IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004492

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF HARI PRASAD DHAKAL

Findings of:	Coroner David Ryan
Delivered on:	30 March 2026
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria
Inquest hearing dates:	30 March 2026
Counsel Assisting the Coroner:	Leading Senior Constable Kelly Ramsey Coronial Support Unit
G4S Custodial Services Pty Ltd:	Ingrid Nunnink Gilchrist Connell
WorkSafe:	Stella Treanor Lawyer, WorkSafe
Keywords:	Death in custody – mental health treatment - engagement

INTRODUCTION

1. On 4 August 2024, Hari Prasad Dhakal was 57 years old when he passed away at Port Philip Prison (**PPP**). PPP is operated by staff from G4S Custodial Services Pty Ltd (**G4S**) and medical services to prisoners at PPP are provided by St Vincent's Custodial Health Service (**SVCHS**). Prisoners who require inpatient psychiatric treatment are managed by the Victorian Institute of Forensic Mental Health (**Forensicare**).

2. General prison operations at PPP ceased at the end of 2025. It is now primarily used to provide medical care to prisoners who require care in a subacute unit.

BACKGROUND

3. Mr Dhakal was born in Nepal on 9 March 1967. He reported to custodial staff that he had been married in Nepal and had two children. One of those children, Rajan Dhakal, who resides in Nepal, has been in communication with the Court.

4. Mr Dhakal moved to Australia without his family in September 2000. His application for a business visa was denied, and he remained in Australia unlawfully and was estranged from his family. He never became fluent in English.

5. Mr Dhakal gained employment as a chef.

6. On 25 October 2016, Mr Dhakal stabbed a patron at the Ballarat restaurant where he worked as a chef. He pled not guilty to murder on the grounds of self-defence. A jury found Mr Dhakal guilty of murder and on 1 June 2018, he was sentenced in the Supreme Court of Victoria to 23 years imprisonment. He was due to be deported upon his release.

7. There is no evidence that Mr Dhakal suffered from any significant mental health concerns prior to his incarceration. Further, there is no evidence that he had experienced any suicidal ideation. SVCHS staff recorded his medical history as including hyperlipidaemia, severe hepatic stenosis, gastro oesophageal reflux disorder, Bells palsy and Type 2 diabetes. Mr Dhakal was being administered a number of medications at PPP at the time of his death including metformin, atorvastatin and esomeprazole. However, his antipsychotic medication had been ceased in May 2024.

8. In 2019, Mr Dhakal developed signs of what became an enduring psychotic illness. He was subsequently diagnosed with schizophrenia and schizoaffective disorder. Over the following five and a half years, he was admitted to Thomas Embling Hospital (**TEH**) on six occasions where he was treated by Forensicare staff with various psychiatric medications, including long-acting depot antipsychotic medications.

9. The treatment of Mr Dhakal's mental illness was challenging as a result of his persistent lack of insight, and unwillingness to engage with mental health staff and the presence of hostile behaviours towards staff when he was unwell.

10. Mr Dhakal's last period of treatment at TEH was between 17 and 21 May 2024 during which time he was administered a long-acting antipsychotic medication (paliperidone) by injection pursuant to a Secure Treatment Order (**STO**) made under the *Mental Health and Wellbeing Act 2022*.[1]

11. While at PPP throughout June and July 2024, Mr Dhakal was proactive in engaging with medical staff in relation to any physical issues he was having, but his engagement with mental health staff remained poor. He refused to attend outpatient appointments with a Consultant Psychiatrist on 21 June, 4 July and 25 July 2024.

12. Mr Dhakal's SASH[2] risk was constantly assessed and reviewed and there were no episodes of self-harm or any expressions of suicidal ideation. However, Forensicare acknowledged that his SASH risk was challenging to assess given his poor of engagement with staff and lack of insight into his condition.

13. At the time of his death, Mr Dhakal was residing in Room 852 in the Matilda East Unit of PPP.

[1] Given his recognized disengagement with mental health services, Forensicare had put a plan in place for Mr Dhakal to receive three-monthly anti-psychotic medication injections.
[2] Suicide and self-harm.

CORONIAL INVESTIGATION

14. Mr Dhakal's death constitutes a "*reportable death*" under section 4(2)(c) of the *Coroners Act 2008* (**the Act**), as immediately before his death he was a person placed in custody or care. Section 52(2)(b) of the Act requires that an inquest be held into Mr Dhakal's death. In the circumstances, I considered it appropriate to hold a summary inquest which occurred on 30 March 2026.

15. At the hearing, a summary of the evidence was provided to the Court by Counsel Assisting. The individual witnesses who provided statements in the brief were not required to give evidence at the inquest as, after carefully considering all of the material in the coronial brief, I was satisfied that there were no significant factual disputes or controversies which remained unresolved in order for me to make the findings required under section 67 of the Act. The Interested Parties were given an opportunity to make submissions in relation to the evidence.

16. The Coroners Court of Victoria is an inquisitorial court.[3] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

17. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

18. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

19. 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 prevention role.

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[3] Section 89(4) of the Act.

20. Coroners are empowered to:

(a) report to the Attorney-General on a death;[4]

(b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[5] and

(c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.[6]

21. These powers are the vehicles by which the prevention role may be advanced.

22. It is important to stress that coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death. Further, they are specifically prohibited from including a finding or comment, or any statement that a person is, or may be, guilty of an offence.[7] It is also not the role of the coroner to lay or apportion blame, but to establish the facts.[8]

23. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles enunciated in *Briginshaw v Briginshaw*.[9]

24. A directions hearing was held on 28 August 2024 at which it was confirmed that Victoria Police had assigned Constable Tess Edwards to be the Coronial Investigator for the investigation into Mr Dhakal's death. The Coronial Investigator conducted inquiries on my behalf and submitted a coronial brief including statements from the forensic pathologist, various correctional officers, medical and custodial records and CCTV footage. Reports were also provided directly to the Court from the Justice Assurance

[4] Section 72(1) of the Act.
[5] Section 67(2) of the Act.
[6] Section 72(2) of the Act.
[7] Section 69(1) of the Act. 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) of the Act.
[8] *Keown v Khan* (1999) 1 VR 69.
[9] (1938) 60 CLR 336.

Review Office (**JARO**) and the Office of the Chief Psychiatrist (**OCP**). Further, the Court obtained copies of an In-depth Case Review report prepared by SVCHS and a Serious Adverse Patient Safety Event (**SAPSE**) report prepared by Forensicare. Written submissions were also received and considered by the Court from Forensicare and G4S.

25. I will refer only to so much of the evidence as is relevant to comply with my statutory obligations and for narrative clarity.

CIRCUMSTANCES IN WHICH DEATH OCCURRED

26. During the 8.00am head count in the Matilda East Unit on 4 August 2024, Mr Dhakal was handed his daily milk through the trap in his cell door before returning to bed. He did not attend the medication trolley that morning to receive his prescribed medications. At the 12.00pm head count, Mr Dhakal was observed by correctional officers to be speaking with fellow inmates.

27. CCTV footage discloses that at 12.17pm, Mr Dhakal opened his cell door and wedged a ligature in the top of the door jamb before removing it around two minutes later.

28. CCTV footage discloses that at 12.44pm, Mr Dhakal again secured the ligature in the top of the door before closing it.

29. Mr Dhakal did not emerge from his cell for the 5.00pm muster. A correctional officer opened the cell trap and observed Mr Dhakal's back pressed up against the door. He was noted to be unresponsive. A Code Black[10] was called and the cell door was then opened by correctional staff at 5.02pm. Mr Dhakal was observed to fall to the ground, with a ligature tied around his neck. The ligature had been fashioned from the nylon straps of a bag which had been issued to him upon his reception at PPP. He was unresponsive and cold to the touch. The ligature was removed by correctional staff at 5.03pm with the use of a ligature knife obtained from the adjacent unit and cardiopulmonary resuscitation (**CPR**) was commenced. Mr Dhakal was also treated with a defibrillator and oxygen.

[10] A Code Black is a medical term which signifies a serious medical incident requiring urgent assistance.

30. Medical staff arrived at the scene to assist with the emergency response at 5.06pm and emergency services were contacted at 5.09pm. Ambulance Victoria and Fire Rescue Victoria arrived at 5.22pm but Mr Dhakal could not be revived. He was pronounced deceased by paramedics at 5.27pm.

31. Victoria Police also attended the scene and conducted a search of Mr Dhakal's cell. They located several undated letters written by Mr Dhakal and addressed to his victim's wife in which he expressed sorrow and remorse for his actions.

32. Victoria Police did not identify any evidence of suspicious circumstances.

OTHER INVESTIGATIONS

33. Section 7 of the Act requires the coroner to liaise with other investigative authorities and to not unnecessarily duplicate inquiries and investigations.

SVCHS

34. SVCHS conducted an in-depth Case Review into Mr Dhakal's death which found that there was opportunity for increased collaboration between SVCHS and Forensicare when prisoners are being transitioned from TEH to PPP. The following recommendations were made:

    (a) Implement a process to support receiving consistent care information for patients on transition to PPP from a forensic mental health inpatient admission;

    (b) Implement a standard to support ongoing risk mitigation and clinical care discussions between SVCHS and Forensicare; and

    (c) Build into routine practices the opportunity to review a forensic mental health patient's discharge summary on admission to PPP.

Forensicare

35. Forensicare conducted a Serious Adverse Patient Safety Event (**SAPSE**) review which made the following findings:

    (a) There was consistent and assertive outreach by SVCHS staff at PPP;

    (b) Collateral information from custodial and SVCHS staff did not indicate concerns about Mr Dhakal or a change in his risk assessment; and

    (c) Mr Dhakal's non-attendance to scheduled appointments with Forensicare was noted and his engagement with mental health services at PPP was characterised as poor and engagements with SVCHS were superficial and dismissive. It was considered likely that Mr Dhakal's engagement with Forensicare reviews would have been similar.

36. The panel also found that some of Mr Dhakal's documentation was not properly completed, including his discharge summary prior to his last transfer to PPP from TEH.

37. The panel made the following relevant recommendations:

    (a) Strengthen existing processes for when consumers do not attend scheduled outpatient appointments; and

    (b) Implement a 7-days post discharge follow up process to align requirements in place at private prisons where the discharge location is within the same prison location.

38. Forensicare have advised that the implementation of the recommendations are either completed or in progress.

39. In correspondence to the Court in response to the JARO report, Forensicare sought to emphasise the context of the MHWB Act to Mr Dhakal's treatment. In particular, that mental health care in prison is voluntary unless the consumer is deemed to meet the threshold for compulsory treatment. Further, that Mr Dhakal had rights to dignity and

autonomy when engaging with mental health services which included a right to refuse voluntary mental health treatment.

WorkSafe

40. WorkSafe conducted an investigation into Mr Dhakal's death and on 13 April 2025 determined not to pursue any further prosecution.

JARO

41. Mr Dhakal's death was reviewed by JARO which is part of the Department of Justice & Community Safety (**DJCS**) and reported to the Secretary to the Department (**the Secretary**), who is responsible for the monitoring of all correctional services to achieve the safe custody and welfare of prisoners.[11]

42. JARO prepared a report containing its findings and recommendations which it submitted to the Court in October 2025. The review was conducted in collaboration with Justice Health.[12]

43. In summary, JARO made the following relevant findings:

    (a) Mr Dhakal engaged in some preparation and planning in the days prior to his death which he was careful to conceal from custodial staff;

    (b) Despite consistent engagement from health teams and appropriate documentation of care, Mr Dhakal's mental state remained chronically unstable;

    (c) Mr Dhakal's care was consistent with policy and frameworks, with coordinated efforts from mental health and primary health teams. However, there were missed opportunities for early intervention due to the challenges of his ongoing refusal of treatment and poor engagement;

[11] Section 7 of the *Corrections Act 1986*.
[12] Justice Health is a part of the Department of Justice and Community Safety and has responsibility for the delivery of health services to Victoria's prisoners.

(d) The primary health care afforded to Mr Dhakal was appropriate;

(e) Mr Dhakal's custodial management was appropriate and custodial staff proactively attempted to engage him. Further, his security risk and placement were managed in line with policy.

44. JARO identified that the following relevant area for improvement:

(a) Stronger coordination between health services during transitions between secondary mental health and primary health services.

OCP

45. Mr Dhakal's death was reported to the Chief Psychiatrist and was reviewed by the OCP. The role of the Chief Psychiatrist includes overseeing specialist mental health and wellbeing services in custodial settings. The OCP prepared a report containing its findings and recommendations which was annexed to the JARO report.

46. In summary, the OCP made the following relevant findings:

(a) There was no evidence that Mr Dhakal's suicide was in any way foreseeable by those involved in his care at PPP at the time of his death. His death was unexpected and could not have been anticipated or reasonably predicted.

(b) It is likely that Mr Dhakal's death occurred when he had been mentally unwell – most likely psychotic, to varying degrees for months. Notwithstanding, the degree, if any, to which active mental illness contributed to his death is unknowable;

(c) The evidence suggested that Mr Dhakal had not fully recovered from a psychotic relapse that had manifested in January 2024, notwithstanding two subsequent hospital admissions;

(d) Mr Dhakal was an unusually challenging person for specialist forensic mental health services to assess and manage in custody over the longer term, even by the standards of the cohort that they usually treat. Currently, Forensicare has no evident systematic service-wide approach to such prisoners, suffering from what could be termed "complex psychosis";

(e) Over time, the clinical thinking regarding Mr Dhakal shifted such that the role of his psychosis in his presentation was progressively de-emphasised and the supposed role of behavioural disturbance and/or antisocial personality disorder correspondingly became more prominent; and

(f) Mr Dhakal's admission to TEH in May 2024 was for a remarkably short period of time which eliminated the possibility of a review of his involuntary treatment by the Mental Health Tribunal. The brevity of his admission likely reflects the insufficiency of forensic hospital bed numbers to meet the demand for prisoners subject to STOs. Given the competing demands, patients are inevitably discharged from hospital sooner than would be clinically ideal.

IDENTITY OF THE DECEASED

47. On 4 August 2024, Hari Prasad Dhakal was visually identified by Correctional Officer, Geoff Port.

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

MEDICAL CAUSE OF DEATH

49. On 5 August 2024, Dr Brian Beer, Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted an examination and prepared a report of his findings dated 30 August 2024.

50. Toxicological analysis of post-mortem samples detected the presence of hydroxyrisperidone[13] and metformin.[14]

51. Dr Beer formulated the cause of death as "*1(a) Neck compression; and 1(b) Hanging*".

52. I accept Dr Beer's opinion.

FINDINGS AND CONCLUSION

53. Having held an inquest into Mr Dhakal's death, I make the following findings, pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Hari Prasad Dhakal, born on 9 March 1967;

    (b) the death occurred on 4 August 2024, at Port Phillip Prison, 451 Dohertys Road, Truganina,Victoria;

    (c) from neck compression and hanging; and

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

RECOMMENDATIONS

54. I acknowledge the findings and recommendations of the various internal reviews which have already been conducted in relation to Mr Dhakal's death. I consider that they are reasonable and appropriate and it is not necessary to repeat them.

I convey my sincerest sympathy to Mr Dhakal's family.

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 this finding be provided to the following:

[13] Hydroxyrisperidone is a metabolite of risperidone which is used to treat schizophrenia.
[14] Metformin is an antidiabetic drug used to treat maturity-onset diabetes.

Rajan Dhakal, Senior Next of Kin

G4S Custodial Services Pty Ltd

St Vincent's Hospital (Melbourne) Ltd

Forensicare

Constable Tess Edwards, Coronial Investigator

Signature:

Coroner David Ryan

Date: 30 March 2026

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.