IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 5253

FINDING INTO DEATH WITH INQUEST

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

Findings of:	**CAITLIN ENGLISH, ACTING STATE CORONER**
Deceased:	**LESLIE HAWKINS**, born 25 May 1961
Delivered on:	21 August 2019
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	21 August 2019
Counsel assisting the Coroner:	Nicholas Ngai, Family Violence Senior Solicitor
Catchwords:	Suspected homicide, no person charged with an indictable offence in respect of a reportable death, mandatory inquest

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HER HONOUR:

BACKGROUND

1. Leslie Hawkins (**Mr Hawkins**) was born in Williamstown, Victoria, on 25 May 1961. He was 57 years old at the time of his death. Mr Hawkins had been married twice and was married to his second wife, Mrs Kerry Hawkins (**Mrs Hawkins**), for approximately 25 years prior to their deaths.

2. Mr Hawkins attended school until the age of 16 and worked in axle maintenance in the railways and then later as a truck driver.[1] Mr Hawkins is reported to have experienced a number of incidents with his work as a truck driver and ceased employment around 2015.[2]

3. Mr Hawkins was diagnosed with dementia in December 2016 and was being treated with Donepezil[3] by medical practitioners at the Cognitive Dementia and Memory Service located in the Footscray Hospital.[4]

4. Mr Hawkins is also reported to have a prolonged history of excessive alcohol consumption and smoking, drinking *"12 stubbies a day for many years"*[5] and smoking, "*30 cigarettes per day for 40 plus years*".[6] Mr Hawkins reduced his alcohol consumption around January 2016.

5. In May 2018, Mrs Hawkins was diagnosed with late stage pancreatic cancer. Donna Kille (**Donna**), Mr and Mrs Hawkins' daughter, attended their residence on a regular basis in the several months prior to the fatal incident and assisted in caring for her parents. Mrs Hawkins also had a palliative care nurse who visited daily to administer medication and monitor Mrs Hawkins' health.[7]

6. Mrs Hawkins' close friend, Ms Debra Lythgo (**Debra**), also frequently tended to Mr and Mrs Hawkins to assist with household responsibilities and care for the couple in the months leading up their deaths.[8]

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[1] *Coronial Brief*, Report of Dr Saad Albarki dated 25 August 2016, 39-40
[2] *Coronial Brief*, Report of Dr Saad Albarki dated 25 August 2016, 40
[3] Donepezil is a medication used to treat confusion (dementia) related to Alzheimer's disease
[4] *Coronial Brief*, Correspondence from Dr Mark Johannesen dated 2 November 2017, 46
[5] *Coronial Brief*, Report of Dr Saad Albarki dated 25 August 2016, 39
[6] *Coronial Brief*, Report of Dr Saad Albarki dated 25 August 2016, 39
[7] *Coronial Brief*, Statement of Debra Lythgo dated 18 October 2018, 12
[8] *Coronial Brief*, Statement of Debra Lythgo dated 18 October 2018, 12

THE PURPOSE OF A CORONIAL INVESTIGATION

7. Mr Hawkins' death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria[9] and was violent, unexpected and not from natural causes[10].

8. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[11] 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 the death occurred.[12]

9. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[13] It is also not the coroner's role to determine criminal or civil liability arising from the death under investigation,[14] or to determine disciplinary matters.

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

11. For coronial purposes, the phrase "*circumstances in which death occurred,*"[15] 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 death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

12. 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. This is generally referred to as the Court's "*prevention*" role.

13. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[16]

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[9] Section 4 *Coroners Act 2008*
[10] Section 4(2)(a) *Coroners Act 2008*
[11] Section 89(4) *Coroners Act 2008*
[12] See Preamble and s 67, *Coroners Act 2008*
[13] *Keown v Khan* (1999) 1 VR 69
[14] Section 69 (1)
[15] Section 67(1)(c)
[16] Section 72(1)

(b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[17] and

(c) 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.[18] These powers are the vehicles by which the prevention role may be advanced.

14. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[19] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[20] 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.

15. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was as a result of homicide (and no person or persons have been charged with an indictable offence in respect of the death), or the deceased was immediately before the death, a person placed in custody or care, or the identity of the deceased is unknown.

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

Identity of the Deceased pursuant to section 67(1)(a) of the Act

16. On 24 October 2018, Joshua Hawkins visually identified the deceased to be his father, Leslie Hawkins, born 25 May 1961.

17. Identity is not in dispute in this matter and requires no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the Act

18. On 19 October 2018, Dr Joanna Glengarry, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the deceased's body. Dr Glengarry provided a written report, dated 17 December 2018, which concluded that Mr Hawkins died from complications of opioid (hydromorphone and morphine) toxicity and incised wounds of the wrists in a man with ischaemic heart disease.

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[17] Section 67(3)
[18] Section 72(2)
[19] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152
[20] (1938) 60 CLR 336

19. Dr Glengarry commented on the following in her written report:

(a) Toxicological analysis of blood samples taken at the time of admission to hospital detected Hydromorphone and free morphine, however neither medication was administered by ambulance or hospital staff. Hydromorphone is a centrally acting opioid pain medication, an adverse effect of which is respiratory depression. It may also cause hypotension (low blood pressure), particularly in one who is concurrently compromised in their ability to maintain blood pressure due to blood loss. The combination of both hydromorphone and morphine found in the deceased's blood was sufficient to cause his death.

(b) A subcutaneous butterfly catheter was inserted in the right side of the abdomen. This is a small medication delivery tube that sits beneath the skin to slowly deliver medications. This was not inserted by ambulance officers or hospital staff.

(c) There were incised wounds to the wrists, two on the left and one on the right. The incisions of the left wrist inflicted greater severity of injury than the incision of the right wrist as they transected both the radial artery and vein, these being the main blood supply to the hand. It is possible for significant blood loss to result from damage to these vessels and the scene findings of emergency services are suggestive of significant blood loss. There was also an incision of the radius (bone of the thumb side of the wrist and forearm). Both wrists also had transection of tendons and fibrous structures in the wrists.

(d) The autopsy found evidence of natural disease in the form of ischaemic heart disease, fatty liver and diabetic kidney disease. The presence of ischaemic heart disease is potentially contributory to death as it renders one susceptible to the development of cardiac arrhythmias in combination with anaemia or hypotension.[21]

20. Toxicological analysis of post mortem specimens taken from the deceased identified the presence of ethanol, hydromorphone, free morphine, lignocaine and ondansetron.[22] Hospital and emergency services records do not indicate that any oral medication was provided to the deceased, and it would appear that the stomach contents reflect an ingestion of morphine.

[21] Both anaemia or hypotension can result as a consequence of blood loss.

[22] Ethanol (Alcohol) was detected at a concentration of 0.05g/100ml, Hydromorphone was detected at a concentration of 0.3-0.4 mg/L, Free Morphine was detected at a concentration of 0.1-0.2 mg/L, Lignocaine was detected at a concentration of 0.2 mg/L and Ondansetron was detected at a concentration of 0.07 mg/L.

Ondansetron was prescribed in hospital medical records but lignocaine which is commonly used as resuscitation medication was not recorded as being administered.

21. I accept the cause of death proposed by Dr Glengarry.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the Act

22. On 18 October 2018, Mr and Mrs Hawkins were at home with their daughter, Donna, and Mrs Hawkins' carer and long-term friend, Debra. At approximately 11.00am, Mrs Hawkins asked Donna and Debra to leave the house, so that she and Mr Hawkins could spend some time alone together. Donna and Debra left at approximately 12.30pm and returned around 4.00 pm.[23]

23. Donna and Debra were met at the door by Mrs Hawkins who advised them that Mr Hawkins was asleep and that they should return later. Donna and Debra left the residence and did not return until approximately 6.00pm.[24] Donna and Debra walked into the residence and found Mr and Mrs Hawkins lying in their bed in their bedroom which was located close to the front of the house.[25]

24. Mrs Hawkins awoke and spoke to Donna saying that "*you need to call an ambulance*".[26] Both Donna and Debra noticed that Mr Hawkins was struggling to breath. Mrs Hawkins then pulled the doona cover on the bed back to reveal a large pool of blood underneath.[27] Debra called emergency services and whilst on the phone to the emergency operator, Donna performed CPR on Mr Hawkins whilst Mrs Hawkins was touching his face. Donna continued performing CPR for approximately 10-15 minutes before ambulance paramedics arrived on scene.[28] Mr Hawkins was transported to Sunshine Hospital whilst Mrs Hawkins was transported to Footscray Hospital.[29]

25. At 6.55pm, a detective from the Wyndham Crime Investigation Unit attended the scene and spoke to Mrs Hawkins prior to her being transported to hospital for treatment of her injuries. She advised she had cut her own wrists and when asked what had happened to Mr Hawkins,

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[23] *Coronial Brief*, Statement of Debra Lythgo dated 18 October 2018, 12-13; Statement of Donna Kille dated 18 October 2018, 1-2
[24] *Coronial Brief*, Statement of Debra Lythgo dated 18 October 2018, 12-13; Statement of Donna Kille dated 18 October 2018, 1-2
[25] *Coronial Brief*, Statement of Debra Lythgo dated 18 October 2018, 13-14; Statement of Donna Kille dated 18 October 2018, 2
[26] *Coronial Brief*, Statement of Donna Kille dated 18 October 2018, 2
[27] *Coronial Brief*, Statement of Debra Lythgo dated 18 October 2018, 14
[28] *Coronial Brief*, Statement of Debra Lythgo dated 18 October 2018, 15
[29] *Coronial Brief*, Statement of Detective Leading Senior Constable Frank Fierro dated 12 March 2019, 63-64

she stated that she had also cut his wrists and had used a box cutter which was later found on a kitchen bench in the residence.[30]

26. On 19 October 2018 at approximately 3.05am, Mr Hawkins passed away from his injuries and was pronounced deceased by treating emergency physicians.[31]

27. On 27 October 2018, Mrs Hawkins passed away of natural causes in the Werribee Mercy Hospital Palliative Care Unit.[32]

28. On 3 November 2018, a hand-written note was found by Mr Hawkins' son-in-law, Matthew Kille, who attended the Werribee Police Station and handed in the letter signed by Mr and Mrs Hawkins.[33] The letter outlined that both Mr and Mrs Hawkins had entered into a suicide pact after Mrs Hawkins had been diagnosed with terminal pancreatic cancer and Mr Hawkins did not want to go into a nursing home after Mrs Hawkins's death.[34]

29. On 24 November 2018, a palliative care nurse from Werribee Mercy Hospital who was caring for Mrs Hawkins prior to her death, took a bag containing a lotto ticket, chocolates and a thank you card to the Werribee Police Station.[35] The thank you card contained two pages outlining Mrs Hawkins' reasons for the suicide pact between herself and her husband, Mr Hawkins. The reasons for the suicide pact outlined in the thank you card note was again that Mrs Hawkins had been diagnosed with terminal pancreatic cancer and Mr Hawkins did not want to go into a nursing home after Mrs Hawkins's death.[36]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Family Violence

30. For the purposes of the *Family Violence Protection Act 2008* (Vic) (the Act), the relationship between Mr and Mrs Hawkins clearly fell within the definition of "*family member*"[37] under

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30 *Coronial Brief*, Statement of Detective Leading Senior Constable Frank Fierro dated 12 March 2019, 61-63
31 *Coronial Brief*, Statement of Dr David Alexander dated 8 February 2019, 29
32 *Coronial Brief*, Statement of Detective Leading Senior Constable Frank Fierro dated 12 March 2019, 64
33 *Coronial Brief*, Statement of Detective Leading Senior Constable Frank Fierro dated 12 March 2019, 65; Statement of Mathew Kille dated 15 March 2019, 59
34 *Coronial Brief*, Statement of Detective Leading Senior Constable Frank Fierro dated 12 March 2019, 65; Statement of Mathew Kille dated 15 March 2019, 59
35 *Coronial Brief*, Statement of Catherine Adele Burnett dated 11 December 2018, 26
36 *Coronial Brief*, Statement of Detective Leading Senior Constable Frank Fierro dated 12 March 2019, 65
37 Family Violence Protection Act 2008, section 9(1)(b)

that Act. Moreover, in slicing Mr Hawkins' wrists and causing his death, Mrs Hawkins' actions constitute "*family violence.*"[38]

31. Considering Mr Hawkins' death occurred in circumstances of family violence, I requested that the Coroners' Prevention Unit (CPU)[39] examine the circumstances of Mr Hawkins' death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD).[40]

32. The available evidence, however, suggests that there was no discernible history of family violence between Mr and Mrs Hawkins. Both Mr and Mrs Hawkins' actions appear to have been driven by Mrs Hawkins' recent diagnosis of terminal pancreatic cancer and Mr Hawkins' desire to die with Mrs Hawkins to avoid being moved into a nursing home.

33. I am satisfied, having considered all the available evidence, that no further investigation is required.

FINDINGS AND CONCLUSION

34. Having investigated Mr Hawkins' death and having held an inquest in relation to his death on 21 August 2019, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) that the identity of the deceased was Leslie Hawkins, born 25 May 1961;

    (b) that Mr Hawkins' died on 18 October 2018, at 4 Lilac Court, Wyndham Vale, Victoria, from complications of opioid (hydromorphone and morphine) toxicity and incised wounds of the wrists; and

    (c) that the death occurred in the circumstances set out above.

35. I convey my sincerest sympathy to Mr Hawkins' family.

36. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

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

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[38] Family Violence Protection Act 2008, section 5(1)(a)(i)

[39] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety

[40] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community

(a) Ms Donna Kille, Senior Next of Kin; and

(b) Detective Leading Senior Constable Frank Fierro, Coroner's Investigator, Victoria Police.

Signature:

CAITLIN ENGLISH

ACTING STATE CORONER

Date: 21 August 2019