IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 000707

FINDING INTO DEATH WITH INQUEST

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

Deceased:	MAHMOUD TAIBA
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	14 November 2016
Findings of:	CORONER CAITLIN ENGLISH
Counsel assisting the Coroner:	Ms Evelyn Shaw
Representation:	Mr Shane Dawson, Correct Care Australasia Pty Ltd Mr Anthony Maher, G4S Custodial Services Pty Ltd

I, CAITLIN ENGLISH, Coroner having investigated the death of Mahmoud Taiba
AND having held an inquest in relation to this death on 14 November 2016
at Melbourne
find that the identity of the deceased was Mahmoud Taiba
born on 29 March 1976
and the death occurred between 16 and 17 February 2013
at Port Philip Prison, 280 Palmers Road, Truganina
from:
1 (a) HANGING
in the following circumstances:

Introduction

1. Mahmoud Taiba was a 36 year old man who died while serving a sentence of imprisonment at Port Philip Prison ('PPP').

2. Mr Taiba was found hanging, with shoelaces as ligature, from the basin tap in his cell on 17 February 2013.

3. I have had carriage of this investigation since the retirement of Coroner Spooner in February 2014.

The coronial investigation

4. Mr Taiba's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* ('the Act'), based on Mr Taiba's status as a serving prisoner who immediately before death was *a person placed in custody or care.*[1]

5. In such cases an inquest is mandatory. The evident intention of the legislation is to recognise the vulnerability of people placed in the care or custody of the State or its instruments, and to accord to prisoners in particular, the protection afforded by independent scrutiny of the

[1] ss 3 and 4(2)(c) of the Act.

circumstances in which they have died, and to promote accountability on the part of the State or its instruments.[2]

6. 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.

Investigation – Sources of Evidence

7. This finding is based on the materials obtained by the coronial investigation into Mahmoud Taiba's death. This includes the brief of evidence compiled by Detective Senior Constable Chris Black, the additional statements and reports obtained from various witnesses, the submissions made at inquest. In writing this finding, I do not purpose to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

8. In addition to the coronial brief, and of particular note, were the outcomes of three previous reviews of Mr Taiba's death:

    - "Review of the Death of Mahmoud Taiba (CRN 101177) at Port Phillip Prison on 17 February 2013" conducted by the Office of Correctional Services Review (OCSR) dated 14 October 2013;
    - "Report into Death in Custody Mr Mahmoud Taiba CRN 101177" conducted by Justice Health dated 1 July 2013 (which appears as Attachment 1 to the OCSR report); and
    - "Internal Management Review – Unnatural Death in Custody" conducted by G4S Custodial Services (the private operators of Port Phillip Prison) dated 25 February 2013

9. While the approaches taken, the conclusions reached and the recommendations made reflect the remit of the respective reviewers and are not on all fours with a coronial investigation, there is an area of overlap that should be acknowledged.[3]

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[2] Whereas a coroner has a discretion to hold an inquest into any death they are investigating, a coroner *must* hold an inquest into a death which the deceased was immediately before death, a person placed in custody or care: s52 of the Act.

10. I have also taken account of the evidence given by Detective Senior Constable Chris Black at inquest. DSC Black confirmed that the origin of the shoelaces used as ligature by Mr Taiba was unclear. DSC Black noted that there were two pairs of shoes in Mr Taiba's cell, both of which had their laces in situ. DSC Black inspected a number of shoes of the prisoners of Scarborough South Unit and identified a number of shoes with laces missing owing to the prisoner's classification or the fact of having transferred from other prisons where such items were not permitted. He was advised by prison staff that shoelaces were readily available to prisoners and available for purchase at the Prison Canteen.

11. In his evidence, DSC Black outlined the course of the investigation and noted that he liaised directly with Coroner Spooner when she attended the scene on 17 February 2013.

12. I have based this finding on all of the available the evidence. In the coronial jurisdiction facts must be established to the standard of proof which is the balance of probabilities. [4]

Background and personal circumstances[5]

13. Mr Taiba was born in Lebanon, one of five brothers and two sisters. When his immediate family migrated to Australia, Mr Taiba remained in Lebanon with his aunt and uncle.

14. Mr Taiba came to Australia at the age of eleven, to be reunited with his nuclear family, residing in Preston. Mr Taiba was unable to speak English, separated from the familiarity of the country of his upbringing and found it difficult to settle into life in Australia. He engaged in drug use and antisocial teenage behaviour. He became a ward of the state.

15. He attended school to year 8 level and obtained no further qualifications.

16. Over time and despite attempted interventions, Mr Taiba's behaviour and substance abuse continued to deteriorate. He engaged in criminal activities and commenced involvement with the justice system as a juvenile, aged fourteen years.

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[3] See section 7 of the Act: *It is the intention of Parliament that a coroner should liaise with other investigative authorities, official bodies or statutory officer – (a) to avoid unnecessary duplication of inquiries and investigations; and (b) to expedite the investigation of deaths and fires.*

[4] This is subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

[5] The information regarding Mr Taiba's familial background, personal circumstances and upbringing are gleaned from the statement of St Vincent's Hospital consultant psychiatrist Dr [redacted] who assessed and treated Mr Taiba on occasion throughout his prison sentence (Statement of [redacted] (consultant psychiatrist); Coronial Brief pp68-69.) and from the 'Social History' section of the Office of Correctional Services Review (OCRS) report (p5). I note that no members of Mr Taiba's family provided formal statements in the course of the coronial investigation.

17. At age 18 years, he was transferred from youth custody, entering adult custody for the first time. He went on to spend significant portions of his youth and following his adult life in custody. From time to time he worked in the family clothing business but ultimately was predominantly unemployed, used drugs and gambled for financial support.

18. Mr Taiba had seen a large number of health professionals over the years but was unable to achieve abstinence from illicit substances. This permanently impacted his cognitive skills, logical thinking and behaviour. He endured periods of psychosis, often related directly to drug use.

19. Mr Taiba had been assessed by many psychiatric health professionals. He had been diagnosed variously with psychosocial/cognitive ailments, including seizure disorder; poly substance abuse; cluster B borderline personality disorder; paranoid schizophrenia; antisocial personality disorder and having an acquired brain injury. Uncertainty as to his 'true' diagnosis persists.

20. Mr Taiba suffered from chronic pain, which appeared to also cause significant mental problems. It also was a possible cause of his reported insomnia. The treatment for his chronic pain was complicated by his dual infection of Hepatitis B and C. He had evidence of liver cirrhosis and therefore it was inadvisable for him to be provided with regular paracetamol.[6]

21. He was regularly prescribed psychotropic medication, including antipsychotics, but was only intermittently compliant. He was apparently impulse-driven and illogical, making engagement in rehabilitation attempts difficult.

22. A history of deliberate self-harm was a feature of Mr Taiba's mental state,[7] as was noncompliance with prescribed medications[8] and a preparedness to use illicit substances or medications not prescribed to him while in custody.[9]

Circumstances of court appearance and conviction

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[6] Statement of [redacted] (Doctor, Correct Care Australasia): Coronial Brief p92.
[7] OCSR Review, p8. Mr Taiba had four recorded incidents of in custody self-harm, where he was found to have cut himself deliberately. None of the incidents indicated he had made a determined effort to suicide, notwithstanding that he expelled up to half a litre of blood during one incident.
[8] Statement of [redacted] (consultant psychiatrist); Coronial Brief pp68-69.
[9] The Toxicological Report (p15-20 of the Coronial Brief) noted the presence of a metabolite of Clonazepam, a long-acting benzodiazepine which was not prescribed for Mr Taiba.

23. Prior to entering custody on 7 February 2007, Mr Taiba had been living with his girlfriend in Noble Park, for approximately five months. The relationship had become strained and two weeks prior she had effected a separation. Mr Taiba was concerned that the separation would become permanent.

24. On 6 February 2007, Mr Taiba went to the home of Haysan Zayat armed with a knife. Mr Zayat was in bed. Upon entering the bedroom, Mr Taiba stabbed Mr Zayat three times to the chest, causing his death. Present at the house was Ms Harkin, Mr Zayat's girlfriend. She witnessed the attack. Mr Taiba threatened Ms Harkin, stole property (including Mr Zayat's gun, wallet, laptops and a camera) and Ms Harkin's car before leaving.

25. Mr Zayat and Mr Taiba had known each other for around twenty years although Mr Taiba had been friendlier with Mr Zayat's two brothers, both of whom were by that stage deceased. During 2006, Mr Taiba had been purchasing the drug "ice" from Mr Zayat and had accumulated a debt of $2000. Mr Taiba was being pressed for payment. Further, around the same time, Mr Taiba's girlfriend had been staying with Mr Zayat, following her indications that she wished to separate permanently from Mr Taiba.

26. Mr Taiba was initially charged with murder and was remanded in custody on 9 February 2007. On 24 November 2008, Mr Taiba pleaded guilty to defensive homicide in relation to the death of Mr Zayat.[10] On 23 December 2008, he was sentenced to nine years imprisonment with a non-parole period of seven years. Six hundred and eighty four days were declared as served by way of pre-sentence detention. Mr Taiba was therefore eligible for parole on 6 February 2014 and the expiry of his maximum sentence was 6 February 2016.

Period of incarceration

27. Initially, Mr Taiba was received at PPP on 9 February 2007 as he was to be managed and accommodated in Charlotte Unit (a 'management' unit, which can accommodate prisoners with issues of violence, behaviour or security matters). From there, he was variously transferred between the Melbourne Assessment Prison ('MAP'), Metropolitan Remand Centre ('MRC'), and Barwon Prison.

28. Mr Taiba was placed on a long-term management regime given a range of concomitant security concerns with his victim's associates, several of whom were also imprisoned. Mr

[10] R v Taiba [2008] VSC 589.

Taiba presented challenges for prison management due to his high profile, general behaviour and placement concerns within the system. All long-term management prisoners are subject to regular monthly review by the Sentence Management Branch of Corrections Victoria. As Mr Taiba was classified as a Major Offender (related to his high profile and propensity for violence), his reviews were conducted by the Major Offenders Unit ('MOU'), within the Sentence Management Branch. These reviews were conducted on a monthly basis.

29. In early November 2012, Mr Taiba was accommodated at Barwon Prison. A decline in his mental state led Barwon Prison staff to request health staff to review Mr Taiba. He was experiencing auditory, visual and tactile hallucinations. Mr Taiba was also noted to be thought disordered, delusional, paranoid, lacking insight and refusing medication.

30. Mr Taiba's psychiatric rating[11] was reviewed and his "P" rating[12] was revised to **P1** (serious psychiatric condition requiring immediate/intensive care); **S4**[13] remained his suicide risk rating. He was referred to Acute Assessment Unit (AAU) (at the MAP) for assessment, transferring from Barwon to MAP on 6 November 2012.

The MAP (6-29 November 2012)

31. On 6 November 2012, a psychiatric registrar conducted a medical file review, as there was uncertainty about Mr Taiba's mental health diagnosis which, as indicated earlier, contemplated numerous psychiatric comorbidities.

32. On 13 November 2012, he was review by consultant psychiatrist, suggesting Mr Taiba had most likely experienced a true psychotic episode. He was prescribed Olanzapine. Mr Taiba was unwilling to be admitted to the AAU, despite the psychiatrist's recommendation.

33. On 23 November 2012, he was reviewed by a Registered Psychiatric Nurse ('RPN'), who recommended he be reviewed by a consultant psychiatrist prior to his transfer back to Barwon as well as regular psychiatry reviews to continue following transfer out of the MAP.

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[11] The Victorian correctional system employs a series of alerts or risk codes, which are attached to prisoner records to ensure communication about significant issues in relation to six categories of risk (Security; Violence; Suicide/Self Harm ['S']; Psychiatric ['P']; Medical; Placement).

[12] There are four psychiatric codes ('P ratings') that can be allocated to prisoners (*"E*Justice Risk and Recommended Actions"*): P1 (serious psychiatric condition requiring intensive and/or immediate care); P2 (significant ongoing psychiatric condition requiring psychiatric treatment); P3 (stable psychiatric condition requiring appointments or continuing treatment) and PA (Suspected psychiatric condition requiring assessment).

[13] There are four categories for risk of suicide / self-harm ('S ratings') that can be allocated to prisoners after the completion of a health assessment (*"E*Justice Risk and Recommended Actions"*): S1 (immediate risk of suicide/self-harm); S2 (significant risk of suicide/self-harm); S3 (potential risk of suicide/self-harm) and S4 (previous history of suicide/ self-harm).

34. On 26 November 2012, following symptoms of rectal bleeding, Mr Taiba underwent an outpatient colonoscopy and sigmoid polypectomy at St Vincent's Hospital. The polyp was sent for histopathology. This was to be followed up with referral back to the clinic in four weeks and repeat colonoscopy in twelve months.

35. On 27 November 2012, Mr Taiba was reviewed by a consultant psychiatrist at the MAP. The mental state exam was suggestive of Mr Taiba being guarded 'most likely minimising symptoms' and with 'objective improvement'. The psychiatrist noted that Mr Taiba's 'noncompliance would raise mental health concerns' and also noted that Mr Taiba had agreed to continue taking his medication if he were transferred back to Barwon Prison.[14] His E*Justice risk ratings were then adjusted to a **P3** (stable psychiatric condition), **S4** (unchanged). This rating ("P3, S4") remained in place until his death.

Barwon Prison (29 November 2012- 7 February 2013)

36. On 29 November 2012, he was transferred back to Barwon Prison.

37. On 4 December 2012, the outcome of the histopathology following polypectomy was discussed with Mr Taiba by a medical officer – the polyp was cancerous. He was told that there would be follow up and review at St Vincent's Hosptial. He was prescribed zopiclone ('Imovane', a hypnotic sleeping tablet) for three nights only. It is apparent that from this time on, Mr Taiba experienced a degree of preoccupation and stress associated with the knowledge of the polyp having been cancerous; an additional burden to his already vulnerable mental state.

38. On 6 December 2012, Mr Taiba was reviewed by a consultant psychiatrist. The additional stressor of recent cancer diagnosis was noted as 'cancer in polyp biopsy'. Zopiclone was prescribed for an additional three nights to assist Mr Taiba to sleep.

39. On 9 December 2012, Mr Taiba was reviewed by an RPN and was described as 'quite settled' and 'mental state/rapport' intact although nervous about an upcoming gastroenterological appointment.

40. In December 2012, Mr Taiba indicated to the MOU staff that he was keen to seek parole and was motivated to address his offending behaviours. He requested consideration for parole as

[14] OCSR report p23.

well as the opportunity to transfer to the mainstream prison population to access the relevant program requirements.[15]

41. On 8 January 2013, Mr Taiba was reviewed by a doctor, presenting as paranoid. He was still having difficulty managing sleep and anxious about cancer. On this occasion, the doctor ceased his Mirtazapine (anti-depressant). The Mirtazapine had been prescribed to treat sleep difficulties (rather than for its antidepressant properties) and was ceased on this date as it was ineffective and Mr Taiba expressed concern it was causing weight gain.[16] His Olanzapine (antipsychotic) was increased in an attempt to address his insomnia and he was prescribed tramadol for pain management (which was thought to be contributing to his insomnia).

42. On 9 January 2013, during his regular monthly review, Mr Taiba informed MOU staff that he had bowel cancer. The MOU staff made enquiries and were satisfied that he was receiving adequate medical attention.

Scarborough South Unit, Port Phillip Prison (8 February- 17 February 2013)

43. On 7 February 2013, Mr Taiba was transferred from Barwon Prison (Melaleuca Management Unit) to PPP (Charlotte Management Unit). The following day he was transferred from Charlotte to the mainstream unit Scarborough South. Per his management requirements, he was placed in a single occupant cell.

44. G4S is obliged to comply with Commissioners Requirements which are issued by the Commissioner, Corrections Victoria. [redacted]

[15] OCSR report p6, para [5.2].
[16] Statement of [redacted] (Doctor, Correct Care Australasia): Coronial Brief p92.
[17] Statement of Patricia Sellman (Acting General Manager, PPP), pp1-210 of G4S Brief (page 2).
[redacted]

45. [redacted] on his arrival to PPP on 7 February 2013, Mr Taiba was interviewed by correctional staff;[19] interviewed by a G4S Suicide and Self-Harm Officer[20] and assessed by St Vincent's Health RPN[21] for a health review.[22]

46. On 11 February 2013, Mr Taiba attended a follow up appointment at St Vincent's Hospital colorectal outpatient clinic. It was explained to him that during the colonoscopy on 26 November 2012, a sigmoid polyp had been found in his bowel. The polyp was completely removed at that time. It was explained to Mr Taiba that within the polyp was a small focus of carcinoma.[23] The surgeon with whom he met explained that his opinion was that it was a low risk finding, a very early cancer and he was almost certainly already cured.[24] Mr Taiba was told that while the polyp was malignant, the risk of spread to the lymph nodes was low as malignancy was confined to the polyp. He was told that the medical management plan was for ongoing monitoring and testing. The surgeon indicated that:[25]

> *"Mr Taiba seemed very calm and relaxed during the consultation and I did not hold any concerns that he left the consultation in a state of fear or distress as I had been careful to explain that his cancer had almost certainly been cured."*

47. There is a Patient Request Form which was filled out by [redacted] (Registered Nurse) dated 14 February 2013. A Patient Request Form is completed by or on behalf of prisoners to request appointments with medical staff. The outcome of the request form filled out by RN [redacted] is unclear as RN [redacted] has no independent recollection of the form, although he confirms it is his handwriting. He does not believe he would have ignored the request[26] however there is no evidence to suggest that the request was actioned at that time.

48. However on the same date (presumably subsequent) there were also three documented interactions between Mr Taiba and PPP as well as St Vincent's Correctional Health Service staff: namely with correctional officer C/O [redacted], RPN [redacted], and psychiatrist Dr [redacted]:

- C/O [redacted]: Mr Taiba approached [redacted] to request to see a doctor. She called and placed him on the emergency list for an

[19] Copy of the Day of Arrival Checklist and New Admission of a Prisoner form dated 7 February 2013, pp187-188 of G4S Brief.
[20] Copy of the SITUPS ('Structured Interview Tool for Understanding Prisoner Safety') form completed at Mr Taiba's admission to PPP on 7 February 2013, pp190-195 of G4S Brief.
[21] Copy of the St Vincent's Correctional Health Service Prisoner Information Management Form dated 7 February 2013, p197 of G4S Brief.
[22] Statement of Patricia Sellman (Acting General Manager, PPP), pp1-210 of G4S Brief (page 13).
[23] Carcinoma is a type of cancer that develops from epithelial cells.
[24] Statement of [redacted] (Colorectal Surgeon, St Vincent's Hospital): Coronial Brief, p80.
[25] *Ibid.*
[26] Statement of [redacted] (Registered Nurse): Coronial Brief p53.

accelerated appointment. She provided him with a request form and told him to fill it out.

- RPN [redacted]: RPN [redacted] conducted a mental state exam, which classified Mr Taiba as a low risk of self-harm. A nurse from St Paul's Ward (inpatient psych unit at PPP) had spoken to RPN [redacted] prior to him meeting with Mr Taiba and indicated that Mr Taiba would be readily accepted for admission into St Paul's and that there was a 'low threshold' for admission. RPN [redacted] met with Mr Taiba at 11.40am. Mr Taiba indicated that he was stressed and anxious about cancer and required a change in his medication. He rejected the offer for admission to St Paul's. RPN [redacted] booked Mr Taiba to see psychiatrist Dr [redacted] the same day.[27]

- Dr [redacted] (consultant psychiatrist):[28] Mr Taiba attended St Thomas Ward (outpatients) for an appointment with St Vincent's Correctional Health Psychiatrist Dr [redacted] During the course of the consultation, Mr Taiba requested a change to his pharmaceutical management, wanting an increase in zopiclone, the hypnotic medication which he had been temporarily prescribed to combat insomnia. When the psychiatrist declined to do so, Mr Taiba terminated the consultation by exiting the room. No formal mental state exam was conducted by the psychiatrist, but no specific concerns were noted and, as indicated above, a registered psychiatric nurse had already that day conducted a mental state exam.[29] Mr Taiba terminated the consultation when Dr [redacted] refused to increase his zopiclone prescription. The outcome of the consultation was that the pharmacological regime remained in place and Mr Taiba was to be reviewed in four weeks.

Circumstances of death

49. On the evening of 16 February 2013, Mr Taiba was locked down in cell 429 in Scarborough South Unit at approximately 7.40pm. Nothing awry in his demeanour was noted by correctional staff that evening.

50. At about 7.54am on 17 February 2013 Correctional Officers [redacted] and [redacted] were in the process of conducting a morning "hands on trap" count of all

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[27] The Justice Health report describes the interaction: *"On 14 February 2013, Mr Taiba underwent a mental state examination by a RPN. During this interview, Mr Taiba presented as easy to engage with good eye contact. His affect was intense and focused, his mood was anxious and lowered and speech was clear and coherent with normal rate, tone and volume. Mr Taiba's thoughts were goal directed, connected and congruent with no strange or unusual beliefs elicited. He was not observed to be preoccupied or distracted. Mr Taiba identified protective factors. He denied any self-harm plan or intent. A follow up review by the consultant psychiatrist was scheduled for [the same day]."*

[28] At times in the materials Dr [redacted] is referred to as "Dr [redacted]".

[29] The Justice Health report describes the interaction: *"On 14 February 2013, the consultant psychiatrist reviewed Mr Taiba. The consultant psychiatrist noted Mr Taiba was worried and frightened about cancer and that Mr Taiba was due for further investigations* [presumed reference for further review booked with doctor on 3/4/2013*]. This worry was causing anxiety and intense fear for Mr Taiba. The consultant psychiatrist noted medication was reducing the psychotic symptoms. Mr Taiba was also noted to be paranoid, impulsive and pre-occupied with cancer. The consultant psychiatrist suggested increase dose of Olanzapine. It is documented that Mr Taiba wanted to 'extend the dose of Imovane'. When he was informed that 'this was not an option', he left the room."*

prisoners. This is where one officer (C/O [redacted]) dropped the trap on each cell to account for all prisoners, whilst the other officer (C/O [redacted]) marked off prisoners on a board.

51. When C/O [redacted] initially dropped the trap on cell door 429, she noted that Mr Taiba was laying on the ground. This is not unusual in hot weather, prisoners will lay on the concrete floor of cells. However, when she looked into the trap, she appreciated that Mr Taiba was not moving or responding and that he had ligature around his neck, connected to the sink.

52. C/O [redacted] ran to Supervisor [redacted] in the officer's room. Supervisor [redacted] immediately attended cell 429. He used his radio to call a code black and instructed C/O [redacted] to obtain the ligature knife from the officer's room. Supervisor [redacted] cut the ligature and attempted to relieve pressure on Mr Taiba's neck.

53. The medical team arrived shortly thereafter but were unable to find any sign of life and in fact rigor mortis had already set in so resuscitation efforts were not commenced.

The medical cause of death

54. On 19 February 2013, Forensic Pathologist Dr Kate Strachan at the Victorian Institute of Forensic Medicine, conducted a post mortem examination and autopsy. Dr Strachan completed a report, dated 3 June 2013 in which she formulated the cause of death as 1(a) Hanging. I accept Dr Strachan's opinion as to the medical cause of death.

55. Toxicological analysis of post mortem specimens taken from Mr Taiba identified the presence of Tramadol, Olanzapine and Zopiclone at levels consistent with therapeutic use. Also identified was 7-aminoclonazapam (a metabolite of Clonazepam – a drug with which Mr Taiba was not being treated). This indicates that Mr Taiba was accessing a benzodiazepine from within the prison without a prescription. Paracetamol was also detected. There was no evidence of ethanol.

56. Histological examination showed chronic hepatitis with cirrhosis, consistent with the history of hepatitis B and hepatitis C. No other significant natural disease was identified; in particular, no evidence of residual colonic malignancy was seen.

Further investigations

Medical and mental health management

57. I consulted with the Coroners Prevention Unit (CPU) [30] regarding Mr Taiba's medical and mental health issues and the appropriateness of his medical management.

58. The review found that the assessment of Mr Taiba's mental state and associated risks in the days before his death, the assessment by RPN [redacted] and decision to refer to a psychiatrist were appropriate. The assessment by Dr [redacted] does not include a formally documented mental state examination but does suggest an interaction and assessment of Mr Taiba's mental state. Mr Taiba's decision to leave the appointment appears to have been based on Dr [redacted]'s refusal to increase his zopiclone prescription, rather than an objection to the assessment process or interview content. The follow-up assessment appointment was reasonable in light of the scheduled nurse involvement and review appointments. Mr Taiba's medical records document he had rapid fluctuation in presentation with poor engagement in any treatment other than medications, poor impulse control and insomnia.

59. The review also found his treatment for the malignant polyp was appropriate and there were clearly documented plans for further investigation and review with Mr Taiba to discuss the ongoing treatment. It appears that the diagnosis of cancer, irrespective of the polyp having been successfully removed and the plans for further review, caused Mr Taiba increased stress and anxiety and contributed to an exacerbation in his already long-standing anxiety symptoms. The medical staff reassurances do not appear to have been effective in allaying these fears, however he was not exhibiting anxiety symptoms consistently.

60. The CPU identified that the antidepressant mirtazapine (identified as being a dose in the low bracket) had been ceased on 8 January 2013. It had been assumed that it was prescribed for its antidepressant qualities. Further inquiries were made to determine why the doctor had ceased the medication and whether this decision had reviewed by the treating psychiatrist. Following this, a statement from Dr [redacted] (the doctor who had reduced Mr Taiba's antidepressant prescription in the month before his death) was obtained. This clarified that the Mirtazapine had been prescribed in subtherapeutic quantities for its sedative effect in an attempt to address Mr Taiba's insomnia (rather than as an antidepressant). Higher doses paradoxically have a less sedative effect.

Placement in cell with ligature points

[30] The CPU is a specialist service for coroners created to strengthen their prevention role and provide professional assistance on issues pertaining to public health and safety.

61. The second issue identified by the CPU review was the placement of Mr Taiba had been placed into a cell with ligature points. Enquiries were made with G4S on 15 March 2016 requesting an explanation on this point. The response, dated 12 August 2016, was an additional statement on behalf of G4S from Patricia Sellman (Acting General Manager, PPP) which provided detail on this point together with annexures.

62. Mr Taiba at the time of his death was rated S4/P3. His S4 rating was attributable to *previous self-harm/Suicide attempts*, without any present risk identified. S4 is the lowest S-rating. Mr Taiba's assessed level of self-harm risk had remained unchanged from 2010.

63. Mr Taiba had been engaged with mental health professionals throughout his incarceration. His 'P' rating was associated with a loose diagnosis of schizophrenia/depression for which he was being treated, which had been escalated in late 2012 (to P1) in response to a psychotic episode (requiring admission to the AAU at the MAP). He was subsequently deescalated (to P3) on 27 November 2012. P3 is the lowest rating for psychiatric risk[31] and denotes "stable psychiatric condition requiring continuing treatment or monitoring".

64. Although Mr Taiba was documented as worried about his cancer diagnosis, there was apparently nothing in his recent contact with mental health professionals, correctional staff nor fellow inmates that would have indicated he was at immediate risk of suicide or self-harm. His level of anxiety as he presented to others appears to have been variable.[32]

65. Ms Sellman on behalf of G4S advised it is not uncommon for a significant proportion of the prison population at PPP to have a rating of S4 or P3 or both. Prisoners with a rating of S3 or higher, should not be placed in non-Building Design Review Project ('BDRP') compliant cells.[33]

66. The BDRP was established by Corrections Victoria in response to the State Coroner's findings in April 2000,[34] in which the Department of Justice and G4S, were found to have contributed to four suspected suicides at PPP, by failing to minimise hanging points in the design and construction of its cells.[35] The BDRP gave rise to Corrections Victoria's Cell and

[31] Statement of Patricia Sellman (Acting General Manager, PPP), pp1-210 of G4S Brief (page 9).
[32] On 8 February 2013, C/O [redacted] inducted Mr Taiba to the Scarborough South Unit describing him as "happy" to be at the unit: Coronial Brief, p88; On Thursday 14 February 2013, Mr Taiba presented to [redacted] (then Operations Manager at PPP) as in an "upbeat mood" and "thankful" [to Mr [redacted]] for supporting his placement at PPP: Coronial Brief, p86.
[33] Statement of Patricia Sellman (Acting General Manager, PPP), pp1-210 of G4S Brief (page 11).
[34] Victorian Ombudsman, *Investigation into Deaths and Harm in Custody*, March 2014 p72.
[35] *Ibid.*

Fire Safety Guidelines for prison cell design, which included elimination of obvious hanging points.[36]

67. In March 2014, the former Ombudsman George Brouwer reported that (as at 30 June 2013) 42 per cent of all Victorian prisoners had a psychiatric risk rating indicating a mental health issue, and 55 per cent of the Victorian prison population had an identified suicide/self-harm risk rating.[37]

68. Ms Sellman advised that at March 2013 G4S confirmed with the Coroner's Court (in relation to the Inquest into the Death of Timothy Casey[38]) that it would endeavour not to place prisoners with a SASH rating of S3 or higher in non BDRP cells where possible. [39] I note Mr Taiba's SASH rating was S4, namely the lowest S rating. Ms Sellman also noted that once a prisoner is allocated an S rating, his risk will always be a minimum of S4; '*The S4 rating therefore is a flag on an historical but not current SASH risk.*' [40] [redacted]

69. Ms Sellman detailed Mr Taiba's other risk factors which were taken into account for cell placement, which included his maximum security rating, (therefore subject to the management unit), safety concerns regarding the some people with whom he was unable to mix, and the dynamics at PPP between Muslim prisoners.[42] Seven of the prisoners from whom he was to be kept separate were housed in five different units at PPP.

Justice Health[43]

70. One issue identified in the Justice Health Report was:[44]

> *"There is no documented evidence in the medical file that health staff assured Mr Taiba that there was no spread of cancer from his polyp."*

71. And that[45]

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[36] Statement of Patricia Sellman (Acting General Manager, PPP), pp1-210 of G4S Brief (page 10).
[37] Victorian Ombudsman, *Investigation into Deaths and Harm in Custody*, March 2014 pp 56, 72.
[38] COR 2008 1277.
[39] Statement P Sellman p 11.
[40] Statement of P Sellman p 9. [redacted]
[42] Statement of P Sellman, p 14: there were some 40 prisoners in custody from whom he was required to be kept separate.
[43] The Justice Health Report is found as an annexure with the OCSR report (appearing at pp17-26 of the OCSR report).
[44] OCSR report p26.

"It is the expectation of Justice Health that all health service providers comply with the Justice Health Quality Framework, Standard 2.2 Information for Patients/Clients. The health service provider should ensure that Patients/Clients are informed and understand their healthcare including health assessments and diagnostic testing results. This consultation including the writer's perception of the Patients/Clients understanding should be documented in the Patients/Clients health record."

72. Whilst noting that Justice Health did not make any recommendations nor identify any systemic problem or improvement opportunity in its report, part of my investigation was to ascertain whether anything came of the apparent omission in this case to either communicate to Mr Taiba that there was no spread of the cancer or a failure to document this in his health record (if it was in fact communicated to him).

73. By letter dated 10 November 2016, Justice Health confirmed the following actions as a corollary of Mr Taiba's death:

- In June 2013, as part of its quarterly performance review, the Justice Health Standard 3.5 'Allied Health and Diagnostic Services' was audited to ensure that all prisoners provided with health services are in line with community standards to meet their treatment needs. The expectation that 90% of prisoners are advised of clinically significant test results within 10 days of the results being received by the health service provider. The audit found that of the five medical records reviewed, this had occurred in every case.

- In Quarter One (July to August) 2013-2014, Justice Health Standard 4.3 'Health Records Management' was audited for St Vincent's Correctional Health Services at PPP. The audit reviewed a number of medical records to ensure the quality of nursing documentation, legibility of the documentation and that all entries were dated and timed and that all records were identifiable to the specific prisoner. All audited files complied with the standard.

- On 1 May 2013, the specific issue of documentation on in Mr Taiba's record was discussed with St Vincent's Correctional Health Service at the quarterly contract meeting. The then Director of Medical Services for St Vincent's Correctional Health Service advised Justice Health that the medical notes

[45] Ibid.

[presumed to be St Vincent's Hospital Melbourne medical record] for Mr Taiba documented the issue clearly and that Mr Taiba knew his diagnosis.

Comments

74. Mr Taiba had recently transitioned from a management regime at Barwon Prison to the mainstream prison population at PPP, arriving at the Scarborough South Unit on 8 February 2013. This was to enable him to participate in courses and programs to address his eligibility for parole. He was by all accounts happy about the transfer.

75. On 11 February 2013, Mr Taiba had attended an appointment at St Vincent's colorectal clinic during which it was explained to him that the polypectomy he had undergone in November 2012 had removed a cancerous polyp from his bowel. By all accounts, the condition was being treated and monitored appropriately and thoroughly. Although Mr Taiba's surgery had been successful and his prognosis was thought to be very good, he was evidently emotionally affected by the diagnosis of cancer. The OCSR review noted that Mr Taiba's father died from pancreatic cancer in 2010 and that his cell neighbour (since deceased) at the relevant time was terminally ill with cancer and not expected to live long.

76. Although the surgeon at St Vincent's colorectal outpatients clinic had assured him his prognosis was very positive, Justice Health identified a lack of documented evidence in the medical file that Mr Taiba had been given assurances that there was no spread of cancer from his polyp and that health service providers should ensure that patients are informed and understand their healthcare including health assessments and diagnostic testing results. Consultation on this point, including the health service provider's perception of the patient's understanding should be documented in the health record.

77. Although the Justice Health report indicated that it was not explicit in the Justice Health record that Mr Taiba had been assured that there was no spread of his cancer from the polyp, subsequent enquires with both the surgeon who met with Mr Taiba at St Vincent's Hospital on 11 February 2013[46] and with Justice Health[47] have revealed that Mr Taiba was appropriately informed of his very low risk for cancer spread.

78. Mr Taiba carried an S4, P3 rating meaning he had a psychiatric condition requiring treatment and a history of self-harm/suicidality but was not considered presently 'at risk'. At the time of and immediately preceding his death, he denied any suicidal or self-harm

[46] Statement of [redacted] (Colorectal Surgeon, St Vincent's Hospital): Coronial Brief, p78ff.
[47] Letter from Jan Noblett, Executive Director of Justice Health to Coroners Court of Victoria dated 10 November 2016.

thoughts and was described by as in good humour. As recently as two days before his death, he was assessed by a Registered Psychiatric Nurse and a Consultant Psychiatrist. He underwent a mental state exam which did not reveal any thoughts of suicide or self-harm.

79. The Victorian Ombudsman tabled a report in Parliament on 26 March 2014 - *Investigation into deaths and harm in custody* which identified *inter alia* that[48]

Corrections Victoria poorly managed a $50 million project to eliminate hanging points, including removing $11 million in project funding without adequate assessment of the impact on cell safety.

And that[49]

Corrections Victoria was unable to provide key documentation in relation to the project, such as the initial risk assessments conducted by private consultants, to explain the rationale for the priority given to cell upgrades. Corrections Victoria could not provide such basic information as a breakdown for each financial year in relation to how many cells were made compliant with the guidelines and how much funding this required.

And that (as at the date of the report)[50]

Approximately 1230 prison cells, or 38 per cent of all cells across the prison system, still do not comply with cell and fire safety guidelines. Port Phillip Prison, a maximum security prison, has only 204 out of 752 cells that comply with the cell and fire safety guidelines.

80. I note that following the BDRP risk analysis at PPP, cells in the Charlotte and St Paul's Units became compliant in 2007/8. The cells in the Barrowdale Unit (opened April 2003) are also compliant, and in 2013 the Salamander and Fishburn Units became compliant, as did the cells in the Matilda Unit in 2014.

81. In circumstances where there are insufficient cells that comply with the standards, it is reasonable that the BDRP compliant cells available be provided to prisoners with a higher identified risk of suicide and/or self-harm. I understand that at PPP, approximately 65-70% of prisoners are classified at S4, the same level as Mr Taiba's risk. [51]

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[48] Victorian Ombudsman, *Investigation into Deaths and Harm in Custody*, March 2014: pp 6, 13, 71, 85-86.
[49] *Ibid*, 86.
[50] *Ibid* 88.
[51] Statement of [redacted] (General Manager, PPP): Coronial Brief p74.

82. I have been advised[52] that all new accommodation units at PPP are built according to the relevant Cell and Fire Safety Guidelines. In relation to units built prior to the BDRP and the introduction of the Cell and Fire Safety Guidelines (save for two units at PPP where funding was provided by the State of Victoria for refurbishment):

- There is no project at present to fully refurbish or retrofit those units in compliance with the Cell and Fire Safety Guidelines;
- Nevertheless, as cells in those units undergo refurbishment, the item which is the subject of refurbishment will be renovated in compliance Cell and Fire Safety Guidelines.

83. Ideally all prison cells would be BDRP compliant.

Finding

84. I find that Mahmoud Taiba died from 1(a) Hanging between 16 and 17 February 2013 at in Scarborough South Unit, Port Phillip Prison, Dohertys Road, Truganina, Victoria in circumstances where he intended to end his own life.

I direct that a copy of this finding be provided to the following:
Mrs Jamila Taiba, Senior Next of Kin
DSC Chris Black, Coroner's Investigator, Victoria Police
Ms Kellie Dell'Oro, Meridian Lawyers for Correct Care Australasia
Ms Ingrid Nunnink, Marsh Maher Lawyers for GS4 Custodial Services P/L
Ms Melanie Kyezor, St Vincent's Correctional Health Service
Mr Andy Bogle, OCSR

Signature:

CAITLIN ENGLISH
CORONER
Date: 22 November 2016

Coroners Court of Victoria

[52] Via email from Ms Ingrid Nunnink to Ms Evelyn Shaw dated 18 November 2016.