CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Elias Melhem
Hearing dates:	30 November 2021
Date of findings:	30 November 2021
Place of findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, cause and manner of death
File number:	2019/00388175
Representation:	Mr H Mullen, Coronial Advocate Assisting the Coroner Ms S Pickard for the Commissioner of Corrective Services New South Wales Ms N Szulgit for Justice Health & Forensic Mental Health Network
Findings:	Elias Melhem died on 9 December 2019 at the Outer Metropolitan Multi Purpose Correctional Centre, Berkshire Park NSW 2765. The cause of Mr Melhem's death was atherosclerotic and hypertensive cardiovascular disease, with type 2 diabetes mellitus being a significant condition contributing to the death but not relating to the disease or condition causing it. Mr Melhem died from natural causes, whilst in lawful custody serving a sentence of imprisonment.
Non-publication orders:	See Annexure A

Table of Contents

1. Introduction

1.1 At the time of his death, Elias Melhem was 49 years old and in lawful custody at the Outer Metropolitan Multi Purpose Correctional Centre, serving a sentence of imprisonment. Mr Melhem had a history of hypertension, hyperlipidaemia, type 2 diabetes mellitus and a right renal transplant.

1.2 On the morning of 8 December 2019, Mr Melhem complained of feeling chest pains to a fellow inmate. Mr Melhem later reported that he was feeling better, and made no mention of the pains to anyone else. During the evening, Mr Melhem went to sleep in a common lounge room area within the facility where he was housed. The following morning, as preparations were being conducted for the daily morning muster, Mr Melhem was found to be still in the lounge room area, unresponsive and with no signs of life. Resuscitation efforts were immediately initiated, and emergency services were called. However, Mr Melhem tragically could not be revived and was later pronounced life extinct.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

2.3 A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Mr Melhem was not appropriately cared for and treated whilst in custody.

3. Mr Melhem's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way. Regrettably, only limited information is available regarding Mr Melhem's personal history prior to his incarceration.

3.2 Mr Melhem was born in Lebanon, and later emigrated to Australia with his parents when he was six years old. Mr Melhem completed Year 10 in a high school in Burwood, and later worked at a variety of jobs, including in sales and security. Due to a number of health conditions, Mr Melhem was unable to work from 2015 onwards and began receiving social security payments.

3.3 Mr Melhem was previously married, and had one daughter from this relationship. Following the end of this relationship, Mr Melhem resided with his mother in Concord.

3.4 After entering custody, Mr Melhem was reportedly well liked by his fellow inmates. Mr Melhem also had no issues in his interactions with correctional officers during his time in custody.

3.5 There is no doubt that Mr Melhem's passing has been deeply felt by his family members and loved ones, and that they continue to miss him enormously.

4. Mr Melhem's custodial history

4.1 On 18 October 2018 Mr Melhem was convicted in the District Court in relation to a number of fraud-related offences. He was subsequently sentenced to a term of imprisonment of 3 years and 10 months, with a non-parole period of 1 year and 9 months, making his earliest eligible release date 17 October 2020.

4.2 Following his conviction, Mr Melhem was initially transferred to the Metropolitan Remand and Reception Centre, and later transferred to the Dawn De Loas Correctional Centre (**DDLCC**) on 25 October 2018. After being housed temporarily at South Coast Correctional Centre from November 2018, Mr Melhem returned to DDLCC in March 2019. On 30 May 2019 Mr Melhem was transferred to the Outer Metropolitan Multi-Purpose Correctional Centre (**OMMPC**) at Berkshire Park, where he remained until his death.

4.3 Whilst at the OMMPC Mr Melhem was housed within Honour House, and resided in room 200 with another inmate at the time of his death.

4.4 Honour House is a minimum security facility attached to the OMMPC which houses inmates who are in the process of being integrated back into the community following completion of terms of imprisonment. Typically, a morning muster is conducted at 7:00am to ensure that all inmates are accounted for, before certain inmates are permitted to leave in order to work within the community or within the John Morony Correctional Complex.

4.5 Whilst at the OMMPC, Mr Melhem was employed in the kitchen as a leading hand, preparing and supplying meals to other inmates within the facility. In August 2019 Mr Melhem was promoted to kitchen storeman. Mr Melhem had progressed to a C3 classification, which is deemed minimum security and with electronic monitoring when employment is gained outside in the community.

5. Mr Melhem's medical history

5.1 Mr Melhem had a history of insulin-dependent type 2 diabetes, hypertension, epilepsy, asthma and hyperlipidaemia. In 2015, Mr Melhem underwent a right renal transplant secondary to end stage

renal disease. As a result, whilst in custody, Mr Melhem received haemodialysis three times per week, and had regular pathology testing with his blood sugar levels (**BSL**) taken three times per day.

5.2 Available Justice Health & Forensic Mental Health Network (**Justice Health**) records indicate that Mr Melhem declined referrals to specialists on a number of occasions whilst in custody:

(a) On 22 October 2018, whilst been reviewed by a general practitioner, Mr Melhem indicated that he did not want any referral to a specialist.

(b) On 8 November 2018, whilst at South Coast Correctional Centre, it was noted that Mr Melhem's BSL were elevated However, Mr Melhem continued to decline referrals to specialists despite encouragement and education.

(c) On 29 January 2019 Mr Melhem agreed to be transferred to a Sydney correctional centre for treatment, but later declined all medical appointments, indicating that he no longer wish to be transferred. After the risks of not attending appointments were explained to Mr Melhem, he signed a cancellation form.

6. What happened on 8 and 9 December 2019?

6.1 On 8 December 2019 Mr Melhem worked in the kitchen as part of his usual daily routine. Mr Melhem was working with another inmate, putting meals into a box. At around 10:30am or 11:00am Mr Melhem picked up a box, grabbed his chest and complained of chest pains. Mr Melhem's fellow inmate told him to put down the box and to sit down to rest. After sitting for approximately 20 to 30 minutes, Mr Melhem indicated that he was fine. A short time later Mr Melhem went to lunch before returning to Honour House.

6.2 At around 5:00pm, Mr Melhem attended a Justice Health clinic, together with the inmate that he had been working with earlier in the day, in order to receive his prescribed insulin injection. The inmate asked Mr Melhem if he was alright, and Mr Melhem indicated that he was. Whilst receiving his insulin injection Mr Melhem made no mention to Justice Health staff of the chest pains that he had experienced earlier in the day, or of any other health concerns.

6.3 After receiving his insulin injection Mr Melhem returned to his unit and had a shower. Sometime between around 6:00pm and 7:00pm, Mr Melhem's cellmate returned to the room and found that Mr Melhem had just woken up. Mr Melhem reported that he had left work earlier in the day after experiencing chest pains and then returned to his room, where he had slept for a few hours and then felt better.

6.4 After waking, it appears that Mr Melhem left his room and went to the common lounge room area within Honour House. During the evening Mr Melhem was seen by other inmates to be playing a card game on the computer, and to be watching television. Nothing amiss was noted during the course of the evening. Sometime before 10:30pm Mr Melhem returned to his room where it is believed he went to sleep.

6.5 At around 11:00pm, Mr Melhem's cellmate heard Mr Melhem leave the room, believing that Mr Melhem was going to the bathroom. Instead, it appears that Mr Melhem returned to the lounge room where he lay down on a lounge near the television.

6.6 The following morning, at around 5:30am on 9 December 2019, an inmate walked to the lounge room and found Mr Melhem lying on his right side on a lounge, apparently asleep. After the inmate turned the television on, there was no response from Mr Melhem, which was considered to be unusual as Mr Melhem was known to be usually awake by this time. The inmate considered that nothing was amiss and that Mr Melhem had simply had a bad night's sleep. Accordingly, no concern for welfare was raised at this time.

6.7 Shortly before the daily muster time at 7:00am, the inmate pushed on Mr Melhem's leg and called out Mr Melhem's name in order to wake him. When Mr Melhem did not respond, the inmate placed his hand on the back of Mr Melhem's neck and felt that it was cold to touch. Realising that something was wrong, the inmate notified Corrective Services New South Wales (**CSNSW**) officers, who by this time were preparing to conduct the morning muster. When CSNSW officers checked on Mr Melhem he was found to be unresponsive and with no pulse.

6.8 In response, two CSNSW officers placed Mr Melhem on the floor and immediately commenced cardiopulmonary resuscitation. Assistance was sought from Justice Health staff and emergency services were contacted. Justice Health staff arrived on the scene a short time later. Defibrillator pads were placed on Mr Melhem's chest and he was found to have no shockable rhythm. NSW Ambulance paramedics later arrived on scene at 7:15am. Despite continued resuscitation efforts, Mr Melhem could not be revived and was pronounced life extinct at 7:24 AM.

7. What was the cause of Mr Melhem's death?

7.1 Mr Melhem was later taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Sairita Maistry, forensic pathologist, on 13 December 2019. Examination revealed an enlarged heart with left ventricular hypertrophy and significant severe atherosclerosis of the three coronary arteries which supply the heart muscle with blood and oxygen.

7.2 Sites of critical stenosis were located in the left anterior descending, circumflex and right coronary arteries, with areas of mottling of the myocardium. Histological examination identified evidence of acute ischaemic injury to the myocardium, with sections of the coronary arteries showing stenotic calcified atherosclerotic plaques.

7.3 In the autopsy report dated 28 October 2020, Dr Maistry opined that the cause of death is atherosclerotic and hypertensive cardiovascular disease, with type 2 diabetes mellitus being a significant condition contributing to the death but not relating to the disease or condition causing it.

8. Conclusions

8.1 Having regard to the relevant records from CSNSW and Justice Health regarding Mr Melhem's period in custody, and the findings from the postmortem examination, it is evident that Mr Melhem died from progression of a natural disease process, with death being sudden and unexpected.

8.2 Although the chest pains experienced by Mr Melhem on the morning of 8 December 2019 were most likely of pathological significance, the only person who Mr Melhem made aware of this was a fellow inmate. Relevantly, when Mr Melhem interacted with Justice Health staff later in the afternoon in order to receive his insulin injection, he made no mention of the chest pains or of any other health concerns.

8.3 Had information regarding the chest pains been disclosed, it is likely that this would have prompted some action in order to investigate the nature and significance of Mr Melhem's condition. Indeed, evidence gathered by the police officer in charge, Detective Senior Constable Adam Long, from the Justice Health Nursing Unit Manager at the OMMPC indicates that if Mr Melhem had disclosed such information he would have been transferred to hospital, in accordance with established protocols, for investigation and treatment.

8.4 Overall, the available evidence indicates that Mr Melhem was provided with appropriate medical care, to address and treat his various chronic medical conditions, whilst in custody. Mr Melhem was regularly reviewed in relation to his renal issues and type 2 diabetes. However, it appears that Mr Melhem was not always inclined to accept recommendations for his medical issues to be reviewed by appropriate specialists.

8.5 Relevantly, no CSNSW or Justice Health staff member was informed of Mr Melhem's health complaints on the morning of 8 December 2019. Accordingly, there is no evidence to suggest that any action could have been taken by CSNSW or Justice Health staff to potentially alter the eventual outcome. There is also no evidence to suggest that any aspect of Mr Melhem's medical care, or the care provided by CSNSW and Justice Health staff, contributed in any way to his death.

9. Findings

10.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Mr Howard Mullen, Coronial Advocate, for his excellent assistance both before, and during, the inquest. I also thank Detective Senior Constable Long for his role in the police investigation and for compiling the initial brief of evidence.

10.2 The findings I make under section 81(1) of the Act are:

Identity

The person who died was Elias Melhem.

Date of death

Mr Melhem died on 9 December 2019.

Place of death

Mr Melhem died at the Outer Metropolitan Multi Purpose Correctional Centre, Berkshire Park NSW 2765.

Cause of death

The cause of Mr Melhem's death was atherosclerotic and hypertensive cardiovascular disease, with type 2 diabetes mellitus being a significant condition contributing to the death but not relating to the disease or condition causing it.

Manner of death

Mr Melhem died from natural causes, whilst in lawful custody serving a sentence of imprisonment.

10.3 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to Mr Melhem's family and loved ones for their loss.

10.4 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
30 November 2021
Coroners Court of New South Wale

Inquest into the death of Elias Melhem

File Number: 2019/00388175

Annexure A

Pursuant to section 74(1)(b) of the *Coroners Act 2009* (the Act), the following material contained within Exhibit 1 is not to be published:

Tab	Document
1	Report of Suspected Death to the Coroner (P79A) • names of inmates other than the deceased (pp.1-3) • direct contact details of CSNSW staff (pp.5, 7)
3	Identification Statement • direct contact details of CSNSW staff (p.1)
5	Statement of Detective Senior Constable Adam Long • Information identifying buildings and facilities shown by map screenshots of the Correctional Centre (p.2, para [5] and p.4 paras [6]-[7]) • Arial photograph of Honour House (p.5) • Timeframe that Honour House gates are open and times that musters are conducted (pp.4-5) • Map of Honour House evacuation plan (p.6) • names and MINs of inmates other than the deceased (pp.4-8, 11, 14, 22, 46-60) • Still images of the deceased and the correctional centre (pp.15-17)
8	Part 3 – Justice Health Records for Elias MELHEM • direct contact details for CSNSW (pp.3, 259)
10	CSNSW Investigation Report by Peter Jones, Senior Investigation Officer, dated 27 April 2020 • names and MINs of inmates other than the deceased (pp.4-8, 11, 14, 22) • still images of the deceased and the correctional centre
	Attachments • private contact details and VINs of family and friends of deceased (pp.3, 37, 40, 77-78, 129, 145-146, 174, 214, 226, 247, 253, 260-268, 271-282, 316, 322, 329, 336) • names and MINs of inmates other than the deceased (pp.3, 7, 8, 14, 55-56, 82-83, 88-89, 114 – 119, 151, 167, 286, 303-311, 315-319, 321-326, 328-331, 352) • direct contact details of CSNSW contractors (pp.19, 65, 350 • still images of the deceased (pp.28-29, 452-455, 457) • map of the correctional facility (pp.62, 342) • direct contact details of CSNSW staff (pp.80, 83-84, 180-182, 236, 241, 381-383, 385, 417 • procedural information on securing inmates (p.411, [2.4], third sentence) • procedural information on forensic processing (p.433, [4.1], para one, two, four and procedure column of table) • CCTV footage, Offender Telephone System (OTS) audio and hand-held video camera (HHVC) footage (pp.26, 270, 344, 346)
4 X DVD'S containing police interviews with inmates; video footage of resuscitation attempts; triple zero recordings; audio version from NOK.	

Pursuant to section 65(4) of the *Coroners Act 2009:*

1. A notation is to be placed on the Court file that if an application is made under s 65(2) of the Act for access to CSNSW documents in the Court file, that material shall not be provided until the Commissioner of CSNSW has had an opportunity to make submissions in respect of that application.

Magistrate Derek Lee
Deputy State Coroner
30 November 2021
Coroners Court of New South Wales