JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	6 JUNE 2025
DELIVERED	**:**	22 JULY 2025
FILE NO/S	**:**	CORC 3145 of 2022
DECEASED	**:**	ELSAMIN, SAMAAN SALAH TILMIZ

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S. Markham appeared to assist the coroner.

Mr M. Williams (of counsel, instructed by MinterEllison) appeared for the Joondalup Health Campus, Ms S. Sutton, Mr R. Jenkins, and Dr M. Chapman.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Samaan Salah Tilmiz ELSAMIN*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth on 5 - 6 June 2025, find that the identity of the deceased person was* ***Samaan Salah Tilmiz ELSAMIN*** *and that death occurred on 9 November 2022 at Joondalup Health Campus, 60 Shenton Avenue, Joondalup from unascertained causes in the following circumstances:*

Table of Contents

INTRODUCTION

1. Samaan Salah Tilmiz Elsamin (Mr Elsamin) was 21 years of age when he died at Joondalup Health Campus (JHC) on 9 November 2022. Despite a thorough post mortem examination, the cause of Mr Elsamin's death could not be ascertained.[1,2,3,4]

2. At the time of his death, Mr Elsamin was the subject of an involuntary treatment order (ITO)[5] made under the *Mental Health Act 2014* (WA) (the MHA). Accordingly, immediately before his death Mr Elsamin was an "*involuntary patient*" and thereby a "*person held in care*", and his death was therefore a "*reportable death*".[6]

3. In such circumstances, a coronial inquest is mandatory and where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[7] On 5 - 6 June 2025 at Perth, I held an inquest which examined the circumstances of Mr Elsamin's death, and the supervision, treatment and care he received while he was the subject of an ITO.

4. The Brief of evidence tendered at the inquest consisted of one volume, and included a report on the police investigation into Mr Elsamin's death, expert psychiatric reports, and Mr Elsamin's medical records.

5. The following witnesses gave evidence:

a. Mr H. Chimbama (Director, New Dawn Healthcare Services);[8]
b. Mr R. Jenkins (Enrolled nurse, JHC);[9]
c. Ms S. Sutton (Registered nurse, JHC);[10]
d. Dr A. Brett (Independent consultant psychiatrist);[11] and
e. Dr M. Chapman (Consultant psychiatrist, JHC).[12]

[1] Exhibit 1, Vol. 1, Tab 1, P100 Report of Death (27.08.24)
[2] Exhibit 1, Vol. 1, Tab 3, P92 Identification of Deceased Person - Visual Means (10.11.22)
[3] Exhibit 1, Vol. 1, Tab 4, JHC Death in Hospital Form (09.11.22)
[4] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (24.07.24)
[5] An order made under the MHA that a person receive treatment on an involuntary basis.
[6] Section 3, *Coroners Act 1996* (WA)
[7] Sections 22(1)(a) & 25(3), *Coroners Act 1996* (WA)
[8] ts 05.06.25 (Chimbama), pp9-23
[9] ts 05.06.25 (Jenkins), pp23-42
[10] ts 05.06.25 (Sutton), pp42-51
[11] ts 05.06.25 (Brett), pp52-72
[12] ts 06.06.25 (Chapman), pp76-104

MR ELSAMIN

Background[13,14,15,16]

6. Mr Elsamin was born in Sudan, and he came to Australia with his family when he was three years old. Mr Elsamin reportedly enjoyed soccer and basketball, but at around 14 years of age Mr Elsamin reportedly began using alcohol and cannabis and his behaviour deteriorated.

7. Mr Elsamin accumulated six criminal convictions for offences including assault occasioning bodily harm, and criminal damage. Until his admission to JHC in May 2022, Mr Elsamin lived in accommodation supported by carers funded by the National Disability Insurance Scheme (NDIS). Mr Elsamin had previously lived with his father, but this arrangement ceased after Mr Elsamin assaulted his father in 2019.

8. Mr Elsamin required assistance with activities of daily living, including: showering, dressing, meal preparation, basic household tasks and medication management. As a result of his mental health issues and his intellectual disability (discussed in the next section), Mr Elsamin required continual support. To ensure his safety and well-being, and due to the risks he posed to support staff, he required two support workers.

Mental health diagnoses[17,18,19,20,21,22]

9. Mr Elsamin was diagnosed with severe, treatment resistant schizophrenia, and a moderate to severe intellectual impairment.[23] He had a history of polysubstance use including alcohol and cannabis (and possible solvent use), as well as frontal lobe dysfunction with sexual disinhibition. Mr Elsamin's presentation was: "*characterised by features of a tendency to be impulsive, limited emotional control, disinhibition and difficulties with anger management*".[24]

---

[13] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator L Jackson (21.08.24), p7
[14] Exhibit 1, Vol. 1, Tab 9, SAC1 Investigation Report (14.03.23), p3
[15] Exhibit 1, Vol. 1, Tab 26.1, Report - Dr A Brett (12.04.25), pp1-2 & 11-12 and ts 05.06.25 (Brett), pp53-54
[16] Exhibit 1, Vol. 1, Tab 27, WAPOL Person Summary (14.08.24)
[17] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator L Jackson (21.08.24), pp7-9
[18] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), pp31-32 and ts 06.06.25 (Chapman), pp80-81
[19] Exhibit 1, Vol. 1, Tab 26.1, Report - Dr A Brett (12.04.25)
[20] Exhibit 1, Vol. 1, Tabs 13 & 13.1-13.3, JHC Discharge summaries (06.12.21, 11.03.22, 04.05.22 & 09.11.22)
[21] Exhibit 1, Vol. 1, Tab 31, Medical Notes - Butler Village Medical Centre
[22] Exhibit 1, Vol. 1, Tab 32.1.1, Adachi clinical handover (Undated)
[23] Mr Elsamin's IQ was estimated to be 57, see: Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), p2
[24] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), p31

10. Mr Elsamin also presented with extremely challenging behaviours including aggression, and a proclivity to unpredictable, violent assaults against those around him including family members, carers, clinical staff and hospital security officers. Mr Elsamin's treatment and care was further complicated by his limited verbal skills.[25]

Involuntary Treatment Order[26]

11. The MHA provides that a person is not to be placed on an ITO unless: "*[T]he person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making an inpatient treatment order*".[27] Mr Elsamin was placed on an ITO following his admission to the PICU at JHC in May 2022 "*because of his lack of insight and risk to self and others during his psychotic relapses*.[28]

12. An ITO was required in Mr Elsamin's case because his serious mental illness and his moderate to severe intellectual disability meant he was a risk to himself and others. Mr Elsamin also lacked insight and did not have the capacity to make treatment decisions about his mental health.[29] Having carefully reviewed the available evidence, I am satisfied that the decision to treat Mr Elsamin as an involuntary patient was justified on the basis that this was the least restrictive way to ensure that he was provided with appropriate treatment for his mental health conditions.

Management in the community[30,31,32,33,34]

13. When Mr Elsamin was released from prison in 2020, following a serious assault on his father, he could no longer live in the family home. As a result, Mr Elsamin lived in supported accommodation in Nollamara managed by a disability services and support organisation (Adachi). Mr Elsamin's accommodation at Adachi was funded by the NDIS.[35]

---

[25] ts 05.06.25 (Sutton), pp45-46
[26] Exhibit 1, Vol. 1, Tab 12, Medical report - Dr L Randall (07.09.22)
[27] s25(1)(e), *Mental Health Act 2014* (WA)
[28] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), pp2-3
[29] s25(1), *Mental Health Act 2014* (WA) and Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), p2
[30] Exhibit 1, Vol. 1, Tab 32, Report - New Dawn Healthcare Services (undated) and ts 05.06.25 (Chimbama), pp9-23
[31] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator L Jackson (21.08.24)
[32] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25) and ts 06.06.25 (Chapman), pp76-104
[33] Exhibit 1, Vol. 1, Tab 26.1, Report - Dr A Brett (12.04.25) and ts 05.06.25 (Brett), pp52-72
[34] Exhibit 1, Vol. 1, Tab 9, SAC1 Investigation Report (14.03.23), p4
[35] Exhibit 1, Vol. 1, Tab 32.1.1, Adachi clinical handover (Undated)

14. On the basis that his "*mental disability*" meant that Mr Elsamin was unable to "*make reasonable judgements in respect of matters relating to all of his estate*", the State Administrative Tribunal (SAT) appointed the Public Trustee as "*plenary administrator*" of his estate in 2019. The SAT also ordered that the Public Advocate be appointed as Mr Elsamin's "*limited guardian*" to make decisions about where he should live, what treatment he should receive, and the services he should have access to.[36]

15. On 16 December 2020, Mr Elsamin's care was transferred to a disability services and support organisation called New Dawn Healthcare Services (New Dawn). Mr Elsamin moved into a New Dawn home in Alkimos which was funded by the NDIS.[37]

16. The philosophy of New Dawn is to allow residents to live as independently as possible in their own home, with a range of services and assistance. It was thought that New Dawn may have the staff and services to deal with Mr Elsamin's challenging behaviour.[38]

17. Mr Elsamin's NDIS package for his New Dawn accommodation included funding for two carers (2:1 care) 24 hours per day, 7 days a week. For a brief period, after Mr Elsamin had engaged with a Behaviour Support Practitioner, his level of supervision was reduced to 1:1 care. However, Mr Elsamin's unpredictable violence towards New Dawn staff and members of the public meant that 2:1 care had to be reinstated.[39]

18. As a result of his challenging behaviours, Mr Elsamin was socially isolated and while he was under New Dawn's care, his goals were recorded as:

- I would like to learn to look after my new home;
- I would like to learn how to manage my emotions and not get so angry;
- I would like to meet new people and make some friends; and
- I would like to be able to tell others what I want and need so they understand me, and I understand them.[40]

[36] Exhibit 1, Vol. 1, Tab 10, SAT Orders GAA1959/2019 (03.10.19)
[37] Exhibit 1, Vol. 1, Tab 32, Report - New Dawn Healthcare Services (undated) and ts 05.06.25 (Chimbama), pp9-23
[38] Exhibit 1, Vol. 1, Tab 32, Report - New Dawn Healthcare Services (undated), p1 and ts 05.06.25 (Chimbama), p11
[39] Exhibit 1, Vol. 1, Tab 32, Report - New Dawn Healthcare Services (undated), p2
[40] Exhibit 1, Vol. 1, Tab 32, Report - New Dawn Healthcare Services (undated), pp2-3 and ts 05.06.25 (Chimbama), pp16-18

19. New Dawn's records are replete with examples of Mr Elsamin's aggressive and violent behaviour towards his carers, who at times would have to leap out of the home's windows to escape Mr Elsamin's attempts to attack them. At other times, Mr Elsamin would suddenly throw objects (including cups of drink) at walls and/or staff, for no apparent reason.[41,42,43,44]

20. Mr Elsamin was a large man, and his unpredictable and violent behaviour made him extremely difficult and dangerous to manage. The extremely challenging nature of his ongoing proclivity to violent behaviour is obvious from New Dawn's records. In that context, the perseverance of New Dawn staff, and the compassionate care they provided to Mr Elsamin in these circumstances is to be warmly congratulated.

21. At times, Mr Elsamin would display warning signs of his intention to behave violently. Staff would sometimes notice he seemed unsettled or anxious and he would start pacing, giggling to himself, and/or staring at others. However, at other times, Mr Elsamin's violent outbursts and/or assaults were completely unprovoked and unexpected.[45]

22. At the inquest, Mr Chimbama (Director of New Dawn) gave the following example of an unprovoked assault by Mr Elsamin. This incident occurred at the New Dawn home when Mr Chimbama was talking to Mr Elsamin about activities and outings he would like to do:

> Because even myself I was at the end of the punch at one point. I went into the house, and I was just trying to see what was happening. And yes, we are standing together, and we are talking, let's do this, let's do this. Samaan, if you want - if you do this, you know, that kind of thing. Because I was trying to encourage the staff to do more activities with him. And before I realised, yes, I get punched. And you try to understand why he punched me, and it…doesn't even make any sense.[46]

[41] Exhibit 1, Vol. 1, Tab 32, Report - New Dawn Healthcare Services (undated), pp3-4
[42] Exhibit 1, Vol. 1, Tab 32.1.2, New Dawn Healthcare Services Incident Reports (11.10.21 - 10.05.22)
[43] Exhibit 1, Vol. 1, Tab 32.1.5, New Dawn Healthcare Services Progress Notes (04.10.22 - 10.05.22)
[44] ts 05.06.25 (Chimbama), pp12-15 & 18-21
[45] Exhibit 1, Vol. 1, Tab 32, Report - New Dawn Healthcare Services (undated), pp3-4 and ts 05.06.25 (Chimbama), pp9-23
[46] ts 05.06.25 (Chimbama), pp18-19

23. By May 2022 Mr Elsamin was engaging in behaviours that New Dawn staff had not seen previously seen including running around naked, punching walls and hard objects causing injury to himself, saying that he wanted to die, appearing to be frightened, and asking for help.

24. As a result of his behaviour, Mr Elsamin was admitted to JHC on several occasions for treatment of injuries following violent incidents at his New Dawn home. From March 2022, New Dawn had realised that it was no longer safe for two carers to attempt to manage Mr Elsamin, and so repeated requests were made to the NDIS for funding for a third carer to provide additional support to Mr Elsamin.

25. In an email dated 28 March 2022, a senior planner from the NDIS advised New Dawn that their request for 3: 1 care was refused because that level of support was not reasonable and necessary under the NDIS legislation. In simple terms, the request for additional finding was refused because the NDIS took the view that Mr Elsamin's care needs were related to his mental health, and not his intellectual disability.[47,48]

Management at JHC[49,50,51,52,53,54,55,56,57,58,59,60,61,62,63,64,65,66]

26. On 10 May 2022, Mr Elsamin burned his hands and feet with hot water and he was taken to JHC for treatment, and a review of his mental health. Despite an indication by JHC doctors that Mr Elsamin could return to his accommodation, before he could be discharged New Dawn decided that it could no longer care for him.

---

[47] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), pp3 & 15
[48] Exhibit 1, Vol. 1, Tab 32.1.4, Email - Senior Planner, NDIS (28.03.22)
[49] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator L Jackson (21.08.24), pp7-9 and ts 05.06.25 (Brett), pp59-60
[50] Exhibit 1, Vol. 1, Tab 9, SAC1 Investigation Report (14.03.23), p3
[51] Exhibit 1, Vol. 1, Tabs 13 & 13.1-13.3, JHC Discharge summaries (06.12.21, 11.03.22, 04.05.22 & 09.11.22)
[52] Exhibit 1, Vol. 1, Tab 20, JHC Category Sighting Chart (01.11.22 - 09.11.22)
[53] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25) and ts 06.06.25 (Chapman), pp76-104
[54] Exhibit 1, Vol. 1, Tab 26.1, Report - Dr A Brett (12.04.25) and ts 05.06.25 (Brett), pp52-72
[55] Exhibit 1, Vol. 1, Tab 34, Statement - Ms P Tende (03.05.25)
[56] Exhibit 1, Vol. 1, Tab 36, Statement - Mr R Jenkins (05.05.25), paras 117-155 and ts 05.06.25 (Jenkins), pp23-42
[57] Exhibit 1, Vol. 1, Tab 37, Statement - Mr D Tafirenyika (31.05.25), paras 26-38
[58] Exhibit 1, Vol. 1, Tab 39, Statement - Ms S Sutton (04.06.25), paras 44-80 and ts 05.06.25 (Sutton), pp42-51
[59] Exhibit 1, Vol. 1, Tab 40, Statement - Ms D Hollands (28.05.25), paras 13-27
[60] Exhibit 1, Vol. 1, Tab 11, JHC medical records relating to Mr Elsamin's restraint and seclusion (09.11.22)
[61] Exhibit 1, Vol. 1, Tab 12, Medical report - Dr L Randall (07.09.22)
[62] Exhibit 1, Vol. 1, Tab 14, JHC medical records relating to Mr Elsamin's restraint and seclusion (29.10.22 - 09.11.22)
[63] Exhibit 1, Vol. 1, Tab 33, JHC MHS Staff Training (02.21)
[64] Exhibit 1, Vol. 1, Tab 33.1, JHC Guideline: Physical Restraint (08.19)
[65] Exhibit 1, Vol. 1, Tab 33.2, JHC Facility Document C19.71: MHS Restraint and Seclusion (11.22)
[66] Exhibit 1, Vol. 1, Tab 33.3, JHC Facility Policy No. SU13.04: Managing Aggressive Behaviours Programs - Education (03.22)

27. On 12 May 2022, New Dawn indicated that they were withdrawing their services to Mr Elsamin, on the basis that they could no longer provide adequate and safe care for him. New Dawn's position was that Mr Elsamin required intensive mental health treatment in a hospital setting which they could not provide.[67,68] Mr Chimbama also noted that:

> The main limitation in the support of (Mr Elsamin) in our view was funding and resource constraints, the disapproval of more funding to increase the support ratios to 3:1. As New Dawn that was our main reason for withdrawing our services as well as the fact that we felt our house was no longer adequate after (Mr Elsamin) had kicked one of the doors in when he wanted to attack the staff on duty. In this scenario staff had to leave the house through the windows as they wouldn't be able to restrain (Mr Elsamin) safely with only two staff. The staff hitting was becoming a regular occurrence making it very difficult to provide consistent supports as staff were requesting some time off.[69]

28. At the relevant time JHC's mental health facility consisted of the Mental Health Unit (an open ward) and the Psychiatric Intensive Care Unit (PICU). The PICU had 10 patient rooms and two seclusion rooms and it was generally staffed by four or five nurses, with at least one registered nurse on each shift. Prior to working on the PICU, all clinical staff were required to participate in a specialised training program dealing with how to manage patients displaying aggressive behaviours.[70,71]

29. While he was a patient in the PICU, Mr Elsamin required 1:1 nursing care, which was initially supported by two, and later three security guards due to his aggression and unpredictability. At times, Mr Elsamin was allocated two rooms in the PICU, and a foam sofa was placed in the corridor leading to his room (rooms) to prevent him from charging at staff in an aggressive manner. Caring for Mr Elsamin in the PICU required a whole of team approach, and it was usual practice to rotate his allocated 1:1 nurse during the day.[72]

---

[67] Exhibit 1, Vol. 1, Tab 32.1.4, Email, Ms L Yu (12.05.22)
[68] ts 05.06.25 (Chimbama), pp21-22
[69] Exhibit 1, Vol. 1, Tab 32, Report - New Dawn Healthcare Services (undated), pp4-5
[70] Exhibit 1, Vol. 1, Tab 39, Statement - Ms S Sutton (04.06.25), paras 25-43 and ts 05.06.25 (Sutton), pp44-45
[71] Exhibit 1, Vol. 1, Tab 36, Statement - Mr R Jenkins (05.05.25), paras 40-47 and ts 05.06.25 (Jenkins), pp24-26
[72] Exhibit 1, Vol. 1, Tab 36, Statement - Mr R Jenkins (05.05.25), paras 19-39 and ts 05.06.25 (Jenkins), pp26-28 & 31

30. During his admission, Mr Elsamin displayed aggressive, and self-harming behaviours, and he assaulted numerous staff. The frequency of Mr Elsamin's violent assaults is staggering, and the SAC1 report[73] noted:

> From the time of his admission in May 2022 (Mr Elsamin) was involved in 36 assaults to staff, required restraint on 6 occasions and required seclusion to preserve safety on the unit 35 times.[74]

31. It was extremely difficult for clinical staff to assess whether Mr Elsamin's actions were driven by psychosis, largely because he had limited verbal skills. Staff also had great difficulty identifying the triggers for Mr Elsamin's violent behaviour,[75] and he was managed using a combination of medication and a behavioural management plan.

32. Mr Elsamin was started on clozapine at the end of June 2022. From other inquests I have presided over I am aware clozapine is a "*novel antipsychotic that is used in treatment resistant schizophrenia*" and is regarded as "*the gold standard*" for treatment resistant schizophrenia.

33. Clozapine has been shown to have very good results in some patients, but weekly blood tests are required for the first 18 weeks with monthly blood tests thereafter. This is also necessary to monitor clozapine levels because the medication can cause serious side-effects including heart issues, seizures and a decrease in an individual's white blood cells count.[76,77]

34. An echocardiogram undertaken at the start of Mr Elsamin's clozapine trial was normal, and his dose was carefully titrated to 800-850 mg daily. Mr Elsamin was carefully monitored for potential side effects and his clozapine levels remained within a therapeutic range during his admission. Although Mr Elsamin's aggressive behaviour did decrease after he was started on clozapine, there were ongoing episodes of aggression and assaults, as well as incidents of self-harm.[78]

---

[73] Following Mr Elsamin's death, a clinical investigation was conducted, and report was prepared (SAC1 report).
[74] Exhibit 1, Vol. 1, Tab 9, SAC1 Investigation Report (14.03.23), p3
[75] ts 05.06.25 (Jenkins), pp27-28 & 30-31
[76] [2022] WACOR 24, Record of Investigation of Death - Mr B Drleski (13.04.21), paras 73-74
[77] See also: www.nps.org.au/australian-prescriber/articles/clozapine-in-primary-care
[78] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), pp19-21 and ts 06.06.25 (Chapman), pp81-83

35. The SAC1 report made the following observations about Mr Elsamin's medication regime:

> (Mr Elsamin) also suffered from a severe psychotic illness. Numerous antipsychotic and other medications were trialled in the past and during the admission, several medications were used on a regular basis and also medication provided to assist with his agitation. After a number of opinions and in conjunction with his guardian, (Mr Elsamin) was trialled on the antipsychotic Clozapine. During the admission his Clozapine levels were repeatedly monitored in conjunction with haematological and ECG measures. There was a reduction in agitation, level of symptoms and decrease in the number of restraint and seclusion events.[79]

EVENTS LEADING TO DEATH[80,81,82,83,84,85,86,87,88,89,90,91,92,93,94]

36. During the day on 9 November 2022, Mr Elsamin's behaviour had escalated and by about 5.00 pm he was ignoring nursing requests, jumping on a couch, and throwing snacks at staff. Mr Elsamin ignored the efforts of nursing staff to de-escalate his behaviour, and by 6.00 pm he started pacing back and forth, and making sounds that suggested to staff who were familiar with his care, that his behaviour was escalating.

37. Mr Elsamin was given an intramuscular injection of haloperidol to try to manage his increasing levels of agitation, but this had little apparent effect. Although nursing staff continued their efforts to de-escalate Mr Elsamin's agitation, and when their efforts failed, security staff were asked to restrain Mr Elsamin in a three-point seated restraint.

---

[79] Exhibit 1, Vol. 1, Tab 9, SAC1 Investigation Report (14.03.23), pp3-4
[80] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator L Jackson (21.08.24), pp1-6
[81] Exhibit 1, Vol. 1, Tab 9, SAC1 Investigation Report (14.03.23), pp4-6
[82] Exhibit 1, Vol. 1, Tab 13.3, JHC Discharge summary (09.11.22)
[83] Exhibit 1, Vol. 1, Tab 14, Form 11D - Record of Observations made of secluded person (09.11.22)
[84] Exhibit 1, Vol. 1, Tab 15, JHC Integrated Progress Notes (09.11.22)
[85] Exhibit 1, Vol. 1, Tab 19, JHC Medical Emergency Team Record (09.11.22)
[86] Exhibit 1, Vol. 1, Tab 21, JHC Mental Health 6 hour ACE Monitoring Chart (09.11.22)
[87] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), pp31-32
[88] Exhibit 1, Vol. 1, Tab 26.1, Report - Dr A Brett (12.04.25), pp1-2 & 11-12
[89] Exhibit 1, Vol. 1, Tabs 28 & 29, WAPOL Incident Report & Running sheet (09.11.22)
[90] Exhibit 1, Vol. 1, Tab 34, Statement - Ms P Tende (03.05.25)
[91] Exhibit 1, Vol. 1, Tab 36, Statement - Mr R Jenkins (05.05.25), paras 165-266 and ts 05.06.25 (Jenkins), pp23-42
[92] Exhibit 1, Vol. 1, Tab 37, Statement - Mr D Tafirenyika (31.05.25), paras 39-84
[93] Exhibit 1, Vol. 1, Tab 39, Statement - Ms S Sutton (04.06.25), paras 81-142 and ts 05.06.25 (Sutton), pp42-51
[94] Exhibit 1, Vol. 1, Tab 40, Statement - Ms D Hollands (28.05.25), paras 28-92

38. As security staff attempted to restrain Mr Elsamin, he began throwing his considerable body weight backwards causing the chair he was sitting in to tip. When released from the three-point restraint, Mr Elsamin became increasingly agitated and began waving his fists around.[95]

39. Given that efforts to de-escalate Mr Elsamin's behaviour had failed, Ms Sutton (a clinical nurse on the PICU) decided to place Mr Elsamin in seclusion. Mr Elsamin was led into the seclusion room and placed face down on a mattress on the floor. It was hoped that a period of seclusion would allow the medication Mr Elsamin had been given to take effect.

40. Staff continued to restrain Mr Elsamin on the mattress, with one staff member at his feet, one at each arm, and one at his head to communicate with him. Another nurse monitored Mr Elsamin's heart rate and oxygen saturation, both of which remained within normal limits. Each time staff attempted to release Mr Elsamin and leave the room, he started struggling and wrestling.

41. Over a period of about 25 minutes Mr Elsamin gradually calmed down, and staff were able to exit the seclusion room safely one by one. The psychiatric registrar was informed of Mr Elsamin's seclusion, and from 7.00 pm nursing staff began recording visual observations of Mr Elsamin by looking through the window of the seclusion room. These observations were made every 15 minutes thereafter and nursing staff also monitored Mr Elsamin from the nurse's station via a screen which displayed CCTV footage from the seclusion room.

42. The following observations were recorded during the period Mr Elsamin was in the seclusion room:

> *19:15*: Agitated and pacing. Pushing furniture in seclusion around.
>
> *19:30*: Sitting up on bed.
>
> *19:45*: Standing in same position staring @ mattress. Catatonic like, bizarre.

[95] For restraint training and techniques, see: Exhibit 1, Vol. 1, Tab 36, Statement - Mr R Jenkins (05.05.25), paras 48-116

20:00: Lying down, staring up @ ceiling. Observed breathing OK. Non-verbal response, bizarre.

20:15: Restless, standing and kneeling + doing 'push ups', very bizarre behaviour + constantly pressing intercom.

20:30: Increased agitation, intentional shaking body and banging legs on floor. Lying on mattress in prone position.

20:45: Laying on mattress awake.[96]

43. At about 8:50 pm, nursing staff were preparing to remove Mr Elsamin from the seclusion room when it was realised that he was not breathing. Nursing staff and security guards entered the seclusion room and cautiously approached Mr Elsamin, who was face down on the mattress.

44. Mr Elsamin was described as sweaty and "*floppy*", and his blood-oxygen saturation and pulse rate were very low. A Code Blue medical emergency was called, and CPR was commenced. However, despite extensive resuscitation efforts, Mr Elsamin could not be revived and he was declared deceased at 9.53 pm on 9 November 2022.[97,98]

[96] Exhibit 1, Vol. 1, Tab 14, Form 11D - Record of Observations made of secluded person (7.15 pm - 8.45 pm, 09.11.22)
[97] Exhibit 1, Vol. 1, Tab 4, JHC Death in Hospital Form (09.11.22)
[98] Exhibit 1, Vol. 1, Tab 15, JHC Integrated Progress Notes (10.40 pm, 09.11.22)

CAUSE AND MANNER OF DEATH[99,100]

45. Two forensic pathologists (Dr D. Moss and Dr L. Downs) conducted a post mortem examination of Mr Elsamin's body at the State Mortuary and reviewed CT scans. Dr Moss and Dr Downs noted Mr Elsamin had an increased body mass index, and scattered soft tissue injuries to his head and limbs. Mr Elsamin's lungs were also congested, which is regarded as a non-specific finding.[101]

46. Microscopic examination of tissues showed "*a very focal mixed inflammatory cell aggregate in the heart muscle from the right ventricle*" which Dr Moss and Dr Downs said was "*of uncertain significance*". The remaining tissue samples were otherwise normal.[102]

47. Microbiological testing found the bacteria *Staphylococcus aureus*, in Mr Elsamin's lungs, but "*in the absence of an inflammatory focus microscopically*", this finding was considered to be post mortem overgrowth. Testing for major cardiac and respiratory viruses (including the COVID-19 virus), were negative.[103]

48. Biochemical analysis found normal kidney function, and Mr Elsamin's glucose levels were not raised. A blood test showed Mr Elsamin's had normal thyroid function, and inflammatory markers (CRP and procalcitonin) were not raised, and although one of his liver enzymes (ALT 1280) was "*markedly elevated*" the other enzymes were at normal levels.[104]

49. Specialist examination of Mr Elsamin's brain found "*dilation of the temporal horns of the lateral ventricles*" which was of uncertain significance. Microscopic examination of the brain reported findings of uncertain significance and post mortem changes, but there was no evidence of meningitis or encephalitis.[105,106]

---

[99] Exhibit 1, Vol. 1, Tab 5.1, Post Mortem Report (14.11.22)
[100] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (24.07.24)
[101] Exhibit 1, Vol. 1, Tab 5.1, Post Mortem Report (14.11.22), p1
[102] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (24.07.24), p3
[103] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (24.07.24), p3
[104] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (24.07.24), pp3-4
[105] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (24.07.24), p4
[106] Exhibit 1, Vol. 1, Tab 7, Neuropathology Report (21.11.22)

50. Toxicological analysis detected therapeutic levels of chlorpromazine, citalopram, clozapine, clopenthixol, and valproic acid in Mr Elsamin's system along with ephedrine/pseudoephedrine, haloperidol, olanzapine, paliperidone, propranolol, and zolpidem. Mr Elsamin had a urine alcohol level of 0.011%, but as alcohol was not detected in his blood this finding may be due to post mortem production.[107,108,109]

51. Given the complexity of Mr Elsamin's case, an opinion on the toxicological analysis was obtained from Professor Joyce (a clinical pharmacologist and toxicologist)[110] who noted:

> Ante mortem clinical history, drug dosing history, post mortem findings and post mortem blood concentrations of drugs provide little evidence for a drug-related cause of death. Our judgement would be that there is not enough evidence to propose drug causation or a drug contribution to the cause of death. We would acknowledge that our understanding of drug effects can't be universal, so that it is not possible to set aside drug contribution with absolute certainty. We would observe, though, that (Mr Elsamin) had tolerated similar therapy and similar doses for a long time, without misadventures that could suggest a susceptibility to lethal effects. That does provide some additional reassurance that the drugs were safe for him.[111]

52. At the conclusion of their post mortem examination, Dr Moss and Dr Downs expressed the following opinion:

> Despite a full post mortem examination and extensive ancillary investigations, a definitive cause of death has not been identified and remains unascertained. We cannot comment on whether the death was due to natural causes.[112]

53. On the basis of the available information, I have been unable to ascertain the cause of Mr Elsamin's death. Accordingly, I make an open finding as to the manner of his death.

---

[107] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (24.07.24), p4
[108] Exhibit 1, Vol. 1, Tab 6.1, Toxicology Report (14.11.22)
[109] Exhibit 1, Vol. 1, Tab 6, Supplementary Toxicology Report (08.07.24)
[110] See: Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (24.07.24), p4
[111] Exhibit 1, Vol. 1, Tab 8, Email - Emeritus Prof. D Joyce to Dr L Downs (14.07.24)
[112] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (24.07.24), p4

INDEPENDENT ASSESSMENT OF MR ELSAMIN'S CARE

SAC1 investigation[113,114]

54. As noted, following Mr Elsamin's death a clinical investigation was conducted and panel identified the following "*system and process gaps*" in the SAC1 report:

> 1. Difficulty visualising respirations through the observation window and on CCTV during the episode of seclusion may have contributed to a delay in recognition of deterioration;
>
> 2. Shared responsibility of mental health nurses allocated to observe the seclusion room may have impacted continuity of assessment and may have contributed to a delay in identifying deterioration;
>
> 3. Assessment of signs of life and oximeter usage were not consistent with ARC BSL algorithm and may have contributed to a delay in commencement of CPR; and
>
> 4. The scribe for the MET call was acting outside their scope of practice, which contributed to the incomplete recording of events of resuscitation.[115]

55. The panel made four sensible recommendations addressing the identified issues, and expressed the following conclusion, with which I agree:

> The panel recognised that the care provided during this most recent episode of restraint and seclusion was provided in accordance with both the Mental Health Act and facility procedures. The review identified some improvements to facility layout for the new mental health unit. A key limitation in the review process was a lack of clarity regarding the cause of death as coronial findings were not available at the time of review. Whilst a death on a mental health unit is a rare event the panel suggested a review of processes to improve observations and additions to Basic Life Support training for mental health staff.[116]

[113] Exhibit 1, Vol. 1, Tab 9, SAC1 Investigation Report (14.03.23)
[114] Exhibit 1, Vol. 1, Tab 9.1, Additional information from JHC (17.04.23)
[115] Exhibit 1, Vol. 1, Tab 9, SAC1 Investigation Report (14.03.23)
[116] Exhibit 1, Vol. 1, Tab 9, SAC1 Investigation Report (14.03.23)

56. The clinical review panel reconvened on 17 April 2023, and confirmed that Mr Elsamin was restrained in the prone position for 30 minutes, due to "*the level of ongoing agitation*". The panel also confirmed the observations made while Mr Elsamin was in seclusion were consistent with the recommendations of the Office of the Chief Psychiatrist.[117]

57. In relation to the changes in the monitoring of patients in seclusion following Mr Elsamin's death, the panel noted that:

> Patients in seclusion at JHC are now monitored continuously with 1 staff member allocated and located in a control room outside of the seclusion room. A new mental health facility is due to open at the end of 2023 and the design has included improvements to facilitate this higher level of observation. An ideal solution to monitor respirations could be use of remote technology to continuously monitor and alarm with changes to oxygenation and pulse rate. It does not appear there are solutions at present that suitable for use in such a setting.[118]

Dr Brett's report[119]

58. Dr Brett (an experienced consultant psychiatrist) was asked to conduct an independent assessment of Mr Elsamin's care. Dr Brett reviewed Mr Elsamin's medical records and provided a report to the Court, and he gave evidence at the inquest. In his report, Dr Brett expressed the following opinion about Mr Elsamin's care whilst he was an involuntary patient at JHC:

> I believe that (Mr Elsamin's) overall care was poor. I believe that his care highlights a number of systemic issues, that the mental health advocate noted to be human rights issues. I believe that his cognitive impairment was not adequately taken into account in the management of his schizophrenia. I believe that the treating team did not have the expertise to manage him. I believe that he was being managed in an inappropriate setting. His community management plan and package were inadequate. There was inadequate oversight of his clinical care.[120]

[117] Exhibit 1, Vol. 1, Tab 9.1, Additional information from JHC (17.04.23)
[118] Exhibit 1, Vol. 1, Tab 9.1, Additional information from JHC (17.04.23), p2
[119] Exhibit 1, Vol. 1, Tab 26.1, Report - Dr A Brett (12.04.25) and ts 05.06.25 (Brett), pp52-72
[120] Exhibit 1, Vol. 1, Tab 26.1, Report - Dr A Brett (12.04.25), p12

59. After reviewing Dr Chapman's report about Mr Elsamin's treatment and care, Dr Brett also made these observations in an email to Ms Markham:

> Dr Chapman and his team appear to have done due diligence, however, I still believe that Mr Elsamin's overall care was poor due to those reasons. (Mr Elsamin) was being medicated for behavioural problems due to environmental issues as much as medical issues. (Mr Elsamin's) medication would have been significant in just treatment resistant schizophrenia. (Mr Elsamin's clinical team) obviously worked hard to try and manage (Mr Elsamin) but there were a number of obstacles in the way, as the coroner noted. It is akin to asking a surgeon to do intricate surgery with one arm tied behind his back, the clinicians were trying to help a man in an inappropriate environment with inappropriate tools. There did not appear to be an end goal in sight. There needs to be specialist beds available for intellectually impaired and neurodevelopmental issues.[121]

60. At the inquest, Dr Brett made it clear that he was not critical of individual clinicians,[122] and also acknowledged there are no suitable long-term options for managing patients like Mr Elsamin.[123] I acknowledge that Dr Brett does criticise Mr Elsamin's care and treatment at JHC. However, I have concluded that when considered in context, Dr Brett's main concern was that Mr Elsamin was being managed in a facility that was not appropriate for his long-term care.[124]

Dr Chapman's report[125]

61. Dr Chapman was Mr Elsamin's treating psychiatrist during his admission at JHC between May to November 2022. Dr Chapman prepared a very detailed and comprehensive report about Mr Elsamin's treatment and care, and gave evidence at the inquest. I acknowledge the obvious care Dr Chapman put into his 40-page report, which took over two weeks to prepare, and required him to trawl through numerous volumes of Mr Elsamin's medical records.[126]

---

[121] Exhibit 1, Vol. 1, Tab 41, Email - Dr A Brett to Ms S Markham (06.06.25)
[122] ts 05.06.25 (Brett), p61
[123] Who present with a constellation of severe mental illness, intellectual disability, and extremely challenging behavioural issues.
[124] ts 05.06.25 (Brett), pp56-59
[125] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25) and ts 06.06.25 (Chapman), pp76-104
[126] ts 06.06.25 (Chapman), p99

62. I have carefully reviewed Dr Chapman's very helpful report, which noted that Mr Elsamin was diagnosed with moderate to severe intellectual disability, frontal lobe disorder with sexual disinhibition, and treatment-resistant schizophrenia. Dr Chapman said these conditions were "*unremitting*", and: "*The constellation of his severe conditions placed Mr Elsamin into a category of the most severe of all mental health patients*".[127]

63. Dr Chapman also noted that despite the "*extensive treatment*" provided to Mr Elsamin by various mental services, and medical and allied health practitioners across "*numerous disciplines*" there had been:

> [N]o apparent long-term improvement in Mr Elsamin's condition. Although he had periods of relative short-term stability, my impression of his long-term trajectory is one of a progressive decline. In my experience, this can occur with treatment-resistant schizophrenia.[128]

64. Dr Chapman said Mr Elsamin's medication regime included antipsychotics, mood stabilisers, blood pressure, and sleep medications all of which were maintained within therapeutic ranges. Mr Elsamin was closely monitored for side effects, and his medication regime "*proved effective in reducing the symptoms of his psychiatric conditions*".[129]

65. However, Dr Chapman also noted that Mr Elsamin: "*punched, kicked, spat and threw things at his carers, security guards, paramedics, police, other patients, nurses and doctors involved in managing his psychiatric condition*".[130] These frequent and unpredictable episodes of aggressive behaviour and violence were managed using "*proactive management strategies, de-escalation attempts, sedatives, physical restraint and seclusion*". Whilst not ideal, I accept that regular periods of restraint and seclusion were required in Mr Elsamin's case to deal with his "*repeated unexplained acts of violence*".[131]

---

[127] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), para 1.5, p2
[128] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), p2
[129] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), p2
[130] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), p2
[131] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), pp2-3

66. Dr Chapman noted that the Hospital Extended Care Service offered by Graylands Hospital might have been an option for Mr Elsamin, but that "*Repeated attempts by JHC to refer Mr Elsamin there were denied due to Mr Elsamin apparently not fitting the criteria for admission there*".[132] Dr Chapman also confirmed there are currently no appropriate facilities for providing treatment to patients like Mr Elsamin, noting that:

> A person with Mr Elsamin's forensic history would typically be managed in the forensic psychiatric system. The forensic psychiatric system has practitioners with experience and expertise in managing mental health concomitant with serious offending behaviour.[133]

POSSIBLE FUTURE CARE OPTIONS

Information from the Mental Health Commission[134,135]

67. The Mental Health Commission (the Commission) was established in March 2010 and works closely with the Department of Health and service providers to "*lead mental health reform throughout the State and work towards a modern effective mental health system that places the individual and their recovery at the centre of its focus*".[136]

68. At an inquest I presided over in 2022, Ms J McGrath (who was then the Mental Health Commissioner) spoke about a planned facility known as Secure Extended Care Unit (SECU). In the investigation into death that was published after that inquest, I noted that:

> (SECU)…are intensive inpatient rehabilitation units. They are designed for individuals admitted on an involuntary basis, who have severe and chronic mental health illnesses with co-occurring conditions and challenging behaviours, who pose a significant risk. The goal of treatment at a SECU is for the patient to be transitioned to community rehabilitation and eventually to either supported, or independent living. A planned 12-bed SECU, to be located on the Bentley Hospital campus, is due to open in the next few years.[137]

[132] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), p3
[133] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), pp2-3
[134] [2022] WACOR 24, Record of Investigation of Death - Mr B Drleski (13.04.21), para 80
[135] See also: ts 06.06.25 (Chapman), p83-85 & 88
[136] Exhibit 1, Vol. 1, Tab 42, Letter - Commissioner M Lewis, Mental Health Commission (20.06.25)
[137] [2022] WACOR 24, Record of Investigation of Death - Mr B Drleski (13.04.21), para 83(a)

69. In a letter to the Court dated 20 June 2025, the current Mental Health Commissioner (Ms M Lewis) provided the following update regarding Secure Recovery and Rehabilitation Units (formerly known as SECU):

- The John Milne Centre at Bentley Hospital previously provided a 12-bed inpatient intensive mental health rehabilitation and treatment service. This centre was demolished to allow for construction of a new 12-bed Secure Recovery and Rehabilitation Unit…on the site.
- The Department of Health (DoH) through the Graylands Reconfiguration Taskforce (GRAFT) received capital funding via the 2023-24 Budget Process for 12 additional beds at the Bentley site to result in 24 SRRU beds on completion.
- DoH has oversight of the proposed infrastructure and construction timelines would need to be confirmed with the DoH. The latest information received is that the unit is expected to be completed in 2026-27.

70. It is unclear whether Mr Elsamin would have been considered suitable for admission to a SRRU, but if such a facility had been available at the relevant time, it is at least possible that he might have been admitted. At present, such a facility would seem to be the only viable long term treatment facility capable of addressing Mr Elsamin's particular constellation of mental health, intellectual, and behavioural issues.

QUALITY OF SUPERVISION, TREATMENT AND CARE

71. The evidence establishes that Mr Elsamin had very complex needs, including severe, treatment resistant schizophrenia, and a moderate to severe intellectual impairment.[138] Mr Elsamin also had a history of polysubstance use, frontal lobe dysfunction with sexual disinhibition, and a proclivity to unpredictable aggressive behaviour and assaults. The management of Mr Elsamin's dangerous behaviours was hampered by his limited verbal skills and the fact that observable "triggers" were very difficult, if not impossible, to reliably identify.

[138] Mr Elsamin's IQ was estimated to be 57, see: Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), p2

72. Clinical staff caring for Mr Elsamin did their best to manage his complex needs by a combination of "*proactive management strategies, de-escalation attempts, sedatives, physical restraint and seclusion*".[139,140,141] Whilst this management approach enabled Mr Elsamin to be managed in the PICU it was not necessarily "*recovery focussed*" and seemed instead to be aimed at maintaining the status quo.

73. It is undeniable that Mr Elsamin's physical size, and his unpredictable and violent behaviour were factors which made the ongoing management of his mental health extremely difficult, and at times very dangerous. This much is evidenced by the fact that two, and sometimes three security officers had to be allocated to him in order to keep staff and other PICU patients safe.

74. It is clear that the PICU was not an appropriate place for Mr Elsamin to receive long-term care, and clinical staff were clearly hampered by the fact that were no appropriate facilities to which Mr Elsamin could be transferred for long-term care.[142] Further, the absence of a disability service provider willing to assume responsibility for Mr Elsamin's care in a community setting, essentially meant he was "stuck" at the PICU.

75. Whilst I accept that it is not certain that Mr Elsamin would have met the eligibility criteria for admission to a SRRU, it is at least possible that he might have. If Mr Elsamin was able to meet those criteria, then following a long-term admission to a SRRU, it may have been possible to transition him to a community care unit, with the ultimate goal of placing him in supported accommodation.[143]

76. Having carefully considered the available evidence, I have concluded that Mr Elsamin's management whilst he was an involuntary patient at JHC was reasonable, when considered in the context of the resources available to his clinical team at the relevant time. I also accept that there were no practical alternatives which would have enabled Mr Elsamin to have been safely managed in the community.

---

[139] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), pp2-3
[140] See also: ts 05.06.25 (Jenkins), pp27-28 & 30-31
[141] Exhibit 1, Vol. 1, Tab 12, Medical report - Dr L Randall (07.09.22), p3
[142] Exhibit 1, Vol. 1, Tab 24.1, Report - Dr M Chapman (30.05.25), p3 & 39 and ts 06.06.25 (Chapman), pp102-103
[143] ts 06.06.25 (Chapman), pp95-96

77. However, given that in the absence of any suitable alternatives Mr Elsamin had to be managed in the PICU, his supervision, treatment and care during the time he was an involuntary patient at JHC cannot be said to have been optimal. I want to make it clear that this observation is not a criticism of Mr Elsamin's clinical staff at JHC, it is simply a recognition of the circumstances Mr Elsamin found himself in.

78. Mr Elsamin's supervision, treatment and care may have been enhanced if his clinical team had been able to admit him to a facility like a SRRU, where his intellectual disability, mental health issues, and unpredictable violent behaviour might have been addressed in a coordinated fashion.

CONCLUSION

79. Mr Elsamin's case demonstrates the practical difficulties faced by clinicians attempting to care for individuals with complex needs whose intellectual disability adversely impacts on their treatment for chronic, treatment resistant mental health illnesses.

80. It is my hope that the Commission will continue to use its influence to ensure that facilities like SRRU are made available to mental health consumers as quickly as possible, so that consideration can be given to the suitability of such facilities for patients like Mr Elsamin.

81. Although Mr Elsamin's family were not able to attend the inquest, I would like to convey to them (as I did at the conclusion of the inquest) my very sincere condolences to them for their terrible loss. I would also like to convey my condolences to all those who cared from Mr Elsamin. Despite his extremely challenging behaviours, Mr Elsamin's death was a great shock to those staff, and clearly affected them.

MAG Jenkin
Coroner
22 July 2025