

#### CORONERS COURT OF NEW SOUTH WALES

Representation:	Sergeant Timothy O'Donnell, Advocate Assisting Ms Katie Llewelyn for Corrective Services NSW Ms Sophie Li for Justice Health NSW
File number:	2016/1459
Catchwords:	CORONIAL LAW – Cause and manner of death Death in custody Natural causes
Findings of:	A/State Coroner Teresa O'Sullivan
Place of findings:	State Coroners Court, Glebe
Date of findings:	07 March 2018
Hearing dates:	07 March 2018
Inquest:	Inquest into the death of Saker MOHAMED

<ol> <li>The direct and personal contact details of CSNSW staff.</li> <li>Any references to the care and placement of Saker Mohamed's children with the Department of Family and Community Services.</li> <li>The names and Master Index Numbers of any persons in the custody of Corrective Services New South Wales, other than Saker Mohamed.</li> </ol>		
<ul> <li>5. The Employee Daily Schedule dated 31 December 2015.</li> <li>6. CCTV footage of camera 'MSU Observation' in</li> </ul>	Non Publication Order	<ul> <li>other personal information that might identify: <ul> <li>a. any of Saker Mohamed's family;</li> <li>b. any person who visited Saker Mohamed while he was in custody (other than legal representatives or visitors acting in a professional capacity); and</li> <li>c. any victim of the offence for which Saker Mohamed was serving a custodial sentence</li> </ul> </li> <li>2. The direct and personal contact details of CSNSW staff.</li> <li>3. Any references to the care and placement of Saker Mohamed's children with the Department of Family and Community Services.</li> <li>4. The names and Master Index Numbers of any persons in the custody of Corrective Services New</li> </ul>
2015. 6. CCTV footage of camera 'MSU Observation' in		<ul><li>and Community Services.</li><li>4. The names and Master Index Numbers of any persons in the custody of Corrective Services New</li></ul>
		<ol> <li>The Employee Daily Schedule dated 31 December 2015.</li> </ol>

Findings:	Identity of deceased:
	The deceased person was Saker Mohamed
	<b>Date of death</b> : Mr Mohamed died on 31 <sup>st</sup> of December 2015
	<b>Place of death</b> : Mr Mohamed died at Long Bay Hospital, 1300 Anzac Pde, Malabar, New South Wales
	Manner of death: Mr Mohamed died of natural causes whilst serving a custodial sentence
	Cause of death: The cause of death was Hodgkin's Lymphoma

# **Table of Contents**

Introduction:	1
The Inquest:	
The Evidence:	1
Background:	1
The events leading to his death:	2
What caused Mr Mohamed's death:	3
Care and treatment:	3
Conclusion:	3
Findings required by s81(1)	3
The identity of the deceased	3
Date of death	3
Place of death	3
Cause of death	
Manner of death	

The Coroners Act 2009 (NSW) in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of Saker Mohamed.

### Introduction:

Mr Saker Mohamed was born on the 11<sup>th</sup> of February 1971. At the time of his death he was serving a custodial sentence at Long Bay Correctional Facility, and was being held in Long Bay Hospital due to his poor health.

As Mr Mohamed was in lawful custody at the time of his death, an inquest is required to be held pursuant to sections 23 and 27 of the Coroners Act.

## The Inquest:

The role of a Coroner, as set out in s 81 of the Coroners Act, is to make findings as to:

- (a) the identity of the deceased;
- (b) the date and place of the person's death;
- (c) the physical or medical cause of death; and
- (d) the manner of death, in other words, the circumstances surrounding the death.

Pursuant to s 82 of the Act a Coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

### The Evidence:

#### Background:

Saker Mohamed, also known as Saher Hamed Ramadan Mohamed, was born in Egypt on the 11<sup>th</sup> of February 1971. Little information has been received regarding his early years and background, but it is known that he has a brother, believed to be residing in Saudi Arabia. He spoke Arabic and limited English. In 2008, Mr Mohamed travelled to Australia. He commenced an intimate relationship soon after, which led to Mr Mohamed becoming the father of two female children. They married in 2014, however the relationship ended later that year.

On The 16<sup>th</sup> of May 2014, Mr Mohamed was charged by police with aggravated sexual assault of a victim with cognitive impairment. He was initially bail refused, but was later released on conditional bail in August 2014. A plea was entered on the 11<sup>th</sup> of June 2015 in the Downing Centre District Court. Mr Mohamed was entered into the Surry Hills Court Cells, before being placed at Parklea Correctional Centre on the 16<sup>th</sup> of June. On the 4<sup>th</sup> of August 2015, Mr Mohamed was sentenced to two years

imprisonment, commencing on the 14<sup>th</sup> of March 2015, and was due for release on the 13<sup>th</sup> of March 2017.

### The events leading to his death:

On the 24<sup>th</sup> August 2015, during a mental health review, Mr Mohamed showed the nurse some lumps under his armpits that were causing him pain. He was placed on the Primary Health waiting list, and then on the 26<sup>th</sup> of August, reported that the lumps were no longer causing him any pain.

On the 31<sup>st</sup> of August, Mr Mohamed presented to staff with headaches and dizziness. At assessment he had low blood pressure and his temperature was elevated. He was treated with paracetamol.

On the 4<sup>th</sup> of October at 2:10pm, Mr Mohamed reported lower abdominal pain. He was initially treated for constipation, but then at 3pm his physical observations deteriorated and he was transferred to the Prince of Wales Hospital.

On the 30<sup>th</sup> October, following numerous clinical investigations at the Prince of Wales Hospital, a liver biopsy resulted in a diagnosis of non-Hodgkin's Lymphoma, stage 4B. Mr Mohamed declined chemotherapy treatment, stating through interpreters that he would leave his fate to God.

On the 24<sup>th</sup> of November, Dr Carol Cheung, Senior Medical Officer at Prince of Wales Hospital, reported that Mr Mohamed was likely to die within a few weeks or months if chemotherapy was not commenced and recommended palliative care. Mr MOHAMED's condition continued to deteriorate and he was also diagnosed with anaemia. The treating team at the Hospital reported that the risks of treatment far outweighed the benefits, and palliative care at Long Bay Hospital was recommended.

On the 2<sup>nd</sup> of December, Dr Anne Wand at Prince of Wales Hospital completed a Mental Health Assessment and diagnosed Mr Mohamed with delirium. He was deemed to be lacking the capacity to make medical decisions and an application for a guardianship order was made as there was no reasonable Next of Kin available in Australia. Mr Mohamed was transferred back to Long Bay Hospital on the 4<sup>th</sup> of December to continue receiving palliative care.

On the 8<sup>th</sup> of December, Mr Mohamed received a blood transfusion at Prince of Wales Hospital, before being transferred back to Long Bay Hospital on the 10<sup>th</sup> of December. On the 11<sup>th</sup> of December, Mr Mohamed confirmed through an interpreter that he did not wish to be resuscitated if his health deteriorated.

On the 24<sup>th</sup> of December, a marked deterioration in Mr Mohamed's presentation was recorded by nursing staff. On the 31<sup>st</sup> of December at 4:32am, nursing staff found Mr Mohamed no longer had a pulse or heart beat, and had stopped breathing. He was declared deceased.

#### What caused Mr Mohamed's death?

Based on the post mortem report, and medical records obtained as part of the investigation, it is evident that Mr Mohamed died as a consequence of Hodgkin's Lymphoma.

#### Care and treatment:

When a person is detained in custody, the responsibility for ensuring that person receives adequate care and treatment rests with the State. Even when a person in custody dies of apparent natural causes an inquest is required to independently assess whether the State has discharged its responsibility.

The Corrective Services and Justice Health records reveal Mr Mohamed's care and treatment were appropriate. The Officer in Charge of the Investigation, Inspector Ben Johnson, reached the same conclusion, and wished to raise no issues with the care and treatment afforded to Mr Mohamed.

#### **Conclusion:**

I find that Mr Mohamed's death is not suspicious and that he died as a consequence of natural causes. I also find that Mr Mohamed received care and treatment of an appropriate standard whilst in custody.

I would like to thank the officer in charge of the investigation, Detective Inspector Ben Johnson and the Advocate Assisting, Sergeant Timothy O'Donnell.

Finally, I would like to offer my sincere condolences to the family of Mr Mohamed.

### Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

#### The identity of the deceased

The person who died was Saker Mohamed.

#### Date of death

Mr Mohamed died on the 31<sup>st</sup> of December 2015

#### Place of death

Mr Mohamed died at Long Bay Hospital, 1300 Anzac Parade, Malabar, New South Wales

### Cause of death

The cause of death was Hodgkin's Lymphoma

#### Manner of death

Mr Mohamed died of natural causes whilst serving a custodial sentence.

I close this inquest.

Magistrate Teresa O'Sullivan A/State Coroner

Date 7 March 2018