

CITATION: *Inquest into the death of Christopher Mark Malyschko*  
[2020] NTLC 003

TITLE OF COURT: Coroners Court

JURISDICTION: Darwin

FILE NO(s): D0136/2019

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HEARING DATE(s): 9, 10, 11 November 2020

FINDING OF: Judge Greg Cavanagh

**CATCHWORDS:** **Death in custody while under influence of synthetic cannabis ‘Kronic’, failure to adequately respond to ‘Kronic’ by prison management, death contributed to by boredom, failure of educational and entertainment system in new prison, not remedied after 6 years**

**REPRESENTATION:**

Counsel Assisting: Kelvin Currie  
Counsel for Police: Peter Bellach  
Counsel for Corrections: Helena Blundell

Judgment category classification: A  
Judgement ID number: [2020] NTLC 003  
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IN THE CORONERS COURT  
AT DARWIN IN THE NORTHERN  
TERRITORY OF AUSTRALIA

No. D0136/2019

In the matter of an Inquest into the death of

**CHRISTOPHER MARK MALYSCHKO**

**ON: 19 - 20 August 2019**

**AT: Cell 8, Block 7-E-1, Holtze  
Correctional Facility**

**FINDINGS**

Judge Greg Cavanagh

**Introduction**

1. The deceased, Christopher Malyschko (Chris) was born 3 October 1987 in Adelaide to Bronwyn Buttery and David Malyschko. He had one younger brother, Matthew and two siblings through his father's previous marriage. His parents separated in 1992. He stayed with his mother in South Australia until she moved to the Northern Territory, in 2007. His brother lived with his father.
2. By 2011 his mother had entered into a relationship with Mr Raffaeli (Ray) Niceforo and purchased the Waterworks Laundry business in Katherine. However, the relationship with Mr Niceforo deteriorated. When Chris moved to Katherine one of his objectives was to assist his mother to leave the relationship. He arrived in February 2011. He was 23 years of age.

3. On 2 June 2011 Chris and his mother obtained a full non-contact domestic violence order against Mr Niceforo. It is said that Mr Niceforo made threats to Chris's mother that he might kill Chris. He is said to have continually breached the order.
4. His mother provided to Chris \$15,000 to obtain assistance from two others with a view to killing Mr Niceforo. One of those was Zak Grieve (Zak), a friend of Chris and the other, Darren Halfpenny (Darren) who was known to Zak. On the evening of 24 October 2011, Zak said he couldn't go through with the killing and went home. Chris and Darren went to the unit of Mr Niceforo, killed him and then dumped his body in a ditch about 12 kilometres out of Katherine on Gorge Road.
5. Chris, Zak and Darren were arrested on 27 October 2011. Chris's mother was arrested a month later. She was convicted of manslaughter and the three men of murder. Chris was imprisoned for life with a non-parole period of 18 years (backdated to 27 October 2011). The other two received non-parole periods of 20 years. Chris was due for parole on 27 October 2029.
6. In sentencing Zak (who was not present when Mr Niceforo was killed), the judge indicated that he considered a non-parole period of 12 years appropriate, however due to the mandatory sentencing regime was obliged to sentence him to a non-parole period of 20 years. On 19 December 2018 Zak had his non-parole period reduced to 12 years imprisonment by the Administrator of the Northern Territory exercising the prerogative of mercy. His non-parole period expires on 27 October 2023.
7. In prison, Chris and Zak remained good friends. Although they were not always in the same block or sector, they looked out for each other. Initially they had problems fitting in. Zak said they were both attacked and bashed.<sup>1</sup> He attributed much of that to Chris being Caucasian in a primarily

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<sup>1</sup> Grieve 1 p 4

Aboriginal prison population. Zak said he was also attacked. He is of Aboriginal heritage but Caucasian in appearance. However he said his Aboriginal language and culture was of assistance. He said:

“I’ve been mobbed, I’ve been bashed, I’ve been attacked same as him. He was 29 and 0, that’s how many losses he had.”<sup>2</sup>

8. On two occasions, assaults on Chris were reflected in prison reports:
  - a. On 20 January 2012 he was noted to have visible signs of assault. When asked what happened he said, “I fell in the shower boss”.
  - b. On 18 July 2016 he was assaulted in the bathroom by two other inmates. Much of it was captured on CCTV. It appeared to follow dissatisfaction by a prisoner with his meal.<sup>3</sup> Chris said there was no assault. He refused protection, to be rehoused, or police involvement. He said the facial and head injuries were from playing football. However the next month he was moved to low security.
9. Until sentencing Chris had been a high security prisoner in Block C. On 10 January 2013 his security rating was downgraded to ‘medium’. He was transferred from the Berrimah Correctional Centre to the Darwin Correctional Centre at Holtze on 27 November 2014. On 19 August 2016 his security rating was changed to ‘Low 1’. From that time he was housed in Sector 7. Zak got a Low security rating on 4 January 2018. On 30 March 2018 Chris and Zak were moved into block 7-E-1, a block set up for the ‘lifers’ so they didn’t have to endure constant new faces coming and going.
10. The block had two wings and a communal area with kitchen, dining and television areas. Each wing had its own bathroom facilities. The cells were utilised as single cells.

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<sup>2</sup> Grieve 1 p 4

<sup>3</sup> Chris worked in the kitchen preparing the special diet meals.

11. Zak said:

“We were actually quite good. I’d got my low security rating. I went to sector 7. We moved into the same unit and it was good just to be around family again, like someone that when you knock on their door at 9 o’clock at night you find them sitting in their room with a jar of cookies, that’s how Chris was.”

12. They were in cells 11 and 12 and on 30 July 2019 they changed to cells 8 and 9. Zak said there had been no issues with assaults in the last year. From his point of view the main problem was boredom. Chris worked in the kitchen and he worked in education, the rest of the time was, “mundane”. Chris read a lot. He enjoyed science fiction and liked to listen to heavy metal music.

13. From 27 September 2013 Chris was generally employed in the kitchen. From 5 September 2018 to 12 August 2019 he worked as a librarian. But on 12 August 2019 he moved back to the kitchen. His prison case reports noted him to be of excellent behaviour, having a positive work ethic and being a role model to others.

14. Chris had been attempting to get fit and lose weight. In the afternoons after work he would generally power walk around sector 7 with Mr Shane Thomas (Shane). After lockdown they spent another hour, boxing (which they did by hitting toilet rolls in socks), sit ups and other core exercises. Chris had lost 15 kilograms. After they trained they then ate the meals received at lockdown.

15. Chris and Zak both smoked Kronic whenever they could. Of Chris, Zak said:

“He had no way to take out his stress. He had no options to go and do anything at night like it was either watch TV or read the same books that he had in his cell for the thousandth time ...so me and Chris used to smoke Kronic ... we’d get high some nights [sometimes for] a whole month straight ... We had a rule, ‘go hard or go home’. There

was nothing more that we could have done or enjoyed more than going to get high.”<sup>4</sup>

16. They had both smoked cannabis prior to prison and while in the Berrimah Correctional Centre. However after the move to the new prison at Holtze, Kronic was cheaper and had more “bang for buck” and was said to be “readily accessible”.<sup>5</sup>
17. Chris was known as ‘Bumbles’ due to a tattoo of a VW Beetle on his shoulder from the Transformers cartoon (named Bumblebee). It is said that on seven or eight occasions he smoked Kronic until paralytic. At such times Zak referred to him as, “A pile of bumbles”. Chris was never violent and did not exhibit sexualised behaviours while under the influence of Kronic.
18. Kronic was known on occasion to make the user vomit. Because of that, on the evenings they smoked they generally skipped dinner. They prepared a place to spit, and water to wash out the “disgusting” taste. They played their favourite music. If Chris was a “pile of bumbles”, Zak put him into the recovery position.<sup>6</sup>
19. On Monday, 12 August 2019 Zak and Chris smoked Kronic together. That night they put on music, they got high and Chris fell asleep.
20. On Friday, 16 August 2019, Zak’s security rating was revised back to ‘medium’ and he was moved out of Sector 7. On his story he made an inappropriate comment to a Corrections Officer. Chris was at work at the time. When he got back from the kitchen that day and saw Zak with his belongings on the trolley, he held his arms up in despair.
21. On Monday, 19 August 2019, Chris got his evening meal and the block was locked down as per usual at about 6.00pm. He did not train with Shane that

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<sup>4</sup> Grieve 1 p 9 - 11

<sup>5</sup> Grieve 1 p 30

<sup>6</sup> Grieve 1 p 13, 19, Grieve 2 p 4

evening because his towel (he used as a mat for sit ups) had gone missing and Shane's iPod (music to which they trained) was being charged at the officer's station. He went back to his room to eat.<sup>7</sup> He was seen by another inmate, Mr Phu Trinh (Phu) at about 8.10pm. He was said to have been in good spirits.

22. In the mornings the early workers would be let out of the block to go to their workplaces. Chris was one of those workers. There were normally three in his block that worked from 6.00am and they would wait in the kitchen of the block for the door to be unlocked. On the Tuesday morning Chris was not seen. It was thought he had slept in.
23. At about 7.45am it was time to get ready for muster. Phu had taken it upon himself to ensure the prisoners in his wing were ready for muster each morning. He knocked on Chris's door. There was no response. He continued to knock. Eventually, the door handle was tried but the door was locked. There was a towel over the door window for privacy and to keep out the light from the bathroom that was across the hallway. The towel was folded and part of it was over the top of the door, the rest hung down the inside. It was firmly wedged at the top of the door. Phu and Shane pulled on the towel so as to raise it on the inside. When it was raised a little they could see Chris lying, face down and motionless on the floor. Shane went to the open air cage area to alert officers that had entered the sector to start unlocking for muster. It was 7.50am.
24. Officers came and unlocked the outside door at 7.51am. A Code Blue was called immediately on entering the block. An officer ran from the block to get a defibrillator returning a minute later. The cell door was unlocked and Shane went into the cell. Shane saw Chris was blue. He put his hand on his

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<sup>7</sup> Horrell p3

leg to turn him over and realised rigor mortis had already set in. He left immediately telling the officers “he’s gone”.

25. Three officers went into the cell. They found Chris lying on his left side with his left arm underneath his body. His right arm was extended in front of him and his head was resting on his chest. They confirmed that rigor mortis had set in. They found him to be cold and stiff. Nevertheless they thought they should commence CPR, but were unable to turn him over.
26. Members from the immediate action team (IAT) arrived at 7.54am. They were considering what to do when a nurse arrived at 7.55am. He found the body to be “freezing”. He told the corrections officers there was nothing they could do. Chris was clearly deceased. The forensic pathologist provided advice that his body being ‘cold and stiff’ indicated the interval from death was a minimum of eight hours.<sup>8</sup>
27. The Ambulance arrived at about 8.20am. There was nothing they could do. They described him as being cool to the touch with ‘dependent lividity’.
28. The Crime Scene Examiner, Senior Constable Tim Sandry arrived at 9.17am, examined the cell and took photographs. He found nothing suspicious within the cell.
29. The Major Crime Squad arrived at 9.43am. The cell was searched. Various implements used to smoke synthetic cannabis were found sitting on the desk and in the shelving storage area of the cell. They were seized along with a small quantity of what was presumed to be synthetic cannabis.
30. An autopsy was conducted, by Forensic Pathologist, Dr Marianne Tiemensma, Director of Forensic Pathology at the Royal Darwin Hospital. She provided the opinion that Chris died from positional asphyxia due to synthetic cannabis use and obesity. Toxicological analysis found the

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<sup>8</sup> Email from Marianne Tiemensma dated 28 October 2020



synthetic cannabinoid, Cumyl-Pegaclone ('Kronic') in his blood and from analysis of his hair (showing more prolonged use).

31. There were however two aspects found at autopsy that were of some concern. Fresh bruising in two places and fresh anal lacerations and blood on his buttocks. Dr Tiemensma provided a description of the bruising in these terms:
  - a. Deep bruise to the right antero-superior area of the chest, over the 2<sup>nd</sup> rib.
  - b. Two bruises (one fresh, one apparently older) below the umbilicus [belly button] with some contusion of the small intestines underlying the bruise.
32. Toxicological analysis showed:
  - o CUMYL-PEGACLONE in the iliac vein blood and liver.
  - o 5F-CUMYL-P7AICA and 5F- CUMYL-PEGACLONE in the pubic hair.
33. Initially there were a number of hypotheses as to the circumstances in which those injuries were acquired. Prisons are places where non-consensual sex might be thought consistent with such injuries.
34. There was also evidence that Chris had problems with defecating and one of the theories was that the anal lacerations were from hard stools. However Dr Tiemensma did not find that to be the case at the time of his death. The large intestines contained soft faecal matter. There was evidence of lubricant and talc on his anal skin.
35. Dr Tiemensma stated:

The fresh anal lacerations, were in my opinion, a result of blunt force anal penetration, with possible explanations (in order of likelihood) the following:

- a. Self-inflicted injuries, either during a process of “body pushing”, i.e. insertion of illegal substances in anus/rectum in an effort to conceal the items, or possibly masturbation.
  - b. Sexual activity involving another party, whether consensual or not.
36. However, there were a number of factors that made the second possibility unlikely. For instance, those that lived in the block with him were adamant that Chris was “straight”. Chris was a fairly big and strong man. Even after losing 15 kilograms he was still about 130 kilograms. He had no defensive or restraint injuries. Nor did swabs taken at autopsy provide evidence of semen or DNA from another person.
37. As to the preferred option of Dr Tiemensma (‘body pushing’), there was a finger of a latex glove found at the scene. It was assumed that if it had been used for “body pushing” or “shelving” (as it was called at the prison) there would be traces of faecal matter or blood on it. It was swabbed inside and out, but tested negative to both faecal matter and blood.
38. It was not until the inquest that one of the prisoners explained how the gloves were used. He said items are concealed in one of the fingers of the glove and a knot tied in that finger. The knotted finger was then pushed into another finger of the glove. The glove would then be wrapped up and the whole glove inserted into the rectum. When the glove was removed the knotted finger would be separated from the rest of the glove and everything excepting the knotted finger flushed. That suggested that it was unlikely that blood or faecal matter would be found on the ‘finger’ of the glove. The explanation is also consistent with the remainder of the drugs and other paraphernalia found in the cell.
39. The fresh bruises are a little more difficult to explain. The forensic pathologist provided the opinion that to inflict them there would need to be moderate force. The other prisoners in the block were sure that the bruises

were not inflicted by any other person. The evidence was to the effect that whether in their block or elsewhere in the prison, they would have heard about an assault. Moreover, their block was known to have no issues and all of the occupants were described by the prison authorities as being model prisoners. I called four of those prisoners to provide evidence at the inquest. They were good witnesses and were visibly saddened in recalling the events surrounding his passing. I accept their evidence.

40. There was some furniture in the cell and it is possible that in falling he had made contact with part of the desk or the chair or perhaps it was not the first time he fell that evening. The prisoners explained that often when a person smoked Kronic they became 'stuck'. That was the expression used in the prison. In effect, after smoking Kronic a person might become physically immobilised in a position. That is certainly likely to have happened to Chris before he fell to the floor and likely contributed to him being unable to move to take the weight off his lungs as he lay face down.

## **Issues**

### *Kronic*

41. Kronic is a variety of synthetic cannabis. It is known to be dangerous as are all varieties of synthetic cannabis. They consist of chemicals sprayed onto non-psychoactive vegetable matter (leaves and the like), that is then smoked similarly to cannabis. The chemicals are changed from time to time to circumvent the developing law. It has often been sold as a 'herbal high'. It metabolises quickly in the body and is believed to be used by workers in industries where drug testing is regularly undertaken.
42. Because the various chemicals used are not subject (so far as anyone is aware) to human testing prior to distribution, they can be dangerous. The Alcohol and Drug Foundation information states:

“There is no safe way to use synthetic cannabis ... the effects of synthetic cannabinoids are unpredictable and are more dangerous than plant-derived cannabis.”

43. In the Northern Territory synthetic cannabis was first sought to be made illegal in August 2011. There have been various warnings about the dangers of using it since including stories carried in the local media in 2015 and 2017 about significant numbers of users being hospitalised.
44. On 22 March 2018 Western Australian Coroner Linton delivered findings from an inquest held to warn of the dangers and lethality of synthetic cannabis.<sup>9</sup>
45. It was not until 6 April 2020 the Government Gazette provided notice that pursuant to the *Medicines, Poisons and Therapeutic Goods Act 2012* the primary psychoactive substances in Kronic were prohibited:

CUMYL-PeGACLONE (also known as SGT-151)

5-fluoro CUMYL-P7AICA (also known as 5F-CUMYL-P7AICA or CUMYL-5F-P7AICA)

46. One of the issues is the significant quantity of Kronic that was in the prison at the time. There seems no real dispute that it was easily obtainable and used by many of the inmates. Some of the prisoners said it was ‘rife’, in every sector of the prison. Zak described it as a “Kronic epidemic”. Mr Victor Williams, the Security Chief when speaking to police on 22 August 2019 said:

“our biggest issue at the moment is obviously this Kronic, because the dogs aren’t trained to detect Kronic ... that’s getting into the centre, so it’s a big bug bear for us at the moment.”<sup>10</sup>

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<sup>9</sup> Death of Steven John Colloff Ref 4/2018

<sup>10</sup> Statutory Declaration p 9

47. It was said that there had been some Kronic in the prison from just before the move from Berrimah to the new prison at Holtze in 2014. However it had really taken hold in a big way from the end of 2018.<sup>11</sup> One of the IAT members said “all prison officers were aware of Kronic through the prison”.<sup>12</sup> He went on to say prisoners had been found unconscious as a result of the use of Kronic <sup>13</sup> and there had been “multiple incidents where prisoners have had Kronic” prior to Chris’s death. He said:

“I think there’s a bad batch going around and it is causing prisoners to vomit a lot, act erratically and it’s also caused schizophrenia in some”.<sup>14</sup>

48. Three days before Chris died, Mr Bradley Murdoch “growled” at the other inmates in the block about Kronic use. He told everyone he was sick of people smoking it and someone was going to die. During his evidence at the inquest he said it turned people into zombies. He said:

“it’s in all sectors whether in max sector or medium sector or open or whatever, in all sectors its rife. Well it was rife, it’s slowed down a little bit now ... probably this COVID-19.”<sup>15</sup>

### *Boredom*

49. The prisoners attributed the popularity of Kronic to boredom. The issue of boredom was said to have started when they moved from the old prison at Berrimah to the new Darwin Correctional Facility at Holtze. At Berrimah the prisoners had accumulated devices and material for their entertainment and learning. That included books, DVD’s, music CD’s, musical

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<sup>11</sup> Bradley Murdoch, Transcript p 99

<sup>12</sup> Transcript p 25

<sup>13</sup> Ibid p26

<sup>14</sup> At the inquest the witness sought to back away from some of those aspects, but it is clear that Kronic was recognised by the Security Group as a major issue.

<sup>15</sup> Transcript p99

instruments, like guitars and devices to play videos and music. They were purchased with money earned working in the prison.

50. When the prisoners were transferred to Holtze, the items they had accumulated were removed and destroyed. It was said they would not need them because of the computer entertainment and educational system in the new prison. It was called the prisoner information and learning system (PILS). The problem has been that PILS never worked. Initially it was said to be teething problems. But 6 years on and it still does not work. I was told a new system will be installed by mid-2022.
51. Just before the new prison opened, judges and others were invited to tour the facility. I went and was shown through by Mr Bill Carroll, Superintendent, Security and Regional Operations. He gave evidence at the inquest:

Coroner: Six or seven years ago you showed me through the new goal. I remember you saying it was all about best practice. You were very proud of it. And you had a confident expectation at the time of that occurring, both with the prisoners and the staff. Isn't that right?

Mr Carroll: Yes, that's correct your Honour.

Coroner: However, the operations over the last few years, because of contract and resource problems after the opening, has not resulted in what was hoped for?

Mr Carroll: Less than expected, your Honour, yes.

52. In talking about those issues, Mr Murdoch said:

“I personally lost about \$4000 worth of property in the sense of computers, CDs. CD players, Walkman's, we weren't allowed to have it, were not allowed to have it. CAD drawing programs, I was starting to teach myself because I am that old school and don't know. So came to the new gaol and we lost the lot, the whole lot of it and then had nothing. We had nothing. There was nothing ... and that's where it comes from, boredom, there's nothing left to do, nothing at

all ... That's why other people smoke Kronic. It takes them to another place."<sup>16</sup>

53. That analysis was supported by the General Manager of the prison, Mr Jonathan Jones. He said in a statement dated 28 October 2020:

“it is recognised that a key contributor to the use of any drug by prisoners is boredom.”

54. Mr Carroll said:

“I concede that we haven't been able to fill the gap of the evenings because of the PILS not working or other activities being made available.”<sup>17</sup>

55. Mr Carroll was asked whether the failure of PILS left a void that brought in Kronic. He said:

“whether it's directly related to Kronic or another drug of choice, whether that be marijuana or whether it be you know ice or the like. It's not necessarily that it would be Kronic ... [but] a drug”<sup>18</sup>

56. Mr Shane Thomas provided a written statement toward the end of his evidence. For him the issues ran a little deeper than just boredom. While his statement was being tended he said:

“A man that's lost hope or doesn't have any positive incentive to be on the right track is going to go down the path of drugs, fighting, poor behaviour. If there's no level of enrichment or possibility of progression to become a better person, it's becoming a culture within the facility of - It's making good people bad and bad people worse.”

57. He set out a number of points:

- a. NT Corrections has been deteriorating;

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<sup>16</sup> Transcript p100

<sup>17</sup> Transcript p 130

<sup>18</sup> Transcript p 129

- b. There were many more rehabilitative schemes at Berrimah that did not transfer to the Darwin Correctional Centre in 2014;
- c. The lack of appropriate pathways for progressive enrichment had demotivated inmates. Open rating was no longer earned and the reputation of inmates in the community had dropped;
- d. There were no longer avenues for progression for life-sentenced prisoners;

58. In his opinion, Chris's attitude had changed:

“He began to not care about consequences so much as there was no light of progression or reward for good behaviour, in fact good behaviour and decency was/is often met with resistance and targeting within the precinct.”

59. Zak spoke of the education options being limited. He said he and Chris had enrolled in diplomas through the University of Southern Queensland. He was wanting to do psychology and Chris wanted to undertake a music program. But he said the prison took the options away. Instead the options were business related through Batchelor Institute.

### **Difficulty detecting Kronic**

60. Kronic was not able to be detected by the dogs or the normal forms of drug testing. Even if prisoners were found 'stuck' they could allege they were having a fit. According to the prisoners, three or four hours later the drug had worn off and persons found using it would be discharged from the medical centre.

61. However, the prison authorities did not respond to the difficulties detecting Kronic presented. Mr Carroll said:

We, as an organisation, may not have seen the consequences coming and, through our conventional drug-detection techniques, we treated it as a drug. We have drug strategy and, obviously, utilise that to the best of our ability. When I say that the matter with - the deceased's



passing elevated that, that made us now have another look at this drug.<sup>19</sup>

62. The drug strategy primarily relied upon random searches and the sniffer dogs to detect drugs. Without the effectiveness of the dogs that left virtually no ability to find Kronic. Indeed, the evidence was that it was generally only detected after someone was brought to the attention of the security group by their intoxicated behaviour.<sup>20</sup>

## **Crime Scene**

63. There was a failure by correctional services officers to preserve the crime scene until police attended. The initial attendance by correctional staff was commendable. They attended quickly when notified by Mr Shane Thomas that there was a problem in the block and responded in an appropriate manner. The nurses were there within minutes to ascertain if assistance could be provided. Both nurses had left before 8.00am. That was only 10 minutes after the alarm was raised. What happened after that point and why it happened is less certain.

### *The CCTV*

64. The CCTV vision from outside the block shows that fifteen minutes after he was declared deceased, that is, at 8.15am four correctional staff entered the block together. The only reason any of them have given for entering is that they were doing so for the purpose of taking photographs for the police. Given that police were in transit to take their own photographs that was difficult to understand.
65. The four officers approached the block in a total group of eight officers. As they neared the block, Mr Williams was walking with an IAT member ahead

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<sup>19</sup> Transcript p 121, 134

<sup>20</sup> Transcript pp 57, 58

of the group and appeared to be talking to him. The IAT member then went into the block followed by Mr Williams, a Senior Correctional Officer with the Security Group then followed and Mr Sizeland went in last.

*The IAT officer*

66. The IAT officer had been one of the four IAT members who had attended at 7.54am. He had left three minutes later after being told by the nurse there was nothing that could be done for Chris. He said he returned to the block at 8.15am to take photographs at the scene for the police.<sup>21</sup> He said he was handed the camera by the Senior Correctional Officer while outside the block and was directed by that officer to take the photographs.<sup>22</sup>
67. He took eight photographs (that were provided to police). The first showed the number of the cell (cell 8). The second showed the cell from the doorway. The third showed the desk. The TV was on, the clock radio was reading 8.14am. There was a toilet roll sitting on the desk along with a bottle of water, a cup with water in it, an empty black plastic bag, Tupperware container with a yellow substance or stain around the lower inside of it and rolled up tissue within. There was a fan without the front grill.<sup>23</sup> The fourth photograph showed the bed with a fitted sheet and the pillows and coverings stacked neatly at the far end.
68. The fifth photograph showed the inbuilt storage shelving to the right hand side of the door. Stacked neatly inside the shelving was Chris's property. That included his partly eaten meal on the second shelf down on the left. The plastic bag sitting on top of the meal container contained, milk powder, used satchels of sweet and low, a used biscuit packet, an apple core, the core of a toilet roll with a hole punched toward one end, the 'finger' of a latex

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<sup>21</sup> Transcript p 13

<sup>22</sup> Statement paragraph 3

<sup>23</sup> The prisoners remove the front grill to increase the air flow (there is no air conditioning or ceiling fans).

glove with a knot in one end, 2 foil cones, a small round plastic container and paper towel.



Fifth photograph taken by IAT member of the storage shelving

69. The sixth photograph showed the back of Chris's head, neck and shoulders. His T-shirt was being pulled away by a latex gloved hand. The seventh photograph showed Chris's leg with his iPod close to his foot with his name clearly visible. The eighth photograph was of the bed with the mattress pulled back showing what appeared to be a dried yellow substance on the floor below.

*Senior Corrections Officer (the Senior)*

70. When the Code Blue was called, the Senior was in the Security office. Mr Williams said to her he was going to the scene and for her to stay in the office. He later called and asked that she bring a camera to the scene. She said that when she got there an officer already in the 'crime scene' and so she handed the camera to him to take the photographs. She was asked what the IAT were doing in the crime scene. She said, "I can't answer that question".
71. The CCTV vision shows the Senior come out of the block three minutes later and talk to Mr Williams for 25 seconds before returning inside. She came out on another two occasions and remained outside from 8.25am. She said she was handed the camera by the IAT member after the photographs were taken.
72. She said that when back at the office she asked Mr Williams what he would like done with the photographs. She said, he didn't want them. She uploaded the photographs to a Word document and saved the document to a secure drive. It was provided to the police investigators.

*Mr Williams*

73. Mr Williams had gone to the scene. He got there just as the first nurse was leaving at 7.58am. While there he rang the Senior and asked her to bring a

camera to the scene. The following questions were asked and answers given during the inquest:

Q. Were you the person that asked the Chief of the IAT area to take a camera down?

A. I believe so. I can't recall. But I believe so, yes.

Q. Were you aware at that time that the IAT members had cameras?

A. Yes.

Q. What was the purpose of taking a camera down?

A. Just to make sure that we had one there, just in case, yeah.

Q. What was the purpose of taking photographs?

A. I didn't instruct anyone to take the photographs, so - - -

Q. But what were your instructions to the officer when you told her to take the camera down there?

A. Yeah I just told her to bring the camera down.

Q. But you didn't want photographs?

A. Well I didn't instruct the photos to be taken.

...

Q. Did you have any conversation with Officer Sizeland about photographs?

A. No I don't believe so.

*Mr Sizeland*

74. Mr Sizeland is a Chief Correctional Officer. On the morning of 20 August 2019 he was acting as the Deputy Superintendent of Accommodation. At the time of the Code Blue he was near the Medical Centre and so escorted the nurse to the scene. He arrived with the nurse at 7.55am. After both nurses had left, Mr Sizeland called the Police Communication Centre at 8.02am to report the death. During the course of that call he said: We've got an ambulance on the way out here, did you want us to take photographic evidence? The call taker responded, "yeah that would probably be a good idea".
75. When Mr Sizeland got to the scene he said he "maintained the space". He said that included him reminding people not to touch anything in the space. He agreed that was to ensure there was no further contamination of the scene.<sup>24</sup> He said that there was an officer placed at the door of the cell to ensure the space was maintained. He was asked why anyone would need to go into the block after it was determined that Chris had died. He said, "I can't answer that".<sup>25</sup> The following questions were then asked and answers given:
- Q. What about the cell. Why would they go into the cell?
- A. I don't think anyone outside of the security team actually did.
- Q. Why would the security team go in there?
- A. Well on this occasion they went in to take photographs, since I – since I found out the security team went to take photographs.

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<sup>24</sup> Transcript p 50

<sup>25</sup> Transcript p 51

Q. Are you aware, from your time with Corrections why that would be?

A. Well it is actually general practice for us to record critical 1 incidents, it is in our operational procedures. That's a fairly standard procedure for us to either record on CCTV or to take still photographs of a – of a critical incident. Granted that these types of instances, death in custody aren't common, they certainly fall within that category where we would gather evidence as part of our evidence collecting I suppose, for lack of better words.

Q. So you have a separate investigation running from the police?

A. I wouldn't call it a separate investigation, but I would say that we certainly gather evidence ... But again, I didn't give the directions for the photographs to be taken.

76. In evidence Mr Sizeland said he could not recall calling the police himself. He said he instructed staff to do so. He said he could not recall asking about the taking of photographs.<sup>26</sup>

77. Mr Sizeland went into the block at 8.15am with the Security Team. He remained inside until 8.41am. He said he stayed with the officer he had asked to guard the door. He left three minutes before police entered the block at 8.44am. They set up a crime scene at 8.46am. The Crime Scene Examiner took a photograph of the storage shelving after his arrival at 9.17am:

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<sup>26</sup> Transcript p 49



Photograph taken by police forensic examiner of the storage shelving



78. That photograph clearly shows that over the hour between when the Security Team went in at 8.15am and when SC Sandry took the photograph, the headphones had been moved up a shelf. The shelf to which they were relocated was also the shelf where the drugs were located by the Major Crime Squad members.
79. After the issue of tampering with the scene was raised with witnesses, Correctional Services said they would conduct a review. That review was provided to my office on 4 December 2020. It mentioned that one of the officers when finding Chris deceased at 7.51am had looked at items to ascertain his identity. However, that is not relevant as it occurred well prior to the photograph being taken after 8.15am. The tampering happened after that time.
80. The reviewers spoke to 13 of the 15 officers that entered the block before police arrived. They noted also that the shoes in front of the shelving unit had been moved. The reviewers stated that they were unable to establish who moved the headphones and shoes but went on to offer the following:

“However a possible scenario is that at some point after [the officer] took the photographs, someone stood in front of the shelving unit and in doing so moved the shoes out of the way, and while standing there they may have brushed up against the shelf. If this occurred, it is possible that the headphones were then picked up and placed back on a different shelf.

The review undertaken by PSU was unable to determine who moved the items within the cell or why, however there was no indication of any deliberate cover up regarding the movement of the items. It is considered that the most logical explanation is that the items were moved accidentally.”

81. However the picture taken at about 8.15am did not show the headphones in a precarious position. By the time the photograph was taken there was no need for anyone to be in the cell, let alone sufficient numbers that would lead to accidentally displacing items.

82. What happened was in breach of Directive No. 2.8.2. At 5.5.5 that directive states:

“Correctional officers will secure the scene, including any adjacent areas, and access will only be granted for urgent/critical reasons on the authority of the General Manager.”

83. None of the photographs taken at or about 8.15am were necessary, urgent or critical. The only benefit to this investigation is that they show that the crime scene was contaminated well after Chris was declared deceased and prior to the arrival of Police.

84. Whatever the purpose of the Security Team and/or Mr Sizeland for being in the block and the cell after Chris was declared deceased, it was inappropriate. Whatever the purpose of the Security Team and/or Mr Sizeland for looking through the storage shelving prior to police arrival, it was inappropriate.

#### *Police Investigation*

85. The police investigation was initially poor. It seems that the detective allocated the investigation was relatively junior and there was no adequate supervision. That was later recognised by Police and steps were taken to correct the shortcomings.

86. This is not the first time police have allocated a complex case to an inexperienced officer without sufficient supervision and support. In the inquest into the death of Sasha Green I recommended that Police ensure that the investigators allocated to major cases have sufficient skill and experience and ensure that appropriate supervision is provided.<sup>27</sup>

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<sup>27</sup> *Inquest into the death of Sasha Loreen Napaljarri Green [2018] NTLC 016*

## *Cameras*

87. One of the first aspects that provided difficulty in the investigation of this death was that there are no camera's inside the blocks in Sector 7 (the low security sector). The medium security blocks have CCTV cameras in the common areas and looking down the corridors of each wing. Not only does the absence of cameras make it difficult to assess whether anyone went into or came out of Chris's cell during the relevant period, it is difficult to understand how the care and supervision of prisoners can be thought adequate without the ability to understand what happens inside their locked blocks from lockdown until muster.
88. The evidence from Mr Carroll was that placement of cameras in the blocks of Sector 7 is "considered to be an unnecessary infringement of privacy".<sup>28</sup> He went on to say:

"Sector 7 accommodates Low and Open rated prisoners and as such current CCTV coverage is deemed sufficient when balancing risk against other factors such as privacy and amenity."

89. The Security Chief Mr Williams was asked about the cameras. He thought that from a "health and wellbeing perspective, camera's in the area would be a good idea".<sup>29</sup> Mr Sizeland speaking about the lack of cameras in the low security areas said: "the problem with that obviously we don't know what goes on after-hours a lot of the time in those areas, which can cause problems."<sup>30</sup>

### **Failure to recognise and mitigate the risk**

90. Smoking of synthetic cannabis has been known to result in injury and death for almost a decade. The authorities, along with the prisoners, were aware

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<sup>28</sup> Statement paragraph 80

<sup>29</sup> Transcript p 30

<sup>30</sup> Transcript p 52

that the dogs could not detect it and they knew it did not show up in drug testing. The cases detected were where prisoners admitted to smoking the substance.

91. During the inquest, Mr Carroll was asked, “So, until this week in 2020, do I understand your evidence to be that the jail didn’t realise they had a problem with Kronic?” He answered, “That can be assumed, yes”. Certainly in the institutional response prepared for the inquest there were some assertions that would support that position. For instance, it was said that detection rates of illicit drugs in NT prisons compared favourably with other jurisdictions.<sup>31</sup> When the drug of choice in Darwin Correctional Facility is not able to be detected, that must necessarily be the case.

92. Mr Carroll sought to categorise the extent of the Kronic problem by reference to “nine presentations” of intoxicated persons. I said to him, “from what we have heard, it’s front and centre, big time, as a risk to the general health of the prison population. Would you agree with that?”

A. Your Honour, if I may, the presentations of people that are intoxicated, I think, leading up to the passing of the deceased, was nine in the months leading up to it.<sup>32</sup>

93. In relation to another question he responded:

“I would go on the presentations that did occur, on the evidence that was provided to us. So, if nine occurrences in the lead-up to the passing of the deceased are prevalent or rife, as has been discussed previously, I wouldn't suggest that being the case.”

94. However on the figures provided by Corrections, from 1 July 2018 to 19 August 2019 there were 51 incidents involving what was thought to be Kronic. Thirteen of those included prisoners likely to be under the influence

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<sup>31</sup> Bill Carroll statement para 44

<sup>32</sup> Transcript p 120

of Kronic. One had collapsed, one was “freaking out”, one was vomiting a black substance and another was found unconscious in his bed.

95. The Security Group understood Kronic was a major issue in the months leading to Chris’s death as has been noted previously. The Senior Corrections Officer said:

“it was quite out of control there for a while ... for maybe two or three months before the incident ... was when it started to increase”.<sup>33</sup>

96. It was thought that the Kronic was coming in with the returning work parties. Those prisoners when returning were subject to the drug detection dogs and random searches.<sup>34</sup> It was said that to properly search all returning prisoners would take approximately three hours using four to six staff and it was said that was not practical.<sup>35</sup>

### **Changes made and sought to be made by Correctional Services**

97. Since the death of Chris, Correctional Services have made some changes and hope to make more. The major changes continuing to be pursued are:
- a. A new IT system, Secure PC, is said to have been approved to replace the non-functioning PILS. It is expected to be installed and operational before the end of the 2021/2022 financial year.
  - b. New Zealand has successfully trained dogs to detect synthetic cannabis. Alice Springs prison has been proactive in obtaining vials from New Zealand to train their dogs. A trial is about to commence and if successful that training will be extended to Darwin.

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<sup>33</sup> Statement p 10

<sup>34</sup> Transcript p 124

<sup>35</sup> Transcript pp 124 - 125

- c. A full body detection system using millimetre radio waves (Nuctech MW1000AA), similar to that used at airports is being pursued to screen staff, visitors and contractors.
  - d. An X-ray full body inspection system (Nuctech HT2000GA) for searching working prisoners on return to the facility. However a licence needs to be obtained from the Department of Health. Application was made in March 2020 but has as yet not been approved.
98. In the meantime the prisoners have been provided access to board games, magazines and newspapers. Internet access in any form and for any purpose is not available. Mr Carroll indicated that he knows that is provided in the ACT prison system through a firewall. However he was not aware that it had been discussed in relation to the Darwin facility.

### **Allegation of victimisation**

99. After the inquest it was alleged that one of the witnesses had been victimised by prison authorities due to the evidence he provided. It was said that the prisoner had been made to reapply for his position and was then sacked.
100. The prisoner had indicated that there was a culture of “divert and deflect” at the prison that meant that very little of the programs said to be available to the benefit of prisoners, were actually available or of benefit. He said that was often because of the scarcity of resources and the number of prisoners wishing to participate. He was also critical of the lack of pathways for rehabilitation and reintegration, particularly for long-term prisoners.
101. By letter of 18 December 2020 I was assured by the Commissioner of Corrections that there was no victimisation and there had been a number of process issues (and I am assuming miscommunication) and the prisoner would be reinstated to his position and an investigation undertaken. I am

grateful to the Commissioner for that indication. I have not yet received an indication as to the outcome of the investigation. It would be inappropriate for any institution to attempt to discipline or victimise any person who was assisting a coronial investigation (whatever the opinions and views expressed). This aspect of the matter will be finalised when I am satisfied that there was no victimisation or that it has ceased.

## **Formal Findings**

102. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

- (i) The identity of the deceased was Christopher Mark Malyschko born on 3 October 1987 in Adelaide, South Australia.
- (ii) The time of death was after 8.30pm on 19 August 2019 and before 7.45am 20 August 2020. The place of death was Cell 8, Block 7-E-1 Darwin Correctional Facility at Holtze in the Northern Territory.
- (iii) The cause of death was positional asphyxia due to synthetic cannabis use and obesity.
- (iv) The particulars required to register the death:
  1. The deceased was Christopher Mark Malyschko.
  2. The deceased was not of Aboriginal descent.
  3. The deceased was a prisoner at the time of his death.
  4. The death was reported to the Coroner by Correctional Services officers.
  5. The cause of death was confirmed by Dr Marianne Tiemensma, forensic pathologist.
  6. The deceased's mother was Bronwyn Buttery and his father was David Malyschko.

## **Comment**

103. I can clearly remember the expressions of hope and enthusiasm for the new prison. The then Commissioner was reported to have said every prisoner would be expected to work. That the facility would be the cutting edge of rehabilitation and its effectiveness would be easily judged.<sup>36</sup>
104. Sadly, that vision has to date not been fulfilled. Having removed from the prisoners the sources of entertainment and learning acquired while at the old prison, they could not get PILS to function. That left a void, conceded by the authorities, that has not been filled in the last 6 years. That lapse of time was conceded to have been inappropriate.
105. The boredom that is inevitably part of the prison experience was exacerbated and with the readily available drug Kronic, led to an epidemic of use. It concerned the security group members and concerned at least one of the older prisoners. But it seems it did not overly concern the prison authorities.
106. They did not respond to the presence of Kronic in the Darwin Correctional Facility prior to the death of Chris. They had a drug policy and thought that should be sufficient. The fact that the major forms of detection were ineffective did not prompt any form of review.
107. After the death of Chris there was inappropriate movement of items in his cell, likely due to the prison authorities seeking to assess the circumstances of his death prior to police arrival.

## **Care Supervision and Treatment**

108. Section 26(1) of the *Coroners Act*, requires that I investigate the ‘care, supervision and treatment’ of a deceased person held in custody.

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<sup>36</sup> ABC news report 19 May 2014



109. There was the failure of the PILS system, a failure that continues six years later. There was the failure to provide activities for the evenings. There was boredom. There was appreciation that boredom contributes to drug use and it was known that a cheap and easily sourced drug was in the prison system in Darwin and causing problems.
110. Kronic was known to be fatal. It was known that it was not detectable by sniffer dogs and drug testing. That left random searches as the only means utilised. The random searches were applied to cells as well as persons returning from work. However there is no evidence that they were increased appreciably to meet the evident need.
111. Nor was there any ability to check what prisoners in the low and open security Sectors were doing after lockdown because there were no cameras in the blocks for that cohort of prisoners. True it is that very little of the CCTV vision is able to be monitored in real time. However, without it there is simply no ability to check.
112. In my opinion it is clear that the care and supervision of Chris was inadequate.

### **Recommendations**

113. I **recommend** that the Commissioner of Police do all things necessary to ensure that management and supervisory positions in the crime structure are recruited to in a timely and efficient manner and filled by suitably qualified investigators to ensure consistency and continuity and that they undertake their roles in facilitating, supervising and providing governance in relation to all major investigations.
114. I **recommend** that the Commissioner of Corrections do all things necessary to ensure that on the death of an inmate the scene is not contaminated.

115. I **recommend** that the Commissioner of Corrections provide such activities and learning to the prisoners so as to ensure that the failure of the PILS system does not adversely impact on their activities and rehabilitation.
116. I **recommend** that the Commissioner of Corrections take all necessary actions to ensure that the ability to detect and prevent the entry of synthetic cannabis into the prison is expedited.
117. I **recommend** that the Commissioner of Corrections install CCTV cameras in the common areas and hallways of all prisoner accommodation.

Dated this 15 day of January 2021.

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GREG CAVANAGH  
TERRITORY CORONER