IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2021 000109**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the **Coroners Act 2008***

| | |
|---|---|
| Findings of: | Coroner Leveasque Peterson |
| Deceased: | Jason Thomas Muir |
| Date of birth: | 29 June 1982 |
| Date of passing: | 5 January 2021 |
| Cause of passing: | 1(a) COMPRESSION OF THE NECK<br>1(b) HANGING |
| Place of passing: | 520 / 99 A'Beckett Street, Melbourne, Victoria, 3000 |

***Aboriginal and Torres Strait Islander readers are advised that this Finding contains the name of a deceased Aboriginal person.***

***Readers are warned that there may be words and descriptions that may be distressing.***

## INTRODUCTION

1. Jason Thomas Muir (**Jason**), was a proud Latji Latji man, who was 38 years old at the time of his passing.

2. Jason had a complex psychosocial history, involving an extensive history of criminal justice interaction, drug use, mental illness and family violence.

3. On 12 December 2020, Jason was released from Fulham Correctional Centre after serving a sentence of 18 months imprisonment.

4. After participating in ReLink, Jason was considered suitable to participate in the extended ReConnect Program on release. ReConnect provided an emergency release package for Jason to collect on release, which included a mobile phone and details of emergency accommodation organised for him at the City Edge Hotel in Melbourne.

5. ReConnect subsequently extended Jason's emergency accommodation from 12 December 2020 until 5 January 2021.

6. On 5 January 2021, Jason was discovered in his room having passed by hanging.

## THE CORONIAL INVESTIGATION

7. Jason's passing was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

9. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Jason's passing. The Coroner's Investigator conducted inquiries on my behalf, including

taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the passing of Jason Thomas Muir including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

## MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

### Circumstances in which the passing occurred

12. Jason Thomas Muir was a proud Latji Latji man who was 38 years old at the time of his passing. Jason had a complex psychosocial history, involving drug use, mental illness, family violence, and multiple periods of incarceration.
13. Jason passed from suicide 24 days after being released from custody. His passing occurred on the last day that Jason had access to emergency accommodation organised through ReConnect.
14. In the year prior to his passing, Jason was incarcerated across three facilities, with dates as follows:
    a) 20 June 2018 until 12 June 2019 – Loddon/Middleton Prison.
    b) 12 June 2019 until 30 June 2020 – Ravenhall Correctional Centre; and
    c) 30 June 2020 – 12 December 2020 – Fulham Correctional Centre.
    d) Pre-release support
15. Throughout his time in custody, Jason engaged in programs offered under the CV Reintegration Pathway. These are described in the statement of Andrew Reaper at paras 70-101. Notably:
        i. Jason was assessed in 2018, early in his incarceration, as high risk/need and prioritised for the ReLink program.
        ii. On 20 June 2019, a Reintegration Assessment was completed by a psychologist noted his history of suicide attempts and identified a wide range of risk factors including being released into a high risk situation with limited

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

support, impulsivity and cognitive distortions. The report recommended additional psychological support upon his release.

16. Jason was moved to Ravenhall Correctional Centre before the completion of this report on 12 June 2019. The ReLink and ReConnect programs were not available at Ravenhall, ceasing Jason's access and participation.

17. On 19 June 2020, a Reintegration Assessment Form was completed at Ravenhall which assessed that Jason had "high and complex reintegration needs".

18. Jason reportedly declined to engage in reintegration programs at Ravenhall so was transferred to Fulham Correctional Centre.

19. On 31 July 2020, a ReGroup Phase – Reintegration Assessment interview was completed at Fulham. No response was recorded on this form to the prompts, "Do you have a history of diagnosed mental illness" and "Have you ever attempted suicide or self-harm". However, the Form did record Jason's risk assessments as:

    a) S4 – the lowest level of suicide or self harm risk, meaning the prisoner has previously attempted suicide or self-harmed but does not currently demonstrate behaviour and/or risks associated with higher levels; and
    b) P3 – the prisoner has a stable psychiatric condition requiring continuing treatment or monitoring.

20. In the lead up to his release, various supports were facilitated for Jason including:

    a) Supports to organise housing (appointments with Community Housing Victoria, a public housing history check, support to file a change of housing application details form);
    b) ReConnect Leaving Prison, Health and Mental Health, Community Correctional Services, and Centrelink Information Sessions; and
    c) Support to complete a Centrelink Claim.

21. On 6 November 2020, Jason resumed and completed Level 2 of the ReLink Program.

22. Jason was released from custody on 12 December 2020. He was referred for six-month extended package support from Re-Connect to assist with reintegration.

23. On 17 December 2020, the ACSO case worker phoned Jason to perform a welfare check, booked 7 additional nights' accommodation for him, until 24 December 2020, and reminded him that he needed to actively engage with Launch Housing to discuss long-term housing.

24. Also on 17 December 2020, Jason presented to Sunshine Police Station and disclosed to Police that he was "recently released from prison and didn't know what to do, and that he

was better off dead" (CB p 37). Jason was transferred to Sunshine Hospital for assessment under section 351 of the Mental Health Act. Jason was sedated and kept overnight. The following morning, Jason was assessed, and it was determined to discharge him on the basis that he was no longer acutely suicidal. Jason disclosed that he was homeless and sought assistance with housing. He was referred by the Hospital's Advice, Coordination and Expertise team (ACE) to St Kilda Crisis accommodation service.

25. On 21 December 2020, Jason phoned his ACSO case worker and advised that he had attended an appointment with a GP and was taking antidepressant Mirtazapine 15mg daily. The ACSO case worker offered Jason accommodation in a share house in Dandenong, but Jason declined as he required accommodation in Sunshine or Frankston nearby his brother who was sick so that he could visit regularly. The ACSO case worker advised Jason to contact Launch Housing Cheltenham and sent him details of the Salvation Army Social Housing and Support Network.

26. On 22 December 2020, the ACSO case worker submitted an Initial Assessment and Planning referral to Launch Housing Cheltenham Office. Launch Housing recommended that ReConnect continue to fund accommodation until 2021 when they would have capacity to see Jason.

27. On 23 December 2020, the ACSO caseworker extended the accommodation booking until 5 January 2021. Six days later, on 29 December 2020, the ACSO case worker contacted Jason and notified him of the extended motel booking until 5 January 2021. Jason had received his first Centrelink payment and stated that he was still looking for stable accommodation. The ACSO case worker reminded him to stay in contact with a housing access point, and to contact the ACSO case worker for further support.

28. At 1.10pm on 5 January 2021, the day that Jason was due to check out of his accommodation, the ACSO case worker attempted to call Jason on his mobile phone to check on his progress. The mobile phone appeared to be switched off. The ACSO case worker then attempted to call City Edge Apartments to confirm if he had checked out and was informed he had not.

29. At approximately 1pm, hotel staff attended Jason's room and discovered him deceased by hanging. A suicide note was located on a side table nearby.

30. The note expressed Jason's love for his children and family, and apologised for the pain he may have caused to people. Though Jason referred to "his situation", he did not specify what aspects of his situation may have contributed to his decision to take his own life.

**Overview of the Reconnect Program**

31. Jason's referral to the Extended Reintegration Stream of Reconnect suggested that Corrections Victoria considered that he had complex needs/risks.

32. The ReConnect program is intended to provide "targeted, intensive outreach and practical assistance to prisoners post-release and is delivered by regional external service providers. ReConnect support workers commence working with prisoners before their release, and provide outreach and links to other services in the community."

33. At the time of Jason's release, prisoners were eligible for Reconnect if:

    a) they had participated in the ReLink Level 2 individual program and been recommended for post-release support

    b) were assessed as having high level and/or complex transitional needs in the Reintegration Assessment; or

    c) were Aboriginal/female prisoners who received a sentence of over 3 months' imprisonment.

34. At the relevant time, the Reconnect Program was delivered through two service streams:

    a) The Targeted Reintegration Stream provided up to four weeks support for prisoners with more immediate transitional needs;

    b) The Extended Reintegration Stream provided up to 12 months' post-release support and was focused on prisoners with more entrenched and complex needs who are typically at higher risk of offending.

35. There have since been a number of changes to the ReConnect program.
36. Jason participated in the extended stream of the Reconnect Program.
37. On 9 November 2020, Jason attended his first meeting in the Reconnect Program with a case worker from ACSO in Gippsland. Various issues were discussed including Jason being "very stressed" about having nowhere to go post-release. The case worker advised that support services would provide short-term crisis accommodation on release and referral to a housing

access point. Jason advised the case worker about his history of depression but indicated he did not believe he would require mental health support post-release.

38. On 7 December 2020, Jason remotely attended a second pre-release Reconnect meeting with a new case worker from ACSO in Dandenong. Mr Muir engaged with this ACSO case worker as part of the ReConnect program until his passing. The case worker arranged 5 nights' accommodation at City Edge on Elizabeth Apartments, Melbourne and advised Jason to contact the housing support services including Launch Housing, Wayss or Salvocare for long-term housing.

**Identity of the deceased**

39. On 10 January 202, Jason Thomas Muir, born 29 June 1982, was identified via fingerprint identification.

40. Identity is not in dispute and requires no further investigation.

**Medical cause of death**

41. Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 7 January 2021 and provided a written report of his findings dated 1 March 2021.

42. The post-mortem examination revealed injury to the neck and a superficial sharp force injury to the left wrist.

43. Toxicological analysis of post-mortem samples identified the presence of amphetamines.

44. Dr Burke provided an opinion that the medical cause of Jason's passing was 1 (a) COMPRESSION OF THE NECK.

45. I accept Dr Burke's opinion.

**JARO REVIEW**

46. JARO operates as an internal assurance and review function to advise the Secretary of DJCS on ways to achieve higher-performing, safer and more secure youth justice and adult corrections systems. It achieves this objective by reviewing all deaths in adult prisons and youth justice facilities, reviewing selected deaths in the community, assessing and reviewing serious and significant incidents according to risk, and conducting thematic reviews and targeted analyses of issues posing systemic risk.

47. JARO has scope to review deaths in the community where meet following criteria are met:

    a) the offender died within three months of their release from custody; and

    b) the offender was supervised by Community Correctional Services (CCS) at the time of death; and

    c) the death was not due to natural causes.

48. Taking into account these criteria, JARO determined it did not have scope to review Jason's passing given that at the time of his passing, he was not subject to any supervision by CCS.

49. Despite this, due to possible interest by the Coroner, JARO determined to complete an assessment of the supports offered to Jason prior to and following his release from prison.

50. JARO considered that the Coroner may have interest in Jason's matter given he was Aboriginal and died 24 days after release from prison. Further, JARO noted that it was aware that the Coroner was considering investigating a cluster of suicides in the Mildura area, where Jason had lived prior to his incarceration.

51. JARO provided its assessment to CV in the form of an attached memorandum to the Commissioner of CV dated 21 April 2021.

52. The memo stated that its purpose was "[t]o bring to your attention JARO's concerns about the level of support provided to Mr Jason Muir (CRN191072) through the Reconnect program prior to his death in the community on 5 January 2021".

53. JARO highlighted three particular areas of concern as follows:

    a) ReConnect did not transfer Mr Muir to a local ReConnect Worker in the city (where he was housed in emergency accommodation), as advised by his ReConnect Case Worker who was located in Gippsland. ReConnect did not meet with Mr Muir in person after his release from custody.

    b) There are no notes by ReConnect regarding follow-up on Mr Muir's application with Aboriginal Housing nor his housing options after his emergency accommodation was due to end on 5 January 2021.

c) Mr Muir had a history of mental health issues including suicidal ideation. It does not appear that prison or community supports were put in place to assist Mr Muir with this, other than to refer him to a local General Practitioner on release from custody.

54. JARO concluded that, "given the shortcomings we have identified, and the possibility that this case will be considered as part of a larger coronial investigation, we recommend that Corrections look more closely at the service provided to Mr Muir."

55. More specifically, JARO recommended that "Corrections Victoria's Transition and Reintegration Unit conduct an audit of the Reintegration Pathway Service provided to Mr Muir to determine if the support provided was adequate."

56. JARO qualified that it was not in a position to determine whether the support provided to Jason met the contractual requirements or expectations of service delivery.

**CORRECTIONS VICTORIA REVIEW**

57. In accordance with JARO's recommendation, a review was undertaken by Corrections Victoria's Transition and Reintegration Unit.

58. In response to the concerns identified by JARO, TRU found that:

(a) Being based from ACSO's Dandenong office in the South-East Metro region meant that Jason's caseworker was situated approximately 35kms from the motel that had been arranged by ACSO for Jason's release. TRU did not consider this unreasonable given ACSO are contracted to provide ReConnect support in the Loddon Mallee, Hume, Gippsland and South-East Metro regions. Additionally, this support episode was occurring during a period in which the majority of pre-and-post release support being offered by ReConnect providers had been almost exclusively remote in response to COVID-19 lockdown measures.

(b) TRU considered that while there were no case notes specifically expanding on Jason's Aboriginal Housing Application, the case worker had provided housing support by booking and extending the emergency accommodation, referring Jason to housing providers, and emphasising that ACSO was not a housing provider and Jason would need to maintain sustained contact with housing providers to obtain a long term solution.

(c) In relation to Jason's mental health, TRU considered that supports were provided including contact details for mental health assistance and confirming that Jason had

attended an appt with a General Practitioner, but noted that it was unclear whether the General Practitioner had developed a mental health care plan in this case.

59. TRU identified as a remedial action that it would discuss the incident at the next ACSO quarterly meeting and reiterate:

    (d) The expectation of direct service provision now that COVIDSafe plans are approved

    (e) The expectation that any ongoing applications (such as housing applications) are followed up and have outcomes clearly documented on RPS as part of support provision

    (f) The importance of exploring culturally-specific support services generally for the Aboriginal participant cohort, including housing options in this instance.

    (g) The need to clearly specify in case notes how identified mental health needs are being supported, including stipulating whether a mental health care plan is being pursued via a GP, to inform future referrals to mental health support.

60. Meeting minutes confirm that TRU did discuss this matter with ACSO as planned.

61. In his statement dated 4 August 2023, Andrew Reaper, Acting Deputy Commissioner of Custodial Operations Divisions in CV, noted that certain requirements in the Sentence Management Manual had not been complied with in relation to Jason's custodial management. Specifically, the requirement to hold a Pre-Release case management review committee meeting (CMRC meeting) six to eight weeks before release was not fulfilled.

62. The Sentence Management Manual Part 3 Prisoner Management PM 1 - Case Management Review Committees dated 8 November 2017 (Exhibit AR2-7) cl 3.6 requires a pre-release CMRC meeting to occur six to eight weeks prior to a prisoner's release. The focus of the Pre-Release CMRC meeting is to ensure that adequate preparation for release has occurred, which includes "whether the prisoner has … accommodation upon release".

63. Jason attended an induction CRMC meeting on 4 August 2020 following his reception into Fulham. Under GEO procedures at the relevant time, a prisoner's next CMRC meeting was scheduled between six and twelve months later, depending on their Expected Discharge Date, Earliest Eligibility Date, individual needs, and whether they were on remand, at trial, or sentenced. In accordance with the process at the time, Jason's next CRMC meeting was scheduled for February 2021, so he was not included on the list of required Pre-Release

CRMC meetings in October or November 2020, and no Pre-Release CRMC meeting was held.

64. Mr Reaper advised that GEO had informed him that its processes would be updated to prevent similar occurrences in the future.

65. I commend Corrections Victoria, JARO and TRU on the reviews that were undertaken in response to this passing, and the steps taken to ameliorate the risks that were identified during the review process. These actions will benefit individuals who are released from custody in the future.

**CPU Review**

66. After reviewing the brief of evidence, I determined it may assist me to have some statistical information on the issues and challenges facing newly released prisoners. In particular I was focussed on the prevalence of suicide amongst newly released prisoners. I referred this case to the CPU seeking some statistics. The CPU review of available information concluded that due to significant data limitations, it was not possible to collate accurate and meaningful information about people who suicide in Victoria within 12 months of release from prison. The CPU concluded that this lack of accurate data undermined opportunities to explore how Jason Muir's death might form part of a broader public health issue, with regards to support for recently-released prisoners.

67. While I agree that a lack of data undermines opportunities to explore improving supports for newly released prisoners, I understand the challenges to data collection in this context.

**FINDINGS AND CONCLUSION**

68. Pursuant to section 67(1) of the Coroners Act 2008 I make the following findings:

a) the identity of the deceased was Jason Thomas Muir, born 29 June 1982;

b) the death occurred on 05 January 2021 at 520 / 99 A'Beckett Street, Melbourne, Victoria, 3000, from COMPRESSION OF THE NECK; and

c) the death occurred in the circumstances described above.

Having considered the circumstances, including the note he left in his diary, I am satisfied that Jason intentionally took his own life.

**COMMENTS**

Pursuant to section 67(3) of the Act, I make the following comments connected with Jason's passing.

> Poor housing options for newly released prisoners is a cause of some concern for me. There is evidence to suggest that insecure housing increases the risk of recidivism, and may compromise both physical and mental health.
>
> The circumstances of Jason's passing raise concerns about the impact of the precarious housing situation on Jason's mental health, however I do not have sufficient evidence to be comfortably satisfied that it caused or contributed to Jason's decision to take his life.

I convey my sincere condolences to Jason's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Robin Muir, Senior Next of Kin

Corrections Victoria,

Department of Justice and Community Safety

First Constable Valentine, Coroner's Investigator

Signature:


Coroner Leveasque Peterson

Date : 24 February 2025

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NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.