OI (Operational Instruction) [redacted] to Corrections Victoria for endorsement. The OI will reflect Commissioners Requirement 3.2.1 *Management of Visits to Prisoners* dated 2015 and ensure Reception Staff, where required, refer a visitor with a flag/intelligence alert to PPP's Prison Intelligence Unit.' [28]

76. During the Inquest, Ms Nunnink was asked to confirm the status of the amended OI No 29. She advised as follows: [29]

'The Port Phillip Prison Operational Instruction No 29 *Reception Area Process and Control of Entry and Exit* was further amended in June 2016. Relevantly, in relation to screen assessments of visitors and referral of those victors to the Prison Intelligence Unit, the current policy provides as follows:

- *The reception officer will check the visits screen during the process to ensure that there are no flags, warnings or notifications from any prison across the state that could impede on this persons right to visit.*

- *Further to this they will check the PIMS screen for any flags, warnings or notifications alerting them to contact the Prison Intelligence Unit before this visitor can be processed. The Prison Intelligence Unit will then make a determination if the information is current intelligence holdings and relevant to the visit about to occur.*

Following the August 2016 Commissioners Requirement, Port Phillip Prison Operational Instruction No 29 will be amended to add the further instruction, following on from the above section:

- *Where a visitor has a flag in PIMS, staff processing the visit on the PIMS Visits Module, are to record the manner in which the flag has been actioned. E.G "Visitor offered Non – contact visit"*

This inclusion is yet to be endorsed by Corrections Victoria, but is expected to be approved as it complies with the Commissioners Requirement.'

77. Jan Shuard, Corrections Commissioner noted in Corrections Victoria's response to OCSR's draft report that this was accepted in principle. She acknowledged that better recording of how these flags are recorded would be beneficial, although it is maintained that staff appear to have acted appropriately on this occasion in relation to the dated intelligence on Ms Parsons. [30]

78. Mr Thomas, rejected the second matter for attention and consideration, 'That PPP consider developing policies to initiate crime scene procedures when prisoners present as unwell in

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[28] Coronial Brief, volume 2, p
[29] Email from Ingrid Nunnink to CCOV dated 19 December 2016.
[30] Coronial Brief, volume 2, p 149.

suspicious circumstances', taking the view that individual incidents need to be managed according to the information that is current at the relevant time. While Mr Hutchinson's cell was not sealed as a crime scene, it was initially quarantined (locked) and became a crime scene when Mr Hutchinson died.[31] The initial decision was based on information from Mr Hutchinson suggesting he had food poisoning.

79. Mr Thomas, General Manager of PPP agreed with Commissioner Shuard's comments that the intelligence reports for Ms Parsons were historical in nature and there was no current intelligence to suggest Ms Parsons was attempting to bring drugs into PPP. The addition of baby Jaylee to Mr Hutchinson's family structure would have made non-contact visits in 2015, without intelligence to indicate a current risk, unlikely to have been imposed. Further, on this reasoning there was no basis for her to be strip searched on 6 June 2015. [32]

80. The OCSR report also notes that Mr Hutchinson's telephone calls for the week prior to his death were reviewed. It was found that he and Ms Parsons had discussed her bringing contraband into prison on more than one occasion.

81. On 5 June 2015 the two discussed when Ms Parsons will visit next and she replies, 'When I get it, I guess.' Mr Hutchinson admonished her for saying this over the telephone.

82. As Mr Hutchinson was not on the prison's targeted list for phone calls, none of his calls were randomly selected for auditing during his time at PPP.

83. The OCSR review was satisfied: 'that there was no reasonable cause for Mr Hutchinson to be targeted [33] for phone monitoring and recognises that his calls were not identified to be randomly listened to.' [34]

84. I note the telephone intercept of this conversation represented current intelligence of Ms Parsons' intent to introduce contraband into PPP that was not audited by PPP.

Conclusion

85. In her taped record of interview with police, Ms Parsons indicated that Mr Hutchinson had said to her he would be 'knocked' or would have to 'knock' others if she did not bring drugs into PPP. In response to my direct inquiry on point, DSC Prodan indicated she did not come

[31] Ibid, p11.
[32] Coronial Brief, volume 2, p 9.
[33] It is not clear what the criteria is for a prisoner to be on a 'targeted list' for calls to be audited.
[34] Coronial Brief volume 1, p 170.

across any information in relation to this issue during her investigation. When I inspected Mr Hutchinson's cell on 7 June 2015, a Corrections Officer remarked to me that the family photos on his cell wall may have made Mr Hutchinson vulnerable to intimidation. There is no further information available about this which may explain Mr Hutchinson's motivations.

86. Ms Parsons also expressed her alarm that after swallowing the balloon, Mr Hutchinson then proceeded to drink so much liquid. The evidence confirms following the visit he obtained some food for dinner, which he took back to his cell and consumed. It is not known whether Mr Hutchinson made any effort to retrieve the balloon that evening from his throat, or whether he was expecting it to pass through him.

87. Mr Hutchinson asked Ms Parsons to bring drugs into prison for him. It is unknown whether this was for his own use (he had a history of drug use, including amphetamines) or for trafficking purposes. He took a deliberate and calculated risk and unfortunately and tragically the risk associated with ingesting drugs was realised.

88. PPP and Corrections Victoria have been able to use this tragedy as an opportunity to strengthen procedures to mitigate against the transfer of contraband into prisons through contact visits.

89. The cooperation of Ms Parsons has assisted with this in light of her frank and candid detail of how she brought the drugs in and transferred them to Mr Hutchinson.

90. The OCSR report noted that 'there has been a significant increase in prisoners testing positive to amphetamines this has more than doubled from 2013/14 to 2014/15, which is greater than the prison's rate of population growth.'[36]

91. The public interest outcome of the coronial investigation is to reduce preventable deaths. The outcome of the tragic death of Mr Hutchinson whilst on remand is to potentially prevent the introduction of drugs into prison in the future.

Finding

92. I find that Cain Hutchinson died from 1(a) Methylamphetamine Toxicity on 7 June 2015 at Port Phillip Prison, Dohertys Road, Truganina, Victoria in circumstances where the balloon containing methylamphetamine that he had ingested the previous afternoon burst and its contents leaked into his gastrointestinal tract.

[36] Coronial Brief, volume 1, p167.

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

Ms Jaymi Lee Parsons

Mrs Beverly Hutchinson

Mr Keith Hutchinson

Ms Jo-Ann Payne

DSC Karina Prodan, Coroner's Investigator

Ms Ingrid Nunnink, Marsh Maher Lawyers for GS4 Custodial Services P/L

Ms Joanne Herbert, St Vincent's Hospital

Ms Emma Catford, OCSR

Signature:

CAITLIN ENGLISH
CORONER
Date: 20 December 2016

GREGORY MCNAMARA
CORONER
Date: 11 January 2017