FINDINGS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

SAXON GEORGE HYATT

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Saxon George Hyatt, with an inquest held at Hobart in Tasmania, make the following findings.

Hearing Date

12 March 2021

Counsel Assisting

J Ansell

Circumstances Surrounding the Death

1. On 14 January 2019, Saxon George Hyatt died at Risdon Prison, Risdon Vale.

2. His death is subject to the *Coroners Act* 1995 (the "Act"). The Act relevantly provides that an inquest must be held where a death occurs in Tasmania and the deceased person was, immediately before their death, a person held in custody.

3. Accordingly an inquest was held into Mr Hyatt's death in Hobart on 12 March 2021.

4. As a result of the evidence tendered at that inquest I make the following formal findings pursuant to section 28 (1) of the *Coroners Act* 1995:

   (a) The identity of the deceased is Saxon George Hyatt;
   (b) Mr Hyatt died in the circumstances set out further in this finding;
   (c) The cause of Mr Hyatt's death was exsanguination, the result of the deliberate infliction by him of wounds to his left brachial artery and multiple wounds of right and left wrists; and
   (d) Mr Hyatt died on 14 January 2019 at Risdon Prison, Risdon Vale.

Background

5. Mr Hyatt was born on 5 July 1963 at the Queen Alexandra Hospital, Battery Point in Tasmania. He was the youngest of five children.[1]

[1] Exhibit C9

6. Mr Hyatt was 55 years of age at the time of his death.

7. Mr Hyatt grew up in Howrah with his parents and sisters. His father died in 2003 from emphysema and his mother was still alive at the time of Mr Hyatt's death.[2]

8. During his life Mr Hyatt worked variously in labouring jobs.[3]

9. He led an isolated existence. It would seem that due to his mental health Mr Hyatt had difficulty maintaining friendships.[4] At the time of his death, Mr Hyatt was not in a relationship. There is no evidence he had fathered any children.

Health

10. The evidence was that Mr Hyatt had, at various times during his life, been diagnosed as suffering from schizophrenia, bipolar disorder, anxiety, obsessive-compulsive disorder and major depression.[5] It is very evident that Mr Hyatt was at best "inconsistent" with respect to his compliance with the use of medication prescribed for him, choosing instead to frequently self-medicate with alcohol and cannabis.

11. The other health issue of significance occurred in 1984, when Mr Hyatt was involved in a motor vehicle accident, as a passenger on the back of a motorbike. The motorbike clipped a car and lost control. Mr Hyatt was thrown from the bike, landing on his head. Mr Hyatt appears to have suffered a left arm injury[6] as well as a head injury[7] in the accident.

12. A significant incident, in the context of Mr Hyatt's mental health, occurred on 30 June 2015. At the time Mr Hyatt was living alone in Clarendon Vale when a local GP mistakenly entered his residence (on a GP home visit intended for someone else). Mr Hyatt held the GP inside his home against her will until police arrived. Mr Hyatt was plainly delusional and believed the GP was an impostor. Police arrived and rescued the GP from Mr Hyatt. Police submitted a mental health referral to the CAT team for assessment. A complaint was taken by police at the time but later withdrawn by the GP. The CAT team attended the home of Mr Hyatt and spoke to him through the door. His engagement was limited and ultimately it was necessary for police to take Mr Hyatt to the RHH for his mental state to be assessed.

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[2] Exhibit C9
[3] Exhibit C9
[4] Exhibit C9
[5] Exhibit C36, page 90
[6] Exhibit C38, page 8, Exhibit C36, page 80
[7] Exhibit C36, page 90

13. Mr Hyatt was admitted to PICU under an assessment order. He was subsequently discharged with no ongoing follow up for mental health.

14. In the months leading up to his death, Mr Hyatt was incarcerated on several occasions. Each period of incarceration involved, *inter alia*, engagement with prison health services. Relevantly the timeline is as follows:

    (a) On 28 December 2018 Mr Hyatt was remanded in custody after assaulting his mother. He spoke with medical staff at the prison for his Tier 1 process assessment. At this time he was showing signs of alcohol withdrawal from being a heavy drinker. He reported that his mental health was well managed and he denied any previous or current thoughts of self-harm.

    (b) On 3 January 2019, Mr Hyatt was returned to prison (after being bailed and breaching a restraint order) and a Tier 1 process assessment was completed by the medical staff in the prison system. He was placed on suicide and self-harm (SASH) alert, as a precaution. Records tendered at the inquest indicate that during the process Mr Hyatt was settled and again denied any suicidal thoughts. Nor did he reveal the incident in which resulted in him being incarcerated (i.e. an assault upon his mother). Mr Hyatt was kept on SASH alert overnight.

    (c) The following day, 4 January 2019, Mr Hyatt was seen by Dr C J Wake and indicated he had been diagnosed with Hepatitis C which was likely from a tattoo in 1984. Dr Wake noted that Mr Hyatt was taking Duloxetine 60mg a day for depression. He told Dr Wake he was smoking 3 cannabis "joints" a day, was drinking heavily and using medication to help him sleep. Mr Hyatt did not mention any thoughts of self-harm to Dr Wake. Later the same day, Mr Hyatt was reviewed by the prison Risk Intervention Team (RIT). The records tendered at the inquest of that assessment indicate that Mr Hyatt was settled and polite. No concerns by the RIT were noted. Mr Hyatt strongly denied current SASH issues and was informed of the support that could be provided to him. RIT agreed to discharge him from the RIT process. Mr Hyatt noted he would seek support as he required and no other follow up at this time. The SASH alert was ended.

    (d) Once the SASH ended there was no further mental health assessment, nor was there any need for one, in my view. No mental health concerns appeared to correctional staff and Mr Hyatt did not show any signs of suicide or self-harm from this point forward.

(e) At approximately 11.15am on 11 January 2019, Mr Hyatt was taken from the Hobart Reception Prison in a correctional vehicle to the main Risdon Prison complex. At 11.27am, whilst *en route*, a prisoner welfare check was conducted and Mr Hyatt was noted as 'OK'. The vehicle arrived at Risdon Prison at 11.40am. Mr Hyatt spent the rest of the time until his death in Risdon Prison in cell C5 of the Barrington Unit.

Circumstances of Death

15. At approximately 2.24pm on 14 January 2019 in the Barrington Charlie Unit, Mr Hyatt was assaulted[8] by a fellow inmate, Rodney Bailey. Bailey struck Mr Hyatt to the left side of his face. The incident was caught on CCTV. In the immediate aftermath prison staff asked Mr Hyatt whether he required medical assistance but he declined. He also declined to make a complaint which would have involved Tasmania police. It did not appear to prison staff that Mr Hyatt had suffered any injury; as a consequence, not unreasonably in my view, he received no medical treatment.

16. Mr Hyatt requested he be moved to a minimum security unit and the duty supervisor at the time told Mr Hyatt he was unable to move straight away but that his file would be reviewed to see if Mr Hyatt could be put in for a discretionary classification. Mr Hyatt was asked if he felt safe to return to his unit and he said that he did.[9]

17. After the assault, Mr Hyatt went back to his usual activities and nothing appeared out of character. Mr Hyatt did not show any signs of self-harm or suicide and did not raise any concerns with correctional staff.[10]

18. At 7.31pm, Christopher Goss, a fellow prisoner, was in his cell (C3) and heard someone say "help help". Initially, Mr Goss ignored it as he thought someone was playing a joke on him however he heard "help" again and realised it was coming from near the toilet. Mr Goss got up and walked towards the toilet blocks and stopped at C5 (Mr Hyatt's cell). Mr Goss called out to Mr Hyatt and said "are you alright?"[11]

19. Mr Hyatt replied "I've slashed up". Mr Goss ran to the intercom and requested medical to come and help.[12] He then went back to C5 and bashed on his door (it was locked from the inside). Mr Hyatt continued to call for help. Mr Goss asked him to open the

[8] Exhibit C42
[9] Exhibit C12
[10] Exhibit C14
[11] Exhibit C24
[12] Exhibit C24

door and he eventually did so (CCTV shows it occurring at 7.34pm). After opening his cell door, Mr Hyatt collapsed on the bed in the cell.

20. Meanwhile prison staff responded immediately to a 'code blue' (medical emergency). The evidence at the inquest satisfies me that the response of prison staff (including medical staff) was timely and appropriate. Upon their arrival, staff found Mr Hyatt on the floor of his cell covered in blood, although responsive. All prisoners in the unit were ordered to return to their cells.

21. Mr Hyatt was pale, weak and not very coherent. Mr Hyatt told TPS that he had self-harmed and showed TPS cuts to his inner elbow joints. There was blood on the floor, mattress, clothing, bed sheets and towels in the cell.[13]

22. When asked why he had cut himself, Mr Hyatt had responded "just life".[14]

23. Ambulance Tasmania was phoned at 7.41pm. Using a sheet, prison staff took Mr Hyatt to a common area to commence first-aid. Mr Hyatt, who was still at this stage responsive, was provided with oxygen therapy. Paramedics from Ambulance Tasmania arrived at 7.59pm. Shortly after their arrival, Mr Hyatt went into cardiac arrest. CPR was commenced and continued until about 9.30pm when a doctor pronounced Mr Hyatt deceased.

Investigation

24. The fact of Mr Hyatt's death was reported in accordance with the requirements of the *Coroners Act* 1995. Police, including uniform, detectives and forensic experts, attended the prison and carried out a thorough investigation. I also attended in the company of Dr Christopher Lawrence, Forensic Pathologist.

25. Nothing was identified as part of the investigation which would suggest that Mr Hyatt's death was anything other than suicide or anyone else was involved.

26. His body was formally identified and then taken by mortuary ambulance to the Royal Hobart Hospital where Dr Lawrence carried out an autopsy. Dr Lawrence expressed the opinion in his report, which I accept, that the cause of Mr Hyatt's death was exsanguination.

[13] Exhibit C13
[14] Exhibit C13

Conclusion

27. It is apparent that Mr Hyatt had a lengthy history of mental health issues, which well predated him being detained in prison. He also had a history of difficulties with alcohol. I am quite satisfied that his non-compliance with medical advice exacerbated his health issues. I am satisfied that the actions which caused his death were undertaken by him voluntarily, alone and with the express intention of ending his own life.

28. The evidence at the inquest satisfies me to the requisite legal standard, that the care, supervision and treatment of Mr Hyatt whilst incarcerated at HMP Risdon was adequate and in no way contributed to his death.

29. The circumstances of Mr Hyatt's death do not require me to make any further comments or recommendations pursuant to section 28 of the *Coroners Act* 1995.

30. I express my particular thanks to Ms Jane Ansell, counsel assisting.

Dated 19 March 2021 at Hobart in the State of Tasmania.

Simon Cooper
Coroner