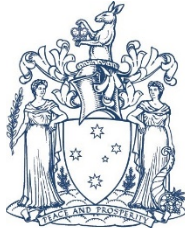

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 005092

FINDING INTO DEATH FOLLOWING INQUEST

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

Inquest into the death of Muhammad Jaffar Hassan

Delivered on:	10 October 2022
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	10 October 2022
Findings of:	Judge John Cain, State Coroner
Counsel assisting the Coroner:	Nicholas Ngai, Family Violence Senior Solicitor
Department of Justice & Community Safety	Ashleigh Dupe, Legal Advisor
Keywords:	Death in custody; family violence offender; suicide

BACKGROUND:

1. Muhammad Jaffar Hassan was aged 45 at the time of his death and was in custody at Metropolitan Remand Centre (**MRC**) on Middle Road in Ravenhall, Victoria.

2. Mr Hassan was born in Pakistan and married Ms Fatima Batool in Pakistan on 22 May 2010. Mr Hassan arrived in Australia on 18 April 2012. Ms Batool did not accompany him to Australia. Ms Batool gave birth to their daughter Emel on 23 May 2012. On 16 February 2014, Ms Batool and Emel arrived in Australia moving into a flat in Dandenong with Mr Hassan.

3. On the 11 May 2014, a family violence incident was reported to police and as a result Ms Batool moved out of the family home. Mr Hassan was charged with assault related offences arising from that incident.

4. After a few months living apart, Mr Hassan contacted Ms Batool asking that she move back to live with him. Eventually Ms Batool agreed to reconcile and move back to live with Mr Hassan as she wanted Emel to have her father in her life.

5. On Saturday 7 July 2018 at approximately 11:48 AM, Mr Hassan called 000 police emergency and reported that he had killed Ms Batool. Police and Ambulance Victoria attended at 19 Redwood Avenue, Hampton Park and discovered Ms Batool deceased at the premises.

6. A post-mortem examination was conducted on Ms Batool's body, and the cause of death was determined to be *'ligature strangulation'*. Mr Hassan was charged with murder and remanded in custody. Mr Hassan entered the Melbourne Assessment Prison (**MAP**) on 9 July 2018 where he remained until 30 July 2018 when he was transferred to the MRC.

THE PURPOSE OF A CORONIAL INVESTIGATION

7. Mr Hassan's death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as Mr Hassan ordinarily resided in Victoria[1] and the death appears to have been unexpected and whilst he was a person placed in custody.[2]

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

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[1] *Coroners Act 2008* (Vic) s 4

[2] *Coroners Act 2008* (Vic) s 4(2)(a)

9. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[3] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[4]

10. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[6] or to determine disciplinary matters.

11. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

12. For coronial purposes, the phrase "*circumstances in which death occurred*,"[7] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

13. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

14. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[8]

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[9] and

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3 *Coroners Act 2008* (Vic) s 89(4)
4 *Coroners Act 2008* (Vic) preamble and s 67
5 *Keown v Khan* (1999) 1 VR 69
6 *Coroners Act 2008* (Vic) s 69 (1)
7 *Coroners Act 2008* (Vic) s 67(1)(c)
8 *Coroners Act 2008* (Vic) s 72(1)
9 *Coroners Act 2008* (Vic) s 67(3)

(c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[10] These powers are the vehicles by which the prevention role may be advanced.

15. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[11] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[12] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

16. Senior Constable Paul Barrow was appointed the coroner's investigator and he prepared a coronial brief in this matter.

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

IDENTITY OF THE DECEASED PURSUANT TO S.67(1)(a) OF THE ACT

18. Fingerprint comparison was undertaken by the Victorian Institute of Forensic Medicine and identified the deceased as Muhammad Jaffar Hassan, born 14 August 1973.

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

MEDICAL CAUSE OF DEATH PURSUANT TO S.67(1)(b) OF THE ACT

20. Dr Melanie Archer, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, performed an autopsy examination on Muhammad Jaffar Hassan and provided a written report of her findings.[13]

21. Post-mortem examination revealed that death was due to plastic bag asphyxia. A plastic bag and pillowcase were completely covering the face therefore occluding the nose and mouth. The

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[10] *Coroners Act 2008* (Vic) s 72(2)
[11] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152
[12] (1938) 60 CLR 336
[13] Medical Examiners Report prepared by Dr Melanie Archer, dated 4 December 2018.

mechanism of death is oxygen deprivation combined with accumulation and consequent rebreathing of the respiratory waste product carbon dioxide.

22. The plastic bag was secured around the neck with a ‘rope’ fashioned from at least one additional plastic bag. There did not appear to be significant neck compression and the plastic ‘rope’ was relatively loose around the neck.

23. There was no evidence of natural disease that could have caused or contributed to death.

24. Dr Archer concluded that a reasonable cause of death was

    1(a) Plastic bag asphyxia

25. Toxicological analysis showed no ethanol (alcohol) and no common drugs or poisons.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO S.67(1)(c) OF THE ACT

26. On 8 October 2018 at 8.00pm, Mr Hassan was secured in his single cell in the Billingham Unit.[14] This was the last time he was seen alive.[15]

27. On 9 October 2018 at 8.00am Prison Officers stationed in the Billingham unit of the MRC commenced the morning count in accordance with their usual practice. This involves going to each cell and checking each prisoner and counting the number of prisoners in each cell. When the Prison Officer arrived at cell number 37 where Mr Hassan was located, the privacy cover was removed to enable the inside of the cell to be viewed.

28. Mr Hassan was observed to be lying face down and in foetal position. The viewing screen was tapped by the Prison Officer in an attempt to raise Mr Hassan but there was no response. The trapdoor on the main cell door was then opened and Mr Hassan’s name called. The Prison officer also looked to see if Mr Hassan appeared to be breathing. There was no response.[16]

29. The Prison Officer then called a Code Black which indicated an emergency involving serious injury or death. A prison officer working at the console responded to the code black and they

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[14] Billingham Unit (Billingham) is a mainstream accommodation unit for remand prisoners within Area 2 of the prison. The accommodation consists predominately of single cells, although a number of double occupancy cells are available within the unit.

[15] Coronial Brief, pg. 41.

[16] Coronial Brief, Statement of Tracey Ellens, pg. 13.

both entered the cell and found Mr Hassan to be unresponsive, his skin was mottled and purplish in colour.[17]

30. Ambulance Victoria were called and attended and at 8.32am, Mr Hassan was pronounced deceased.

31. At approximately 8:45am Detective Leading Senior Constable Paul Barrow (DLSC Barrow) attended at MRC and conducted an examination of cell 37 Billingham unit. Upon entering cell 37, DLSC Barrow observed a plastic bag over the head of Mr Hassan and that this bag had what appeared to be condensation inside it. A number of plastic bags appeared to have been fashioned into a ligature and were observed to be around Mr Hassan's neck and then around the back of his right knee. This configuration was likely to maintain pressure on the ligature found around Mr Hassan's neck.

FURTHER INVESTIGATIONS AND CPU REVIEW

Mental health investigation

32. In light of Mr Hassan's death occurring whilst in custody and receiving mental health treatment, I requested that the Coroners' Prevention Unit (**CPU**)[18] examine the circumstances of Mr Hassan's death and the mental health treatment provided to him.

Mr Hassan's mental health treatment history in MAP and MRC

33. Mr Hassan was remanded into custody and transferred to MAP[19] on 9 July 2018,[20] where he was reviewed by the Registered Psychiatric Nurse (RPN) and was described as '*very depressed and anxious'*.[21] Mr Hassan self-reported a mental health history of mild anxiety, depression, trauma, hearing voices, flashbacks, waking feeling warm and symptoms of persecution. He was initially ambivalent regarding his suicide intent, stating '*I don't know'*,[22] later stating he '*will*

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[17] Ibid.

[18] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

[19] Melbourne Assessment Prison is a maximum-security facility providing the primary statewide assessment and orientation services for male prisoners received into the prison system. Melbourne Assessment Prison comprises units with different roles or functions such as protection or workforce and the Acute Assessment Unit, a 15-bed, secondary psychiatric facility catering for all of the state's male prisoners. Where possible, prisoners with similar status, such as 'remanded' or 'sentenced', are accommodated together.

[20] Coronial Brief, pg. 44.

[21] Justice Health medical record, pg. 22.

[22] Justice Health medical record, pg. 22.

not suicide'[23] and identified Emel as a protective factor. His risks were rated as P1[24] and S3.[25] The plan was to clarify if Mr Hassan was experiencing a serious mental illness, particularly if the voices and flashbacks were trauma-related or due to psychosis. Accordingly, he was placed on 60-minute custodial observations, referred for review by the psychiatric registrar, made aware of the crisis call procedure and RPN review again in three days. There were no identified Client Management Interface (CMI)[26] episodes listed.

34. On 12 July 2018 Mr Hassan was reviewed by the RPN, who noted he was guarded but became warmer as the review progressed. He reported his mood was '*not good'*[27] and expressed themes of hopelessness, guilt, and remorse. He stated to have had some psychological intervention at school but no regular medication. He indicated he wanted a single cell due to an unpleasant experience with a co-prisoner. Mr Hassan denied thoughts or intention of suicide or self-harm. He was noted to be anxious and vulnerable with poor coping skills and at risk of deterioration. His risk was rated P1 and S3, with hourly custodial observations continued.

35. At 4.10pm, the psychiatrist reviewed Mr Hassan. He denied a formal history of mental illness and alluded to traumatic experiences in Pakistan before fleeing in 2012. He denied current issues with other prisoners and appeared '*weary and subdued'*.[28] Mr Hassan admitted he felt overwhelmed but denied thoughts of suicide or self-harm and was reassured observations would continue for his safety. There was no evidence of a major mental illness, and he was noted to require '*regular review at least every three days if not more frequent*'[29]. The documentation did not specify who was to conduct the reviews; however, it appears it was the RPN.

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[23] Justice Health medical record, pg. 22.

[24] Psychiatric ratings are referred to as P ratings and denote the severity of an existing psychiatric condition and required intensity of care and treatment. P1 – serious psychiatric condition requiring intensive and/or immediate care; P2 – significant psychiatric condition requiring psychiatric treatment; P3 – stable psychiatric condition requiring continued treatment or monitoring; PA – suspected psychiatric condition requiring assessment.

[25] Suicide ratings are referred to as S ratings and denote the level of observation indicated by clinical assessment. S1 – immediate risk of suicide / self-harm; S2 – significant risk of suicide / self-harm; S3 – potential risk of suicide / self-harm; S4 – Previous history of risk of suicide / self-harm (these prisoners are not considered to be "at risk", their risks are historical only). Prisoners with an S1 rating require custodial observations every 15 minutes, an S2 rating every 30 minutes, and an S3 rating every 60 minutes

[26] Client Management Interface (CMI) and Operational Data store (ODS) is the Victorian public mental health client information management system and comprises of the CMI as the local client information system used by each public mental health service and the ODS manages select data items from each CMI and is used to allocate a unique (mental health) registration number for each client, known as the statewide unit record (UR) number. ODS shares select client-level data between Victorian public area mental health services (AMHS) to support continuity of treatment and care. The ODS meets the various reporting requirements of the Department and supports the statutory functions of the Chief Psychiatrist and the Mental Health Tribunal.

[27] Justice Health medical record, pg. 21.

[28] Ibid pg. 20.

[29] Justice Health report, death in custody, Muhammad Hassan (CRN216278), dated 17 December 2018, Justice Health medical record, pg. 20.

36. On 15, 18 and 21 July 2018 the RPN reviewed Mr Hassan. His mood remained low on all occasions with themes of hopelessness and helplessness. He denied experiencing perceptual disturbances or thoughts, plans, or intent to self-harm/suicide. He was noted to be '*incredibly vulnerable and requires ongoing support'*.[30] His risk ratings remained P1 and S3 with hourly custodial observations.

37. On 24 July 2018 Mr Hassan was reviewed by the RPN. According to the RPN he was initially pleasant but became irritable with questions and appeared confused about the rationale given for the same. There continued to be no signs of mental illness, and he denied suicidality. The RPN recommended cessation of custodial observations and for a psychiatrist review. At 3.05pm, the psychiatrist reviewed Mr Hassan, and he reported poor sleep. The psychiatrist's impression was '*no current mental illness. Some ongoing adjustment difficulties in custody and would benefit from support as the trial approaches*'.[31] It was documented that Mr Hassan was more focused on legal matters and adjusting to prison life. He agreed to consider seeing a psychologist in the future and said he felt supported at the present time. His risk ratings were reduced to P2 and S4, and he was scheduled for psychiatrist review in two weeks.

38. On 29 July 2018 Mr Hassan was noted as fit for transfer to MRC[32] based on a file review only. His risk remained P2 and S4. Corrections Victoria confirmed that it is part of the usual process that file reviews are conducted to consider a prisoner's suitability for transfer and a prisoner may be noted as medically and psychiatrically fit for transfer on the basis of a file review only.

39. On 30 July 2018 Mr Hassan was transferred to MRC, and Registered Nurse Donna Colby conducted an inter-prison health transfer assessment. Mr Hassan reported anxiety, depression, and gastrointestinal issues with no suicide or self-harm concerns.

40. The next time Mr Hassan was reviewed by a healthcare professional was on 29 August 2018 for physical health related reasons.

41. On 4 September 2018 Mr Hassan was reviewed by the RPN at the mental health outpatient clinic following a self-referral. He was noted to be slightly anxious. He described feeling

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[30]Justice Health medical record, pg.18.

[31] Ibid pg. 15.

[32] Metropolitan Remand Centre (MRC) is a maximum-security prison for maximum, medium and minimum security, predominantly unsentenced, prisoners who have been remanded into custody. The MRC also houses a small percentage of sentenced prisoners to maintain the workforce and who may have placement issues. The MRC includes variable-sized accommodation to meet the specific needs of particular groups, such as young adult prisoners, low risk prisoners, vulnerable prisoners, prisoners with a disability, culturally and linguistically diverse prisoners, and prisoners with substance abuse issues. Programs and services focus on integration into the system and court preparation although still provide transition services to those who are sentenced. Prisoners are transferred to other prisons once sentenced.

depressed but was reportedly confused about the difference between depression and anxiety. He was preoccupied with his legal proceedings and expressed nervousness, poor concentration, stress, and lack of motivation. He denied suicidal and self-harm thoughts or intent, there was no evidence of psychotic symptoms, and his insight and judgement were intact. The plan was ongoing review by the RPN and to discuss a referral to the Mobile Forensic Mental Health Service[33] (MFMHS), which Mr Hassan was initially ambivalent about, requesting time to discuss again. Mr Hassan was booked into the next available session with the RPN to discuss the referral and booked in to see the psychiatric registrar. This is the first reference to the MAP requested psychiatry review in MRC. It appears there was some discussion regarding medication, and it was documented Mr Hassan '*agreed he did not want medication at this time*'.[34]

42. On 7 September 2018 Mr Hassan failed to attend a planned appointment with the psychiatric registrar. The psychiatrist requested the appointment be rescheduled within three weeks and the appointment was made for five weeks, by which time Mr Hassan was deceased.

43. On 17 September 2018 Mr Hassan failed to attend a review with the RPN. This was the second missed appointment.

44. On 26 September 2018 Mr Hassan was reviewed by the RPN. It was reported that he appeared stable, with '*diurnal variation of mood*'.[35] He did not have suicidal or self-harm intent. The RPN documented Mr Hassan was '*currently P2 but nil current treatment*'.[36] There was no evidence of thought or perceptual disturbances, and his insight was intact. Mr Hassan was scheduled for review by the psychiatric registrar on 16 October 2018 to '*discuss issues with depression and anxiety*'.[37]

[33] Forensicare provides forensic mental health services for prisoners at the MRC through its Mobile Forensic Mental Health Service (MFMHS). The service model includes group programs, specialist neuropsychology 'inreach' to the MAP to facilitate supported prisoner movements to the MRC, and transition outreach to regional prisons for sentenced clients.

[34] Justice Health medical record, pg. 13.

[35] Diurnal mood variation is when a person's mood is worse in the morning and improves as the day goes on. Justice Health medical record, pg.8.

[36] Justice Health medical record, pg. 8.

[37] Coronial Brief pg. 70; Justice Health report, death in custody, Muhammad Hassan (CRN216278), dated 17 December 2018; Justice Health medical record, pg. 8.

COMMENTS

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

45. The availability and accessibility of plastic bags within the MRC and the prison system more broadly, and the mental health care of Mr Hassan, were the focus of my investigation and warrant further discussion.

The availability of plastic bags in Victorian prisons

46. Mr Hassan had a number of individual plastic bags in his cell and also a roll of plastic bags. These bags were most likely obtained by him from the collection point located at the bottom of the stairs in the accommodation area. These particular bags are described as 'pack bags' (as distinct from bin liners) and are used by prisoners to pack their belonging in when they are moving to another cell, unit, or prison. These bags are slightly larger than bin liner bags; pack bags are 60 litre capacity and bin liners are 54 litres.

47. The policies that were applicable at the time were Commissioners Requirements (**CR**) 2.3.1. Section 5.7 of CR 2.3.1 in particular deals with prisoners' access to plastic bags. At risk prisoners with '*at risk'* rating of S1 or S2 are not permitted to retain plastic bags or plastic wrap.[38] Other prisoners, (those not classified as S1 or S2) while having access to plastic bags and plastic wrap, are not permitted to access spare bin liners and garbage bags. Mr Hassan was classified as an S4 risk at the time of his death, so not considered in the high-risk category. A prisoner's risk of suicide or self-harm is rated by a "S" classification, S1 being the highest and S5 the lowest.

48. The Justice Assurance and Review Office (**JARO**) conducted a review of Mr Hassan's death. JARO is a business unit within the Department of Justice and Community Safety (**DJCS**) and operates as a review and assurance unit for the Secretary of DJCS reviewing the performance of Corrections Victoria. JARO conducts a review of all deaths in custody in Victoria.

49. As part of JARO's review of Mr Hassan's death the availability of plastic bags within prisons was considered. JARO identified nine incidents between July 2014 and December 2018 in which prisoners have used a plastic bag to commit self-harm via asphyxiation.[39]

50. JARO acknowledged that there is a continued risk associated with unmonitored access to plastic bags in accommodation units. The report concludes '*allowing prisoners to access pack bags*

[38] Commissioners Requirements 2.3.1 at 5.7.1.
[39] JARO report, pg. 12.

from a self-service central collection point when they are packing their cell likely reduces the administrative burden on staff in mainstream units. However, based on the number of deaths and self-harm incidents involving the use of plastic bags, JARO considers that Corrections Victoria should explore whether there is an opportunity to strengthen existing policy and processes to reduce system risk.'[40] It appears likely that Mr Hassan obtained plastic bags from the central collection area within the Billingham unit at the MRC.

51. JARO recommended:

    - That corrections Victoria amend CR 2.3.1 to ensure that the management of all spare plastic bags of a similar nature to bin liners and garbage bags such as pack bags in is in line with existing policy.

    - That Corrections Victoria make any necessary amendment to CR 2.3.1 including reinforcing measures outlined at section 5.7.4 to encourage the use of alternatives to plastic bags for safety and environmental purposes.[41]

52. In relation to these two recommendations Corrections Victoria advised JARO that they accepted the first recommendation and that the second recommendation was accepted in principle.

53. The Court wrote to Corrections Victoria requesting an update on their implementation of the JARO recommendations and were advised that the first recommendation was *'accepted and in progress'*.[42]

54. Corrections Victoria advised that the impact of COVID-19 on prison operations and the deferral of some coronial inquests have meant that the review of the Commissioners Requirements (**CR**) and Deputy Commissioner's Instructions (**DCI**) were put on hold.

55. Corrections Victoria did however advise that:

    '*in the interim, prison managers were informed of the risks of a larger bin liners and requested to ensure prisons had in place processes to account for all plastic bags in mainstream units, to further reduce the risk of prisoners being able to take these larger plastic liners in their cells or to provide to other prisoners. For example, in units and areas with communal large bins or pack bags, in many prisons, these are now located in staff supervised areas so that staff are aware who is taking the bags. Large bin liners are not available in areas that Corrections*

[40] Ibid pg. 13.
[41] Ibid.
[42] Department of Justice and Community Safety, correspondence to the Court dated 23 September 2021.

Victoria has determined as high risk, unless a prisoner billet and under staff supervision is collecting paper bag rubbish from these units. These billets are not prisoners who are at risk of suicide and/or self-harm but from other units.'[43]

56. Corrections Victoria have advised that prisons have implemented local changes to ensure the accountability of plastic bags in prisoner accommodation, and where practicable, alternatives to plastic bags, such as paper bags, are used throughout the prison, not only those areas and units designated as 'high risk'. They also advised that the amended CR is now operationally implemented, and that the outstanding policy work on the amended CR is due to be finalised by the end of November 2022.

57. It is not clear why Corrections Victoria treated '*pack bags'* differently to '*bin liners'* when it appears that the risk of misuse was similar if not identical. Nevertheless, I am satisfied that the actions taken by Corrections Victoria in response are appropriate in reducing the risk.

58. In relation to the second recommendation Corrections Victoria have advised that it considers the recommendation completed as after some attempts, they have not been successful in finding an acceptable alternative to plastic bin liners particularly when dealing with wet or damp rubbish. I accept that alternatives have been trialled, but an acceptable alternative has not been found. Corrections Victoria advise that the DJCS Environment and Climate Change team and Correction Victoria's Security and Standards Unit will continue to monitor research development in this area as further alternative solutions may be identified.

Assessment of the mental health treatment provided to Mr Hassan

59. The circumstances of Mr Hassan's death raise for consideration the assessment and management of his mental health. I have been provided with a report prepared by Justice Health which conducted a file review of Mr Hassan's medical records. Justice Health is a business unit of the DJCS with responsibility for the delivery of health and alcohol and other drug services for prisoners across the Prison System. Justice Health sets policy and standards for Health care and alcohol and other drugs services and programs in prisons, monitors the delivery of health care and alcohol and other drug programs, and contract manages the health service providers in public prisons.

60. Each prisoner upon entry into custody is assessed and assigned a risk rating which is used to identify risk factors and guide the management of the prisoner whilst in custody. This risk rating

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[43] Ibid.

also assists in determining the level of oversight and supervision required to manage the prisoner. On 9 July 2018 when Mr Hassan entered MAP, he was assessed and assigned a risk rating of P1 (Serious psychiatric condition requiring intensive and or immediate care) and S3 (Potential risk of suicide or self-harm).

61. While at MAP, Mr Hassan was monitored by Forensicare staff and on 24 July 2018, following a review with a consultant psychiatrist, his risk rating was reassessed and downgraded from P1 to P2 (Significant ongoing psychiatric condition requiring regular monitored psychiatric treatment) and from S3 to S4 (Previous history or risk of suicide or self-harm).

62. This updated risk assessment (P2 and S4) was maintained when he was moved from MAP to MRC. Whilst at MRC, Mr Hassan was reviewed and reassessed initially on 4 September 2018. He was scheduled for further review with a psychiatric registrar on 7 September 2018 but refused to attend. This was rescheduled to 17 September 2018, and he again did not attend.

63. The most recent review prior to his death occurred on 29 September 2018 and was conducted by a mental health nurse. At that assessment it was noted that '*Mr Hassan appeared stable although he reported that "some days were better than others". He did not express any ideas of suicide or self-harm and there was no sign of any formal thought disorder. Mr Hassan was not prescribed any medications and he was informed that a further review was planned with a psychiatrist'*.[44]

64. Following my review of the Justice Health Report, I requested that the CPU conduct a review of Mr Hassan's mental health management and care. The CPU advised me that they considered that the management and care of Mr Hassan met the minimum standards of care and was appropriate in the circumstances.

65. I do however note that whilst Mr Hassan's mental health presentation was not overly complex, his mental health concerns still needed to be addressed. The documentation by treating clinicians suggests Mr Hassan was not considered to be experiencing a severe acute mental illness or at imminent risk of suicide in MRC. However, it indicates possible issues relating to depression and anxiety that may have required further psychiatrist review. The available evidence suggests that despite this, during his time in MRC Mr Hassan was not treated for any mental health condition.

[44] Justice Health Report dated 1 November 2018, pg. 7.

66. DJCS advised that the initial focus of Mr Hassan's care at MRC was the stabilisation of his condition and Mr Hassan was able to self-report any change to his mental health presentation at any time. The RPN documented a plan for Mr Hassan to meet with a RPN again to discuss a referral to the MFMHS and to attend an appointment with the Psychiatric Registrar. This was intended to work towards treatment of Mr Hassan's mental health concerns at a pace he was comfortable with. As Mr Hassan was not subject to an involuntary treatment order under the *Mental Health Act 2014* (Vic) he could not be compelled to attend any appointments he did not wish to attend or undergo any treatment he did not agree to.

67. From the responses provided to the Court by Justice Health and the DJCS, it remains unclear if there was a more formalised process of handover if the psychiatrist appointment that was initially scheduled at MAP would have been rescheduled at MRC sooner. Despite this, it is acknowledged that an appointment was made which Mr Hassan did not attend.

68. DJCS advise that Forensicare now provides a clinical coordinator who schedules mental health bookings and is responsible for triaging and booking appointments for Forensicare specialists and services. This coordinator will be aware of a prisoner's need to be re-booked for mental health appointments at a new facility as a result of discussions with, and direct referrals from, nurses conducting inter-prison health transfer assessments, as well as review of fit for transfer summaries which list all appointments scheduled prior to transfer. Assessing nurses conducting inter-prison health transfer assessments are also required to ensure that appointments scheduled prior to transfer are manually re-booked for the prisoner at their new facility.

69. Justice Health also indicated they are developing a new comprehensive mental health care plan that will cover immediate assessment and needs, collateral information, risks, available family and social supports, recognition of NDIS plans and needs pre- and post-incarceration, discharge planning and prisoner goals.[45] This is considered a good improvement and is in line with contemporaneous mental health care.

70. Overall, the CPU assessment confirmed the conclusion that I had formed following my review of the Justice health Report. I therefore accept the conclusion of the Justice Health Report that there was nothing to suggest that care provided to Mr Hassan was not in accordance with the *Justice Health Quality Framework 2014*.

[45] Statement of Department of Justice and Community Safety (Justice Health), dated 29 June 2022.

FINDINGS AND CONCLUSION:

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

    (a) The identity of the deceased was Muhammad Jaffar Hassan born on 14 August 1973;

    (b) That the death occurred on 9 October 2018 at the Melbourne Remand Centre, Middle Rd, Ravenhall, Victoria from 1(a) Plastic Bag Asphyxia; and

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

72. Having considered all the circumstances, I am satisfied that Mr Hassan intended to end his own life.

73. Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

    Mr Ghulam Hussain and Mrs Mumtaz Khanum, Senior Next of Kin

    Dr Neil Coventry, Chief Psychiatrist, Office of the Chief Psychiatrist

    Mr Ben Lloyd, Russell Kennedy

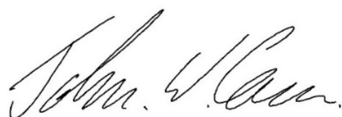
    Ms Ashleigh Dupe, Department of Justice & Community Safety

    Ms Kellie Dell'Oro, Meridian Lawyers

    Ms Melissa Westin, Deputy Commissioner, Custodial Operations, Corrections Victoria

    Detective Senior Constable Paul Barrow, Coroner's Investigator

Signature:



JUDGE JOHN CAIN

STATE CORONER

Date: 10 October 2022

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 of time under section 86 of the Act.