IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 3888

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

(Amended pursuant to section 76 of the *Coroner's Act 2008* as at 19 February 2020)*

Deceased:	**GARY HIETANEN**
Findings of:	**CORONER DARREN J BRACKEN**
Delivered on:	23 December 2020
Delivered at:	Coroners Court of Victoria Kavanagh Street, Southbank
Hearing date:	20 to 23 August 2019
Appearances:	Ms N. Hodgson appeared on behalf of St Vincent's Correctional Health Services and St Vincent's Hospital Mr R. Harper appeared on behalf of G4S Ms V. Katotas appeared on behalf of Ms J. Camilleri
Counsel assisting the Coroner:	Mr King Taylor

*Refer to Schedule of Correction of Errors at page 38.

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HIS HONOUR:

BACKGROUND

1. On 8 August 2017 Mr Gary Hietanen was 45 years old when he was found in his cell in the Borrowdale Unit of Port Phillip Prison ("**the Prison**") after having passed away.[1] Mr Hietanen had entered custody at the Melbourne Assessment Prison on 3 February 2011 after having been convicted of manslaughter and sentenced to 10 years imprisonment with a non-parole period of seven years; this term of imprisonment was Mr Hietanen's first.

2. Mr Hietanen was a Muslim Indigenous Australian with a long-time partner with whom he had one son, who himself had two children, both of whom were born while Mr Hietanen was in gaol.

3. The Borrowdale Unit of the Prison is a 'security unit' used to accommodate prisoners who are security risks or like Mr Hietanen, prisoners against whom threats had been made.[2]

4. The Prison is operated by G4S Custodial Services Pty Ltd ("**G4S**"). St. Vincent's Hospital provides medical services to prisoners on site at the Prison via St. Vincent's Correctional Health ("**SVCH**") and at St. Vincent's Hospital Melbourne in Fitzroy via a security ward, St. Augustine's ("**SVHM**").

5. The Victorian correctional system, including G4S, utilises a series of 'alerts' allocated to prisoners to signify assessments undertaken by custodial staff in relation to the prisoners';

   (a) propensity for violence (V rating),

   (b) placement considering the prisoner's vulnerability to imposition by other prisoners (T rating),

   (c) psychiatric condition (P rating),

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[1] Port Phillip Prison is a maximum-security male prison privately operated by G4S Custodial Services Pty Ltd under contract to the Department of Justice and Regulation.

[2] JARO report: Review into the death of Mr Gary Hietanen at Port Philip Prison on 8 August 2017 dated 20 April 2018 p24 of 30; CB.

(d) medical condition (M rating),

(e) security status, taking into classification[3] (A1, A2, B rating); and

(f) suicide and self-harm rating (S rating).

6. At time of his death Mr Hietanen was rated;

(a) V3 acknowledging his history of significant violence,

(b) P3 acknowledging that his psychiatric state was stable but required regular or ongoing treatment; and

(c) M2 acknowledging that his medical condition required regular or ongoing treatment.

7. At the time of his death, Mr Hietanen did not have a 'suicide / self-harm' rating the absence of which indicated that prison authorities held no concerns that he may seek to harm himself.

8. Shortly before his death, Mr Hietanen's security rating was reduced from A2 to B; he was to be transferred to Loddon Prison, a medium security prison, on 9 August 2017 in anticipation of release on or about 24 January 2018.

9. Mr Hietanen had a long history of illicit drug use and of improperly using prescription medication, both medication which had been prescribed for him and which he had obtained from other prisoners. Mr Hietanen had admitted to hoarding prescribed medication so that he could take a bigger than prescribed dose and experience an increased effect.[4]

10. From time to time throughout his time in custody[5] Mr Hietanen was allocated a 'Identified Drug User' (**IDU**) status connoting involvement in drug or alcohol related offences or incidents in prison. The conferral of such a status results in a prisoner being searched more often, screened more often for drugs and his contact visits being limited.

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[3] Classification is the process of determining the level of security for the prisoner. Prisoners will be placed in accommodation or correctional facility which serves that classification.

[4] Exhibit 2 and T.8.

[5] For a total of three years during the time he spent in prison.

Such prisoners are also actively encouraged to participate in reviews to discuss their drug or alcohol treatment with a view to minimising the harm that their substance abuse may cause. On 2 April 2015, Mr Hietanen was accorded IDU status 3BR[6] which remained current until the week before his death when it was altered to 'neutral' as a result of Mr Hietanen not having been involved with further illicit use of drugs;[7] it remained at that level until 8 August 2017.

11. Mr Hietanen had an extensive medical history including asthma, high blood pressure, hepatitis C, gastric reflux, constipation, poly substance abuse and he was a heavy smoker. He was prescribed a long list of medications to deal with his complex health issues including anti-depressants, anti-coagulants, pain relief and blood pressure medication. When he died Mr Hietanen weighed 135 kilograms and had a BMI of 40.3 that placed him in the morbidly obese category.

12. On 8 August 2017, Mr Hietanen was found in his single cell by prison staff conducting the morning muster after having passed away.

THE PURPOSE OF A CORONIAL INVESTIGATION

13. Mr Hietanen's death constituted a '*reportable death*' pursuant to section 4 *Coroners Act* 2008 (Vic) (**the Act**); his death occurred in Victoria and was one or more of unexpected or unnatural. Further, Mr Hietanen was a person under the care control or custody of the Secretary to the Department of Justice[8] and pursuant to section 52(2) of the *Coroners Act* (2008) because Mr Hietanen was in custody when he died, an inquest is mandatory.

14. The Act requires a Coroner to investigate reportable deaths such as Mr Hietanen's and, if possible, to find:

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[6] The 3 in 3BR is irrelevant for these purposes. The B signifies that the prison had been involved in minor trafficking offences involving small amounts of drugs, possession of non-prescribed or illicit drugs (other than cannabis), consuming alcohol or a drug of dependence (other than cannabis) and refusing to submit to or interfering with drug testing. The R signifies a review of the prisoners who had committed B offences and the reintroduction of contact visits and an eligibility to access the Drug-Free Incentive Program (**DFIP**).

[7] T.535.

[8] Section 4, *Coroners Act 2008.*

(a) The identity of the deceased;

(b) The cause of the death; and

(c) The circumstances in which the death occurred.[9]

15. For coronial purposes, "*circumstances in which the death occurred*"[10] refers to the context and background of the death including the surrounding circumstances. Rather than being a consideration of all the circumstances which might form part of a narrative, culminating in the death, required findings in relation to circumstances are limited to those circumstances which are sufficiently proximate to be considered relevant to the death.

16. The Coroner's role is to establish fact, rather than to attribute or apportion blame for the death.[11] It is not the coroner's role to determine criminal or civil liability[12] nor to determine disciplinary matters.

17. One of the broader purposes of coronial investigations is to reduce the number of preventable deaths in the community and Coroners may:

(a) Report to the Attorney-General on a death;[13]

(b) Comment on any matter connected with the death including matters of public health or safety and the administration of justice;[14] and

(c) Make recommendations to any minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[15]

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[9] See Coroners Act 2008 (Vic) preamble; s 67

[10] *Coroners Act 2008* (Vic) s 67(l)(c).

[11] *Keown v Khan* [1999) 1 VR 16.

[12] *Coroners Act 2008* (Vic) s 69(1).

[13] *Coroners Act 2008* (Vic) s 72(1).

[14] *Coroners Act 2008* (Vic) s 67(3).

[15] *Coroners Act 2008* (Vic) s 72(2).

18. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities applying the principles of such proof set out by the Chief Justice in *Briginshaw v Briginshaw*.[16] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[17] Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the finding, and effect.[18]

19. Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[19] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[20] Such a description should interpreted in the context of the coronial jurisdiction being inquisitorial and having nothing to do with guilt or innocence.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased - section 67(1)(a) of the Coroners Act 2008

20. On 8 August 2017 Ms F, Custodial Officer at the Prison identified the deceased as Mr Gary Hietanen.

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[16] (1938) 60 CLR 336, pp. 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte; Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 9, 95.

[17] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd. Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pl 70- 171 per Mason CJ, Brennan, Deane and Gaudron JJ.

[18] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams*(1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.

[19] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.

[20] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pl 70-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

21. Mr Hietanen's identity is not in dispute and requires no further investigation.

Cause of death - Section 67(1)(b) of the Act

22. On 10 August 2017 Dr Gregory Young, Forensic Pathologist practicing at the Victorian Institute of Forensic Medicine, performed an autopsy upon Mr Hietanen's body. Dr Young provided a written report in which he opined that the cause of Mr Hietanen's death was "*1 (a) Combined drug toxicity*".[21] I accept Dr Young's opinion.

THE INVESTIGATION, THE INQUEST & CONTROVERSIES

The Investigation

23. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[22]

24. I conducted an inquest into Mr Hietanen's death on 20 March 2019 and between 28 August 2019 and 23 August 2019, during which, 12 witnesses gave evidence, 29 exhibits and the balance of the Inquest Brief were tendered. The court received written submissions on behalf of G4S, SVHM, SVCH[23] and Mr Hietanen's partner, Ms Camilleri,[24] as well as submissions from G4S in reply to Ms Camilleri's submissions and from SVHM in reply to G4S submissions.

25. The submissions explicitly and implicitly concede that many of the facts surrounding Mr Hietanen's death are uncontroversial, including those surrounding his incarceration and the time and date he was found having passed away. Ms Camilleri, G4S and SVHM nominated as issues of controversy as;

    (a) SVCH and SVHM sharing prisoner health information with G4S,

    (b) A safe and efficient method of dispensing medication in Borrowdale Unit; and

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[21] Medical Examination Report of Dr Gregory Young dated 9 November 2017; Coronial Brief p. 76-88.

[22] Section 89(4) *Coroners Act 2008.*

[23] St. Vincents Hospital Melbourne ("SVHM") and St. Vincent's Correctional Health ("SVCH").

[24] Mr Hietanen's partner.

(c) Evening lockdown procedure at the Prison – observance of positive signs of life and well-being of each prisoner incorporating the 'toast run' and what constituted a verbal response.

The Inquest and Controversies

(a) SVCH, SVHM Sharing Prisoner Health Information with G4S

26. Ms Camilleri's submissions that at the time of Mr Hietanen's death that there was no policy in place between G4S and SVHM in relation to them sharing prisoners' medical information [25] is not strictly accurate, although that which was in place was inadequate and, in relation to Mr Hietanen's last visit to SVHM and return to the Prison not strictly followed.

The 2015 Policy

27. As at August 2017 the process that the triumvirate of SVHM, SVCH and G4S, employed to facilitate appropriate sharing of medical information, was set out in a policy document headed "*St. Vincent's Hospital Melbourne – Communication Between Health Service and Correctional Provider / Clinical Services* " ("**the 2015 Policy**").[26] The 2015 Policy contemplates SVCH 'having access to prisoners' medical files', SVHM "*Discharge Summaries*"[27] and "*St. Vincent's Correctional Health Service Returning Form St. Augustine's Mental State and Risk Assessment*"[28] form ("**Returning Form**").

28. Prior to a prisoner being returned to the Prison any Discharge Summary and the Returning Form were to be completed by SVHM staff, accompany the prisoner back to the Prison and become a part of the prisoner's medical history. G4S staff did and do not have access to prisoners' medical histories.

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[25] "*Closing Submissions of Ms Camilleri*" [13]. Correctional provider in this case is G4S.

[26] Attachment to Exhibit 23. This document purports to have been last reviewed in July 2015.

[27] CB Pp. 191-199.

[28] CB Pp. 316-320.

SVCHS staff did and do have access to prisoners' medical history (including any Discharge Summaries and Returning Forms) from which they were required to complete a form known as the, "*Prisoner Health Information Form*" setting out the prisoner health information that SVCHS staff considered relevant to be provided to G4S. Prisoners are asked to sign completed "*Prisoner Health Information Form*[s]" consenting to the information in it being provided to G4S.

29. That principles of privacy and medical confidentiality dictate that not all prisoners' medical information gleaned by St. Vincent's Hospital, whether as SVHM or SVCHS should be passed on to G4S is uncontroversial. That some such information may bear on the secure running of the Prison is also uncontroversial. Careful assessment of information, balancing of rights, obligations and needs is required to decide what of prisoners' medical information should be appropriately passed onto G4S.

30. When Mr Hietanen was discharged from SVHM on 27 July 2017, the Discharge Summary referred to Mr Hietanen having been admitted to hospital because he had saved-up pills, perhaps four or five, and taken them all at once to reach a 'happy state' and to him having done that on a number of previous occasions. Such information according to Mr Vale was information relevant to the security of the prison, including to Mr Hietanen's management, safety and well-being[29] and so should have been included on the Prisoner Health Information Form; it was not.

31. I note that when Mr Hietanen returned to the Prison on 27 July 2017 the practise was that a psychiatric nurse would complete the *Prisoner Health Information Form*; no staff had been specifically trained to complete this form.[30] Mr Hietanen's *Prisoner Health Information Form* was completed by a SVCHS staff member on 27 July 2017, although despite enquiries,[31] the identity of the staff member remains unknown. Mr Hietanen signed the form consenting to its content being provided to G4S staff.[32] The form contained scant information; there was no reference to:

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[29] T.86.

[30] T. 448-449.

[31] Exhibit 22.

[32] Pp.314-315 Vol. II CB.

i. The cause of Mr Hietanen's admission to SVHM on 27 July 2017,

ii. Of him allegedly hoarding his medication and taking doses in excess of that which were prescribed to reach a 'happy state' or

iii. Of him having admitted to having hoarded medication on other occasions; and

iv. Of an unknown mixture having been found in his room.

32. Whilst there is tension between what health information should be provided to G4S and what must remain confidential, I note that the completed "*Prisoner Health Information Form*" could have included the information in the Discharge Summery to which I referred in paragraph 31 above, and Mr Hietanen could have been asked for his consent that this information be provided to G4S. There is no evidence about why this material was not included in the *Prisoner Health Information Form.*

33. Dr Smith, an employee of SVHM, gave evidence that she believed that the information in the Discharge Summary was provided to G4S.[33]

34. When Mr Hietanen returned to the Prison on 27 July he was also reviewed by Dr McLaren, an employee of SVCHS. Dr McLaren read the Discharge Summary from SVHM but didn't pass its contents onto G4S believing that G4S would have already known that information.[34] Further, Dr McLaren considered that the "*Prisoner Health Information Form*" ought to only contain information in relation to a prisoner being violent.[35]

Evidence of Dr Belinda Smith

35. Dr Smith was a visiting medical officer and Director of Physician Training at SVHM. Two written statements made by Dr. Smith were tendered.[36]

36. In her first statement, Dr Smith recounts Mr Hietanen arriving at St. Vincent's Hospital on 21 July 2017 by ambulance from the Prison because prison staff had noticed him to have a reduced level of consciousness, an erratic heart rate and normal blood pressure.

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[33] T.7 -8.

[34] T86-87. 97.

[35] T.64.

[36] Exhibits 1 & 2.

Mr Hietanen underwent an echocardiogram and was reviewed by the cardiac registrar because his troponin levels had 'risen minimally'. Subsequent cardiac monitoring did not raise any concern and Mr Hietanen's gabapentin was recommenced. On 27 July 2017, Mr Hietanen was discharged back to the Prison – with arrangements being made for a psychiatric follow-up, and a thallium stress test[37] to be followed by an appointment in the outpatient clinic at the Prison when the test results were available.

37. Dr Smith was taken to the notes made by the ambulance staff who brought Mr Hietanen to SVHM and the notes by Dr Leader, the doctor who first saw Mr Hietanen in the emergency department.[38] Dr Smith explained that when Mr Hietanen arrived at the hospital, staff had concerns about him having taken an overdose of gabapentin or pregabalin[39] or both.[40] Dr Smith said that:

(a) She first became aware that Mr Hietanen had taken extra gabapentin from Dr Christiansen the overnight registrar.[41]

(b) She spoke to Mr Hietanen and he told her that he had taken 'extra' of his prescribed gabapentin tablets to 'lift his mood', to 'feel good' and that he was shocked that he became unwell because, he said, it was not uncommon for him to self-medicate with Gabapentin to make himself 'feel good'.[42]

(c) Mr Hietanen told her about having taken 'extra' gabapentin or pregabalin, she wasn't sure which.[43]

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[37] Such a test checks how well blood flows into the heart under exercise.

[38] At 12.03am 22 July 2017 CB.204, T.13.

[39] Not a drug that was prescribed to Mr Hietanen.

[40] Both. drugs and any combined effect and perhaps an altered conscious state T.14-15.

[41] T.20. As set out in her statement on CB.63.

[42] CB.63. T 20-21.

[43] T.30-31; Exhibit 2 p.2.

38. Dr Smith was unable to recall which drug Mr Hietanen referred to and was not confident of the contents of the notes. Dr Smith ordered a psychiatric review which did not occur at the hospital and despite an intention that it occur at the Prison neither did it occur there.[44] Mr Hietanen was given a reduced dose of his prescribed gabapentin.[45]

39. Dr Smith gave evidence that she believed that the Prison was aware that Mr Hietanen had taken extra medication in the past.[46]

40. Dr Smith gave evidence that after prisoners are treated at SCVH the hospital prepares a *'Discharge Summary'* to accompany each prisoner back to where-ever they are being held.[47]

41. Despite ambulance notes[48] that Mr Hietanen told ambulance staff that he had taken 600mg of Lyrica, and that he had taken from another prisoner possibly together with extra gabapentin was no reference to that in Mr Hietanen's "*Discharge Summary*" and so was not available to the person at the prison who filled in the *Prisoner Health Information Form.*

42. The *Prisoner Health Information Form,* the process for its completion and the lack of adequate training in its use[49] were reviewed after Mr Hietanen's death, and the "*Communication between Health Service and Correctional Provider / Clinical* Services" policy became the "*Communication of Health Information Between SVCHS and Correctional Services*" policy. The new policy facilitated a greater scope of information being provided to SVCHS and being made available to G4S. This new policy specifically contemplated health information management issues seperately from safety from violence (security) issues and detailed relevant training for those completing associated forms as set out in Mr Vale's[50] and Mr Castle's[51] evidence.

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[44] T.17.

[45] T.18

[46] T.17.

[47] T.6.

[48] Extra Material Tab 3 p.88.

[49] T.458, 468.

[50] Exhibits 22 & 23.

43. Given the evidence of Mr C and Ms F, canvassed below, even if they had been aware of:

    (a) IDU,

    (b) History of hoarding; and

    (c) Diverting of drugs.

    Subsequent trap-to-trap distribution of medication to Mr Hietanen and the 'evening muster' may not have been conducted differently and Mr Hietanen may have died as he did anyway.

(b) Lockdown Procedures and Morning Muster Procedure at the Port Phillip Prison

44. A final muster or 'Lock Down' of all prisoners is performed each day in Borrowdale Unit at the evening lockdown. This usually commences at about 7.30pm. 'Lock Down' is a check to make sure that all prisoners are in their allocated cells and alive; it is considered a 'welfare check',[52] before the Unit is 'locked down' for the night.

45. The staff performing the final count are required to attend each cell and sight the prisoner through the trap and record their presence in the unit on the daily master sheet. In doing so, they are required to pay attention to the prisoner's well-being. The final muster also requires correctional officers to perform other security activities.[53]

46. Prisoners in the Borrowdale Unit spend up to 23 hours of every day alone in their cells. They are allowed out for at least an hour to exercise, generally alone. Any effect of such a draconian regime on prisoners is not within the scope of this inquest, albeit that the regime may have influenced Mr Hietanen's drug abuse. I note that Mr Hietanen was not resident in the Borrowdale Unit because he posed a security risk but was there for his own protection.

47. Correctional officers Mr C and Ms F provided statements[54] and gave viva voce evidence, during which they each described, conducting the 'Lock Down' in the Borrowdale Unit

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[51] Exhibit 26.

[52] T. 542-543.

[53] Volume 2, p45; CB.

[54] Exhibit 6;7;8; 11 and 12.

in the late afternoon / evening on 7 August 2017. Given the regime of the Borrowdale Unit, the need for such 'welfare checks' is obvious. Mr C and Ms F also gave evidence of the method by which medication is dispensed to prisoners in the Borrowdale Unit, and Mr C gave evidence of finding Mr Hietanen in this cell on 8 August 2018 having passed away.

Evidence of Correctional Officer Mr C

48. Mr C provided the court with written statements dated 8 August 2017,[55] 13 October 2017[56] and 19 August 2019.[57] He gave viva voce evidence on 21 August 2019.

49. Prior to his statement dated 19 August 2019 being tendered, Leading Senior Constable Taylor (**LSC Taylor**) asked him whether there was anything that he wanted to change (in his statements) to which Mr C replied:

> *"Um, just um, I've recently recalled that um Mr Hietanen was snoring um when – I did the truck* [sic] *count....yeah the night shutdown, yeah....on the 7th, yes.".*[58]

50. When LSC Taylor asked Mr C about this recent recollection. Mr C told him:

> *"Um, I'll be honest with you, on Monday after speaking with the solicitors, I went back home and my wife was snoring and it just brought back a memory of that and for some reason it triggered – it triggered that in my head".*[59]

51. When cross-examined Mr C agreed with Ms Katotas that he typed his statement dated 8 August 2017:

    (a) On that day when things were freshest in his mind.

    (b) That Mr Hietanen's death was the first death in custody in which he was involved.

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[55] Exhibit 7.

[56] Exhibit 6.

[57] Exhibit 8.

[58] T.152.

[59] T.152.

(c) He was conscious when he typed the statement that it was very important that he record all of the detail that he could possibly remember because there was going to be an investigation and, in all likelihood, he would have to give evidence.

(d) He knew that him discovering Mr Hietanen's death was significant and that an investigation was to ensue.

(e) That the document should contain his best recollection of precisely what went on, on the same date as the event.[60]

52. Ms Katotas asked Mr C about why he didn't include having seen Mr Hietanen breathing in his officer's report of 8 August 2017 as he gave evidence that he had.[61] Mr C gave evidence that he thought that that report was meant to only refer to what occurred on 8 August 2017,[62] that the purpose of the form was to record the events of what occurred on that day.[63]

53. Mr C gave evidence that the statement dated 13 October 2017 was written out for him by police on the basis of what he told them, he initialled each page and signed it and that:

(a) At that time, he was aware that Mr Hietanen's death was a very serious matter being investigated by police.

(b) He was conscious that it was particularly acutely significant that he tell investigating police everything he remembered.

(c) After police had written out the statement, he read it. Mr C seemed to obfuscate when asked if he read it carefully but subsequently agreed that he did.[64]

(d) Police who 'took the statement' asked him if the document was an accurate description of what he had told them.

(e) He was aware that the statement dealt with a very important matter – Mr Hietanen's death in custody.

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[60] T.209.

[61] T152.

[62] T.165.29-166.4.

[63] T234.

[64] T.212.

(f) He was asked to initial each page of the statement and to sign it at the end.

(g) He signed the statement as being accurate.

(h) If there was anything inaccurate, he would have told the police to change it and he would have made sure that they did, but that he didn't then think there was anything he needed to change.[65]

54. Ms Katotas asked Mr C further questions:[66]

> *"...'Sprightly in the mornings'. You don't refer to seeing him breathing in that paragraph? I wasn't asked that question at the time by the police.*
>
> *Well, I'll ask you now, do you remember seeing him breathing or hearing him breathing? Yes.*
>
> *You recall hearing Gary breathing? Hearing him snoring, yes.*
>
> *No, no, that's not my question, I'll get to the snoring. Do you hear Gary, do you hear him breathing on the evening muster on 7 August? Yes.*
>
> *Do you see his stomach moving up and down? Yes.*
>
> *Do you hear him snoring? Yes.*
>
> *You don't mention any of those things in paragraph 8 or indeed of that particular statement taken by the police on 13 October? I didn't realise I needed to be that specific."*[67]

Mr C agreed that the statement does not refer to him hearing or seeing Mr Hietanen breathing or hearing him snoring, and said that this was because he was not asked by the police who 'took the statement' about these issues.[68] Ms Katotas continues:

> *"...You don't think that that was important to tell the police officer? It wasn't questioned at the time.*

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[65] T.212.

[66] Questions asked are underlined.

[67] T164; T165 Underlined sections are questions put to Mr C.

[68] T.164-165.

THE CORONER: That wasn't the question. Answer the question, if you would? Ah, it may have been important to raise that at the time, yes, but I didn't.

....

Now you can answer that question, Mr C? Can I hear the question again please?

Didn't you think it was important that you tell the police that you saw his chest or stomach rising and falling when you spoke to them on the morning of the 8th?

MS KATOTAS: 13th. Well, this statement was taken on 13 October.

THE CORONER: 13th, I'm sorry, yes? I – I didn't think it was important to note it at the time. I didn't realise that – that it would be – that – that it would be that important."[69]

55. Ms Katotas put to Mr C that he was aware[70] that paragraph 8 of this statement of 19 August 2019[71] recounts what he, Mr C said that he saw of Mr Hietanen when he checked him on the evening of 7 August 2017 and that that account makes no reference to him seeing Mr Hietanen breathing to which Mr C replied:

"I didn't realise that I needed to be that specific."[72]

56. Mr C said that the statement dated 19 August 2019 was typed out for him, he made some changes and signed it.[73]

57. Ms Katotas asked if when Mr C saw Mr Hietanen, during the evening muster (on the evening of the 7th), he saw Mr Hietanen's face. Mr C responded:

"I do not recall whether Mr Hietanen spoke to me but I am sure I received some sort of verbal or physical acknowledgement or sign of life (such as chest rising falling, sounds of breathing or snoring or physical movement) from him to complete the welfare check because I would not have moved on otherwise.

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[69] T165.9-T165.28 Underlined sections are questions put to Mr C.

[70] As he was giving evidence.

[71] Exhibit 8.

[72] T164-165.

[73] T.163 & 215.

So he says I am sure I received some sort of verbal or physical acknowledgement. You don't say, do you, that you heard him breathing and snoring. It says sounds of breathing or snoring or physical movement. Do you agree that that's what the statement says? That's what the statement says.

It doesn't say, does it, that on 7 August muster, when you did the welfare check, that you heard him breathing or that you heard him snoring. It says that it was 'or', you either heard or saw him breathing or snoring. It's not a confirmation that you saw or heard him breathing? I wouldn't have moved on had I not received a confirmation of life.

THE CORONER: That wasn't the question. Answer the question please? Could you repeat the question?

MS KATOTAS: The paragraph, and I'll read it to you again, 'I do not recall whether Mr Hietanen spoke to me but I'm sure I received some sort of verbal or physical acknowledgement or sign of life (such as chest rising and falling, sounds of breathing or snoring, or physical movement).' Do you agree that you don't say in that statement that you heard him breathing or you saw him breathing or you heard him snoring, it was I either, I either heard him snoring or breathing. It's an or, it's not an and, do you agree? It could be interpreted that way.

So what is your evidence then now, today, on 21 August 2019?

THE CORONER: Can I just stop you there. Can we go back one step. Have you got paragraph 26 in front of you? Yes.

You don't say in that statement I heard him snoring, do you? No.

Thank you. Nor do you say I heard him breathing, do you*? No."*

Thank you. I'm sorry to interrupt, Ms Katotas.[74]

58. Ms Katotas asked Mr C about his recent recollection of having heard Mr Hietanen snoring of the evening of 7 August 2017.

"...Do you want to alter your evidence at all in relation to your memory? Well I – I had a recollection on, like I said, on Monday night after meeting with the solicitors

[74] T166.9-T167.16 Underlined sections are questions put to Mr C.

and reading the statement. My wife was snoring in bed and it reminded me of that day, that night, that evening when I dropped the trap and did muster. It brought a memory back to me that Mr Hietanen, Gary was on his bed, he was snoring, breathing.

Two years later, two years later, your wife is snoring. Has she not snored in the last two years? She has

Or was Monday the first time in the last time that you heard your wife snoring? No".[75]

59. Mr C agreed that none of his three statements contain any reference to him hearing Mr Hietanen's snoring.[76] Mr C explained the reference in his statement of 19 August 2019 to Mr C being sure that when he checked Mr Hietanen during the 'lock down' he,

> "...*received some* [unspecified] *sort of verbal or physical acknowledgement or sign of life.*"[77]

60. When questioned about the content of his three statements Mr C appeared to obfuscate.[78] He said specifically that he did not know why he didn't include, in his statement of 8 August 2019, any reference to having obtained a positive or in some way some positive sign of life from Mr Hietanen on the evening of 7 August 2017; he agreed that not including it "...*didn't make much sense.*"[79]

61. Mr C acknowledged that he said in his statement of 19 August 2019 that he was sure that on 7 August 2017 he saw some or heard some physical sign of life from Mr Hietanen.[80] When asked about what he saw Mr C said:

> "...*He was snoring. His chest was rising and falling. Or his belly, chest area was rising and falling.*"

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[75] T 167.17-167.29 Underlined sections are questions put to Mr C.

[76] T. 217; Exhibit 8 para. 26.

[77] Exhibit 8 para. 26.

[78] T.215-216.

[79] T.217.

[80] T.217.

That's not what the statement says, though, is it? No, sir.

That's not referred to in any of the other documents that you compiled, is it? No, sir.

Why not? I don't know, sir.

You don't know. Even if – you say that you had seen his chest rising and falling, and you heard him snoring? Yes.

How is it that you were satisfied that that was sufficient as a welfare check? He could easily have been unconscious or under the influence of some drug, couldn't he? I know that now. Um, I didn't at the time. I didn't think that he was under the influence at the time.

So a sign of positive – let me rephrase that – a sign of life that's satisfactory to you was the rising of the chest and the snoring? I thought that he was asleep.

Possibly, yes. It could equally be that, as I say, he was under the effect of some sort of drug or in fact unconscious or dying? I know that now, sir. I didn't at the time.

You didn't think that at the time you needed a little bit more in the way of positive sign of life? I didn't think there was any cause for concern at the time, which is why I...

On the basis of what?... 'Cause he was alive and breathing, sir."[81]

62. Ms Katotas asked Mr C some questions about how he went about looking at Mr Hietanen through 'the trap' and the window of the cell door on the evening of 7 August 2017. Mr C told Ms Katotas that when conducting a 'welfare check' on a prisoner in a cell he believed that he was obliged by prison regulations to obtain a 'verbal response', and that he believed that this was the case on 7 August 2017 because the 'lock-down' was a welfare check.[82] When put to him that he had not given any evidence of having obtained such a verbal response on 7 August 2017, Mr C responded that he had because he:

"heard...the...the prisoner making sounds behind the door."[83]

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[81] T218.2 – 218.27 Underlined sections are questions put to Mr C.

[82] T.180. and T182.

[83] T.180.29-.30.

63. When I asked Mr C further questions about this, explicitly directing him to the issues in the question, he agreed that he did not obtain a 'verbal response'.[84]

64. This response was different from the one he provided to Ms Katotas when she asked him questions about whether he had obtained a verbal response.[85]

65. Mr C described not recalling if Mr Hietanen spoke to him during the 'lock down', but of believing that he saw some sort of verbal of physical acknowledgement because if he had not (seen such a sign), he would not have moved on.[86]

66. Ms Katotas explained to Mr C that on 21 July 2017, Mr Hietanen had been found in his cell and was not able to be awoken by Mr Sullivan, and so Mr Sullivan called the assistance of other officers and went into Mr Hietanen's cell to try to wake him. Mr Sullivan called a 'code black'. Ms Katotas asked Mr C that if he had known of this event on 7 August would he have woken Mr Hietanen during the 'lock down' check. Mr C said "*...possibly yes*".[87]

67. When asked about how he could be sure that his evidence of the recollection he had on 19 August 2018 was of hearing Mr Hietanen snoring on 7 August 2017, Mr C said that he could not be sure that his memory was of Mr Hietanen snoring on 7 August 2017, although he went on to say that the memory triggered was of hearing Mr Hietanen snoring on 7 August 2017.[88]

68. Mr C agreed that his recollection of Mr Hietanen snoring on 7 August 2017 was a very significant event, and when asked about whether he told his solicitors on 20 August 2018 of this recollection, he said that he had didn't because:

    (a) "*...I didn't realise the substantiation of, of that evidence.*"[89]

    Then later,

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[84] T.181.

[85] T180-181.

[86] T.226.4-226.9.

[87] T.185.

[88] T.227-228.

[89] T229.1-.2.

(b) *"I thought it, I thought it was covered in what I had written, which is why I didn't..."*[90]

Then later still,

(c) *"I thought that it was covered in s.26 of my statement."*[91]

69. When asked about whether he had seen Ms F's statement Mr C first said:

"...No, I haven't. I haven't had contact with her"[92]

Then later,

"...No, I haven't. No, she no longer works at Port Phillip Prison."[93]

70. When asked further questions, Mr C said that he had seen Ms F since Mr Hietanen's death. He said that had seen her:

(a) Maybe in February 2019 at a pub in Werribee.

(b) They had never discussed their recollections about what had happened or the statements that they had made.

(c) He did talk to Ms F about the event.[94]

(d) He couldn't recall discussing the events with Ms F.[95]

(e) He saw her at work after Mr Hietanen's death and might have discussed the events with her, albeit that Ms F didn't tell him at any time that she had included in her statement that she had heard Mr Hietanen snoring during the 'lock down' on 7 August 2019.[96]

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[90] T229.4-.5.

[91] T233.6.

[92] T.219-220.

[93] T.220.2-.3.

[94] T.221.20-221.21.

[95] T.221.28.

[96] T223.12-223.15.

(f) He may have spoken to Ms F about the events surrounding Mr Hietanen's death[97] but didn't talk to her about their recollections of events.[98]

(g) He didn't speak to her about the events of the night, nor the content of their statements at work.[99]

71. In his evidence Mr C provided some commentary to the video footage of the 7 August 2017 'Lockdown'[100] during which he described lifting the curtain on the window of Mr Hietanen's cell, unlocking the trap and looking into the cell and knocking on the cell door with the cell key. Mr C says:

> "...[I] *unlock the trap with my key and put my face down to the trap.*
>
> *...And if you see my hand movement there, I – I'm knocking the door with a key to get a response from Gary and then I advise the supervisor F to put him down for toast.*
>
> *So at that stage you were concerned you didn't get a response...I knocked on the door, um...to obviously get a – a better response from him, um, by the look of it, it was obtained and I initiated the toast for Ms F to write down*
>
> *Well having watched the video then, does that - can you explain to His Honour why it is that you appeared to have spent a longer time at Gary's cell door than, say, the other checks you did that evening? Um maybe I was trying to get a – a further response from him um and just to make sure that he was safe for the evening.*
>
> *...Well it's a muscle memory thing. I left the flap, have a look, drop, drop the trap and put my head in. I, I drop the trap on, on all of those counts to ensure that I have a, an interaction with the prisoner behind the door."*[101]

72. On more than one occasion throughout his evidence, Mr C didn't answer the question asked of him unless explicitly re-directed to it.[102] After having seen

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[97] T.229.28.

[98] T.230.5.

[99] T230.14-230.19.

[100] Exhibit 28.

[101] T.207. Underlined sections are questions put to Mr C.

Mr C in the witness box and having heard all his evidence, my impression is that Mr C was an intelligent, thoughtful man who did not always directly answer questions put to him not because he misunderstood them or didn't understand them at all, but rather he preferred to answer another question. Further, I formed the view that some of his evidence was at least implausible. When for example, Mr C was directed to answer Ms Katotas' question about whether he thought it was important to tell police on 13 October 2017 that he had seen Mr Hietanen breathing and snoring, when he conducted the "lock down" on 7 August 2017 – the night before he found him in his cell having passed away, Mr C said that:

> *"I didn't think it was important to note it at the time. I didn't realise that -that it would be – that – it would be that important."*[103]

73. I find it at least very surprising that Mr C made no mention in his Officer's report of 8 August 2017, of allegedly having seen Mr Hietanen breathing when he checked him in his cell on 7 August 2017 (the previous night) because he said that the report only dealt with events of 8 August 2017.[104] His assertion that in his report of 8 August, Mr C didn't refer to having allegedly seen Mr Hietanen alive some 12 hours earlier seems at least odd. This is especially so when Mr C was concerned about the circumstances surrounding Mr Hietanen having been found in his cell having passed away:

> *"...a crime scene and maintaining that crime scene.'.*[105]

74. I take into account that Mr C found discovering Mr Hietanen in his cell having passed away was confronting for him and perhaps all the more so because Mr C said that Mr Hietanen resembled his, Mr C's recently deceased father.[106]

75. I found Mr C's evidence that the day before he gave evidence he remembered hearing Mr Hietanen snoring on a specific night some two years prior and that this memory was

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[102] T149-T234.

[103] T.165.

[104] T.166.

[105] T.189-190.

[106] Exhibit 8 p.2.

triggered by having heard his wife snoring the night before he gave evidence frankly, implausible. His evidence that he definitely did not discuss hearing Mr Hietanen snoring with Ms F was not explicitly supported by Ms F's evidence; she was uncertain about whether she discussed this matter with Mr C.[107] Ms F's reference in her statement of November 2017 to Mr C looking into Mr Hietanen's cell and she hearing Mr Hietanen snoring at least provides some consistency to her evidence that she heard Mr Hietanen snoring on 7 July 2017, albeit that in her statement of 16 August 2019 she refers to '*...believing...*' that she heard Mr Hietanen, said there to be a known loud snorer, snoring. This evidence does not necessarily support Mr C having remembered in 2019 that he heard Mr Hietanen snoring in 2017.

76. I am not satisfied that Mr C heard Mr Hietanen breathing or snoring, or that he saw his chest or stomach moving up and down when he conducted the final count on 7 August 2017. Nor am I satisfied that he, Mr C, "*...received some sort of verbal physical acknowledgement or sign of life (such as chest rising falling, sounds or breathing or snoring or physical acknowledgement*"[108] from Mr Hietanen when he conducted the count on 7 August 2017.

Evidence of Correctional Officer Ms F

77. Officer Ms F provided the court with written statements dated 3 November 2017[109] and 16 August 2019[110] and gave viva voce evidence. She gave evidence that, amongst other things she had not had the opportunity to read, "*...anyone else's statement...*" and that she had not seen the CCTV footage.[111] She gave evidence that she had worked with Mr C at the prison between August 2017 and September 2018, and when she stopped work she did not discuss the evening of 7 August 2017 with him.[112] She later gave

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[107] T.252.

[108] T.166.9-166.27.

[109] Exhibit 11.

[110] Exhibit 12.

[111] T.252.

[112] T.252.16.

evidence that she "*...can't recall if I did*",[113] but that she was concerned about Mr C's welfare because he was distressed about that day.[114]

78. Ms F told LSC Taylor that when police took her second statement on 3 November 2017 they had "*...our reports that I collated from that day...*".[115] She told LSC Taylor that she knew that Mr Hietanen was a drug "*...diverter...who would try to acquire other people's* [drugs]." Ms F gave evidence that she had a memory of the 'trap muster' on 7 August 2017 and of remembering hearing Mr Hietanen snoring from outside the cell when the trap was opened.[116]

79. Ms F gave evidence that she was not aware of a 'code black' having been called in relation to Mr Hietanen in July 2017.[117]

80. Ms F gave evidence that on morning of 8 August 2017, she saw Mr Hietanen "*...pretty much sitting on the bed, legs over the edge, facing the tv area which was the desk.*"[118]

81. Ms F gave evidence that she and Mr C heard Mr Hietanen snoring:[119]

> *THE CORONER: "Just a couple of things, if I may. How did you know that Mr C heard him snoring? We may have spoken about it but, again, I - I can't recall. Again, sir, I - I honestly can't remember.*
>
> *You may have spoken to Mr C about that? We may have, um...*
>
> *Mr C's given us some evidence about having spoken to you on a couple of occasions. One, shortly after this event about welfare issues? Yep.*
>
> *Do you remember that? No, sir.*
>
> *You don't remember that? No.*

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[113] T252.18-.22.

[114] T.252.18-252.22.

[115] T.238-239.

[116] T.239 & T.256-259.

[117] T.242. A 'code black' refers to a death or serious medical event.

[118] T.265.

[119] T.270.10-T.270.12.

He also said that he's seen you at work a number of times after the event before you finished? Yep, yep.

Could it have been during that period when you and he spoke about the snoring issue? Maybe, but again I can't recall 'cause again a lot of things have happened in that time.

Yes. He also mentioned meeting you a couple of times socially in relation to American football at a hotel I think, in was it Werribee or something like that? Yep, yes.

On two occasions? M'hmm.

Could you have spoken to him there about the snoring? No. We don't talk about work outside of work.

But you could have spoken to him at some point in time about the snoring? I could have but I can't 100 per cent guarantee I did.[120]

82. Ms F gave evidence that she spoke to Mr C after he looked into Mr Hietanen's cell and they moved on to the next cell, being satisfied that Mr Hietanen was alive.[121] Ms F was adamant that they would not have moved to the next cell had they not been satisfied that Mr Hietanen was alive, but that she could not remember what the discussion with Mr C was albeit that she agreed that it was something that Mr C told her that allowed her to be satisfied that Mr Hietanen was alive or they would not have moved on,[122] and that the conversation was an important one.[123] Ms F agreed that there was nothing in her "officer's report" about any such conversation because that report only dealt with what occurred on the 8th of August 2017.

83. Ms F agreed that the statement taken on 16 August 2019 was a detailed one and that she was aware when she was making it that it was being taken for the inquest into

[120] T270.12- T271.8 Underlined sections are questions put to Ms F.

[121] T.271.9-T.271.24.

[122] T.272.12-T272.20.

[123] T.273.17-T273.18.

Mr Hietanen's death, a very important issue.[124] She agreed that the statement made on 16 August 2019[125] makes no reference to the conversation that she said that she had with Mr C as they inspected Mr Hietanen on 7 August 2017. Ms F also agreed that her statement taken 3 November 2017[126] makes no reference to that conversation and when asked she could not say why.[127]

84. In answer to questions from Ms Katotas, Ms F said that had she known on 7 August 2017 that on 21 July 2017 Mr Hietanen had been the subject to a 'code black' and he went to hospital as a result of an overdose on medication, she would have done something different on the night of 7 August 2017 and checked on him.[128]

85. When she gave evidence, Ms F had little if any direct memory at all of the events of 7 and 8 August 2017 and, she said, of any discussion she had with Mr C shortly afterward, perhaps unsurprising given that those events were two years earlier. Any subsequent discussion she may have had with Mr C was certainly more recent, albeit her recollection of that or those discussions was at best vague. Her evidence about having moved on to another cell after having checked Mr Hietanen on 7 August 2017 was more consistent with her having believed that she or Mr C had perceived signs of life in Mr Hietanen because they moved on rather than them having actually seen or heard such a sign or signs and so moved on. Mr C's evidence had a similar tenor.

86. Having viewed the video of the cell check of 7 August 2017, Mr C can be seen to be closer to Mr Hietanen's cell and the open trap door, when Ms F says that she heard Mr Hietanen snoring. Absent Mr C having some hearing difficulty, of which there is no evidence, if Mr Hietanen was snoring Mr C may have been able to hear him.

87. The alternative is that Mr Hietanen wasn't snoring, and Ms F was incorrect or mistaken in her statements of November 2017 and August 2019 and so was Mr C in his later triggered memory.

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[124] T.273.3-T.273.13.

[125] Exhibit 12.

[126] Exhibit 11.

[127] T.273.20-T.274.3.

[128] T.278.31-T.279.12.

88. Ms F was asked a number of questions about what if any conversation she had with Mr C after Mr C looked through the window and the trap in the cell door that caused her to believe that Mr C had established that Mr Hietanen was alive. She said nothing about Mr Hietanen asking for 'toast' in the morning or of Mr C telling her to mark Mr Hietanen down for 'toast'.[129]

89. Likewise, Mr C said nothing about Mr Hietanen asking for toast despite being asked a number of times about what led him to believe that he saw Mr Hietanen to be at least alive when he, Mr C looked into the cell on the evening of 7 August.

90. I am unable to form a view about why Mr C unlocked the trap door and looked into Mr Hietanen's cell after having first looked through the window in the door. It is at least possible that it was because he was not satisfied that Mr Hietanen was alive after having looked through the window. Mr C seemed to explain the reason for him opening the trap and looking into the cell was in order to "*...have a, an interaction...*"[130] with Mr Hietanen, but at no point in his evidence does he explain what that interaction was.

91. Having heard Ms F and Mr C give evidence, I am not satisfied that they or either of them heard Mr Hietanen snoring when they checked him on 7 August 2017, nor that Mr C had an 'interaction' with him through the trap door nor am I satisfied that Mr Hietanen asked for toast.[131]

92. On the basis of the evidence, I am unable to say whether Mr Hietanen was alive when Mr C and Ms F checked him during the 'lock down' on 7 August 2017.

(c) Dispensing Drugs to Prisoners in the Borrowdale Unit

93. Mr C described the dispensing of drugs at the Borrowdale Unit as occurring 'trap-to-trap'. This process entails a pharmacy assistant going to the Borrowdale unit and together with a correctional officer, dispensing medication to prisoners whilst the prisoners remain in their cells. At each cell the correctional officer opens the trap door (a small door), a part of the main door of each cell located below the window in the door

[129] T259-261; T271-274.

[130] T207.29.

[131] T180-182.

about waist height from the floor. The pharmacy assistant identifies the prisoner and passes the prisoner's medication through the trap door to the prisoner. The correctional officer watches this and then via the window in the cell door, watches the prisoner take the medication. The prisoner is then asked to open his mouth so that the correctional officer can see (through the window) that the medication was consumed. Evidence is that the officer cannot see the medication all the time from when it is handed to the prisoner through the trap until when it goes into his mouth.[132] Mr C described this process as "*...often not ideal...*".[133] Later in his evidence, Mr C is referred to his statement made on 19 August 2019 and explained that using this process, it is not "*...as easy to conduct observations*".[134]

94. Mr C gave evidence that other methods had been tried, including taking prisoners from their cells to the medical room in Borrowdale or opening the cell doors so that correctional officers can better see prisoners consuming medication. Mr C too referred to methadone that is dispensed only from the medical room.[135]

95. Mr C explained that medication can be dispensed up to three times per day in the Borrowdale Unit.[136] In mainstream units, medication is dispensed to all prisoners from a central point in their unit. Mr C explained that when a prisoner is to take prescribed methadone, he is taken from the cell to the Opioid Substitution Therapy Program Room ("**the medical room**") in the Borrowdale Unit and provided with the medication. Prison officers then stand next to the prisoner and have a clearer view of consumption of the medication.[137]

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[132] T.243-244.

[133] T.158.13.

[134] T.191-192.19.

[135] T.159.

[136] T.159.

[137] T159.

96. Mr C gave evidence that a particular prisoner having an IDU rating would make no difference to the diligence with which he supervised his drug dispensation.[138] Ms F gave evidence to similar effect.[139]

Mr Sellman adopted Mr Castle's statement and in particular, gave evidence that an IDU 3B status would not have changed the way that Mr Hietanen was managed in the Borrowdale Unit, other than the specific effects of the attribution of the IUD 3B status.

97. Mr G, another prison officer gave evidence that dispensation of all medication in Borrowdale could be conducted at the "medical room" window which would allow correctional officers to see the prisoners taking their medication better.[140] Mr G referred to a very limited trial of this alternative method of dispensation having been undertaken[141] but could provide only a very little evidence of the results.

98. Ms. Mizzen, a health services manager for G4S at the Prison, gave evidence of the operation of the trap-to-trap dispensation of medication. She referred to some prisoners receiving medication out of their cells and of G4S giving some consideration to 'trap-to-trap' dispensation of medication:

> "*...ought to be changed permanently but for the reasons set out above which are largely staffing levels, time constraints and commercial issues it was decided not to. Ah in addition to that it was the drug screening as well which didn't show any improvement.*"[142]

99. Other witnesses spoke about trials of medication dispensation by other than trap-to-trap method,[143] one reference was made to a trial over a weekend.[144]

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[138] T.193.

[139] T.245.

[140] T.306.

[141] T.309-310.

[142] T.530.

[143] T502-506; T563-T564.

[144] T504.10-.13.

100. Mr G gave evidence that dispensing medication through the trap in Borrowdale Unit and making sure that it is consumed is quite difficult, and had he known a particular prisoner was hoarding medication he would have paid more attention to making sure that they were taking the drugs provided to them. [145]

101. Dr Joseph, the medical director of St. Vincent's Correctional Health Service agreed that dispensation of medication in Borrowdale Unit through cell door traps is less than perfect and that if medication were dispensed outside the medical room that gaps in supervision of consumption would be less likely. Dr Joseph asserted that a balancing exercise needs to be undertaken between "*...the commercial effects and the management effects...*". Dr. Joseph gives evidence that he does not know if hoarding or overdoses involving Lyrica at the Prison is contributed to by the way that the drug is dispensed.[146] Dr Joseph explained that when prisoners take a number of central nervous system supressing drugs, the combined effect of all the drugs must be carefully considered.[147]

CONCLUSIONS AND FINDINGS

Conclusions

St. Vincent's Hospital Melbourne – St. Vincent's Correctional Health Services & G4S Sharing Health Information.

102. Mr Vale's 'concession' that with 'hind-sight', Dr McLaren should have told G4S staff of Mr Hietanen's history of stockpiling medication, suggests a problem with an individual when the problem with communication was an underlying management and protocol deficit. The problem experienced by Dr McLaren was the lack of an explicit and functioning practice and process whereby SVHM and SVHCS could inform G4S staff of material in a prisoner's medical file that effected the safe operation of the prison. Such an issue is not one that only becomes clear with the benefit of hindsight, but rather a fundamental structural requirement. Dr. McLaren should not have been required to rely

[145] T.343.

[146] T.404-405.

[147] T.405-407.

on 'reasonable expectation' or a 'belief' that G4S staff knew that Mr Hietanen had been subject to the 'Code Black'.[148]

In a similar vein Dr Medis should not have been obliged to rely on what she 'would have believed' or 'assumed' or indeed what she understood was 'usually reported'.[149]

103. The Policy and Procedural changes set out paragraphs 34 – 40 of St. Vincent's written submissions appear to deal with the underlying deficient management and structural problem to which I have referred. Adequacy of such structural change ought to be monitored and audited.

A Safe and Effective Method of Dispensing Medication in the Borrowdale Unit

104. Trap-to-trap distribution in the Borrowdale Unit involves, at the very least, the potential for prisoners to accumulate prescribed drugs. Such conduct is not unknown in the Prison particularly when prisoners believe that a larger than prescribed dose will provide a desirable effect. The danger posed by accumulation of, particularly central nervous system depressants is that a larger than prescribed dose may be fatal.

105. As I have set out G4S staff all gave evidence in notably similar terms, that regardless of a prisoner' having IDU rating, history of hoarding or diverting of drugs, the trap-to-trap medication distribution would not have been conducted any differently. The exception to this was Mr G and Ms F who referred to them possibly acting differently if they had been aware of the 'Code Black' in which Mr Hietanen had been involved in on 21 July.[150] Further still, this position was maintained when questions were put about whether they would have more closely monitored dispensation of medication to Mr Hietanen had they known that he had told medical staff of hoarding medication, and taking doses in excess for an enhanced effect.[151] This is disturbing. Axiomatically prisoners with histories of such conduct may be usefully subjected to heightened scrutiny when drugs are distributed.

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[148]Paragraph 18 Written Submissions by St. Vincent's Hospital.

[149] Paragraphs 22-25 Written Submissions by St. Vincent's Hospital.

[150] T304; T279.

[151] T279.1-12.

106. Such an apparent unwillingness to recognise particular problems with particular prisoners and deal with them is concerning.

The custodial officers' response – to the effect that regardless of the prisoner's history or circumstances supervision of medication, that distribution is at least unhelpful and ignores the difficulties of trap-to-trap medication distribution and the potentially fatal effects of prisoners accumulating drugs, especially central nervous system depressants. Custodial staff should be made aware of prisoners' illicit drug use histories and any proclivities to hoard medication and take those histories and proclivities into account when overseeing medication dispensation.

107. As at 18 August 2017 a large percentage, 75 – 80%[152] of prisoners in the Borrowdale Unit were taking prescribed medication. Evidence at the Inquest was replete with references to drugs being hoarded and diverted by prisoners.[153] Ensuring each prisoner consumes the drugs he is prescribed according to the prescribing doctor's orders is an essential task for custodial management. The effect of failure is at least ill health and possibly death.

108. Dispensation of drugs to prisoners with a history of hoarding medication should be more assiduously supervised and may only be effective if not undertaken 'trap-to-trap'. 'Commercial and management issues' in particular staffing levels of the Borrowdale Unit, must clearly bear on how Borrowdale is run but such issues must be balanced with the dangers posed by hoarding medication.

The 'Lockdown' Process at Borrowdale

109. Mr Hietanen's management may not have been any different had G4S staff known of his drug hoarding history and proclivity, including the 'Code Black' from July 2017 subject to what Ms F,[154] Mr G[155] and Mr C[156] said. Such knowledge should have made a difference to his management.

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[152] T.308.

[153] T.8; T404-405; T291.

[154] T.278.31-T.279.12

[155] T304; T279

Instructions to staff undertaking lock-down in the Borrowdale Unit would usefully be reiterated specifically required a spoken response from each and every prisoner. Such reiteration may be as simple as clarifying the obvious; a verbal response is a spoken one and not snoring nor hearing breathing.

Findings

110. Pursuant to section 67(1) of the *Coroners Act 2008* find that:

(a) The identity of the deceased was Gary Hietanen born 4 May 1972.

(b) Mr Hietanen's death occurred on 8 August 2017 in the Borrowdale Unit of Port Philip Prison 451 Dohertys Road Truganina, Victoria 3029 from combined drug toxicity.

(c) In the circumstances set out in paragraphs 103-109 above.

111. Having considered all the circumstances I am satisfied that Mr Hietanen's death was the inadvertent result of him intentionally ingesting a number of drugs including methadone, amitriptyline, gabapentin and paracetamol.

RECOMMENDATIONS

112. Pursuant to section 72(2) *Coroners Act 2008)* I recommend that:

1. G4S commission independent research into the safest efficient way to dispense medication to prisoners in the Borrowdale Unit of Port Phillip Prison incorporating consideration of:

   a) 'Trap-to-trap' dispensation and alternatives including but not limited opening cell doors to dispense medication,

   b) Dispensing medication directly to prisoners form a central point in the Unit; and

[156] T.185.

c) Whether different dispensation methods ought to be used for different prisoners taking into account the nature of the medication being dispensed and each prisoner's history of medication and drug use and abuse.

2. G4S reiterate to staff undertaking the 'lock-down' of the Borrowdale Unit that a verbal, spoken response must be obtained from each and every prisoner. If such a response is not forthcoming from an enquiry made through the 'trap', the cell door is to be opened and a verbal response then obtained from the prisoner.

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

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

(a) Ms Joanne Camilleri, senior next of kin;

(b) Ms Jan Seaton, mother of the deceased;

(c) Mr Hugh Middleton, Martin & Richard Lawyers;

(d) Ms Michelle Gavin, Justice Assurance Review Office;

(e) Ms Trish Sellman, General Manager Port Phillip Prison;

(f) Ms Deborah Coombs, Victorian Government Solicitor's Office;

(g) Ms Ingrid Nunnink, Marsh & Maher Richmond Bennison,

(h) Mr Mark O'Sullivan, Minter Ellison; and

(i) Detective Leading Senior Constable Frank Fierro, Coroner's Investigator, Victoria Police.

Signature:

DARREN J BRACKEN

CORONER

Date: 2 March 2021.

SCHEDULE OF CORRECTION OF ERRORS

Paragraph 22, which read:

"On 10 August 2017 Dr Gregory Young, Forensic Pathologist practicing at the Victorian Institute of Forensic Medicine, performed an autopsy upon Mr Hietanen's body. Dr Young provided a written report in which he opined that the cause of Mr Hietanen's death was "Mixed drug toxicity (heroin, alcohol, diazepam)". I accept Dr Young's opinion" has been changed to read:

"On 10 August 2017 Dr Gregory Young, Forensic Pathologist practicing at the Victorian Institute of Forensic Medicine, performed an autopsy upon Mr Hietanen's body. Dr Young provided a written report in which he opined that the cause of Mr Hietanen's death was "1 (a) Combined drug toxicity". I accept Dr Young's opinion."

Paragraph 22; footnote 21 which read:

"*Medical Examination Report of Dr Melissa Baker dated 16 January 2018; Coronial Brief p 177"* has been changed to read:

"*Medical Examination Report of Dr Gregory Young dated 9 November 2017; Coronial Brief p 76-88"*