The Hon Ryan Park MP
Minister for Health
Minister for Regional Health
Minister for the Illawarra and the South Coast

Your Ref: 2019/00108352
Our Ref: COR23/16

The Hon. Michael Daley, MP
Attorney General
52 Martin Place
SYDNEY NSW 2000
office@daley.minister.nsw.gov.au

Coronial inquest into the death of Ziad Hamawy

Dear Attorney General

I write in relation to the findings and recommendations made on 21 July 2023 by Deputy State Coroner Harriet Grahame regarding the death of Ziad Hamawy.

Mr Hamawy died aged 51 years of complications of opiate toxicity. He had a history of mental health issues and polysubstance drug use, with admissions to hospital for mental health or drug related issues, and sporadic contact with community health services.

By 2019, Mr Hamawy had experienced multiple interactions with NSW Police. Mr Hamawy was arrested on 13 March 2019, and the following day at Burwood Local Court had a mental health assessment by a Clinical Nurse Consultant of the Statewide Forensic Mental Health Community and Court Liaison. Following the assessment, the Magistrate ordered that Mr Hamawy be taken by police and detained in the mental health facility for assessment at Concord Hospital in accordance with the Mental Health Act 2007. If Mr Hamawy was found not to be a mentally ill person or mentally disordered, he was to be brought back before a Magistrate.

Mr Hamawy was involuntarily admitted to Concord Hospital from 14 March to 18 March 2019. He was discharged into the community in circumstances of significant confusion. Following discharge, Mr Hamawy used drugs that same day. He had a cardiac and respiratory arrest that led to irreversible significant hypoxic brain injury and died at Bankstown-Lidcombe Hospital on 7 April 2019.

Magistrate Grahame made 2 recommendations to NSW Health organisations in relation to the review and update of the *Memorandum of Understanding – NSW Health – NSW Police Force*. Both recommendations are supported.

Sydney LHD and South Western Sydney LHD, both parties to this inquest, support the review of the MOU to reflect legislative changes and support participation in the MOU review consultation. Further, Sydney LHD has consulted with the Ministry of Health Workplace Relations Branch and the Mental Health Branch regarding the coronial recommendations.

Recommendation 1

The Deputy State Coroner recommended:

That parties to this inquest (NSW Police and Sydney Local Health District and South Western Local Health District) engage with the process apparently being undertaken to update the Memorandum of

Understanding – NSW Health – NSW Police Force to reflect the current legislative framework under the Mental Health and Cognitive Impairment Forensic Provisions Act 2020.

The review of the NSW Health – NSW Police Force Memorandum of Understanding commenced in February 2023. The Ministry of Health and NSW Police are currently engaged in broader dialogue on the Health / Police operational interface. Sydney LHD and South Western Sydney LHD will be consulted when the Memorandum of Understanding revision resumes.

Recommendation 2

The Deputy State Coroner recommended:

That parties to this inquest provide input into that process (and to the review of the Memorandum of Understanding between NSW Health and Corrective Services NSW) that will alert those undertaking the review to the problems that occurred in this case in relation to the communication between agencies and the documentation of orders and decisions.

A review of the Memorandum of Understanding with Corrective Services NSW will commence in early 2024, with a view to completion by October 2024. Parties to the inquest will be engaged during the review to ensure the revised document addresses the issues identified. It is intended to enhance the instruction in the MOU and support that additional content with a series of information resources for use by NSW Health staff. The attached information sheet has been provided to local health districts and is also available to all NSW Health staff via the intranet.

I trust that this response confirms NSW Health's commitment to a process of continuous improvement and delivering safe and high-quality care to all patients of the NSW health system.

For more information, please contact Joanne Edwards, Executive Director, System Management Branch, NSW Ministry of Health at moh-systemmanagementbranch@health.nsw.gov.au.

Yours sincerely

Ryan Park MP
Minister for Health
Minister for Regional Health
Minister for the Illawarra and the South Coast

CC: NSW Coroner's Court

Encl. Coroner's report – *Inquest into the death of Ziad Hamawy; Information sheet – Arrival of Mental Health Forensic Patients*

Arrival of Mental Health Forensic Patients (Section 19 or 21 of the Mental Health Cognitive Impairment Forensic Provisions Act 2020)

Memorandum of Understanding between NSW Health and Corrective Services NSW

NSW GOVERNMENT | Health

This information sheet summarises the process when Corrective Services NSW (CSNSW) arrive to a Declared Mental Health Facility with a person who is under Section 19 or 21 of the Mental Health Cognitive Impairment Forensic Provisions (MHCIFP) Act 2020.

The person is taken by CSNSW to a Declared Mental Health Facility (DMHF) on the order of a Magistrate or authorised Justice under **Section 19 or 21** of the MHCIFP Act. Prior to transport, CSNSW will contact the Nurse Unit Manager (NUM) of the DMHF. CSNSW must transport the person immediately.

CSNSW attends triage and begins handover of the person. This includes providing a copy of the magistrate's order and any other relevant information including related to any known risk.

Section 19 (a) or 21(1)(a) of the MHCIFP Act

CSNSW clearly state they are handing care of the person to DMHF. Once transfer of care occurs, CSNSW departs. CSNSW is not legally able to remain. DMHF is now responsible for the person, including managing security risk. If there is a public safety risk, the police must be called.

- The person is not admitted and following their assessment, DMHF contacts the police to check if the person is to be transferred into custody.
- The person is admitted and they remain the responsibility of DMHF. When treatment/admission concludes, DMHF must contact the police to confirm if the person must be transferred into custody.

Sections 19 (b) or 21(1)(b) of the MHCIFP Act

CSNSW clearly state they will remain with the person for their assessment.

- The person is not admitted and CSNSW will return the person back to the police station or court.
- The person is admitted and DMHF assume care of the person. CSNSW departs.
  - When treatment/admission concludes, DMHF must contact the police to confirm if the person must be transferred into custody.

If police confirm the person must be transferred into custody, DMHF staff are authorised to hold the person for up to 2 hours, if safe to do so (S39 Mental Health Act).

DMHF must inform all relevant staff about the 2-hour holding period to ensure the person is not released prior to Police arrival.

For more information please see: https://nswhealth.sharepoint.com/sites/WR-MOH/SASI/SitePages/NSW-Health---Corrective-Services-NSW-Memorandum-of-Understanding-2021.aspx