IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 001907

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: RAHUL PRASAD

Delivered On:	25 November 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne
Hearing Dates:	9 October 2013
Findings of:	PHILLIP BYRNE
Representation:	Ms D Coombs for Corrections Victoria Ms S Law for Forensicare
Police Coronial Support Unit	Sgt Dave Dimsey

I, PHILLIP BYRNE, Coroner, having investigated the death of RAHUL PRASAD

AND having held an inquest in relation to this death on 9 October 2013

at the Coroners Court of Victoria, Melbourne

find that the identity of the deceased was RAHUL PRASAD

born on 11 July 1981

and the death occurred on 21 May 2010

at Intensive Care Unit, St Vincents Hospital

from:

1 (a) GLOBAL CEREBRAL ISCHAEMIC INJURY

1 (b) HANGING

in the following circumstances:

1. Mr Rahul Prasad, born in Fiji on 11 July 1981, migrated to Australia with his parents, Mr Mahendra Prasad and Mrs Bharti Prasad, in 1987. He married his wife, Mrs Priya Prasad, in 2000 and together they had a son, Amolak.
2. On 11 March 2009, Mr Prasad was arrested and remanded in custody in relation to alleged serious crimes. While in custody, two unsuccessful applications for bail were made and he remained in custody until the events that led to his untimely death.
3. In very broad terms (I will address the circumstances in detail later in this finding), on the morning of 18 May 2010, shortly after the 11:00am hourly observations, Mr Prasad attempted to take his own life by hanging. Mr Prasad was located by his cellmate hanging from the top rungs of the ladder to a bunk bed. He was resuscitated and conveyed to St Vincents Hospital where he was diagnosed with a severe hypoxic brain injury. It became clear the extent of the brain injury was such that Mr Prasad's position was irretrievable and he died at St Vincents Hospital on 21 May 2010 as a direct result of the attempted hanging on 18 May 2010.
4. I took over carriage of the matter on 24 July 2013 and, in light of its age, determined to progress this case as a priority. The matter had been listed by the Coroner who previously had carriage of the matter for a Mention/Directions hearing scheduled for 26 August 2013. I conducted the scheduled hearing on that day but for several reasons I was unable to progress the matter as far as I had hoped. Additional important material from Corrections Victoria was not available and furthermore the family was not legally represented; it was unclear as to whether Mr Peter

Morrisey, of counsel, who represented Mr Prasad in the outstanding criminal matter would continue to represent the family in the coronial proceeding.

5. In the event, I listed the matter for a further Mention/Directions hearing on 9 October 2013, with a view to isolating the relevant issues and establishing the scope and parameters of the subsequent formal inquest if one was to be held. It is to be noted that as the death of Mr Prasad occurred whilst he was in custody the matter was required to proceed as a mandatory inquest.

6. On 9 October 2013 the family was not legally represented, but Mr Prasad's wife and mother were present and the additional material I was awaiting was available. The family had anticipated being legally represented, but the cost to them of the legal representation was prohibitive.

7. It became clear to me on examining the comprehensive Brief of Evidence that the two parties who originally were involved in the proceeding could be excused from further attendance as I, and importantly the family, had no issues with them. Therefore, St Vincents Hospital, where Mr Prasad succumbed to his injury, and GEO Group Australia Pty Ltd and Pacific Shore Healthcare, who were contracted to provide primary healthcare services to the Melbourne Assessment Prison, were excused from further attendance.

8. The remaining entities who were relevant to the coronial proceedings, Corrections Victoria and Forensicare, Victorian Institute of Forensic Mental Health, were represented at the scheduled hearing.

9. At the Mention/Directions hearing on 9 October 2013 important additional material, particularly a comprehensive statement with numerous attachments was provided to the Court and family by Mr Brett Ryan, General Manager of the Melbourne Assessment Prison, Corrections Victoria.

10. Furthermore, an additional statement was provided by Forensicare, namely a statement with copies of contemporaneous nursing notes from Registered Psychiatric Nurse Ms Courtenay Dunn. Ms Dunn had personally conducted an assessment (including risk of self harm assessment) on 3 May 2010 and 12 May 2010.

11. Following established protocols, two important <u>internal reviews</u> were conducted.

    - Justice Health provided the Court with their Justice Health – Death in Custody Review Report in relation to the death of Mr Prasad

    - Office of Corrections provided the Court with a copy of their Office of Correctional Services Review Report into the death of Mr Rahul Prasad.

12. As the endeavours of the family of Mr Prasad to obtain legal representation had unfortunately not been achieved it seemed to me that the additional material and the significance of the internal reviews had not been fully digested and comprehended by the family. I engaged in comprehensive dialogue with Mr Prasad's mother and wife and sought to explain the significance of the material. I stood the matter down for the family to consider the material and the future course of the matter.

13. Importantly, I advised the family that if the matter were to be finalised at the hearing on 9 October 2013 then my findings would address the fact that the cell in which Mr Prasad endeavoured to hang himself was not "retro-fitted" at that time and the "hanging point" he utilised had yet to be removed.

14. I also indicated that in my finding I would address the issue of the risk assessment made that resulted in Mr Prasad remaining in Unit 13 Melbourne Assessment Prison rather than returning to the Acute Assessment Unit from which he was discharged on 7 May 2013.

15. Upon Mr Prasad's initial reception at Melbourne Assessment Prison it was recognised he had a serious psychiatric condition and was at potential risk of suicide/self harm. He was transferred to the Acute Assessment Unit within 10 days of entering prison on remand. Mr Prasad's condition fluctuated from time to time and he was moved to Metropolitan Remand Centre in May 2009. However, in May 2010 he was again returned to Melbourne Assessment Prison having been reassessed as having a serious psychotic condition and being at "immediate risk of suicide and self harm" and returned to the Acute Assessment Unit for further assessment treatment and closer observation. It is the efficacy of psychiatric management from then until the attempted suicide on 18 May 2010 to which I have turned my mind.

16. As to the discharge from the Acute Assessment Unit on 7 May 2010, I have carefully examined the statement provided by Consultant Psychiatrist Dr Prashant Pandurangi. Dr Pandurangi initially saw Mr Prasad at the Melbourne Remand Centre and subsequently at Melbourne Assessment Prison. Dr Pandurangi's final contact with Mr Prasad was on 6 May 2010 during his admission to the Acute Assessment Unit at Melbourne Assessment Prison. Contemporaneous notes of this assessment are contained at page 38 of the Brief of Evidence (see paragraph 10 of Dr Pandurangi's statement). Significantly he noted (inter alia):

- Pleasant and cooperative
- Happy to go back to Melbourne Remand Centre

- Nil SASH (suicide and self harm/ homicidal ideas)

He concluded as a result of his assessment that Mr Prasad could be discharged from the Acute Assessment Unit and receive mental health follow up at the "outpatients clinic in Melbourne Assessment Prison"

Dr Pandurangi said:

> *"I also assessed that Mr Prasad, at that stage, did not present a high or moderate risk of suicide or self harm but rather posed a potential risk. This assessment was based on his engagement with staff on the AAU, his denial of any suicidal ideas during his admission to AAU and his identifying his family as a protective factor, and his denial of any suicidal ideas in our interview. Accordingly, I assigned Mr Prasad a "S3"Suicide and Self Harm rating in accordance with the system for managing prisoners at risk of suicide or self harm at the MAP set out by Corrections Victoria in the Commissioner's Requirement on E*Justice Risks and Recommended Actions issued 24 December 2009, Director's Instruction 1.2 and Local Operating Procedure 1.2. This procedure, known as the "S" rating system, requires all prisoners considered at risk of self harm or suicide to be allocated a rating."*

Dr Pandurangi also stated:

> *"My view that Mr Prasad could be cleared from the AAU was based on his presentation since admission to the AAU and at our interview. I also took into account Mr Prasad's request to be discharged from the AAU and moved back to the MRC. I did not consider that Mr Prasad met the criteria for involuntary treatment."*

17. On 6 May 2010, shortly after discharge from the Acute Assessment Unit, Mr Prasad requested to see the Forensicare Psychologist as he claimed to again be "talking to the devil". He asked to be returned to the Acute Assessment Unit or preferably to the Thomas Embling Hospital. On 7 May and 8 May he was again reviewed after telling Forensicare Staff the "devil was telling him to self harm". Again on 12 May 2010, Mr Prasad was reviewed by Psychiatric Nurse Ms Dunn after a "crisis call" was raised by Corrections staff concerned for Mr Prasad's wellbeing. Mr Prasad was not upgraded but retained to risk rating P2 S3.

18. I have carefully considered the management/treatment of Mr Prasad's mental illness by Forensicare, paying special attention to the period 1 May 2010 through to the day of the attempted hanging. What I will call "the critical assessment" was undertaken by psychiatric

nurse Ms Courtenay Dunn on 12 May 2010. In her statement she relates that at review following the "crisis call" from prison staff, she believed Mr Prasad's claim that the "devil told him to harm himself" was designed to obtain re-admission to the Acute Assessment Unit. She states that when she advised him that she did not propose to recommend re-admission, Mr Prasad indicated he had at that time "no plan or intent" to self harm and was prepared to return to mainstream unit 7. Ms Dunn also maintains Mr Prasad "guaranteed his own safety", saying the regular visits and the ongoing support of family were "protective factors". Ms Dunn's clinical notes of the interview/assessment are annexed to her statement and form part of the Brief of Evidence.

19. It could be argued that Ms Dunn's assessment of 12 May 2010 was flawed because, as we know, on 18 May 2010, Mr Prasad did attempt to hang himself which resulted in his subsequent death. A decade ago my colleague, Deputy State Coroner West, made a pertinent comment when he said in a finding:

    "This tragedy highlights the dilemma facing health professionals who manage and treat individuals with mental illness and their difficulty in predicting when a patient is at risk of crossing the suicide threshold. The patients actions are frequently impulsive. Prior attempts and risk factors may be well documented, however, such material can rapidly go out of date and thus be less helpful as an indication of future behaviour. While the difficulties associated with fluctuating risk behaviour are well recognised; it is imperative that health professionals remain vigilant in their attempts to identify indicators of anxiety, depressed mood and self harm."[1]

    Risk assessment is an extremely problematic and difficult matter.

20. Overall, I conclude the management of Mr Prasad by various Forensicare personnel, while <u>not optimal</u>, was reasonable; the various risk assessments were, when one looks at all the circumstances, particularly Mr Prasad's assurances, reasonable "calls" open to those making the assessments.

21. The other principle concern raised by the family of Mr Prasad was the existence of cell furniture that provided a hanging point (the bunk ladder). The issue of what is known as "retro-fitting" cells to comply with the <u>Building Design and Review Project</u> (BDRP) standard is addressed by Mr Ryan in his statement and was also covered in the Office of Correctional Services Review

[1] Dennis Petran (dec'd) 3310/01

Report. At the hearing I discussed this issue at some length with Mr Prasad's mother and wife. Mr Ryan described in some detail the practical difficulties in making cells compliant with the BDRP standard, including funding and planning and reorganising prisoner management to facilitate the task. Mr Ryan advised:

> *"For the good order, safety and security if staff and prisoners, units undertaking BDRP upgrades require to be taken off line and managed as a secure building site. These works therefore reduce prisoner bed capacity by closing the entire unit, and require long term planning and prisoner placement."*

He added:

> *"As a result of previous Coroners' recommendations and reviews of prisoner safety, the BDRP was conducted throughout the prison system with the intention of minimising hanging points in cells. Not all cells were upgraded to comply with these new guidelines, but those cells which accommodated prisoners most at risk were upgraded, including a number at MAP."*

Mr Ryan concluded by advising:

> *"Further funding was made available by Corrections Victoria to facilitate the upgrade of more Units within MAP. The upgrade work was completed in early November 2011. Now, all cells on Level 5 (the specialist Units) at MAP are BDRP compliant, together with three units in mainstream. The Units which are not BDRP compliant are Reception and Unite 3, 4 and 5. Now, that there are more BDRP cells available, it is my and MAP policy that no prisoner with an S3 or higher rating will be accommodated anywhere but in a BDRP cell."*

22. The reality is that we live and operate in a world of finite resources, regrettably the cell in unit 7, in which Mr Prasad attempted to hang himself, was not at the time BDRP compliant, but now is.

23. I add that various recommendations made in the Justice Health Review Report and the Office of Correctional Services Review Report were received and mostly accepted; a Corrections Victoria Action Plan was developed and implemented (the completed plan is attachment 6 to Mr Ryan's statement).

24. Having considered the available material, and bearing in mind that Mr Prasad was a prisoner on remand, with all the additional complications that involves, I find it could not reasonably be

concluded the management of Mr Prasad by Corrections staff was other than reasonable and appropriate in the difficult circumstances that prevailed.

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

The family of Rahul Prasad

Ms Debra Coombs, Corrections Victoria

Ms Sonia Law, Forensicare

Ms Michelle Gardner, Justice Health

Dr Janet Ruffles, Victoria Institute of Forensic Mental Health

Ms Liana Buchanan, Correctional Service Review

St Vincents Health

Mr Tamir Katz, Meridian Lawyers

Sgt Robert Derrett, Melbourne CIU

Signature:

PHILLIP BYRNE
CORONER
Date: 25 November 2013