IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 0657

FINDING INTO DEATH WITH INQUEST

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

Findings of:	Katherine Lorenz, Coroner
Deceased:	Travis Thomas Young
Delivered on:	1 February 2022
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	1 February 2022
Assistant to the Coroner:	Mr Dylan Rae-White, Senior Coroners Solicitor

INTRODUCTION

0. Travis Thomas Young was 42 years of age and a prisoner at Hopkins Correctional Centre (**Hopkins**) when he was found hanging in the bathroom of his cottage in the Bolac Community by a fellow prisoner. At the time of his death, Mr Young had served 10 years of his 15-year sentence for multiple criminal offences, including rape.

THE PURPOSE OF A CORONIAL INVESTIGATION

1. Mr Young's death was reported to the Coroner as he was person in care or custody immediately before their death, and so fell within the definition of a reportable death in the *Coroners Act 2008*. The death of a person in care or custody is a reportable death to the Coroner.

2. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the deceased was, immediately before death, a person placed in custody or care. As Mr Young was a prisoner detained at Hopkins at the time of his death, he is deemed to be a person placed in custody or care.

3. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[1] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[2]

4. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[4] or to determine disciplinary matters.

5. The expression '*cause of death*' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

6. For coronial purposes, the phrase '*circumstances in which death occurred*,'[5] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the

[1] Section 89(4) *Coroners Act 2008* (Vic).
[2] Preamble and section 67 *Coroners Act 2008* (Vic).
[3] *Keown v Khan* (1999) 1 VR 69.
[4] Section 69(1) *Coroners Act 2008* (Vic).
[5] Section 67(1)(c) *Coroners Act 2008* (Vic).

death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

7. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners.

8. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[6] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[7] 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 that they caused or contributed to the death.

9. Coroner Olle originally had carriage of this investigation. It was transferred to me after my appointment as a coroner on 8 February 2021.

The position of persons in custody or care

10. All deaths of persons deemed to be in the care or custody of the State are reportable no matter what their cause. Further, whereas a coroner usually has a discretion as to whether to hold an inquest into a reportable death, a coroner is obliged to hold an inquest into the death of a person in custody or care unless the death was due to natural causes. Mr Young's death was clearly not from natural causes and so an inquest was mandatory.

11. The reason for this different treatment is to ensure independent scrutiny of the circumstances surrounding the deaths of persons for whom the State has assumed responsibility, whether by reason of an inability to care for themselves, or because the State has deprived them of their liberty, or for some other reason.

12. Prisoner deaths are not only investigated by coroners, but they are also routinely reviewed by an arm of government called the Justice Assurance and Review Office (**JARO)**. The JARO is a part of the Department of Justice and Community Safety (**DJCS**) and reports to the Secretary of that Department, as the person with responsibility for the monitoring of all correctional services to achieve the safe custody and welfare of prisoners and offenders.[8]

---

[6] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[7] (1938) 60 CLR 336.
[8] Section 7 of the *Corrections Act 1986.*

13. In preparing its report for the Secretary, the JARO invariably has regard to a separate report prepared by Justice Health, another business unit of DJCS. Justice Health has responsibility for the delivery of health services (including drug and alcohol services) to Victoria's prisoners. It contracts out the delivery of primary health care in Victoria's 14 public prisons, including Hopkins, to Correct Care Australasia Pty Ltd (**Correct Care**). Psychiatric services are provided by Forensicare.

14. Whilst coroners are, as a matter of course, provided with JARO and Justice Health reports, the coronial investigation is independent and I have formed my own view on the evidence provided.

Sources of evidence

15. As part of the coronial investigation, the Coroner's Investigator, Senior Constable Julie Morris, prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist, treating clinicians and investigating officers.

16. Additionally, the Court received reports from JARO and Justice Health regarding the circumstances leading to Mr Young's death.

17. This finding is based on the coronial brief and the additional material submitted to the Court. It is unnecessary to summarise all this material, which will remain on the Court file.[9] I will refer only to so much of it as is relevant or necessary for narrative clarity.

BACKGROUND

18. Mr Young was 42 years old and serving his second term in custody. He had a lengthy history of convictions for offences such as theft and drug possession.

19. On 29 December 2008, Mr Young was remanded on charges including rape and indecent acts in the presence of a child under 16 years old. On 18 December 2009, he was sentenced to 15 years' imprisonment, with a non-parole period of 11 years. His earliest eligible release date was 15 August 2020. Due to his offences, he was managed as a 'protection prisoner'. Mr Young was assessed as having a low risk of general reoffending.

[9] Access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

20. Until 4 September 2013, Mr Young was accommodated at Port Phillip Prison (**Port Phillip**). He was then transferred to Hopkins (then known as Ararat Prison). From 17 October 2014, Mr Young resided a part of the prison known as the Bolac Community.

21. In March 2019, Mr Young had been approved to live at one of the cottages at the Bolac Community following improved behaviour and his expressed desire to work on his personal living skills before his release. Mr Young shared the cottage with three other prisoners. The cottages are designed for shared living and cottage residents are free to move around within the community but must seek permission prior to moving to other parts of the prison.

22. The Victorian correctional system employs a series of risk ratings, which are attached to prisoner and offender records to ensure communication about significant issues experienced by that person. Typically, risk ratings are entered only when a prisoner or offender is identified as having issues within that area.

23. A prisoner or offender may have no risks recorded against any of the six identified categories or may have multiple risk statuses. Relevantly, Mr Young had no suicide / self-harm risk rating. He had a psychiatric rating of 'P3', which was a stable psychiatric condition requiring continuing treatment or monitoring, being a generalised anxiety disorder for which he had received ongoing treatment during his incarceration.

24. In addition to his anxiety disorder, Mr Young had several ongoing health issues, including a hernia, tinnitus, panic attacks and sleep problems. He was also being prescribed methadone in addition to other medications. In January 2019, Mr Young reported to health care staff that he had tripped over a cord in his unit. He later complained of abdominal pain and back pain. He was morbidly obese and was trying to lose weight with a prescription of Optifast.

25. Mr Young was prescribed numerous medications during his time in prison. In the week prior to his death, he had been treated with medications for depression and insomnia, gout, oedema, inflammation and melatonin for sleeplessness. Additionally, he was on the Opioid Substitution Therapy Program and was taking methadone daily.

26. In the months preceding his death, Mr Young presented to health staff on numerous occasions with ongoing distress relating to his tinnitus and expressed that he was having difficulty coping.

27. Tinnitus is the medical term for a ringing or buzzing noise in the ears and can have many causes. In the case of Mr Young, his medical records from prison indicate that the cause of his tinnitus had not been established. His records show that he had suffered a previous head and face trauma

in an accident prior to his incarceration, which may have had a causal connection to the tinnitus. Additionally, he had been attempting to 'unblock' his ears by inserting cotton buds into his ears, which is known to be causally related to ear injuries.

28. It is well known that tinnitus can cause emotional distress and anxiety and evidence shows that Mr Young's tinnitus was causing him considerable stress, anxiety and difficulty in sleeping from May 2019 until his death. In May 2019, he reported to health staff that he had been suffering from tinnitus in his right ear for two days. He reported that he used a hearing aid which generated white noise to mask the tinnitus symptoms. He received further treatment for the symptoms including prednisolone (a steroid) and melatonin to assist with sleep from June 2019.

29. From around May 2019, Mr Young's symptoms of poor mental health, including insomnia and high levels of anxiety, generally persisted. On 23 August 2019, he reported to a health staff member that he was not coping with the ringing noise in his ears and stated that he needed to see a doctor or specialist, noting that he was worried he might hurt someone or himself.

30. In the days prior to Mr Young's death he told other prisoners that he 'couldn't handle' the noise in his ears and that he had been thinking of jumping from the top floor railing in their rooms. There is no evidence that the prisoners reported these comments to prison staff.

31. At the time of his death, he was awaiting allocation of an appointment with an Ear Nose and Throat (ENT) specialist at St Vincent's Hospital in Melbourne (St Vincent's). Mr Young had previously refused a referral for an ENT appointment in August 2018 because he did not want to travel to St Vincent's Hospital because it would require him to transfer through Port Phillip Prison.

IDENTITY OF THE DECEASED PURSUANT TO SECTION 67(1)(a) OF THE ACT

32. On 30 September 2019, Aaron Wood visually identified Mr Travis Thomas Young, born 6 November 1976.

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

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO SECTION 67(1)(c) OF THE ACT

34. On 30 September 2019, Mr Young attended at the Bolac Main block to receive his daily medication. Whilst waiting for his medication, he had a conversation with another prisoner,

TW[10] who observed that Mr Young looked white. Mr Young was crying and told TW that 'it's not going to end good for me' and 'everytime I see that railing, I feel like jumping off.' TW did not tell anyone what Mr Young had said.

35. Mr Young returned to his Bolac cottage at approximately 8.30 am.

36. At approximately 10.30 am, another prisoner, PG[11] returned to the Bolac cottage he shared with Mr Young. PG proceeded to go to the bathroom and yelled out, 'Is anyone home?' There was no answer. The door was locked. PG left the cottage and returned a short time later. The door of the bathroom was still locked. PG used a spoon from the kitchen to unlock the door and observed Mr Young slumped over with something tied around his neck from the window hinge. PG described Mr Young's face as being pale in colour.

37. PG immediately notified prison staff and Prison Officer Aaron Wood attended at the cottage shortly after. Mr Wood examined Mr Young and found him to be unresponsive. Mr Wood called a 'Code Black' and attempted to lift Mr Young but was unable to do so. He then attempted to untether a chained knife from the cottage kitchen.

38. Two other Bolac prison officers arrived on the scene from the officers' post to assist but they were unable to safely lift Mr Young's body weight nor cut the ligature.

39. A short time later, other prison staff arrived, including four Security and Emergency Services Group members who use a multi-tool (Leatherman) knife to cut the ligature. They moved Mr Young to the living room floor. Staff loosened the ligature from Mr Young's neck, check for signs of life and commence Cardiopulmonary Resuscitation (**CPR**) efforts.

40. CPR continued with the support of attending health staff. At approximately 10.46am, a doctor arrived and assessed Mr Young. He examined Mr Young and pronounced him to be deceased.

MEDICAL CAUSE OF DEATH PURSUANT TO SECTION 67(1)(b) OF THE ACT

41. On 3 October 2019, Dr Mohamed Hussain Mohamed Ameen Izzath, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy and provided a written report, dated 7 January 2020.

42. Dr Ameen Izzath concluded that a reasonable cause of death was *'hanging*.'

[10] A pseudonym.
[11] A pseudonym.

43. Dr Ameen Izzath commented that an abraded injury to the neck was in keeping with the circumstances of hanging and there was no evidence available to indicate the involvement of any other person in the death of Mr Young.

44. Toxicological analysis identified methadone and a metabolite of methadone in keeping with Mr Young's prescription medication.

45. I accept Dr Ameen Izzath's opinion as to cause of death.

INITIAL INVESTIGATION

46. On 30 September 2019, police attended the Bolac Community and conducted an examination of the scene, including:

    a. Attendance, examination and photographing of the scene.

    b. Seizure of a suicide note found on a desk in Mr Young's room.

    c. Interviewing prison staff relating to the circumstances surrounding the death of Mr Young and the background to it.

    d. Interviewing four prisoners who had recent contact with Mr Young and obtaining statements from them.

47. Following the initial investigation, Senior Constable Morris prepared a brief of evidence which was submitted to the Coroners Court of Victoria.

REVIEWS BY JARO AND JUSTICE HEALTH

48. On 19 March 2021, JARO provided a copy of its review into the death of Mr Young. The review provides an overview of Mr Young's management in custody and the circumstances of his death.

49. The JARO report acknowledged that Mr Young had ongoing concerns regarding his health and progress towards his release in his final two years in custody. These issues impacted his mood. In the direct lead up to his death, JARO found Hopkins' staff did not have knowledge of Mr Young's suicidal ideation. JARO found that Hopkins' custodial management of Mr Young met the prescribed standards of Corrections Victoria and case managers were proactive in assisting him to manage issues. JARO found that there were opportunities to strengthen system wide sentence progression processes where delegations are in place.

50. Additionally, the JARO review identified that the staff who responded to the Code Black were not in possession of an intervention knife that would be required to safely cut a ligature. While intervention knives were available, it was not standard practice to carry them. However, there was no evidence that the lack of an intervention knife impacted the outcome because second responders in possession of a different type of knife arrived at the scene within two minutes. JARO recommended that Corrections Victoria confirm with each prison location that its local policies or procedures ensure an intervention knife is carried by relevant staff when responding to incidents.

51. The JARO report noted that after Mr Young's death, information was reported to Hopkins staff about potential third party involvement and, for example, that Mr Young had accumulated debts with other prisoners. Hopkins referred this information to Victoria Police. This information was not provided to the Coroners Court within the original Coronial Brief, so I sought a statement from Victoria Police about their investigation into these allegations.

52. On 20 November 2021, Malcolm Wineberg from the Ararat Crime Investigation Unit provided a signed statement setting out a summary of the allegations received in relation to Mr Young's death and the police response to the allegations. In his statement, Detective Wineberg stated that in or around 3 October 2019, Hopkins received an information report that prisoners within Hopkins believed Mr Young may not have committed suicide and that he was "strung up".

53. Following receipt of this allegation, Detective Wineberg reviewed the information report with his supervisor, Detective Acting Sergeant Jason Boyd. They dismissed the information on the basis that:

    a. The scene showed no signs of struggle.

    b. Mr Young had no defensive wounds. As Mr Young was a large man it would have taken more than one person to hang him and there were no signs of a struggle. Further, drugs would most likely have been necessary to incapacitate Mr Young in order to suspend him. There was not high levels of drugs in his system identified on post-mortem.

    c. The CCTV footage did not show the involvement of any other person in his death.

    d. Mr Young had expressed a desire to end his own life prior to his death.

54. On 27 January 2022 Just prior to the inquest, Corrections Victoria wrote to the court with additional information. Specifically, An Information Report was generated in Centurion,

Corrections Victoria's intelligence database, on 22 July 2020 that indicates a prisoner at Hopkins Correctional Centre may have extorted significant amounts of money from Mr Young. The prisoner self-reported his actions regarding Mr Young when staff were interviewing him about his behaviours towards other prisoners.

55. This was not included in JARO's report, as at the time the information was reported, JARO's enquiries were complete and finalisation was awaiting the Justice Health addendum. Corrections Victoria noted in its letter to the Court that Victoria Police was made aware of the allegations at the time and the prisoner has since been released from prison. I am satisfied, on the basis from the entirety of the evidence, including that evidence contained in the Coronial Brief the Information Report and the investigations of the Ararat Crime Investigation Unit after Mr Young's death that the issues involving the accumulation of debts and extortion was not a relevant factor in Mr Young's suicide.

56. A report prepared by Justice Health, outlining Mr Young's health management while in custody was also provided to the Coroner. Justice Health's findings address a range of matters arising in the case of Mr Young and make recommendations for systemic improvements arising from Mr Young's death, including ensuring the clarity and consistency of 'at risk' referrals.

57. Corrections Victoria have accepted all the recommendations from the Health Justice and JARO reports.

58. I accept the conclusions of the JARO report and the Health Justice Report and acknowledge the recommendations.

FINDINGS AND CONCLUSION

59. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the Coroners Act 2008 that Travis Thomas Young, born 6 November 1976, died on 30 September 2019 at Hopkins Correctional Centre, Victoria, from hanging in the circumstances described above.

60. Having considered all of the circumstances, I am satisfied that Mr Young intentionally took his own life.

61. The coronial investigation has not yielded any evidence that any other person was involved in Mr Young's death or that he otherwise died in suspicious circumstances. I am satisfied that

Victoria Police investigated the anonymous allegations and find that those allegations were without substance.

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

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

Mr Scott Swanwick, Justice Health
Correct Care Australasia, c/- Kellie Dell'Oro, Meridien Lawyers
Senior Constable Julie Morris, Victoria Police, Coroner's Investigator.

Signature:

KATHERINE LORENZ
CORONER
Date: 1 February 2022