IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2018 000014**

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)
*Section 67 of the **Coroners Act 2008***

INQUEST INTO THE DEATH OF HASSAN JENG

Findings of:	Judge John Cain, State Coroner
Delivered on:	1 February 2023
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	1 February 2023
Assisting the Coroner:	Ms Abigail Smith, Senior Coroner's Solicitor Coroners Court of Victoria
Representation:	Ms Poppy Jacobs on behalf of the Department of Justice and Community Safety Ms Ingrid Nunnink on behalf of G4S Custodial Services Pty Ltd
Keywords:	Homicide; uncharged homicide; death in custody; stabbing; Port Phillip Prison

TABLE OF CONTENTS

BACKGROUND

1. On 1 January 2018, Hassan Jeng (**Mr Jeng**) was 23 years old when he died in custody in the Scarborough North Unit at Port Phillip Prison (**PPP**).

2. Mr Jeng was born on 27 April 1994 in Sierra Leone. In 2006 at 12 years of age, he arrived in Australia with his mother as a refugee. Mr Jeng first came to the attention of the criminal justice system in 2009.

3. Mr Jeng had a history of illicit substance use including cocaine, marijuana, and crystal methamphetamine. He also had a history of mental illness and had been prescribed medication for this condition.

4. On 5 June 2017, Mr Jeng was remanded into custody on charges of recklessly causing injury, intentionally causing injury, theft of a motor vehicle and theft. He was due to stand trial on 11 April 2018. At the time of his death, Mr Jeng was housed in the Scarborough North Unit of PPP.

5. On 1 January 2018, shortly before 7.00pm, Mr Jeng was located in cell 453 of Scarborough North Unit at PPP suffering from stab wounds. First aid was administered but he was later declared deceased in cell 453 by attending paramedics.

THE PURPOSE OF A CORONIAL INVESTIGATION

6. Mr Jeng's death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as Mr Jeng ordinarily resided in Victoria[1] and the death appears to have been unexpected and violent.[2]

7. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the death occurred in Victoria and the deceased was immediately before death a person placed in custody or care.

8. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[3] 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.[4]

---

1 *Coroners Act 2008* (Vic) s 4.
2 *Coroners Act 2008* (Vic) s 4(2)(a).
3 *Coroners Act 2008* (Vic) s 89(4).
4 *Coroners Act 2008* (Vic) preamble and s 67.

9. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[6] 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*,"[7] 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;[8]

    (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;[9] 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.[10] 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.[11] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[12] The effect of this and similar authorities is that coroners should not

---

5 *Keown v Khan* (1999) 1 VR 69.
6 *Coroners Act 2008* (Vic) s 69 (1).
7 *Coroners Act 2008* (Vic) s 67(1)(c).
8 *Coroners Act 2008* (Vic) s 72(1).
9 *Coroners Act 2008* (Vic) s 67(3).
10 *Coroners Act 2008* (Vic) s 72(2).
11 *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
12 (1938) 60 CLR 336.

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. Sergeant Julio Salerno was appointed the Coroner's Investigator and submitted a coronial brief.

16. This finding draws on the totality of the material the product of the coronial investigation of Mr Jeng's death. That is, the investigation and inquest brief and the statements, reports and any documents obtained through the investigation. All this material will remain on the coronial file. In writing this finding, I do not purport to summarise all of the evidence but refer only in such detail as appears warranted by its forensic significance and interests of a narrative clarity.

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

17. On 5 January 2018, Mr Hassan Jeng, born 27 April 1994, was identified by way of fingerprint comparison.

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

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

19. At 10.50pm on 1 January 2018, Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) attended the Scarborough North Unit and observed a deceased male in a prison cell. Dr Glengarry observed stab wounds to the chest and medical paraphernalia present in the cell. She provided an opinion at the scene that the wound appeared to have been inflicted by a weapon with a single edged blade.

20. On 2 January 2018, Dr Khamis Almazrooei, a legally qualified medical practitioner and registrar in forensic pathology, practising at the VIFM performed an autopsy on the body of Mr Jeng. Dr Almazrooei provided a written report of his findings dated 13 April 2018.

21. The post mortem examination revealed:

    - three stab wounds to the chest, one stab wound to the back and one stab wound to the face;

    - right occipital subgalea haematoma, one bruise on the right knee and two bruises on the left shin which were considered to be non-specific;

- bruises on the right and left arms which were most likely secondary to medical intervention; and

- natural disease in the form of histological features of asthma was identified. Dr Almazrooei opined that this did not contribute significantly to Mr Jeng's death.

22. Dr Almarzrooei made the following observations in relation to the stab wounds:

    - '*The stab wounds, by definition, were caused by a sharp implement such as a knife. Many of these injuries came to an acute angle at one end of the wound. This feature is commonly seen when blades with a single sharp edge have caused the injury.*

    - *There are several variables that should be considered when assessing the amount of force required to inflict such an injury. These include the resistive effect of skin, overlying clothing, depth of subcutaneous tissues, sharpness of the tip and blade of the inflicting implement and relative kinetic energy conferred on the blade. Having considered these variables, and on a scale of mild/moderate/severe and considering that the chest and back wounds involved skin, subcutaneous muscle, costal cartilage, and multiple organ layers. In my opinion, the degree of force of these injuries was at least moderate.*

    - *The post-mortem examination showed no evidence of defensive type injuries on the arms or legs which suggests that most likely the deceased had no opportunity to raise hands/arms to grab the blade or ward it off'*.[13]

23. Toxicological analysis of blood detected fluoxetine and its metabolite, norfluoxetine, olanzapine, and celecoxib. Paracetamol, olanzapine, fluoxetine and its metabolite, norfluoxetine were detected in the urine. Ethanol (alcohol) was not detected.

24. Dr Almazrooei concluded that a reasonable cause of death was:

    1(a) STAB WOUNDS TO THE CHEST AND BACK.

25. I accept the opinion of Dr Almarzrooei as to cause of death.

[13] Medical Examiner's Report, p 4.

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

Management of Mr Jeng by Corrections Victoria

26. Before turning to the precise circumstances of Mr Jeng's death, it is relevant to summarise Mr Jeng's management by Corrections Victoria during the time he was remanded in custody from 5 June 2017.

27. On 5 June 2017, Mr Jeng was received into custody at the Melbourne Assessment Prison (**MAP**) where he was assessed by the Sentence Management Panel (**SMP**). SMPs carry out the function of prisoner classification which includes determining a prisoner's security rating and placement, as well as developing a prisoner sentence plan. The SMPs are comprised of a Chairperson and at least one other panel member who is usually an employee of Corrections Victoria. The purpose of a SMP assessment is to determine an appropriate prison to transfer a prisoner to, based on their classification.[14]

28. Mr Jeng was assessed, classified and ascribed a 'P1' alert which meant that he had been assessed as having a serious psychiatric condition requiring intensive and/or immediate care, as well as an 'S3' rating which meant that Mr Jeng was a potential risk of suicide or self-harm. As a consequence of this rating, he was placed on hourly observations.

29. On 8 June 2017, Mr Jeng's 'S3' rating was reduced to a 'S4' rating which indicated that he had previous history of self-harm behaviour.

30. On 29 June 2017, Mr Jeng was reassessed by the SMP and his 'P1' alert was reduced to a 'P2' alert which meant that he was able to be assessed for placement at another facility.

31. On 12 August 2017, following a disagreement, Mr Jeng head butted a fellow prisoner multiple times, and he was subsequently separated from other prisoners.[15] As a result of this incident, Mr Jeng was ascribed an 'A2' rating meaning that he required maximum security placement.

32. On 14 August 2017, the SMP reassessed Mr Jeng and determined that he could be transferred to a mainstream prison. Notwithstanding he was a remand prisoner, it was determined that Mr Jeng should be transferred to a prison capable of taking prisoners with an 'A2' rating. It was determined that Mr Jeng would be transferred to PPP. On 15 August 2017, Mr Jeng was transferred to the Fishburn East Unit at PPP.

[14] Statement of Jennifer Anne Hosking dated 17 September 2021, [14] to [15]. See also AC 2 '*Sentence Management Panels'* of the Corrections Victoria Sentence Management Manual.
[15] Statement of Jennifer Anne Hosking dated 17 September 2021,[22].

33. On 9 November 2017, following an assault by Mr Jeng on another prisoner he was transferred from the Fishburn East Unit to Scarborough North Unit of PPP. Mr Jeng was subsequently placed in a cell with a sentenced prisoner. This prisoner was known to Mr Jeng and they were assessed as having similar background and therefore suitable for sharing a cell.[16]

Events of Monday 1 January 2018[17]

34. On Monday 1 January 2018, CCTV footage from the Scarborough North Unit shows prisoners attending to their daily routines. The correctional officers are seen to be seated at the guard station desk located on the lower level of the Scarborough North Unit at the western end of the complex.

35. At 6:34pm, prisoners Temesgen Gebreyonas (**Mr Gebreyonas**) and Mr Yousef Ali (**Mr Ali**) met on the upper floor tier, where they commenced walking laps of the southern side of the complex for approximately five minutes.

36. At 6:39:34pm, it appears that Mr Gebreyonas' attention was directed towards a group of prisoners seated at a table on the ground level of the complex outside cells 408/409. Jacob Williams (**Mr Williams**) was standing alongside the table and immediately turned to face Mr Gebreyonas and pointed toward him. The CCTV footage shows that words were exchanged between the prisoners. Mr Gebreyonas then turned and made his way into cell 453 which housed Mr Williams and Mr Justin Nikora, (**Mr Nikora**), followed by Mr Ali.

37. Mr Williams and Mr Shaun Franklin (**Mr Franklin**) made their way up the stairs and into cell 453. At the entrance to cell 453, Mr Gebreyonas and/or Mr Ali appeared to attempt to exit the cell when Mr Williams and Mr Franklin forced them back in. Other prisoners who were in the close vicinity appeared to focus their attention on cell 453. There was no movement from the guard station at this time.

38. Another prisoner named Joshua Fuller (**Mr Fuller**) then made his way up the stairs and entered cell 453, before closing the door behind him. There were then five prisoners in the cell, Mr Gebreyonas, Mr Ali, Mr Williams, Mr Franklin and Mr Fuller.

39. At 6:41:31pm, Mr Nikora walked up the stairs and into cell 453, closing the door behind him. At this time, Mr Jeng was seated at a table on the lower level of the Scarborough North Unit located outside cell 399.

[16] Statement of Jennifer Anne Hosking dated 17 September 2021,[50].
[17] This section draws on a review of the CCTV footage from the Scarborough North Unit on 1 January 2018.

40. At 6:41:49pm, the door to cell 453 opened. Mr Gebreyonas is seen to stumble out of the cell followed by Mr Ali. It was at this time that Mr Jeng appeared to notice Mr Gebreyonas and Mr Ali walking back to cell 456. Mr Jeng is seen to make his way up the stairs located at the southwest side of the complex and to Mr Gebreyonas' cell. At this point in time, Mr Williams, Mr Franklin and Mr Nikora remained in cell 453.

41. At 6:42:52pm, Mr Ali is seen to leave cell 456 and make his way down to the ground floor where he approached prisoner Abshir Ali (**Mr Abshir**) who was speaking with other prisoners at the table in the vicinity of cells 408/409. Mr Abshir then followed Mr Ali up to Mr Gebreyonas' cell.

42. Mr Jeng left Mr Gebreyonas' cell and walked around to his cell (cell 448). In the doorway to his cell, Mr Jeng removed his slides (slippers) and put on a pair of runners before closing the cell door behind himself. Approximately 27 seconds later, Mr Jeng came out of his cell and made his way back to Mr Gebreyonas' cell (cell 456).

43. At this time, the CCTV shows the correctional officers sitting at the guard station on the lower level of the Scarborough North Unit engaged in conversation. A number of prisoners can also be seen moving in and around the cells and general area.

44. At 6:45:26pm, Mr Jeng, Mr Abshir and Mr Ali left cell 456 and had a brief discussion, before being followed by Mr Gebreyonas. The CCTV footage shows Mr Nikora leaving cell 453. Mr Abshir then entered cell 453 followed by Mr Jeng, Mr Ali and Mr Gebreyonas.

45. Mr Abshir and Mr Gebreyonas then exited cell 453 and returned to cell 456, followed by Mr Jeng and Mr Ali. The CCTV footage then shows Mr Fuller and Mr Franklin exiting cell 453 and standing against the balustrade outside of Mr Williams' cell looking in a westerly direction toward the guard station.

46. At 6:48:55pm, Mr Abshir walked into cell 453 where Mr Nikora and Mr Williams were located. At 6:49.18pm, Mr Ali, Mr Jeng and Mr Gebreyonas left cell 456 and went to cell 453 where they waited outside the closed cell door. The door to cell 453 opened, and all three entered. Mr Franklin and Mr Fuller then followed them into the cell. The door was shut behind them.

47. At this point in time, there were eight (8) persons inside cell 453 – that being, Mr Jeng, Mr Ali, Mr Abshir, Mr Gebreyonas, Mr Williams, Mr Franklin, Mr Fuller and Mr Nikora. The available evidence suggests that it was at this time that Mr Jeng was stabbed multiple times.

While the CCTV footage shows prisoners on the ground level focusing their attention on the cell 453, the footage does not show any movement from the guard station.

48. At 6:51:41pm, Mr Ali and Mr Gebreyonas left cell 453 and returned to their respective cells. They were followed by Mr Nikora, who was now wearing a green t-shirt and went down the stairs into cell 406. Mr Franklin also exited cell 453 and went down the stairs into cell 408. He was followed by Mr Williams who went down the stairs to cell 406.

49. Mr Williams partially opened the door of cell 406 and remained at the door facing inwards for a few seconds before he returned to cell 453. At the same time, Mr Ali left his cell and returned to cell 453. Mr Williams entered the cell and Mr Ali remained at the door briefly. Mr Ali walked away a short distance before he double backed towards cell 453, when again Mr Williams left cell 453 and went to the ground level of the unit.

50. Mr Ali then walked along the southern side of the top tier of the complex and took the southwest staircase down to the guard station. He reported to the on-duty correctional officers who were still seated at the guard station that Mr Jeng had been injured.

51. A correctional officer accompanied Mr Ali to cell 453 to assess the situation and raised the alarm. The CCTV footage shows Mr Ali returning to his cell and engaging in a brief conversation with a prisoner on the ground floor. Before he enters his cell, Mr Ali is seen to shake his head and gesture to the prisoner, hitting his right hand against the left side of his chest in what appeared to be a stabbing motion.

52. All prisoners were locked down in the cells immediately.

53. Mr Jeng was attended to by the prisoner officers, nurses and others where first aid was administered until paramedics arrived. Sadly, Mr Jeng was subsequently pronounced deceased in the cell.

FURTHER INVESTIGATIONS

54. The focus of my investigation into Mr Jeng's death was on the events leading to the fatal incident, including his custodial management, policies and procedures in place at PPP, including the response and management of the incident by Corrections Victoria.

55. Of relevance to my investigation was the review of Mr Jeng's death by the Justice Assurance and Review Office (**JARO**) and the criminal investigation conducted by the Victoria Police Homicide Squad. I will now deal with each of these investigations in turn.

Review by JARO

56. JARO drives continuous improvement in Victoria's critical justice system, operating as an internal assurance and review function to advise the Secretary of the Department of Justice and Community Safety on ways to achieve higher performing, safer and more secure youth and adult corrections systems.

57. JARO conducts impartial reviews, monitoring and analysis into areas of risk and significant incidents and adopts a continuous improvement approach when finding new opportunities and improvements.

58. On 14 December 2018, JARO provided the Court with a copy of the '*Review into the death of Mr Hassan Jeng (CRN 202557) at Port Philip Prison on 1 January 2018*' (**JARO Report**). The JARO report details and critiques the circumstances surrounding Mr Jeng's death, as well as the response to and management of, the incident. The JARO Report also considered Mr Jeng's custodial management including his placement at PPP.

59. The JARO report found[18]:

Response to and management of the incident

- Staff could have provided additional details when calling codes, so that responding staff could provide a proportionate response.
- Staff waited for the completion of the 'Isolate, Contain and Evacuate' (ICE) method prior to conducting a check of Mr Jeng's injuries.
- Four issues existed with the overall control of the incident, including Correctional Officers directing the response, the number of staff that attended the incident, paramedics difficulty in accessing the prison and the incident reports provided by staff.

Placement of and management of Mr Jeng at PPP

- Mr Jeng's placement at PPP was consistent with Correction Victoria's prescribed standards.

[18] JARO Report, p 4.

- Mr Jeng was met with the required minimum frequency by his case manage in the Scarborough North Unit. However, there may have been scope to engage with him further, to gain a better understanding of his underlying risks and needs.

Other matters relevant to the incident

- In the lead up to, and during the assault on Mr Jeng, the opportunity to challenge the congregation of prisoners inside and just outside cell 453 was missed and there is an inconsistency between PPP staff regarding the type of prisoner behaviour or activity that is considered acceptable.

- Based on intelligence available to staff, there was nothing to suggest that Mr Jeng's safety was of concern, however information pertaining to Mr Jeng potentially being involved in standover activity and the movement of contraband should have been submitted to the Prisoner Intelligence Unit for analysis.

60. The JARO Report also made five (5) recommendations, four (4) of which were directed to the General Manager of PPP.

61. I have discussed in further detail below the findings from the JARO Report which I consider are most relevant to my investigation into Mr Jeng's death.

Placement of Mr Jeng at PPP

62. PPP is a maximum-security facility with capacity to accommodate 1087 prisoners. PPP holds a mix of sentenced and remand prisoners who are either sentenced or charged with serious offences, murder, violent crimes, armed robbery, sex offences, drug and dishonesty offences. As of November 2021, the mix of prisoners was 52% remand and 48% sentenced.[19]

63. G4S Custodial Services Pty Ltd (**G4S**) is subcontracted the operation and management of PPP, under to a Prison Services Agreement between the State of Victoria and the Australian Correctional Facilities Pty Ltd. In performing its obligations, G4S must balance a broad range of competing obligations including, but not limited to, the safety and security of staff and the prison population, providing a safe environment for prisoners and employees, immediate and effective incident response and providing good order and governance.[20]

[19] Statement Patricia Sellman dated 21 November 2021, p 3.
[20] Statement Patricia Sellman dated 21 November 2021, p 3.

64. To ensure the safety and security of prisoners and prison staff in a maximum-security facility with a diverse prisoner population, prisons (such as PPP) are highly regulated. Remand prisoners (such as Mr Jeng) have different management considerations given that they have not been convicted of a crime.

65. As noted above, on 14 August 2017, whilst at MAP, Mr Jeng was reassessed by SMP to determine his future placement. At this time, Mr Jeng had a 'P2' alert (which had been reduced from a 'P1' alert on 29 June 2017) and was assessed as having a S4 rating (past risk of self-harm). He also had a security rating of 'A2', arising from the incident on 12 August 2017, where he had headbutted another prisoner. The 'A2' rating meant that Mr Jeng was required to be housed in a maximum-security prison, where he could remain at MAP or be transferred to Barwon Prison, the Metropolitan Remand Centre or PPP. In SMP making the assessment that Mr Jeng could go to PPP it is accepted that remand prisoners required different treatment.

66. Following the altercation with another prison in the Fishburn Unit of PPP, on 9 November 2017, Mr Jeng was transferred to the Scarborough North Unit and placed in a cell with a sentenced prisoner. Cell allocation at PPP is undertaken in accordance with Operational Instruction (**OI**) 113 – *Cell sharing risk assessments*. Considerations that are taken into account with cell sharing include, but are not limited to, offence and incident history and present, medical advice/physical capacity, age, ethnicity and cultural background.[21]

67. As a prisoner's legal status does not impact upon their cell placement, as long as a prisoner is deemed suitable for a shared cell placement, they will where possible be placed with another prisoner.[22] In her statement to the Court, Ms Jennifer Hosking, Assistant Commissioner of the Sentencing Management Division of Corrections Victoria stated that there is some flexibility for prisons to accommodate remand prisoners with sentenced prisoners if necessary.[23] Further, AC 5 '*Determining a Prisoner's Placement*' of the Corrections Victoria Sentence Management Manual provides that where possible, remand prisoners should be kept separate from a sentenced prisoner. However, it may be necessary for a remand prisoner to be accommodated with a sentenced prisoner in a range of circumstances, such as operational requirements of the prison.[24]

[21] Statement Patricia Sellman dated 21 November 2021, p 6.
[22] JARO Report, p 20; Sentence Management Manual at section 3.1 '*General Principle – placement of remand prisoners*'.
[23] Statement of Jennifer Anne Hosking dated 17 September 2021, [48].
[24] JARO Report, p 20.

68. The JARO Report concluded that while '*Mr Jeng's placement at Port Phillip Prison was consistent with Corrections Victoria's prescribed standards. Mr Jeng was placed in a cell with a sentenced prisoner while there was available accommodation for him to be separated*.'[25]

69. I agree with the finding in the JARO Report that the transfer of Mr Jeng to PPP was consistent with Corrections Victoria prescribed standards. Mr Jeng's cell placement appears to have been reasonable and determined after some consideration. It does, however, appear that there was capacity for Mr Jeng to be placed in a cell on his own. This does not appear to have been offered to Mr Jeng. Whilst I do not make any criticism of this decision, it may be appropriate to consider offering that option to remand prisoners as a matter of practice in the future.

70. In addition, where a remand prisoner is to be placed in a cell with a sentenced prisoner, and there is capacity to accommodate the remand prisoner in a separate cell, Corrections Victoria should consider developing a policy or protocol to ensure that a remand prisoner is made aware of this option of a separate cell, if it is available.

71. I am satisfied that Mr Jeng's initial placement was appropriate and appears consistent with usual practice.

<u>Monitoring of the events leading up to Mr Jeng's death</u>

72. At the time Mr Jeng was fatally stabbed, there were eight (8) prisoners inside cell 453 (including Mr Jeng). This seems to have occurred without any of the corrections officers on duty in the Scarborough North Unit taking steps to investigate or notice that this was occurring.

73. The CCTV footage from the Scarborough North Unit, clearly shows this group of eight prisoners congregating together in the complex. The question then arises as to whether the death of Mr Jeng was preventable had there been greater attention given to gathering or congregating prisoners.

74. The G4S OI 32 '*Surveillance and internal movement of prisoners*' (Version Date 27.06.17) (in place at the time of Mr Jeng's death) highlights the importance of correctional staff actively and regularly observing and interacting with prisoners, as follows:

[25] JARO Report, p 4.

32:10 SURVEILLANCE

'*Checking on the behaviour of prisoners and their actions within the prison will be the responsibility of all correctional staff at all times.*

Correctional Officers *will be vigilant at all times, and will:*

- *Whenever they see a prisoner(s) in a place where it is not clear he/they should be, challenge him/them and take whatever actions is required;*
- *Raise the alarm if the prisoner is threatening good order and security of the prison;*
- *Not assume that because a prisoner is openly in a place, that he necessarily has authority to be there; and*
- *Show interest in the actions and destination of passing prisoners (even though staff may not be directly in charge of them at that moment)*'.

75. OI 32 also states that '*CCTV (will be used to monitor prisoners and also to "sweep" the prison to detect any untoward behaviour/activity)*'.

76. Further, the current version of OI 32 '*Surveillance and internal movement of prisoners*' (Version Date 20.06.2020) includes three additional dot points under '32.10 Surveillance', as follows:

- '*Observe all prisoners congregating in any area of the unit, tier or yard. Ensure that any congregations do not threaten the safety, security or good order of the area, and if necessary challenge him/them and take whatever action is required;*
- *Provide an active presence if 3 or more prisoners are gathering in a cell. This behaviour should be discouraged and should be challenged if continuously occurring, ensuring that PIU are informed where appropriate; and*
- *Ensure that "3 out" cells are treated there possible as transitional accommodation and that prisoners are not held in this style for extended periods of time. If the placement of prisoners in a "3 out" cell is likely to jeopardize the safety, security or good order of the unit surrounding then Vacancy Management must be notified. If this threat is imminent, then immediate action must be taken*'.

77. In its investigation of Mr Jeng's, JARO looked closely at the management of the Scarborough North Unit on 1 January 2018 and concluded:

'*JARO considered the nature of activities that staff reported would occur in cell 453 (Cell 453 was described by staff as the cell that prisoners would go to if they wanted drugs or to organise fights), CCTV footage from Scarborough North in the lead up to and during the assault of Mr Jeng and information gathered from interviews with Port Phillip staff. JARO found that:*

- *staff were stationed in the officers' post for an extensive amount of time;*
- *an opportunity to challenge the congregation of prisoners inside and just outside cell 453 was missed; and*
- *an inconsistency exists among Port Phillip staff regarding the type of prisoner behaviour or activity that is considered acceptable and as such, the response expected of staff in these situations*.'[26]

78. In her statement to the Court Ms Patricia Sellman, General Manager of PPP commented on these findings, noting:

- '*The staff presence in the officers' station between 5.20pm and 6.30pm was when there was increased staff numbers in the unit. This is a form of deterrent separate to staff moving around the unit.*
- *In hindsight, and with the benefit of a dedicated review of CCTV footage, staff did not identify the movement of prisoners in and around cell 453. Accommodation units are very busy at that time of day with increased noise and movement of prisoners. Correctional Officers have a range of tasks they attend to and their ability to observe may be affected by their other duties and activities. At any time, unless a staff member happens to be observing conduct at precisely the right time, some behaviours will not appear untoward or sinister at that time.*
- *I agree that some staff will perceive prisoner behaviour differently. Each situation is different, and training is provided to continue to encourage consistent approaches to prisoner behaviour*'.[27]

[26] JARO Report p 27.

79. Further, the JARO Report recommended that:

> '*the GM, Port Phillip, implement additional training on dynamic security, emphasising the importance of a consistent approach to, and understanding of, unacceptable behaviour. This training should include the importance for staff to:*
>
> - *implement and maintain adequate dynamic security in line with OI 32; and*
> - *challenge prisoner congregation in cells where it is safe to do so*'.[28]

80. In her statement, Ms Sellman stated that staff are regularly trained on the importance and methods of dynamic security at PPP. Dynamic security is conducted by correctional officers interacting with prisoners and is a method of developing situational awareness and being informed about what is going on in the prison at a point in time.[29]

81. Further, additional training covering the principles of dynamic security and challenging unacceptable behaviour is covered within monthly security briefings and via periodic security alerts and general internal comms. At the time of the incident, Standardised Unit Rules were also in circulation to confirm expectations of correctional staff.[30]

82. Ms Sellman also advised that a full staff briefing was conducted in November 2018 to remind correctional staff of the expectation of challenging unacceptable behaviour and the need for regular patrols. It is unclear from the available evidence whether this form of staff briefing has occurred again at PPP.

83. I agree with the finding in the JARO Report that the correctional officers on duty in the Scarborough North Unit on 1 January 2018, missed an opportunity to challenge the congregating prisoners inside and outside of cell 453. Even taking into account hindsight bias, the CCTV footage of the events leading up to the fatal incident shows that there was unusual activity which should have prompted a response from correctional officers in the Scarborough North Unit of PPP.

84. I also agree that there is an inconsistency among PPP staff within the Scarborough North Unit on what prisoner behaviour is considered acceptable and what response is appropriate. The

---

[27] Statement Patricia Sellman dated 21 November 2021, p 18.
[28] JARO Report, p 27.
[29] Statement of Patricia Sellman dated 21 November 2021, p 16.
[30] Ibid at, p 19.

combination of these two factors meant that a possible opportunity to prevent the attack on Mr Jeng was missed.

85. Whilst I do not make any criticism of the steps which have been taken to further educate correctional staff at PPP on the principles of dynamic security and challenging unacceptable behaviour, I am of the view that G4S should consider implementing a more rigorous training regime for correctional staff on an annual basis to reinforce the principles of dynamic security, as well as the practice monitoring and managing prisoner behaviour.

Investigation by Victoria Police Homicide Squad

86. Following Mr Jeng's death, Victoria Police commenced a criminal investigation into the circumstances leading to the fatal incident. This investigation was initially conducted by uniform police who attended the scene and later assumed by the Victoria Police Homicide Squad.

87. The seven (7) prisoners that were in cell 453 at the time of incident were each separated and interviewed. The outcome of the interviews was that all prisoners with the exception of two, either made no comment or refused to answer questions. One prisoner did provide a statement which is included in the coronial brief of evidence but denied any knowledge of how the Mr Jeng was killed.

88. The Scarborough North Unit cells and common areas were searched, and four weapons were located. None of these weapons were connected to the death of Mr Jeng. No additional information was obtained from any other prisoners and a thorough forensic examination of cell 453 did not reveal any information that would assist in identifying the perpetrator.

89. Despite a thorough investigation being undertaken by police, to date, no person or persons have been charged with an indictable offence in connection with the death of Mr Jeng. Having reviewed all of the available evidence, and in light of this extensive investigation, I am satisfied that no investigation which I am empowered to undertake, would be likely to result in the identification of the person or persons who caused Mr Jeng's death.

90. It is important to note that it is not the purpose of a coronial investigation to investigate possible criminal conduct to compile a brief of evidence in preparation for a future criminal trial. Section 69 of the Act expressly prohibits a coroner from including in a finding or a comment, any statement that a person is or may be guilty of an offence.

91. In making this finding, I have been careful not to compromise any potential criminal prosecution in the course of my investigation, mindful that Mr Jeng's death may be the result of a homicide.

92. I note that if new facts and circumstances become available in the future, section 77 of the Act allows any person to apply to the Court for an order that some or all of these findings be set aside. Any such application would be assessed on its merits at the time.

COMMENTS

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

93. JARO has completed a comprehensive review of the issues arising from Mr Jeng's death. While I have not repeated all of the details from the JARO Report in this finding, in my opinion the findings and recommendations are highly relevant to and have greatly assisted in my investigation.

94. The JARO Report stated that while the response to Mr Jeng's death met the prescribed standards '*there are a number of areas that warrant[ed] review and improvement*'.[31]

95. As detailed in the statement of Ms Sellman, much has been done to improve the arrangements at PPP to address the performance issues raised in the JARO Report. I am satisfied that reasonable steps that have been taken at PPP to adopt and implement the findings and recommendations in the JARO Report.

96. Nevertheless, I believe that had more rigorous training programs on dynamic security and situational awareness been in place at the time of Mr Jeng's death, that it would have assisted in identifying the unacceptable behaviour in the Scarborough North Unit on 1 January 2018, including the congregation of prisoners in and outside of cell 453 and provided a better opportunity to prevent Mr Jeng's death.

97. I note that section 7 of the Act makes it clear that I should 'avoid unnecessary duplication of inquiries or investigations'. Having reviewed all of the material provided during the course of the coronial investigation, I am satisfied that no further investigation of the circumstances surrounding Mr Jeng's death by me is appropriate.

[31] JARO Report, p 31.

FINDINGS AND CONCLUSION

98. Having held an inquest into the death of Hassan Jeng, I make the following findings, pursuant to section 67(1) of the Act:

    a) The identity of the deceased was Hassan Jeng born on 27 April 1994;

    b) That the death occurred on 1 January 2018 at Scarborough North Unit at Port Phillip Prison, Victoria from stab wounds to the chest and back; and

    c) That the death occurred in the circumstances set out above.

99. Having considered all the circumstances, I am satisfied that Mr Jeng's death was intentional and violent. Despite a thorough investigation conducted by the Victoria Police Homicide Squad no person or persons have been charged with a criminal offence arising from the stabbing death of Mr Jeng.

100. The circumstances also make it clear that one or more of the prisoners who were in cell 453 at PPP at approximately 6.50 pm on the 1 January 2018 are responsible for Mr Jeng's death.

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

Pursuant to section 73(1) 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 the finding be provided to the following:

Hannah Collier, Senior Next of Kin

Mackie Jeng, Senior Next of Kin

Sergeant Julio Salerno, Coroner's Investigator

Secretary of the Department of Justice and Community Safety - Corrections Victoria

G4S Custodial Service Pty Ltd

Patricia Sellman, General Manager of Port Phillip Prison

Signature:

JUDGE JOHN CAIN
STATE CORONER

Date: 14 February 2023

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 inquest. 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.