IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2014 / 4276

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: James Daniel Simpson

Delivered On:	5 November 2015
Delivered At:	65 Kavanagh Street Southbank 3006
Hearing Dates:	5 November 2015
Findings of:	PETER WHITE, CORONER
Police Coronial Support Unit	Senior Constable Paul Collins

I, PETER WHITE, Coroner having investigated the death of JAMES DANIEL SIMPSON

AND having held an inquest in relation to this death on 5 November 2015

at Melbourne

find that the identity of the deceased was JAMES DANIEL SIMPSON

born on 5 March 1986

and the death occurred between 21 August 2014 and 22 August 2014

at the Melbourne Assessment Prison, 317 Spencer street, West Melbourne, Victoria

from:

1 (a) HANGING

in the following circumstances:

1. James Daniel Simpson was a 28 year old man who at the time of his death, was incarcerated at the Melbourne Assessment Prison (MAP). He was residing in Unit 5 on level 3 of MAP. The cells in Unit 5 were not compliant with the Building Design Review Program (BDRP). James worked in the prison kitchen as a baker and was required to be in the kitchen early to prepare the food for the day.
2. On 21 August 2014, James was taken to the County Court where he was acquitted of the charges laid against him. He was then returned back to MAP as he had further charges pending. He anticipated however that he would be released in the near future.
3. After his return from Court, James made a phone call to his girlfriend, who went by the alias of Patrisha Kerr. He made calls to her from 6.11pm to 6.22pm and 6.22pm to 6.28pm. It appears that James and Patrisha ended their relationship during that phone call. James then called a friend, Ricky Webb from 6.37 to 6.45pm. James told Ricky about the break up and stated that he was devastated.
4. James was then locked in to his cell at approximately 7pm for the evening.
5. On 22 August 2014, at approximately 6.30am, Kitchen Supervisor Graeme Ward went to Unit 5 to unlock James' cell, and another prisoner, to assist him with early kitchen duties. Mr Ward found James sitting on his toilet seat with the torn bed sheet around his neck and strung over the shower screen. The other end of the sheet was attached to the shower taps. Mr Ward then called a Code Black. Staff attended and cut the sheet. Medical staff also attended and examined James for signs of life. An ambulance was called and police were called. James was confirmed to be deceased.
6. As James was in custody at the time of his death, I am required, by section 52 of the *Coroners Act 2008*, to hold an inquest in to his death. I received a coronial brief of evidence from the Coroner's Investigator that includes statements from witnesses, James' criminal history and prison history, medical records from his time in prison, CCTV footage of Unit 5, recordings of his phone conversations, photographs and copies of letters found in his cell, including a letter indicating that he had intended to take his own life.[1] As part of my investigation I also received the report by the Office of Correctional Services Review

[1] See exhibit 2.

(OSCR) into James' death and the review conducted by Justice Health. I have reviewed all of this material and I determined to proceed by way of reliance on the contents of the brief of evidence, supplemented this morning by the evidence of Mr Rod Wise, the Deputy Commissioner, Operations of Corrections Victoria.

7. I note here that Mr Wise has explained in his evidence how when prisoners are returned to MAP following a court appearance, a *Return Assessment Form (Escourt/Court/Telecourt)*, is used to record the results of a prison officers '*check in*' with a prisoner so that his reaction to the appearance, and his level of possible stress or anger arising, can be recorded, with arrangements then made for referral for psychiatric assessment, as and when deemed necessary. I accept his evidence in regard to these matters.

8. I have relied on the above mentioned material that is the brief and the evidence of Mr Wise, in setting out the circumstances of this finding.

9. Forensic Pathology Registrar, Dr Gregory Young, of the Victorian Institute of Forensic Medicine performed a post mortem medical examination. Dr Young provided me with a report of his findings at autopsy. The post mortem examination showed a ligature abrasion around the neck consistent with the in situ fabric ligature. Fractures of the superior cornua of the thyroid cartilage were identified. Toxicological analysis of blood showed no common drugs or poisons or alcohol however methyl amphetamine and paracetamol were detected in the urine. Dr Young concluded that the medical cause of death was 1(a) hanging. I adopt Dr Young's findings in relation to the medical cause of death.

10. James' suicide note, addressed to family and friends, stated that he did not want to live as he was and that even though he would be released from prison soon, he thought it likely that he would return soon. He told his girlfriend that his actions were not as a result of the breakup. On the basis of this evidence, and the CCTV footage of unit 5, I am satisfied that James was solely responsible for his death and that there was no third party involvement. I find that James intentionally took his own life.

11. I have reviewed James' medical record and prison history. James had been placed on an S4 rating for self-harm. S4 is the lowest risk rating for prisoners. On 17 April 2014, when James re-entered custody at MAP, a Forensicare Mental Health Intake Screening Assessment was performed. That assessment noted that suicidality was absent in James. He was put on an S4 rating. In 2008, during an earlier period of incarceration, he was prescribed anti-depressants for a short time. This appears to be the only period where James' mental state was compromised and he was placed on an S2 rating. Since that period, James was consistently rated as S4.

12. On 21 August 2014, when James returned from Court, a *Return Assessment Form (Escort/Court/Telecourt)* assessment was performed by Prison Officer Begbie.[2] It notes that the Court outcome was as he expected and that he felt 'ok' about what had happened. Prison Officer Begbie's assessment that James was not at risk of suicide or self-harm and that he presented to be 'ok'. He remained on an S4 rating.

13. The prison officers on duty that night did not notice anything unusual with James. James did however request that Patrisha's number be removed from his list of phone contacts. Subsequent investigation has revealed that Patrisha was in fact a Corrections Victoria staff member who had entered in to a relationship with James for approximately 2 years and used the alias Patrisha Kerr. That staff member assisted the Coroner's Investigator by downloading the recordings of James' calls to herself as she did not want colleagues to

[2] See exhibit 1.

recognise her voice. That staff member has been suspended. I note the OSCR review was satisfied that the relationship had no bearing on James' management in prison.

14. On the evidence before me, there does not appear to have been any indication from James to prison staff that he was contemplating self-harm. I note that his cell was non BDRP compliant however he was not deemed a high risk prisoner and in February 2015, and his placement in such a cell at that time, was reasonable.[3]
15. On the evidence before me I am satisfied that James intentionally took his own life by way of hanging.

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

The Family of James Simpson.

The Commissioner, Corrections Victoria.

The Chief Executive, Melbourne Assessment Prison.

Signature:

PETER WHITE
CORONER
Date: 5 November 2015

[3] I note here that Correction Victoria have commenced work to convert all remaining units of MAP into BDRP compliant cells.