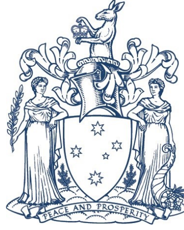

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 3010

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Deceased:	Mohamed Omar
Delivered on:	28 April 2021
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	Inquest: 29 April 2020
Findings of:	Coroner Paresa Antoniadis Spanos
Counsel assisting the Coroner:	Leading Senior Constable Kelly Ramsey from the Police Coronial Support Unit
Representation:	The family of Mr Omar were unrepresented. Ms J. Still appeared on behalf of Justice Health Ms N. Hodgson appeared on behalf of Forensicare

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INTRODUCTION

1. Mohamed Omar was a thirty-year old single man when he died while on remand in the Melbourne Assessment Prison on 25 June 2017.

2. Mr Omar migrated to Australia from Somalia with his family in 2002 when he was 15-years old. He was the youngest in a sibship of four. When they arrived, Mr Omar had no formal education and spoke no English. However, he attended Collingwood English Language School and Collingwood TAFE for a few months, acquiring a good-working knowledge of the English language. Unfortunately, Mr Omar did not complete any courses or receive any formal qualifications to equip him for the work force. His only known period of employment was a brief period working on a tobacco farm.

3. Mr Omar had a history of rheumatic myocarditis treated with a monthly prophylactic injection of penicillin, a mild intellectual disability, a diagnosis of a serious mental illness that will be discussed in some detail below, a history of polysubstance abuse, and a significant criminal history. Prior to his final reception into custody, Mr Omar was in receipt of a disability support pension.

CIRCUMSTANCES IMMEDIATELY PROXIMATE TO DEATH

4. At 5.37pm on 25 June 2017, Prison Officer (**PO**) Vijay Mehta checked Mr Omar in his cell at the Melbourne Assessment Prisoner (**MAP**). He found him lying on his left side on the bed, facing the wall with his back towards the door. PO Mehta knocked on the window of the cell door and, on eliciting no response, called Mr Omar's name and knocked again. Mr Omar raised his right hand which PO Mehta took to mean that he was okay.

5. A short time later, at 6.04pm, PO Andrew Boquest and Health Service Officer (**HSO**) Hossein Mohammed-Asl attended Mr Omar's cell with his morning medication. They found him crouched against a wall of the cell at the foot of his bed in a "prayer position" with a chair and clothing covering his head. When they called out to several times and elicited no response, they notified the Watch Officer of a need for the emergency keys and, in accordance with usual practice, permission was sought from the Duty Supervisor Mr Celms to enter the cell.

6. Immediately on being given that permission, at about 6.08pm, PO Boquest and HSO Mohammed-Asl entered. They found Mr Omar unresponsive, removed the clothing covering him and noted items of clothing wrapped around his neck which they removed. The Duty Supervisor was asked to call a Code Black and Mr Mohammed-Asl latter dragged Mr Omar out to the day room and immediately started cardiopulmonary resuscitation (**CPR**), first clearing his airway which required suctioning of vomitus several times.

7. CPR efforts by Mr Mohammed-Asl continued and nursing staff also came to render assistance with CPR and defibrillation. Mobile Intensive Care Ambulance (**MICA**) paramedics also attended, arriving at about 6.30pm. Unfortunately, all CPR efforts were unsuccessful and Mr Omar was pronounced deceased by MICA paramedics at the scene

INVESTIGATION AND SOURCES OF EVIDENCE

8. This finding is based on the totality of the material the product of the coronial investigation of Mr Omar's death. That is, the brief of evidence compiled by Detective Senior Constable Aaron Price (as re-compiled by Leading Senior Constable Kellie Ramsey from the Police Coronial Support Unit) including statements from custodial staff at MAP; clinical staff working at MAP; psychiatric clinicians involved in Mr Omar's clinical management and care; scene photos; medical records; the autopsy report and toxicology report from the Victorian Institute of Forensic Medicine (**VIFM**); a report from the Justice Assurance and Review Office/Department of Justice (**JARO**); a report from Justice Health/Department of Justice (**JH**); and a statement from Dr Danny Sullivan, Executive Director, Clinical Services Forensicare.

9. All of this material, together with the inquest transcript, will remain on the coronial file.[3] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

10. The purpose of a coronial investigation of a *reportable death*[4] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[5] Mr Omar's death clearly falls within the definition of reportable death, specifically section 4(2)(e) of the Act which includes (relevantly) the death of a person under the control, care or custody of the Secretary to the Department of Justice.

11. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances but is confined to those

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[3] From the commencement of the ***Coroners Act 2008*** (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

[4] The term is exhaustively defined in section 4 of the ***Coroners Act 2008*** [the Act]. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

[5] Section 67(1).

circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[6]

12. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[7] Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and 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.[8] These are effectively the vehicles by which the coroner's prevention role can be advanced.[9]

13. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[10]

IDENTIFICATION

14. The deceased's identity was Mohamed Omar born 1 January 1987. Prison Officer Supervisor Alan Jones signed a formal State of Identification dated 25 June 2017 to this effect before a member of Victoria Police.

15. Identification was not in issue and required no further investigation.

MEDICAL CAUSE OF DEATH

16. Forensic Pathologist Dr Linda Elizabeth Iles, Head of Forensic Pathology, Victorian Institute of Forensic Medicine (**VIFM**) attended the scene of Mr Omar's death at the MAP on 25 June 2017 to observe the scene and make as early an examination of Mr Omar's body where he lay.[11]

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[6] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[7] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[8] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[9] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[10] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

[11] According to her autopsy report at page 11 of the inquest brief, Dr Iles was first contacted by the Coronial Investigator DSC Price at 2018 hours; examined the deceased in situ at 2145 hours on 25 June 2017; and discussed her observations with me in my capacity as duty Coroner at 2210 hours.

17. Scene attendance afforded Dr Iles the opportunity to observe early scattered petechiae on the deceased, vomitus on the long sleeved grey shirt apparently used by the deceased as a ligature; other upper body clothing cut for medical access; medical resuscitation paraphernalia; and confirmation from those present that there was no evidence of suspension. At the time, Mr Omar was only wearing Velcro fastened trainers, black socks and navy-blue tracksuit pants but no underwear.[12]

18. Mr Omar's body was transported to the Coronial Services Centre where Dr Iles subsequently performed a full post-mortem examination or autopsy. Her autopsy findings included natural disease in the form of lymphocytic thyroiditis; subendocardial scarring lateral wall of the left ventricle; pneumoperitoneum and air about the distal oesophagus; and early cardiovascular atherosclerotic changes.[13] There is no suggestion that any of these natural disease processes contributed significantly to Mr Omar's death.

19. In terms of traumatic injury, Dr Iles found congestive changes and scattered petechial haemorrhages about the oral and conjunctival mucosa; small areas of linear abrasion on the left and right sides of the neck; no evidence of superficial or deep bruising to the neck (as may sometimes be seen in strangulation or hanging); a bruise to the right forehead; smaller minor bruises to the frontal scalp; and subcutaneous bruising over the back of the left scapula (likely secondary to resuscitation).[14]

20. Dr Iles formulated the medical cause of Mr Omar's death as 1(a) consistent with neck compression.

21. Dr Iles commented that the clothing received with Mr Omar suggests that the long- sleeved grey heavily vomit stained shirt found with him may have been around his neck. Further, that the formulation of the cause of Mr Omar's death is based on the feint linear abrasions on the left and right side of the neck and the very occasional petechiae around the mucous membranes. Dr Iles commented that while these are non-specific indicators of neck compression, she identified no alternative cause of death. Dr Iles also commented that the formulation she arrived at relies on the circumstances in which Mr Omar died, as observed and as reported by POs and Victoria Police members who were at the scene.

22. As regards the minor bruising to the right forehead and frontal scalp, Dr Iles noted that histological examination demonstrates features of organisation and that while it is not possible to be precise as to the age of these bruises, the presence of organisation indicates they occurred

[12] Dr Iles also reported her understanding that there was no CCTV footage within Mr Omar's cell or in the main area outside the cells as new cameras had been installed but reportedly had not been working. Page 12 of the inquest brief.
[13] Summarised at page 22 of the inquest brief.
[14] Ibid – see also comment 6 at page 23 of the inquest brief.

sometime prior to death and may represent episodes of trauma in the days immediately preceding Mr Omar's death.[15]

THE FOCUS OF THE CORONIAL INVESTIGATION & INQUEST

23. It is appropriate to stress at the outset that there was no issue taken with the resuscitative efforts made by the various prison officers, clinical staff and paramedics from shortly after 6.00pm when Mr Omar was discovered unresponsive and unconscious in his cell, until 6.30pm when he was pronounced deceased. While the coronial investigation did not focus on this aspect of the circumstances in which Mr Omar died, they are each to be commended for their efforts.

24. The primary focus of the coronial investigation of Mr Omar's death, was the adequacy of the clinical management and care provided to him in relation to his mental illness during his last period of incarceration at MAP, particularly in the last of his life. By way of context, the coronial investigation included details of Mr Omar's extensive criminal history and details of the management of his psychiatric illness in the community generally from St Vincent's Mental Health Service which I will briefly address in the following paragraphs.

CRIMINAL HISTORY

25. Mr Omar's criminal history was extensive given his relative youth. He had been charged by Victoria Police members on 43 occasions with a total of 156 offences, notably for numerous contraventions of intervention orders made in favour of one or other of his family members on 43 separate occasions. Charges laid against him included theft, assault, make threats to kill, fail to answer bail and public order offences.[47]

26. On almost all occasions, the place where the offending occurred was Mr Omar's family home and the impugned conduct generally involved breaking-in to the home and standing-over family members demanding money to fund his alcohol and drug use despite an extant intervention order prohibiting such conduct.[48]

27. As a result of their dealings with Mr Omar, Victoria Police data bases had several warning flags regarding Mr Omar including warnings that he suffered from schizophrenia; resisted arrest with OC spray deployed; escaped from custody; was in possession of a knife; heard voices telling him to self-harm; used false names; had a history of suicide/self-harm and a possible heart condition.[49]

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[15] Comment 5 at page 23 of the inquest brief.
[47] Statement of Senior Constable Richard Collins at page 77 and following of the inquest brief.
[48] Ibid.
[49] Ibid.

28. The last offence allegedly occurred on 12 April 2017 when Mr Omar broke into his parents' home and stole a television and his father's passport. At the time there were intervention orders on foot, his father Abdiwahid Abdulle and mother Luul Omar being the aggrieved family members. On 3 June 2017, Mr Omar was arrested for aggravated burglary and persistent breaches of the intervention orders and was remanded in custody.[50]

MANAGEMENT OF PSYCHIATRIC ILLNESS IN THE COMMUNITY[51]

29. When Mr Omar was living in the community, his psychiatric illness had been historically managed by the NorthWestern Mental Health, specifically the Northern Area Mental Health Service (**MHS**). Mr Omar's first hospitalisation to an inpatient psychiatric facility was in July 2006 when he was admitted to St Vincent's Hospital Inpatient Unit at the age of 19. He had 13 subsequent admissions to inpatient facilities, as well as three admissions to community care units, one being a notably long three-year admission.[52]

30. Mr Omar's diagnoses were paranoid schizophrenia, mild intellectual disability[53] and polysubstance use disorder. As regards the latter, Mr Omar was known to use cannabis, methamphetamine, cocaine and alcohol and had repeatedly refused engaged with drug and alcohol services. Mr Omar's symptom profile during relapses included perplexity, incongruent affect, persecutory delusions about people harming him by poisoning, auditory hallucinations of a command nature, disorganization and self-neglect.[54]

31. Mr Omar's last inpatient admission to the Northern Hospital Psychiatric Unit was from 15 to 28 December 2016 when he was brought from MAP due to ongoing psychotic symptoms such as delusions and command auditory hallucinations to kill himself. During this admission he attempted to hang himself in the context of fear of contracting HIV/aids after unprotected sex prior to the admission.

32. Once stabilised, Mr Omar was discharged for follow-up by the community team who treated him with fortnightly IM injections of flupenthixol deaconate (depot injection). Mr Omar accepted his diagnosis of schizophrenia and was not resistant to treatment but was often difficult

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[50] Ibid.

[51] Statement of consultant psychiatrist Dr Sanjeewanie Karunaratne, North Western MHS, employed in the Northern Area MHS at the Community Team South dated 3 July 2017, at page2 63 and following of the inquest brief.

[52] Ibid pages 63-64.

[53] Ibid at page 64 of the inquest brief, paragraph 11 – *"Mr Omar was diagnosed with Mild Intellectual Disability as quantified by neuropsychiatric assessment conducted in October 2016. His IQ was 57. There was a query whether Mr Omar suffered from acquired brain injury as he had reported losing consciousness after head trauma during an assault when he was 17 years old. It was recognised that his significant cognitive difficulties affected his attention and concentration, comprehension, memory, organizational skills and ability to evaluate and understand social situations and the likely consequences of his behaviour."*

[54] Ibid page 64.

to locate in the community, needed assertive follow-up and was often in police custody or on bail with conditions that made it difficult to deliver regular psychiatric care.[55]

33. When last reviewed by consultant psychiatrist Dr Karunaratne on 15 February 2017, Mr Omar appeared stable in his mental state and at his baseline but *"posed chronic risk of self-harm, suicide and reoffending along with risk of relapse of his psychosis in the context of ongoing use of substances."*[56]

34. Mr Omar's last contact with the MHS was on 1 March 2017 when he was transported to the clinic for his depot injection which was overdue. He was assessed by his then key clinician who found him stable with no evidence of psychotic symptoms.[57]

35. Shortly after this contact, and reflective of a pattern that characterised the last few years of his life, Mr Omar was remanded at MAP for breaching an intervention order and a bail condition; released on bail; and remanded again a short time later for breaching an intervention order. As a result of this dislocation, although he was generally compliant with medication, administering Mr Omar's depot injection was a constant challenge.[58]

FORENSICARE AT MELBOURNE ASSESSMENT PRISON

36. Forensicare is a statutory agency established under the ***Mental Health Act 2014*** (MHA) to provide forensic mental health services in Victoria through three streams – inpatient services at Thomas Embling Hospital, community services through its Community Forensic Mental Health Service and prison-based services at several prisons including MAP.

37. Pursuant to a service agreement between Forensicare and Justice Health (a business unit of the Department of Justice and Community Safety), Forensicare provides specialist mental health services at MAP, including operating a specialist 16 bed acute assessment unit (AAU) for high risk prisoners with acute mental health issues, specialist clinics, outpatient services and a mental health reception assessment program.[59]

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[55] Ibid page 65 - Multiple support services were involved in his care and there was close liaison between them.
[56] Ibid.
[57] Ibid.
[58] Ibid. Mr Omar was last seen by a NAMHS clinician on 1 March 2017 when transported to the clinic for his depot injection which was overdue. He was in police custody between 15-17 March 2017 and his depot injection was not administered. Following his release, NAMHS tried to locate him to administer the depot injection but were unable to locate him. He was again taken into custody on 22 April 2017 and given the depot injection while in custody on 26 April, 10 May and 24 May 2017. On 1 June 2017, his case manager again tried to locate him and was informed he had been taken into custody again on 6 June 2017. While there is a suggestion that the depot injection was administered on 7 June 2017 while Mr Omar was still in police custody, Forensicare records which are discussed in paragraph 46 below, suggest otherwise.
[59] See generally, Exhibit B, statement of Dr Danny Sullivan, Executive Director, Clinical Services Forensicare, dated 27 April 2020 where Forensicare's role in mental health service delivery is explained.

38. Also relevant to the investigation of Mr Omar's death is the Russell Unit on the fifth floor of MAP, referred to as Unit 13 in the coronial brief and during the inquest. Unit 13 is staffed by Corrections Victoria (CV) and Forensicare clinicians regularly visit as the unit is dedicated to the accommodation of S1 or S2 rated prisoners, those who are assessed as being at immediate or significant risk of suicide or self-harm.

39. Unit 13 is comprised of six "Muirhead cells", separate shower facilities, an officers' post and a small exercise yard. Each cell accommodates a single prisoner and is designed for minimal environmental risk of suicide, containing nothing but a toilet, wash basin, in-wall intercom and a mattress on a raised concrete platform. An internal Perspex door enables a prisoner to watch a ceiling mounted television and there is also a standard external cell door. Prisoners in Unit 13 are in a lock-down regime unless being seen by clinical staff under CV supervision or spending their allocated time in the yard.[60]

40. As well as the austerity of the cells and the lock-down regime, prisoners transferred to Unit 13, are stripped of their clothing and dressed in a tear-resistant canvas smock. According to Dr Sullivan's statement *"It is accepted that these conditions, while useful in preventing self-harm in the short term, can negatively impact on the prisoner's long term mental health recovery."*[61] Similarly, at inquest, Dr Sullivan described the environment as unpleasant and spartan but nevertheless aimed at reducing the risk of suicide or self-harm (**SASH**) as far as possible and ensuring frequent/15 minutely observation by correctional staff with few other tasks to distract them.[62]

41. Forensicare's care planning for Unit 13 prisoners, focuses on short-term goals and actions, all with the overarching aim of reducing distress and suicide and/or self-harming behaviours as quickly as possible and increasing patient resilience to the point where those risks can be safely managed in a less restrictive environment.[63]

FORENSICARE'S MANAGEMENT OF MR OMAR FROM 9 JUNE 2017

42. When Mr Omar was received into custody at MAP on 9 June 2017, he was entering his tenth period of incarceration since 2015.

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[60] Ibid at page 3. Note that two of the six cells are equipped with CCTV cameras to facilitate the constant observation required of S1 rated prisoners.
[61] Exhibit B at page 3.
[62] Transcript page 48, 52 and 61.
[63] Exhibit B at pages 4-5. In order to do so, Forensicare clinicians on Unit 13 are expected to – review the file and risk history of each patient; conduct mental state and risk assessments and develop a suicide risk formulation for those in crisis with SASH behaviours collaboratively, drawing on all available perspectives; document risk management plans and clinical pathways and discuss daily with CV staff; ensure mental health treatment plans are updated and relevant details discussed with CV staff daily; attend the daily 9.00am collaborative care meetings and weekly clinical review meetings; present patients at the 1.00pm daily Risk Review Team (RRT)/High Risk Review Team (HRAT) meeting and contribute to collaborative risk management and clinical planning with other participants;

43. All prisoners are routinely screening upon reception, whether they have previously screened or not. This screening includes an assessment by correctional staff, a medical assessment by the relevant general health service and a mental health assessment undertaken by a Forensicare clinician, usually a registered psychiatric nurse (**RPN**), and utilises a locally developed structured assessment tool based on an internationally validated instrument.

44. The purpose of the mental health or psychiatric assessment is to determine the prisoner's current mental state, any immediate care needs, their current risk of SASH and any appropriate recommendations for the prisoner's placement. While it is CV who determines the placement of a prisoner, in terms of the prison and unit within the prison, a prisoner's immediate placement and observation level is informed by the "P" and "S" ratings they are assigned at reception.[64]

45. On reception, Mr Omar noted to be cooperative with no evidence of acute psychosis or suicidality. He was given a P1 psychiatric rating, indicating a significant ongoing psychiatric condition requiring intensive and/or psychiatric treatment,[65] and an S3 rating in relation to his SASH risk,[66] requiring his placement in a regular cell with observations conducted at intervals of no greater than 60 minutes, and a risk assessment to be undertaken every three days at a minimum (while continuing to be assessed as S3) and while in a mainstream unit, like Unit 2 where he was initially placed. P and S Ratings are not static and are subject to formal review via At Risk Assessments at frequencies determined in accordance with the ascribed rating, or in response to an At Risk Referral from CV.[67]

46. On 12 June 2017, three days after reception, Mr Omar was reviewed by a Forensicare RPN who noted he was disappointed about returning to prison; denied suicidal ideation or psychotic symptoms; and said he felt comforted being on hourly observations and receiving regular

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[64] Exhibit B at pages 5-6.
[65] Exhibit 7 page 7. The four "P ratings" are P1 – where the prisoner has a significant ongoing psychiatric condition requiring intensive and/or psychiatric treatment; P2 – where the prisoner has a significant ongoing condition requiring psychiatric treatment; P3 – where the prisoner has a stable psychiatric condition requiring continuing treatment or monitoring; and PA – where the prisoner has a suspected psychiatric condition requiring assessment.
[66] Exhibit B page 7. The four "S ratings" are S1 – the highest alert signifying placement in an observation cell; observations are made at intervals of no greater than 15 minutes; daily risk assessments are conducted by Forensicare; and daily discussion of the prisoner at the RRT/HRAT meeting; S2 - these prisoners are placed in an observation cell or, at MAP, a ligature-proof cell in the AAU; observations are required at intervals of no greater than 30 minutes; daily risk assessments are conducted by Forensicare; and daily discussion of the prisoner at the RRT/HRAT meeting; S3 – these prisoners are placed in a regular cell; observations are required at intervals of no greater than 60 minutes; risk assessment are conducted by Forensicare every three days; prisoners downgraded from S2 to S3 continue to have daily risk assessment and to be discussed at the RRT/HRAT meeting until it is determined they are appropriate for three daily review; S4 – any prisoner with a history of attempted suicide and/or self-harm.
[67] Exhibit B at page 7.

psychiatric follow-up. The outcome of this scheduled At Risk Assessment was that Mr Omar's ratings remained P1 and S3.[68]

47. Mr Omar was reviewed by another Forensicare RPN on 13 June 2017. Enquiries of his regular case manager at the MHS confirmed that he had been administered his depot injection on 24 May 2017 and had missed the next appointment on 7 June 2017 as he had been arrested and was in police custody on that date. The RPN noted that Mr Omar described experiencing intrusive auditory hallucinations *("I just get these voices all the time before I go to sleep.")* but denied other psychotic symptoms and thoughts of suicide. As a result of this review, Mr Omar was scheduled for review by a psychiatric registrar as soon as possible to advise about his depot medication.[69]

48. On 14 June 2017, Mr Omar underwent clinical review by a Forensicare psychiatric registrar, primarily to clarify when his flupenthixol depot injection was next due. It was noted, *inter alia,* that Mr Omar was somewhat distracted, wanting to leave to go to the canteen before it shut. He acknowledged occasional auditory hallucinations, mostly at night, of a male voice telling him to kill himself by hanging himself, possibly through using a T-shirt. However, he denied having suicidal intent and was future focused. He asked to remain on quetiapine but was agreeable to changing to olanzapine and to continue his depot injection.[70]

49. The psychiatric registrar documented an ongoing need for an oral antipsychotic as Mr Omar was continuing to experience auditory hallucinations. The preference for olanzapine over quetiapine was informed by Mr Omar's history of trading quetiapine (both in the community and when in custody) and a concern that he was vulnerable to being stood over in custody due to his intellectual disability as quetiapine is considered a high value item in prison.[71]

50. At inquest, Dr Sullivan supported this decision to change from quetiapine to olanzapine and also testified that after clozapine, the most effective antipsychotics (in no particular order) are amisulpride, risperidone and olanzapine.[72]

51. Apart from the change in oral antipsychotics, the plan documented by the psychiatric registrar after this review was a reduction of Mr Omar's ratings from P1S3 to P1S4 with a cessation of observations, administration of flupenthixol depot fortnightly from 19 June 2017 and review by

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[68] I note that Mr Omar also approached a social worker in Unit 2 and had contact with the nurse who administered his monthly antibiotics with no apparent concerns noted for his well-being. See Exhibit B, attachment DS 3 – a copy of the JCare 'Encounters' Clinical Notes for the period 9-25 June 2017 (pages 10-11 of 82).
[69] Exhibit B, attachment DS 3 (pages 8-9 of 82).
[70] Exhibit B at page 10 and DS 3 (pages 8-9 of 82).
[71] Ibid. This change in antipsychotics required a three-day period of titration from 10mg olanzapine at night, before increasing to 20mg at night, while reducing quetiapine XR to 200mg at night for three days then ceasing. See also transcript pages 50-51.
[72] Transcript pages 50-51.

a psychiatric registrar in two weeks.[73] The change from S3 to S4 was discussed at the RRT/HRAT meeting on 15 June 2017 and documented in the HRAT Modified Risk Management Plan.[74]

52. On 19 June 2017, Mr Omar attended for administration of his depot medication and was also reviewed by both a Forensicare RPN and social worker without apparently raising any concerns about his mental state or safety.[75]

53. Two days later, on the afternoon of 21 June 2017, Mr Omar was the subject of an At Risk Referral from CV staff and was reviewed by Forensicare RPN while in his cell in Unit 2.

54. He was reported to have tied a sheet around his neck. The RPN noted that he was anxious. Mr Omar said he had tied a sheet around his neck and was unable to give a reason for doing so. He said he felt "sick"; claimed voices were telling him to hang himself; was unable to distract himself and appeared ambivalent/unable to guarantee his safety. The RPN increased Mr Omar's rating (from P1S4) to P1S2 and he was transferred to Unit 13 with a plan for review the following day. Mr Omar was for constant observations and was noted to have accepted medication and slept after the transfer.[76]

55. As planned, Mr Omar was reviewed by three Forensicare clinicians including a consultant psychiatrist, the following morning, 22 June 2017, documented as at 10.20am. Again, Mr Omar explained that he had tied a sheet around his neck in response to voice telling him to kill himself. He said he had been worried about court and felt "sick". He was still hearing voices which were command in nature telling him to harm himself but denied violent thoughts (towards others). Mr Omar was still scared/distressed but accepting of treatment and willing to take additional medication.

56. Following this review, Mr Omar was to remain P1S2 on Unit 13, to continue on his current medication with the addition of up to 20mg daily of olanzapine on a PRN or "as needs" basis, to be monitored for his response to treatment and for daily review.[77] This plan for Mr Omar was endorsed by all attendees at the RRT/HRAT meeting at 1.00pm on 22 June 2017.[78]

57. At about 12.55pm on 22 June 2017, Mr Omar was reviewed again by the same Forensicare RPN as was involved in the earlier review with a consultant psychiatrist. They noted that Mr Omar

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[73] Exhibit B at page 10, DS 3 (at page 9 of 82).
[74] Exhibit B at page 10, DS 4.
[75] Exhibit B at page 10, DS 3 (at page 6 of 82).
[76] Ibid, DS 3 (at page 6 of 82), DS 5 and DS 6.
[77] Exhibit B at page 11, DS 3 (at page 5 of 82).
[78] Exhibit B, DS 7. Note that on the morning of 22 June 2017, Mr Omar was also seen by an occupational therapist from the Community Integration Program (CIP) involved in planning for his potential release on bail with no apparent concerns for his mental state or safety. See DS 3 (at pages 3-4 of 82) for a comprehensive record of her impressions/plan for Mr Omar.

was unable to guarantee his safety, was to remain on Unit 13 with daily RPN reviews and maintained the ratings of P1S2.[79]

58. The next significant interaction between Mr Omar and Forensicare clinicians was on the morning of 23 June 2017. According to Dr Sullivan, the documented "Unit 13 Review" is a reference to the outcome of the collaborative care meeting held at 9.00am daily and involving Forensicare and the general health service providers which occurs prior to the 1.00pm daily RRT/HRAT meeting. Dr Sullivan inferred that the RPN reviewed Mr Omar individually, as well as discussing his presentation at the collaborative care meeting.[80]

59. The review notes, time stamped 0956 hours, document that Mr Omar engaged reasonably well with some restlessness and incongruity of affect. He was reported to be compliant with medication, denying any current auditory hallucinations and said he felt safe and wanted to leave Unit 13. Mr Omar denied any thoughts of self-harm or harm to others and assured the RPN that he would let staff know if he was experiencing any distress or thoughts of self-harm.

60. The documented plan after the review was for Mr Omar to be cleared from Unit 13 on an S3 rating, with S3 (or hourly) observations, RPN review the day following transfer and three daily reviews as per S3 protocol. This plan was then discussed and endorsed at the RRT/HRAT meeting on 23 June 2017. Mr Omar's rating was altered to P1S3 and, that afternoon, he was transferred from Unit 13 back to a BDRP[81] compliant cell in a mainstream unit with hourly observations.[82]

61. The last documented RPN review of Mr Omar was on the morning of 24 June 2017, time stamped 1050 hours. This was by way of follow-up, as required the day after transfer from Unit 13. The general impression was positive with Mr Omar presenting as polite, pleasant, cooperative, engaging, maintaining eye contact and with a reactive affect. His speech was normal with no evidence of formal thought disorder. Mr Omar denied current perceptual disturbances, current thoughts of self-harm or intent, stated there were "no voices now" and described his own mood as "very good."

62. The RPN concludes by noting that Mr Omar remains unpredictable and impulsive, maintaining the current ratings of P1S3 and documents the need for a review of the observation regime in

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[79] Ibid and DS 3 (at page 3 of 82).
[80] Exhibit B at page 11. See also transcript pages 38 and 67 for Dr Sullivan's explanation of the participants in and remit of the collaborative care meeting.
[81] Building Design XX
[82] Exhibit at page 11 and DS 8. Note that Mr Omar engaged with one of the Unit 13 occupational therapists shortly after the RRT/HRAT meeting and before transfer from Unit 13. He was seen in the yard in his own personal clothing, said he was feeling much improved, had showered and eaten. Mr Omar engaged in a discussion around help-seeking behaviour and said that he is aware from past experience about how to seek help. See the OT's encounter note at DS 3 (at page 2 of 82).

two days' time. The practical effect of the S3 rating was that Mr Omar would remain on hourly observations until further review.[83]

63. In his statement, Dr Sullivan stressed that the decision to clear Mr Omar to a mainstream unit was done in collaboration at the RRT/HRAT meeting where he was discussed on 24 June 2017. It is apparent that the meeting was aware of Mr Omar's history of schizophrenia, history and recent threats of suicide and self-harm and that he would be followed-up by a Forensicare clinician the day after transfer out of Unit 13 and his unpredictability.[84]

64. It is apparent that Dr Sullivan endorsed the various assessments made by Forensicare clinicians, both in terms of their soundness and compliance with the processes and procedures in place at the time.[85] Ultimately, appraisal of Forensicare's clinical management and care of Mr Omar turns on the predictability of his death and the broader question of the predictability of suicide.

65. According to Dr Sullivan, the professional literature is very clear that there are no suicide risk assessment tools which can reliably predict one group of people who will kill themselves and one who will not. Such tools as there are can predict the group who are at higher risk and the group who are at lower risk, but their application is not associated with a significant reduction in the rate of suicide. This is the case in general mental health settings and in the prison population where there is a known increased risk of suicide.[86]

FINDINGS/CONCLUSIONS

66. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications. [87]

67. Adverse findings or comments against individuals or institutions are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and in so doing caused or contributed to the death under investigation.

68. Having applied the applicable standard of proof to the available evidence, I find that:

    a. The identity of the deceased is Mohamed Omar, born on 1 January 1987, aged 30.

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[83] Exhibit B at page 12, DS 3 (at page 1 of 82).
[84] Exhibit B at page 13, DS 8 dated 23 June 2017 and DS 9 dated 24 June 2017.
[85] Transcript page 37 and following.
[86] Transcript pages 59-61.
[87] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 especially at 362-363. "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…"*

b. Mr Omar died at the Melbourne Assessment Prison, 317 Spencer Street, Melbourne, on the evening of 25 June 2017.

c. The medical cause of Mr Omar's death is consistent with neck compression.

d. While the available evidence supports a finding that no third party was involved in Mr Omar's death and that he died as a result of his own actions, it also supports a finding that he was likely responding to auditory command hallucinations to self-harm that were symptomatic of his mental illness and/or that his judgement was impaired such that an intent to suicide or self-harm is not made out.

e. The available evidence does not support a finding that there was any want of clinical management or care on the part of the staff of Forensicare, or any want of supervision or care on the part of correctional staff that caused or contributed to Mr Omar's death.

f. The clinical management and care provided to Mr Omar during his last period of incarceration was appropriate by current standards. He was administered medication as prescribed, had regular mental health reviews including with psychiatrists and psychiatric registrars and a period of acute distress and increased suicidality was responded to appropriately.

g. The decision to return Mr Omar to mainstream accommodation at his request was appropriate and, although his acute distress had resolved, his ongoing suicide risk was acknowledged resulting in his accommodation in a BDRP compliant cell with hourly observations, daily mental health reviews and regular RRT/HRAT discussions.

h. Significantly, the circumstances of Mr Omar's death were different to those of previous suicide attempts when, in accordance with his usual pattern of suicidal behaviour while in custody, he would draw staff attention to his behaviour before coming to any serious harm.

PUBLICATION OF FINDING

69. Pursuant to section 73(1) of the Act, unless otherwise ordered by the coroner, the findings, comments and recommendations made following an inquest must be published on the internet in accordance with the rules. I make no such order.

DISTRIBUTION OF FINDING

70. I direct that a copy of this finding be provided to:

The family of Mohammed Omar

Forensicare

Justice Health

Corrections Victoria

Department of Justice and Community Safety

Justice Assurance and Review Office

Signature:

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Paresa Antoniadis Spanos
Coroner
Date: 28 April 2021