IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2009 / 5986

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: JAYSON PETER HAWKINS

Delivered On:	2 October 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Dates:	2 August 2013
Findings of:	Judge Ian L. Gray, State Coroner
Representation:	Mr L. Brown, on behalf of Corrections Victoria
Counsel Assisting the Coroner	Mr S. McGregor Ms J. Burns, Senior In House Counsel, CCOV

I, JUDGE IAN L. GRAY, State Coroner having investigated the death of JAYSON PETER HAWKINS

AND having held an inquest in relation to this death on 2 August 2013

at Melbourne

find that the identity of the deceased was Jayson Peter Hawkins

born on 8 May 1972

and the death occurred on 27 December 2009

at St Vincent's Hospital, Melbourne

from:

1 (a) HYPOXIC BRAIN INJURY

1 (b) AIRWAY OBSTRUCTION

in the following circumstances:

BACKGROUND

1. Jayson Peter Hawkins (Mr Hawkins) was 37 years old and was on remand at the Melbourne Assessment Prison ('MAP') in July 2009, after being charged with the murder of his ex-partner, Margaret Anne Burton (Ms Burton).[1] .
2. Given the circumstances of his charge and previous known protection issues, Mr Hawkins was secluded from the mainstream prison population and categorised a 'Management Prisoner'. He was assessed and rated 'S3',[2] 'P3'[3] and 'V3'[4] on reception and placed on hourly observations.
3. During the period 3 July 2009 to 28 October 2009, Mr Hawkins was transferred between the Protection Unit and Unit 13 (cells for Suicide and Self Harm risk prevention) on five occasions, and into the Acute Assessment Unit (AAU) on two occasions.
4. Whilst at MAP, Mr Hawkins' 'S' rating fluctuated between S2; S3 and S4 and his 'P' rating fluctuated between P3, P2 and P1, and he was subjected to High Risk Assessment Team (HRAT) reviews whilst on observation. In conjunction with his 'P' and 'S' ratings, Mr

[1] COR 2009 3158.

[2] An S rating reflects Suicide and Self Harm ('SASH') risk varying from S1: Immediate risk and requires continuous observation; S2 Significant risk requiring observation 6 times per hour; S3 potential risk usually requiring hourly observations; S4 History of suicide risk without present ideation. The latter rating does not necessitate additional observations of the prisoner.

[3] The P reflects Psychiatric rating varying from P1: Extreme psychiatric issues and not sane; P2 Medium psychiatric issues; P3 Low or no psychiatric issues and regarded as being mentally stable and sane.

[4] The V reflects a Violence rating. The lower the number, the higher the risk.

Hawkins' presentation fluctuated during this period, presenting at times as being communicative and compliant and at other times as being withdrawn, rambling and articulating threats to self-harm.

5. On 28 October 2009, Mr Hawkins transferred from MAP to Port Phillip Prison. At Port Phillip Prison, Mr Hawkins was placed under observation in the Charlotte Management Unit as an S1 rated prisoner, on intensive watch. Mr Hawkins was transferred back to MAP as a P1 rated prisoner on 4 December 2009, where his ratings again fluctuated and he was subject to HRAT reviews. Mr Hawkins was last reviewed on 20 December 2009 and assessed as being an S3 and P2 rating.

PURPOSE OF A CORONIAL INVESTIGATION

6. The purpose of a coronial investigation into a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[5] In the context of a coronial investigation, it is the medical cause of death which is important (including where possible the mode or mechanism of death) and the context or background and surrounding circumstances of the death sufficiently proximate and causally relevant to the death, but not all circumstances which might form part of a narrative culminating in the death.[6]

7. The broader purpose of a coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role. Coroners are also empowered to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to 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.[7] These are effectively the vehicles by which the prevention role may be advanced.[8]

8. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation.

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[5] Section 67(1) of the Coroners Act 2008.

[6] This is the effect of the authorities- see for example Harmsworth v The State Coroner [1989] VR 989; Clancy v West (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[7] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[8] See also sections 73(1) and 72(5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

9. I assumed control of the coronial investigation into Mr Hawkins death in November 2012, after the previous State Coroner left the jurisdiction. Due to Mr Hawkins being in custody immediately before his death, it was mandatory for me to conduct an inquest.

10. Detective Senior Constable Gerard Whelan was the coroner's investigator and he prepared the coronial brief.

11. This finding draws on the totality of the material the product of the coronial investigation of Mr Hawkins death. That is, the investigation and inquest brief and the statements, reports and testimony of those witnesses who testified at inquest, and any documents tendered through them. All this material, together with the inquest transcript, will remain on the coronial file. In writing this finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

IDENTITY OF THE DECEASED

12. Jayson Peter Hawkins was also known as Jayson Peter Los, Los being his father's surname.

13. In the investigation into Mr Hawkins' death, I received a copy of Mr Hawkins' birth certificate. The certificate verifies that Mr Hawkins' name was Jayson Peter Hawkins, born 8 May 1972. Mr Hawkins was formally identified by Chris Hawkins on 28 December 2009. The identity of the deceased was not in dispute in this matter.

14. I find that the identity of the deceased is Jayson Peter Hawkins, also known as Jayson Peter Los, born 8 May 1972.

MEDICAL CAUSE OF DEATH

15. On 29 December 2009, Associate Professor David Ranson of the Victorian Institute of Forensic Medicine conducted a medical examination on Mr Hawkins' body and concluded the cause of death to be hypoxic brain injury and airway obstruction.[9]

16. I adopt Assoc. Prof. Ranson's medical cause of death and I find that Mr Hawkins died of hypoxic brain injury secondary to airway obstruction.

CIRCUMSTANCES OF THE DEATH

17. On 24 December 2009, Prison Officer Paul Quick (P.O. Quick) was rostered for patrol duties of the AAU Units on level 5. Whilst on level 5, P.O. Quick also conducted additional observations of the prisoners in Unit 8. At 5:30pm, P.O. Quick observed Mr Hawkins

[9] Assoc. Prof. Ranson, *Document detailing the nature of the medical investigation into the death of Jayson Hawkins COR 2009 5986*, dated 12 January 2010.

sitting on his bed in Unit 8 and continued with his observations and welfare checks of the other units at 6:00 pm.

18. After completing his duties, P.O. Quick conducted unscheduled additional welfare checks and observations of Unit 8. At approximately 6:10pm, P.O. Quick checked on Mr Hawkins and observed him lying on his bed. Mr Hawkins appeared to have a plastic bag over his head.

19. P.O. Quick tapped on the window several times in an attempt to rouse Mr Hawkins, without any response. P.O. Quick then called for assistance at Mr Hawkins' cell. Prison Officer HM attended to assist P.O. Quick, contacted his supervisor, KC, and called a Code Black.[10] During this time, P.O. Quick repeatedly hit the glass window of the cell in an attempt to rouse Mr Hawkins.

20. A short time later, KC arrived at the scene. HM unlocked the cell door and entered with KC and P.O. Quick. Mr Hawkins was lying on his bed with a black plastic bag over his head and a green coloured ligature tied around his neck. HM ripped the plastic bag from Mr Hawkins' head and removed the green ligature from his neck.

21. Mr Hawkins had no pulse and was immediately removed from his cell and placed into the corridor, where prison staff commenced CPR, applied a defibrillator and continued with resuscitation until paramedics arrived and took over treatment.

22. On arrival, paramedics found Mr Hawkins still had no pulse. They continued CPR and were able to revive Mr Hawkins, who was then stabilised and conveyed to St Vincent's Hospital.

23. At St Vincent's Hospital, Mr Hawkins was assessed and immediately transferred to the Intensive Care Unit, where he was placed on life support and remained for further assessment and examination.

24. On Sunday, 27 December 2009, Mr Hawkins' life support was removed and he was pronounced dead at St Vincent's Hospital.

25. I find that Mr Hawkins died in the circumstances outlined in paragraphs 17-24, above.

THE INQUEST AND RELATED MATTERS

26. On 1 March 2013 I made a Suppression Order pursuant to section 73(2) of the Act ordering that '*Report into a death in custody: Jayson Peter Hawkins (CRN: 65674) on 27 December 2009*', dated 2 December 2010 prepared by the Office of Correctional Services Review (OCSR) not be published on the basis that publication would be contrary to the public interest

[10] An internal emergency code indicating a serious medical condition.

(the OCSR report). I also note that this same order was revised on 6 March 2013 and the OCSR report remained suppressed. I was later provided with a redacted version of the OCSR report (the redacted OCSR report) which was included in the inquest brief[11]

27. On 2 August 2013, I conducted an inquest into Mr Hawkins death. The following witnesses gave evidence:

- Detective Senior Constable Gerard Whelan;
- Paul Quick;
- John Stanley Arnol;
- Brett Ryan.

28. The scope of the inquest included evidence on matters contained in the redacted OCSR report and the relevant prison controls in relation to access to plastic bags, both before and after Mr Hawkins' death.

29. Prison Officer Quick gave evidence at the inquest[12] that:

- before Mr Hawkins' death, plastic bags were not allowed in the cell but were still allowed in the units on level 5;
- it was possible that Mr Hawkins obtained the plastic bag from underneath a bin liner bag within the communal areas in level 5; and
- after Mr Hawkins' death, all plastic bags were removed from level 5, including bin liner bags for the units and/or in the cells, that the only bags found on level 5 now are paper bags.

30. John Arnol, Manager Reviews, OCSR, agreed in his evidence at inquest that it was likely that Mr Hawkins found a spare bin liner bag underneath an existing bin liner bag on level 5.[13] Mr Arnol advised the Court that all plastic bags, including bread bags and plastic property bags, were removed from level 5 following Mr Hawkins' death.[14]

31. Mr Arnol also gave evidence that the OCSR conducted an inspection of level 5 of the MAP on 27 December 2009 and found that all plastic bags had indeed been removed from level 5

[11] Inquest brief pages 350-657.
12 Transcript, pages 9-13.
13 Transcript, page 18.
14 Transcript, page 18.

and that the MAP complied with the revised local operating procedure 1.023,[15] which was released on 31 December 2009.[16]

32. Brett Ryan, then Acting Regional Director at the MAP,[17] gave evidence at the inquest regarding:

32.1 the issue of plastic bag availability at MAP;

32.2 the likely mode by which Mr Hawkins obtained the plastic bag;

32.3 the action taken by Corrections Victoria since Mr Hawkins' death and the response to the OCSR investigation and report; and

32.4 the lack of similar incidents since Mr Hawkins' death in December 2009.

33. I accept his evidence.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

34. I confirm my comments at the inquest in relation to P.O. Quick, where I stated "*I did want to simply say you I think as I understand it you were checking in an area where you were not routinely obliged to check. You went above and beyond your normal requirements and obligation and in doing so you found Mr Hawkins. So I commend you on your additional work and going to check on cells in others units which were not strictly part of your checking regime.*"[18]

35. The redacted OCSR's review of Mr Hawkins' death made six recommendations and Corrections Victoria responded with an action plan in October 2010, which was completed in March 2013. The OCSR recommended that:

- Prison General Managers ensure that prisoner IMP files contain copies of properly authorised copies of Separation Orders and the Long-term Management Plans where relevant;

[15] At page 648 of the coronial brief.
[16] Transcript, pages 18-19.
[17] Now the General Manager.
[18] Transcript, page 13.

- Melbourne Assessment Prison ensures that all required paperwork for prisoners who are identified at risk of suicide and self harm is attached to prisoners' Individual Management Files;
- Corrections Victoria explores a means by which staff can make random observations in order to reduce the predictability of regularly timed observations as currently practised;
- Melbourne Assessment Prison reinforce with staff the requirements of the Emergency Management Plan (Code Black) checklist in relation to the management and control of prisoner death incidents;
- Corrections Victoria reviews its Director's Instruction 1.12 External Escorts to give permission for:
    (a) unconscious or incapacitated prisoners travelling on medical escorts not to be strip-searched prior to escort; and
    (b) staff accompanying unconscious or incapacitated prisoners on medical escorts not to carry firearms; and
- that Corrections Victoria develops a process to ensure that prisoner next of kin and emergency contact details on PIMS are verified and kept up-to-date;

36. Mr Arnol gave evidence that Correction Victoria had actioned and completed each of the six OCSR recommendations in respect of the investigation into the death of Mr Hawkins.[19] I accept that evidence.

37. The redacted OCSR Report concluded that, at the time of Mr Hawkins' death, Unit 8 was not compliant with procedures restricting level 5 prisoners from having access to plastic bags.[20] The redacted OCSR Report states the MAP has since banned plastic wrap and bags from level 5. This is supported by the evidence given at the inquest.

38. I am satisfied that the corrective actions taken by Corrections Victoria at the MAP in response to the recommendations contained in the redacted OCSR report were appropriate, and that the revised local operating procedures regarding plastic bags were also appropriate. I note that there have been no deaths by similar mechanism since.

[19] Transcript, page 20.

[20] OCSR Report into the death of Jayson Peter Hawkins, page 5.

I convey my sincere condolences to Mr Hawkins' family on his death in 2009.

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

- **Mr James Los, Senior next of kin**
- **The Office of Correctional Services Review**
- **Corrections Victoria**
- **St. Vincent's Hospital**
- **Detective Senior Constable Gerard Whelan**

Signature:

Judge Ian L. Gray
Date: **2 October 2014**