IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 4281/08

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of JASON JEFFREY HESTER

Delivered On:	23 March 2012
Delivered At:	Coroner's Court of Victoria Level 11, 222 Exhibition Street Melbourne Victoria
Hearing Dates:	21 December 2011
Findings of:	JOHN OLLE, CORONER
Representation:	Ms Coombs on behalf of Corrections Victoria
Police Coronial Support Unit (PCSU):	Senior Constable Kelly Ramsey

I, JOHN OLLE, Coroner having investigated the death of JASON HESTER

AND having held an inquest in relation to this death on 21 December 2011
at Melbourne

find that the identity of the deceased was JASON JEFFREY HESTER

born on 31 July 1974

and the death occurred on 22 September 2008

at Judy Lazarus Transistional Centre, 50 Adderley Street, West Melbourne, Victoria 3002

from:

1a. MIXED DRUG TOXICITY (HEROIN, CODEINE AND DOXEPIN)

in the following circumstances:

1. Jason Hester was aged 34 years at the time of his death. He was a prisoner at the Judy Lazarus Transitional Centre.

2. I have received a comprehensive coronial brief. Further, I have been provided the report into a death in custody prepared by the Office of Correctional Services Review (the Review). I am satisfied that the Review is comprehensive and has fully addressed all matters of policy and procedure in respect to this death in custody.[1]

3. At Inquest I heard the summary of evidence read by my coronial assistant.

Background

4. Jason was serving his first term of imprisonment. He had been received into custody on 24 February 2006. He was eligible for release on 8 February 2009.

The Judy Lazarus Transitional Centre (JLTC)

5. The JLTC is a residential facility designed to provide support to prisoners preparing to return to the community. JLTC focuses on helping prisoners to identify employment and accommodation options, develop life-skills and achieve family reintegration.

[1] Section 7 Coroners Act 2008 - Avoiding unnecessary duplication. It is the intention of parliament that a coroner should liaise with other investigative authorities, official bodies or statutory offices - (a) to avoid unnecessary duplication of enquiries and investigations; and (b) to expedite the investigation of deaths and fires.

6. Mr Hester was one of twenty five prisoners accommodated at JLTC. Each individual was required to participate in a range of structured activities and work with a case worker to develop an individualised program. Of note, as part of the program, prisoners leave JLTC under strict leave permit conditions which assist them develop skills in navigating the community. JLTC emphasises that existing community facilities and agencies are utilised to link prisoners to suitable programs and services in the community.

7. Jason had been a prisoner at JLTC for approximately four months prior to his death.

8. Whilst in the custodial system, Jason provided 17 urinalysis samples and 82 breath test samples (all but 14 of which at JLTC). All tests returned negative indicators to illicit drug use.

9. On the morning of 22 September 2008, Jason had approved leave to visit the Melbourne Immigration Museum. He returned to the centre at 12.50pm.

10. Jason was scheduled to again leave the facility at 1.30pm to attend an Alcoholics Anonymous meeting, due to commence at 2.20pm. Jason failed to attend the meeting as planned. Staff had not detected his failure to leave on scheduled afternoon permit.

11. A routine informal count of prisoners was conducted at 1.55pm. All prisoners were identified at the centre, however a reconciliation of the muster list and records of prisoners known to be outside the centre on permits identified that five prisoners (including Jason) should have been sighted. A further check of centre records indicated Jason's whereabouts could not be ascertained.

12. A search was undertaken of the centre by the officer who conducted the initial informal count. She proceeded to the gymnasium area calling Jason's name and returned to the administration area to advise she could not locate Jason. Calls for Jason were made over the centre's public address system.

13. An assumption was made that Jason had left the centre without his movement being recorded on the system.

14. At 2.30pm staff telephoned the facilitator of the Alcoholics Anonymous meeting who confirmed Jason had not yet arrived at his appointment. A subsequent telephone call at 2.53pm confirmed that Jason remained absent from the meeting. Two staff were despatched from the JLTC to conduct a physical compliance check of the AA meeting. Staff confirmed that Jason was not present.

15. At 2.45pm the senior transition officer returned to the centre and undertook a second search including a search of the gymnasium.

16. The gymnasium is set out below ground level and was in semi darkness, lit only by limited natural light. Four prisoners were exercising in the gymnasium at the time with music playing in the background. It was ascertained that the prisoners had been exercising for approximately 40 minutes prior to the search being undertaken.

17. The transitional officer spoke briefly with the four residents and as he left the area checked the small space to the left of the exit thoroughfare. The unlit space contained a rowing machine, behind which the transitional officer located Jason's body slumped in the corner against the wall. Jason was located at 3.50pm.

18. The emergency code black was immediately called. It appeared however that Jason had been deceased for some time.

19. Ambulance staff arrived at 3.57pm and Jason was declared deceased.

20. An unused syringe was located under the mats near Jason's body. Victoria police attended and commenced an investigation.

21. A subsequent search of Jason's room located on the desk a tablespoon with clear residue, on the bed a studded belt, looped similar to a tourniquet and the circumference of an adults arm.[2]

22. The recommendations in the Review are appropriate and do not require recitation in this finding.

23. I note that the days prior to Jason's transfer to the JLTC, he had disclosed to a nurse his concern for relapse into illicit drugs. The Review has identified this issue and considered whether the information contained in the medical service records should have been conveyed to the correctional staff to assist management issues. I note that three months prior to Jason's transfer to the JLTC an assessment was conducted to determine his suitability for placement. A brief medical and psychiatric summary was provided. Further on the day prior to his transfer to the JLTC a final review was conducted by the health services manager who deemed him medically fit for transfer. The issue of information sharing between medical and correctional service was a subject of a recommendation by the review to ensure that important information from a correctional perspective be conveyed by medical staff.

24. Jason had a very troubled existence. He struggled to overcome his addiction to illicit drugs. He loved his son, from whom he was estranged and was making every effort to rehabilitate himself. The tragic circumstances of his death could not have been reasonably foreseen by staff at the JLTC. Although there were systemic shortcomings identified which have been addressed in the office of correctional services review, I note that Jason was appropriately granted leave and had been complying with his leave conditions.

[2] Paragraph 12, Police Summary.

25. It would appear that he ultimately succumbed to illicit drug use. There is no evidence of third party involvement. The investigation has not revealed how Jason obtained the drugs.

26. I note that the initial search failed to locate Jason, however in all the circumstances the staff member should not be criticised. The location in which Jason's body was found was dimly lit and hidden. Only the passage of time and a more comprehensive search was his body able to be located. [3]

27. An employee of JLTC present on the day of Jason's death has raised concerns about systemic issues in respect to the recording of prisoner movements in and out of the JLTC. It is essential that prisoner movements in and out of JLTC be accurately recorded.

28. I offer my condolences to the family of Jason Hester.

Post Mortem Medical Examination

29. On 24 September 2008, Dr Matthew Lynch, Forensic Pathologist with the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Jason Hester. Dr Lynch found the cause of death to be mixed drug toxicity (heroin, codeine and doxepin).

30. Dr Lynch commented:

> *"The cause of death in Mr Jason Hester is mixed drug toxicity. Toxicological analysis detected morphine, the principal metabolite of heroin, in urine and blood. The heroin specific metabolite, 6-monoacetylmorphine was detected in urine. Codeine which is often found as an impurity in heroin was detected in urine and blood. The antidepressant doxepin (and its metabolite nordoxepin) were also detected.*
>
> *Co-existent natural disease was noted in the form of chronic hepatitis. Whilst serological confirmation was not undertaken the appearances are typical of chronic hepatitis C which is a viral infection often occurring in the setting of chronic intravenous drug use.*
>
> *There was evidence of scarring of the heart muscle with fibrofatty replacement within the anterior and septal walls and there was no evidence of coronary artery atherosclerosis. This scarring most likely reflects previous inflammation or coronary artery spasm."* [4]

[3] The Office of Correctional Service and Review noted that the location of discovery of Jason's body was difficult to see without entering the alcove itself and it would be difficult to detect an object or body in this corner when viewing it from the natural thoroughfare. Representatives of the Department of Justice, Occupational Health & Safety Unit conducted a review of the area and a number of recommendations in respect to design and usage were made.

[4] Post mortem report, Dr Lynch

Finding

I find the cause of death of Jason Hester to be mixed drug toxicity (heroin, codeine and doxepin) in circumstances in which he overdosed. There is no evidence that the overdose was intentional.

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

The family of Jason Jeffrey Hester;
Interested Parties.

Signature:

JOHN OLLE
CORONER

Date: 23 March, 2012

Coroners Court of Victoria