IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2018 2769**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MR PHILLIP BYRNE, CORONER**
Deceased:	**JASON WILLIAM CAUSON**
Date of birth:	**08 JANUARY 1972**
Date of death:	**10 JUNE 2018**
Cause of death:	**I (a) COMPLICATIONS OF RUPTURED ANTERIOR COMMUNICATING CEREBRAL ARTERY ANEURYSM (OPERATED)**
Place of death:	**ALFRED HOSPITAL, PRAHRAN. VICTORIA**

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Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***

I, PHILLIP BYRNE, Coroner having investigated the death of JASON WILLIAM CAUSON without holding an inquest:
find that the identity of the deceased was JASON WILLIAM CAUSON
born on 08 JANURARY 1972
and the death occurred on 10 JUNE 2018
at the Alfred Hospital, Prahran, Victoria

from:

1 (a) **COMPLICATIONS OF RUPTURED ANTERIOR COMMUNICATING CEREBRAL ARTERY ANEURYSM (OPERATED)**

Pursuant to section 67(1) of the **Coroners Act 2008** I make findings with respect to **the following circumstances**:

1. Jason Causon, 46 years of age at the time of his death, was an inmate at Hopkins Correctional Facility in Ararat.
2. On 3 June 2018 at about 12.30pm Mr Causon was in the recreation centre at Hopkins exercising using weights. Closed-circuit television (**CCTV**) footage examined after the event demonstrated Mr Causon suffered a sudden collapse. Shortly after another prisoner observed Mr Causon on the floor in the gym and alerted staff. A Code Black was called at 12.35pm.
3. Staff attended promptly and commenced Cardiopulmonary Resuscitation (**CPR**), shortly after health staff attended and continued CPR until the arrival of Ambulance Victoria paramedics. Mr Causon was conveyed by ambulance to Fort Beaufort Hospital before being transferred by air ambulance to the Alfred Hospital (the Alfred) in Prahran.
4. Scans undertaken at the Alfred demonstrated an intracranial haemorrhage due to a ruptured anterior communicating cerebral artery aneurysm. At the Alfred, Mr Causon underwent

emergency surgery to repair the ruptured cerebral aneurysm. Post operatively Mr Causon was transferred to Intensive Care Unit (**ICU**) where he remained in a critical condition. Following the initial major surgery Mr Causon underwent several further procedures, however by 10 June it became clear Mr Causon's condition was irretrievable. After consultation life support was withdrawn and Mr Causon passed away early in the afternoon of 10 June 2018 in the presence of his mother Mrs Lynette Causon.

REPORT OF THE CORONER

5. Mr Causon's death was reported to the coroner. Having considered the circumstances and having conferred with a forensic pathologist I directed an external only post mortem examination.

6. Subsequently Forensic Pathologist Dr Heinrich Bouwer provided an Inspection Report advising Mr. Causon died due to

> *(a) COMPLICATIONS OF RUPTURED ANTERIOR COMMUNICATING CEREBRAL ARTERY ANEURYSM (OPERATED)*

Dr Bouwer referring to Mr Causon's medical/surgical management commented:

> *"He was taken to hospital where investigations revealed acute subarachnoid haemorrhage due to a ruptured anterior communicating artery aneurysm. He underwent coiling, however, the postoperative period was complicated by high intracranial pressure despite maximum medical intervention. He was subsequently palliated".*

ADDITONAL INVESTIGATIONS

7. As Mr Causon was in custody when he suffered the ruptured aneurysm which ultimately resulted in his death, following established protocols, both the Justice Assurance and Review Office (**JARO**) and Justice Health respectively reviewed Mr Causon's correctional management and delivery of health care while in custody.

8. Having examined both reports provided to the Court, I am satisfied Mr Causon's management, including the response of correction staff to his sudden collapse, was in accordance with the standards prescribed by Corrections Victoria. I am further satisfied that the healthcare provided to Mr Causon while in custody was in accordance with the Justice Health Quality Framework 2014.

FINDING

9. I formally find Jason William Causon died at the Alfred Hospital on 10 June 2018 due to complications of a ruptured anterior communicating cerebral artery aneurysm. I am satisfied his untimely death was due to natural causes.

10. Pursuant to section 73 (1) (B) of the *Coroners Act 2008* (Vic), I direct that this finding be published on the Coroners Court of Victoria website.

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

Mrs Lynette Causon, Senior Next of Kin;

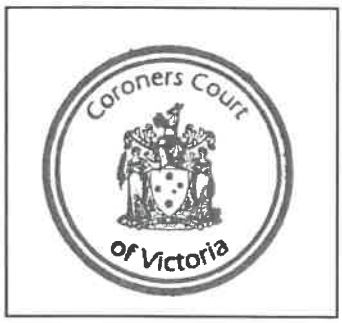
Ms Michelle Gavin, Justice Assurance and Review Office;

Mr Scott Swanwick, Justice Health;

Ms Keren Day, Alfred Health, Alfred Hospital; and

Senior Constable Fionnuala Kennedy, Victoria Police Reporting Officer.

Signature:



PHILLIP BYRNE
CORONER

Date: 28 November 2018