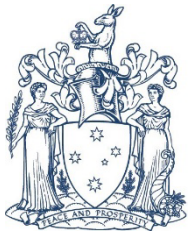

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 006558

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

Inquest into the Death of Abdurahman Faid

Delivered On:	03 November 2023
Delivered At:	Melbourne
Hearing Dates:	2 November 2023
Findings of:	Coroner Leveasque Peterson
Representation:	Ms Jan Moffat, representing Melbourne Health, (NorthWestern Mental Health Services)
Police Coronial Support Unit	Leading Senior Constable Fiona Nation
Keywords	In care death, unascertained

INTRODUCTION

1. On 31 December 2018, Abdurahman Faid was 48 years old when he was found deceased in his hospital bed on December 31 2019, at the Northern Hospital Psychiatric Unit where he was an involuntary patient subject to a temporary treatment order.

2. Mr Faid was a 48 year old Eritrean refugee, with limited English, who resided with his, father Mohammad Nor Humbrirra and mother Fatma Hadeke and sister Hayat at 3 Cleeland Court, Roxburgh Park, Victoria. He had other siblings, sisters, Najet, Intisar, Izzedin, Hasina and Zukia and a brother Abdulmanan.

3. Mr Faid and his family migrated to Australia in 2006, when Mr Faid was 36. Abdurahman's consultant psychiatrist Dr David Muirhead reports (based on information reported by his family) that in 1987, Abdurahman at the age of 17 was diagnosed with malaria while living in Eritrea. This resulted in him suffering an acquired brain injury following an episode of cerebral malaria. He was paralysed for 3 months, resulting in his brain function being severely affected. In 1988, he was diagnosed with chronic schizophrenia and according to his family, never fully recovered.

4. Between 1988 and 2006 Abdurahman was repeatedly admitted to a psychiatric hospital in Sudan where he was treated with electroconvulsive therapy (ECT) and medication.

5. Not long after the family migrated to Australia, Mr Faid was brought to the Inner West Mental Health Service, prescribed daily Olanzapine before changing to mobile clinics at North Western Mental Health Service (NWAMHS) between 2007 - 2010 after persisting hallucinations, delusions along with disorganised and repetitive behaviours.

6. As a result of these symptoms Mr Faid's behaviour would fluctuate from frequent periods of poor sleep and agitated behaviour to cause frequent outbursts of property damage and assaults on his family. He was prone to wander if unaccompanied and would persistently become lost. Apart from 2 admissions to a psychiatric facility in 2007, Mr Faid was cared

for by his family, with attempts to engage him in community-based rehabilitation programs being unsuccessful.

7. From 2010, Mr Faid had been treated by the Broadmeadows community team of NorthWestern Mental Health Services (**NWMS**). He remained unwell despite reviews in medication resulting in 2 prolonged admissions in 2012. Mr Faid's illness became less responsive to medication, such that he was treated with ECT where his behaviour became significantly more settled, and he was able to be discharged with medication and maintenance ECT.

8. Throughout the years between 2013 and 2018, efforts were made to extend time frames between ECT treatments, however this exacerbated symptoms and a deterioration in mental state. Mr Faid, therefore, remained on ECT treatments sometimes weekly.

9. Mr Faid had other health problems, hypertension, obesity and obstructive sleep apnoea. He was commenced on continuous positive airways pressure (CPAP) to treat this, however it was understood that he did not use this as he did not tolerate having the mask on at night.

10. During late 2018, Mr Faid's respiratory health deteriorated with repeated low arterial oxygen readings when he presented for ECT. The ECT was sometimes cancelled because of this.

11. On December 17, 2018, the family took Mr Faid to a respiratory physician, Dr Bassem Daewood, at Sleep and Lung Care, where he was diagnosed as having untreated sleep apnoea and obesity hypoventilation syndrome. He was recommended to use the CPAP machine at night and before and after ECT, however was reportedly noncompliant with this and further investigations recommended.

12. On Wednesday December 26, 2018, at 8.30 p.m. Mr Faid was taken to the ED at the Northern Hospital by his family due to a deterioration in his mental health. He had smashed a window at his home and acknowledged hearing voices. At this time he had not had any ECT for 3 weeks and was reported "labile in mood, being agitated with recurrent episodes of aggressive behaviour and he was unable to be consoled or reasoned with by his family"

13. The medical staff at triage, recognised that Mr Faid's oxygen levels were lower than expected so he was monitored in ED.

14. Following a psychiatric assessment, Mr Faid was placed on a temporary treatment order and transferred on December 27 2018 at 1.15 p.m. to the Intensive Care Area (ICA) at the TNH Inpatient Psychiatry Unit (**IPU**). Almost immediately on transfer, an episode of violence occurred and Mr Faid was again transferred to a secure room within the unit at 3 p.m. that day.

THE CORONIAL INVESTIGATION

15. Abdurahman's death was reported to the Coroner as it fell within the definition of a reportable death in the Coroners Act 2008 (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes. As Mr Faid was an involuntary patient who was subject to a temporary treatment order his death met the criteria for a mandatory investigation and inquest.

16. An inquest commenced on 2 November 2023. As there were no disputes about the facts the evidence was received by way of a summary from Counsel assisting.

17. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

18. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

19. Victoria Police assigned Senior Constable Bengstsson as the Coroner's Investigator for the investigation of Abdurahman's death. Senior Constable Bengstsson conducted inquiries on

my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

20. This finding draws on the totality of the coronial investigation into the death of Abdurahman Faid including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.

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

Circumstances in which the death occurred

21. Mr Faid was assessed and considered to be a high risk mental health patient and was on hourly observations in the secure unit. His oxygen saturations were recorded on the observation chart were between 91 and 95 %. Nursing notes refer to episodes of short-lived periods of lower readings with Mr Faid alternatively sleepy, sleeping or restless and wandering the ward. He was non-compliant with the CPAP machine overnight.

22. On Friday December 28 2018, nursing notes describe that Mr Faid remained mentally unwell and required Panadeine Forte for tooth pain. Nurses noted, that Mr Faid's oxygen saturation level was dropping during his sleep-wake cycle, however if Mr Faid sat upright, his oxygen saturations returned to normal range.

23. A chest X-ray and blood tests were arranged and the results were not indicative of chest infection or other pathology.

24. On Sunday December 30, 2018, Mr Faid's behaviour was unchanged. His recorded oxygen saturation was 95% at midday. His CPAP machine was taken away by family for repairs.

25. On Monday December 31, 2018, staff report that hourly visual observations were taken over night and that Mr Faid was 'asleep and breathing' at a visual check at 5.55 a m.

26. At 7.11am Mr Faid was found unconscious and not breathing. Resuscitation was attempted but was unsuccessful and Mr Faid was declared deceased at 7.23 a m.

Identity of the deceased

28. On 31 December 2018, Abdurahman Faid, born 6 November 1970, was visually identified by his sister, Najet Faid.

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

Medical cause of death

30. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (VIFM) conducted an examination on 3 January 2019 and provided a written report of his findings dated the same day.

31. A complete post mortem medical examination was recommended and ordered to determine the morphological cause of death, however for reasons that I accept, the next of kin did not wish for an autopsy to be performed and the decision to undertake a full autopsy was revoked.

32. A post mortem CT scan showed some lung changes and early internal decomposition. There was also mild cerebral oedema.

33. The external examination showed no other significant external findings.

34. Toxicological analysis of post-mortem samples identified that the level of therapeutic substances including codeine, paracetamol, olanzapine and lorazepam present in Mr Faid's sample, and biochemistry were non-contributory to Mr Faid's passing.

35. In the absence of a full post mortem examination, on the basis of the information available to Dr Bouwer at the time of external examination, Dr Bouwer provided an opinion that the medical cause of death was 1 (a) UNASCERTAINED.

36. I accept Dr Bouwer's opinion.

FAMILY CONCERNS

37. Najet Faid wrote to the court and expressed a number of concerns about the circumstances of the medical care and management for her brother prior to his death. Najet articulated many concerns that fell outside my jurisdictional remit, however I considered it appropriate to examine the care and management that related to Mr Faid's respiratory issues. Specifically I note the family concern that Mr Faid received no CPAP machine support immediately prior to his death.

38. In the context of these family concerns I obtained materials including relevant medical records and other information from NorthWestern Mental Health (NWMU) and referred the information to the Coroners Prevention Unit (CPU) for advice. The CPU is staffed by independent health professionals who provide specialist review of medical care and management.

39. NWMU reported that Mr Faid had been using a CPAP machine whilst in the community, and following Mr Faid's admission, the plan was to continue to use his CPAP machine support. Mr Faid's machine was brought with him to hospital and available. However the use of his CPAP machine was complicated by Mr Faid's deteriorating mental health which resulted in agitation and psychosis and ultimately his persistent non compliance with the CPAP machine. Additionally the hospital had to navigate the poor working condition of his CPAP machine. On day four of his admission Mr Faid's family took his CPAP machine away for servicing and it had not been replaced at the time of his death. The lack of a replacement CPAP machine was reasonably explained in that Mr Faid had not been well enough to undertake the individualised fitting and calibration process that follows a specialist respiratory consultation.

40. Notwithstanding these limitations, Mr Faid's management did include regular physical observations including monitoring his oxygen saturation levels, and undertaking steps including patient positioning to reduce his risk of respiratory complications.

41. Unfortunately my investigation with respect to the impact of Mr Faid's respiratory condition on his death was significantly constrained by the lack of an autopsy. The inability to

identify a cause of death prevented me from being able to establish a causal link between his death and the conduct of any person or individual involved with Mr Faid's care.

42. This was a complex case given the contemporaneous deterioration in Mr Faid's physical and mental health. I have been unable to identify any deficiencies or omissions in medical care and management that can appropriately be characterised as contributory or causal to Mr Faid's death nor have I identified any prevention opportunities.

FINDINGS

43. Pursuant to section 67(1) of the Coroners Act 2008 I make the following findings:

a) the identity of the deceased was Abdurahman Faid, born 06 November 1970;

b) the death occurred on 31 December 2018 at Northern Health, The Northern Hospital, 185 Cooper Street, Epping, Victoria, 3076, from UNASCERTAINED; and

c) the death occurred in the circumstances described above.

I order that this finding be published on the Internet.

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

Nejat Faid, Senior Next of Kin

Senior Constable Matthew Bengtsson, Coroners Investigator

Peter Kelly, Melbourne Health (North Western Mental Health Service)

Neil Coventry, Office of the Chief Psychiatrist,

Signature:

Coroner Leveasque Peterson

Date: 3 November 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.