FINDINGS IN THE INQUESTS INTO THE DEATHS OF:

JOSEFA RAULUNI

AHMED OBEID AL-AKABI

and

DAVID SAUNDERS

at Villawood Detention Centre, New South Wales, in 2010

This inquest took place over more than 3 weeks. It concerned three male immigration detainees who died at Villawood Immigration Detention Centre (**VIDC**) in a three month period on late 2010. Parties represented were the Department of Immigration and Citizenship (**DIAC**), Serco Australia Pty Ltd (**Serco**), International Health and Medical Services Pty Ltd (**IHMS**), nurses, an individual officer from Serco, and the families of each of the three men who died at VIDC. A large number of witnesses gave evidence, both in person and by audio-visual link, including personnel involved with the three men, senior staff of both DIAC and Serco, health staff from IHMS and expert psychiatrists. I was assisted by Ms Sharp of Counsel and instructing solicitors from the Crown Solicitor's Office (**CSO**). Volumes of material were tendered in a large and painstaking brief assembled by the hard work and skill of the police Officers In Charge.

Their deaths occurred within 3 months of each other in 2010, and each was, on the evidence, clearly self-inflicted. Josefa Rauluni (**JR**) jumped to his death from a balcony rail, and David Saunders (**DS**) and Ahmed Al-Akabi (**AA**) each hanged himself in a shower area of one of the centre's bathrooms.

THE ISSUES

- Given the close proximity in time of each suicide, were there systemic issues which may have contributed to the deaths?
- Was the treatment of the three deceased by DIAC, IHMS and Serco staff appropriate and humane?

- Could their deaths have been prevented, or any risk of suicide have been detected?
- Have any necessary changes been made to protocols and procedures at the VIDC following these tragedies?

THE FACTS

The *Migration Act 1958* (Cth) empowers the Minister for Immigration and Citizenship (**Minister**) to detain 'unlawful non-citizens' and to create detention centres. DIAC outsourced its management of all Australian detention centres to the company Serco in December 2009. In January 2009, it outsourced the provision of health services in detention centres to IHMS. DIAC retains a non-delegable duty of care to all immigration detainees (which is essentially a duty to ensure that reasonable care is taken for persons over whom DIAC exercises control and authority).

The numbers of detainees held at VIDC increased strongly in 2010 with an influx coming from Christmas Island. In September 2010, there were 370 detainees.

Mr Josefa Rauluni (JR) was a Fijian citizen who had been in Australia since November 2008, initially on a tourist visa, and subsequently on short-term bridging visas while he applied for a protection visa on the grounds that he feared persecution if he was returned to Fiji, for his political beliefs. That was refused in July, 2010 and he was apprehended by DIAC on 17 August 2010 as an 'unlawful non-citizen', and detained at VIDC. Staff from all three authorities interviewed him shortly after his detention, and assessed him as co-operative and at low risk of self harm. He stated that he wanted to return to Fiji, but only when its forthcoming elections were over. He made an application for a further bridging visa, to that end but was refused it on 27 August 2010. JR again requested a Ministerial Intervention to grant him a protection visa only until the election was over, and on 30 August, applied to the Migration Review Tribunal for a review of the refusal.

Throughout early September, DIAC commenced arrangements for JR's removal under escort while various applications by JR were refused. Z, his DIAC case

officer, advised the other authorities on September 16 that he was to be told the following day of his imminent removal to Fiji. M, the IHMS Mental Health team leader, advised that 'no immediate risk issues are identified'. On Friday September 17, J, a DIAC Removals Officer, informed him that he was to be removed the following Monday, September 20, and that his latest request for a Ministerial intervention had failed. She advised her supervisors and IHMS that he was shocked and fearful and would be lodging another application for protection. JR did so that afternoon, setting out his fears and their confirmation by another Fijian. He stated to his nephew, Eddy, also a VIDC inmate, that if unsuccessful, he 'would try to get media attention and …find somewhere to jump from'. He sent two further faxes to the Minister on Sunday September 19 in which he stated that if he was returned, it would be his 'dead body'.

From 8.00am on Monday, September 20, several Serco staff and D, a DIAC removals officer, spoke with JR who was on the balcony of the first floor outside his doorway in the Gwydir building expressing his fears of returning to Fiji, and threatening to jump. Serco Escort and Removal Officers G and C arrived, then advised their supervisor, A, of the situation. She joined them on the ground below the balcony. Various emails and phone calls took place between Serco and DIAC staff. The Serco Duty Manager, was advised that JR was refusing to move until he received a reply from the Minister to his last request. She went to the scene and asked him to come down and he refused, threatening to jump if approached. She phoned her Senior Manager, P, and sought permission to use force. P said he was happy for her to continue with the removal, but says he was not told that JR was standing up on a railing, and did not realise there was any serious risk that JR could harm himself. He then phoned K, the DIAC Regional Manager, seeking permission to use force to effect the removal. After K phoned H, a DIAC officer in the Case Management Team, she spoke with P and authorised the use of force if necessary. P confirmed to N that authorisation to use force had been given. She in turn passed that on to the Serco Removal Officers, and directed the use of video, and the placing of mattresses on the ground below where JR was stepping up and down on to the balcony railing. The Serco officers and N all returned to the chaotic scene, with people shouting at JR, who was becoming increasingly upset, stepping up onto the balcony railing and then off again, and constantly threatening to jump. A told him

several times that he would be ‘coming down one way or another and going to the airport’.

D arrived at the scene at 9.25am and went up to the landing to discuss with JR the fact that the Minister had received the letter and was looking at it at that moment. After speaking with JR for 5 minutes, D was told to leave by a Serco officer. Soon after his departure, A directed the Escort Team to approach JR. As they commenced up the stairs, JR climbed on to the railing and dived head first on to the concrete further out from the mattresses. He was pronounced deceased at 9.47 am.

I have watched a DVD of the incident from the time that N and her team returned to JR. I also heard the expert opinion of psychiatrist Dr Michael Diamond, a specialist in negotiations, who reviewed the entire incident, watched the DVD, and read transcripts and statements made in this inquest. He was highly critical of the management of the entire situation. In his view, JR was clearly a high risk, and the response to his situation lacked co-ordination and orderliness. It was not clear who was in charge. Serco should have obtained background information on JR. Negotiation in any real sense was non-existent. The sense of urgency should have been de-escalated and deferment of the removal considered. It was entirely open to DIAC and to Serco to abort the removal, and the direction for the use of force was made precipitously and without negotiation. The placing of mattresses would have increased the feelings of threat for JR. Although T himself had conducted himself kindly so as to calm JR, he had not been briefed by DIAC, did not know who was in charge and was told to leave by Serco staff just as his presence was beginning to de-escalate the crisis. Overall Dr Diamond criticised the lack of co-ordination between Serco and DIAC officials as a ‘stand-out’, and deplored the absence of basic awareness, training and capability to handle a situation of this nature. He was of the view that ‘The people dealing with him that morning ignored certain opportunities to begin to engage in a negotiation process, because they were ignorant of them’.

His opinion was echoed by the evidence of Chief Inspector Peter Abel, the most senior negotiator in the NSW Police Force. He too considered that the situation

should have been seen as high risk, there was no evidence of any clear command structure, and nor was there any single negotiator.

Mr Ahmed Al-Akabi (AA)

Mr Ahmed Al-Akabi (**AA**) an Iraqi who was 41 years old at the time of his death, and had been in detention for nearly a year. He arrived by boat at Christmas Island on December 10 2009, and spent the next four months in detention there. He reported a number of health complaints but was assessed by Serco staff as not being at any risk of suicide or mental illness. He made an application for a protection visa on the grounds of religious persecution, and claimed to have been imprisoned, beaten and tortured in Iraq. He made a request for refugee status but in late March this was refused on the grounds of his not being a genuine refugee. In early April, he was transferred to VIDC, having been assessed again prior to his transfer as being at low risk of suicide or self-harm.

Upon AA's arrival at VIDC, Serco completed a Suicide and Self Harm (**SASH**) Risk assessment and he ticked 'yes' to questions as to whether he had felt that life was not worth living, and whether anything had recently happened to him or his family to cause distress or worry, but 'no' to a question whether he had ever considered or tried to hurt himself. The result was not considered high enough to warrant a SASH placement. However, on the same day he requested to see the mental health nurse. IHMS records show that on 7 April, he was prescribed Avanza 15mg, an anti-depressant which assists also in insomnia. The records do not reveal the reason for the prescription or how many tablets were prescribed. Mr Al Akabi saw a mental health nurse on 8 April 2010 and spoke of stress and anxiety about his visa. Three days later, he apparently received news that his sister and two of her children had been killed by a bomb in Iraq. It appears that neither DIAC, Serco or IHMS staff were ever aware of this. He went on a hunger strike, and was briefly hospitalised. A week later, Serco in a Full Client Placement Assessment, found that there was no evidence of a risk of self harm or suicide.

For the next 7 months, AA continued to attend IHMS regularly for both physical and emotional conditions. A considerable number of IHMS Chiron records note his

increasing worry, depression, and insomnia, until in early August, he was referred to a psychiatrist whom he eventually saw on August 30. The psychiatrist, V, may not have fully read the referral notes from the IHMS nurse. She seems not to have been aware that AA had been previously prescribed Avanza but felt it was not helping. She diagnosed his problems as 'Adjustment disorder with Anxiety/Depression" and prescribed him Avanza 30mg. She arranged to see him again a fortnight later, on 13 September 2010, at which time she made very brief notes that he felt good that day and was complying with medication. AA told a Serco officer, the following day, that he was not taking medication.

In early October he was notified that he would be removed from Australia. He told his lawyer, who notified the DIAC Case Manager, that threats had been made against his family in Iraq by fellow detainees. The DIAC Case Manager did not do anything in response to this information and in evidence said he could not remember having been provided with the information. The Case Manager notified Serco and IHMS of the pending removal, but did not request IHMS to provide any support to AA. AA himself had some counselling with the mental health nurse at his own request. Both an IHMS GP and a psychologist, as well as his new Case Manager made notes around this time about AA's distressed, despondent state, his non-compliance with medication and his request to be relocated from VIDC before his return to Iraq. AA was hospitalised again in late October with chest pains. He continued to request a transfer to Melbourne. He was requested by a Serco Officer to put his request in writing which he did on 29 October, stating:

> My health is not very good. I want to be transferred to Melbourne, where I have friends and relatives to look after me…Because of my mental health and heart problems. I need their support. I don't have anyone here, no one visits me here.

No action was ever taken on that request.

On 1 November, he was assessed again by V who found he was a low risk. AA informed her that he felt 'good' and told her he no longer needed the anti-depressants. AA's report that day was inconsistent with the more negative reports he

had made to other IHMS staff over the preceding fortnight. The same day he was hospitalised again with chest pains, and continued to ask for removal. IHMS notes, made on this date, do not refer to his numerous mental health visits, and record that he is on Avanza, though V had noted that he had stopped taking his medication. Although at this period, DIAC staff seem to have made real efforts to expedite his current wish to return to Iraq quickly (because he felt his health was declining and he wanted to see his family), difficulties arose about his travel papers. AA then withdrew the request to return, advising that he feared he would be arrested by Iraqi Intelligence. This man had asked for mental health assistance from his first day at VIDC. It is clear that both his mental and physical health deteriorated gradually over the period of his detention and that though DIAC and IHMS staff recorded that, very little was done to assist him. The SASH protocol, which set out a procedure for ensuring that a detainee's risk of self-harm or suicide was carefully evaluated and monitored, was not followed.

On November 15, he failed to keep an appointment with V. That evening, he was seen to take a phone call which left him upset and distressed. Shortly after midnight, he was found hanging from a pipe in a bathroom.

Associate Professor Suresh Sundram, a consultant psychiatrist with wide experience of asylum seekers and refugees, was critical of the treatment of AA in evidence given from Melbourne by AVL, and his written expert report. He asserted that there was a demonstrated absence of recommended and mandated screening for mental health issues in immigration detainees as required by DIAC. He deplored the ineffective record keeping of IHMS and the failure to disseminate important information between all three authorities. Importance was placed by him on the inaction (or lack of outreach) of IHMS to follow up on AA, particularly after he missed two appointments in the week before his death. He disagreed with V's diagnosis of AA and with the medication prescribed. He called the treatment of AA limited, and without any consideration of altering or augmenting it when it appeared ineffective. It was his strong view that AA should have been diagnosed as having a Major Depressive (rather than an Adjustment) Disorder and that Avanza should have been discontinued when its ineffectiveness was evident.

David Terence Saunders (DS)

David Saunders (**DS**) was a UK citizen. At the time of his death he was aged 29 years. He had been detained at VIDC for 25 days. He had flown to Australia in May 2010 on a tourist visa. He was at the time, under investigation, but not charged, by UK police after allegations that he possessed and distributed child and adult pornography and that he committed sexual assault on a child. The second allegation, however, had been withdrawn by UK Police. The evidence does not clarify whether DS was aware of that withdrawal. I am told that he was on bail, which he breached by leaving the UK, despite not being charged. His extended tourist visa was to expire on November 10 2010. The Australian Federal Police were advised by UK police of the allegations and his breach of bail, and on November 11, Saunders was apprehended on the basis that he was an unlawful non-citizen. He was detained immigration detention and placed into the Blaxland compound, the most high security compound at VIDC.

DIAC was advised of the investigation and of the fact that his partner and infant child had been stopped at Heathrow on their way to join him in Australia and the child taken into care as being at risk in his presence. However, DIAC did not pass that information on to Serco. Federal Police were made aware that Saunders had threatened suicide in the past, information provided by his mother. Federal Agent R considered that he was at serious risk, and advised DIAC accordingly. Serco, knowing nothing of either the allegations or his mother's expressed fears, and accepting what DS told them, assessed him as "nil risk" of self harm. By November 16, his DIAC Case Manager was made aware of the allegations and of his partner and child's aborted attempt to join him. His mother on the same date emailed the UK police for forwarding to 'the Australian High Commissioner of Immigration', details of DS's past attempt at suicide and recent threats to self harm. This information was passed on to DIAC staff and thence, on 18 November 2010, to Serco. The evidence is conflicting as to when it was in turn provided to IHMS. DS was certainly not referred to IHMS for assessment or counselling. He was examined, on a standard Mental State Examination, by an IHMS psychologist, whose evidence was that he knew none of the pertinent information about DS and was misled completely by him including the assertion that he had never thought of or attempted self-harm.

The first date on which there is cogent evidence that IHMS were notified of DS's past suicide attempt is November 24, when a DIAC Manager emailed M as well as Serco staff) an extract of his mother's email. M did not realise that he had also made recent suicidal threats. She did refer him to a counsellor the following day after being advised that DS would receive a 'negative notification'. On 25 November, Serco placed him on 'officers watch' (sometimes called 'security watch'), which required observations every 60 minutes. The reasons for this placement remain unclear. At no time was he placed on SASH watch. Serco officers were not aware of DS's suicidal risk, but thought that he was on watch because of an 29 November 2009 escape attempt by DS.

By December 7, DS was requesting to be returned to the UK. He spoke by phone with his partner in the UK and told her so. Sadly, he was the terrible position that if he returned to her, the child would likely be taken back in to care. Although he and his partner wanted to be together, they could not do so and keep their child. His partner was afraid that he was suicidal during the phone call. It seems he may well have determined to kill himself in order to ensure that his partner could remain with their son.

CCTV footage from the early hours of December 8 shows that the Serco officer required to maintain the 60 minute observations of DS failed to do so. DS is seen to enter the bathroom at 1.27 am. He is not seen again on the footage. At 3.31am he was discovered by another detainee hanging in a running shower. A suicide note was found in his pocket.

I was concerned at reports that his hands were tied by a shoelace, and to his ankle, although he was hanging by a belt and a cord. There was also one witness who claimed that there was a ligature looped around his genitals. Unfortunately, the scene was contaminated partly because of the panic and attempts to rescue DS, but also from apparent ignorance by staff of crime scene protocol. In any case, I am persuaded by all Counsel that this puzzling evidence is not an indication of foul play, and as well, that the ties around his hands were sufficiently loose that he easily could have tied them himself.

CONCLUSIONS

Although speaking particularly about AA, Professor Sundram in his written Report makes a reference which in my view must apply to almost all persons in immigration detention centres, and certainly to all three deceased whose deaths these inquests have investigated. He refers to ’the frustration, resentment and feelings of powerlessness and helplessness at being in immigration detention. These feelings have a potent capacity to exacerbate depressive disorders which in turn will exacerbate these feelings.’

It is surely stating the obvious to observe that persons detained in Immigration Detention Centres must, by the nature of their various situations, be at much greater risk of suicide than the general community. Loss of families, freedom, status, work and length of time must all play their part. The corollary of that is that those responsible for detainees owe a greater than normal duty of care to those persons regarding their health and well being. That DIAC owes a non-delegable duty of care to immigration detainees is indisputable, and it follows that that is an elevated duty. Serco and IHMS bear their own share of that duty. It has to be said that none of the three authorities escape criticism for the manner in which that duty was fulfilled in caring for the inmates at Villawood at least in the last months of 2010.

Despite the above, I note and accept the quotation from Autopsy of a Suicidal Mind (Edwin S Shneidman) that “Hindsight is not only clearer than perception-in-the-moment but also unfair to those who actually lived through the moment.”

Those considering suicide are not necessarily prepared to discuss, warn or threaten those thoughts to health or other professionals in authority. However, in view of the higher risk, it cannot be said that appropriate screenings or protocols were in place, or at least carried out, to minimise the risk or treat appropriately, any of these three men. The lack of consistency arising from constant changing of Case Managers and health professionals was exacerbated by a failure to record or share important information. Policies and protocols were often ignored.

Mr Rauluni was served with his final removal notice for the following Monday on a Friday, quite contrary to DIAC's required standards which recognised that detainees would be in more than usual distress at that point, but that no Mental Health staff were available. Serco staff were completely unprepared and untrained in dealing with him once he had refused to leave and was threatening to jump from the balcony.

Mr Al Akabi was probably misdiagnosed and medicated, his records were both lacking in detail and apparently not consulted. He in fact did make clear to officials that he was depressed and in a poor state both physically and mentally, and that he was extremely fearful and concerned about his family in Iraq and himself if he were to be returned. Very little action or assistance was offered to him. IHMS did not take adequate steps to make DIAC or Serco aware of his true level of risk.

Similarly, Mr Saunders' particularly difficult circumstances, known as they were to DIAC and ultimately to Serco, and partially to IHMS, should have alerted staff to the probability of risk to himself, particularly as it was known that he had made a previous suicide attempt. The failure by IHMS, DIAC or Serco to place him on SASH watch, and by the Serco officer to fulfil his obligations to observe him sufficiently, are deplorable. I accept that the particular officer concerned had not been told that Saunders was a suicide risk, but nevertheless his observations were scant and not in accordance with even the lesser requirements of a security watch.

In all three deaths, some of the actions of some staff were careless, ignorant or both, and communications were sadly lacking. SASH procedures were not followed by DIAC or Serco personnel, DIAC failed to ensure that Serco and IHMS were fulfilling the terms of the contract between them and there were startling examples of mismanagement on the part of DIAC, Serco, and IHMS. However, no one acted in bad faith deliberately, and I consequently see no utility in naming or criticising individuals; it is the failure of systems which in my view require remedy. I am advised that Serco has conducted investigations following the deaths, the result of which has been to implement some appropriate changes to its policies and procedures, which have subsequently been introduced, according to Part 2 of the Submissions of Counsel for Serco.

IHMS must be said to have failed in its duty of care to Ahmed Al Akabi. Its system was under-resourced and under stress. The seriousness of his mental state was not detected, documentation practices were extremely poor and there was a sad lack of continuity in AA's clinical care. Information available to staff on CHIRON went unread or ignored. The principle of patient confidentiality was allowed to take precedence over patient safety, with poor (if any) communication to DIAC or Serco about AA's vulnerability and deteriorating mental state. Of the three suicides, AA's was probably the most foreseeable and therefore, at least theoretically, preventable. There has been no explanation of why SASH protocols were not implemented for AA. Similarly, the SASH Protocol was not followed by IHMS, DIAC or Serco in relation to DS. There is a real question about whether IHMS did assess DS's risk of suicide. There are also doubts about what, if anything, IHMS advised to DIAC and Serco about DS's risk of suicide. It should be said further, however, that IHMS played no role in the deaths of JR. Although Counsel for IHMS submitted that a range of reforms have been introduced at VIDC since these tragedies, no evidence has been led which establishes that.

Neither DIAC nor Serco fulfilled their duty of care to JR or DS. When government chooses to maintain a detention system, it carries a heavy responsibility. Similarly, a company which contracts to shoulder a large part of that responsibility is under a major obligation to fulfil its contract, both to government and to those in its care. For the reasons I have given, it cannot be said that either DIAC or Serco met those responsibilities in full.

During closing submissions, DIAC raised a jurisdictional objection to the making of recommendations directed to the Minister for Immigration and Citizenship (and presumably to DIAC itself). Section 82(1) of the *Coroners Act 2009* (NSW) (**Act**) confers the power to make recommendations. It is in broad and general terms. Section 82(4) imposes an obligation upon a coroner to make a copy of a record including recommendations to persons or bodies to which a recommendation is directed as well as to the "Minister".

DIAC has suggested that the power to make recommendations conferred by s. 82 of the Act is limited to a power to make recommendations directed to State, as opposed to Commonwealth, Ministers. DIAC says that this conclusion follows as the word "Minister" in s. 82(4) must be read as meaning "Minister in and of New South Wales". I reject this submission.

In the first place, there is no reason to think that the Act does not bind the Crown in right of the Commonwealth. While the Act does not contain express provision for this, it seems to me that it must follow as a matter of statutory construction given the purposes of the coronial jurisdiction (see *Bropho v Western Australia* (1990) 171 CLR 1). Of course, a recommendation under s. 82 of the Act does not "bind". Secondly, there is no warrant for applying the presumption against extra-territorial operation found in s. 12 of the *Interpretation Act 1987* (NSW) to s. 82 of the Act. To hold that the words in s. 82 of the Act must be read as including the limitation "in and of New South Wales" would defeat the clear purpose of the Act. I therefore consider that I have the power to make recommendations directed to Commonwealth Ministers, persons or bodies wherever it is necessary or desirable to do so in relation to any matter connected with the death the subject of the inquest.

It is to be hoped that the Minister will wish to improve departmental operations in detention centres after the concerning number of suicides at Villawood, in particular in the last twelve months, and I make recommendations in that spirit accordingly.

FINDINGS

I find that JOSEFA RAULUNI died at Villawood Immigration Detention Centre in the State of New South Wales (but regarded in the law as a Commonwealth place) on September 20 2010, of multiple injuries sustained after he took his own life by diving from a first floor balcony railing on to concrete.

I find that AHMED OBEID AL-AKABI died at Villawood Immigration Detention Centre in the State of New South Wales (but regarded in the law as a Commonwealth place) either late on November 15, or early in November 16, 2010 of hanging, having taken his own life.

I find that DAVID TERENCE SAUNDERS died at Villawood Immigration Detention Centre in the State of New South Wales (but regarded in the law as a Commonwealth place) on December 8, 2010 of hanging, having taken his own life.

RECOMMENDATIONS

I make the following recommendations pursuant to s.82 of the *Coroners Act 2009* (NSW):

To the Honourable Chris Bowen MP, Minister for Immigration and Citizenship:

Use of Force in effecting a Removal

1. DIAC should revise:

   (a) The Serco Contract and the Procedures Advice Manual ("**PAM**") 3 (Removals from Australia) to make clear provision as to the procedure to follow and who has authority to abort a removal in a situation where a detainee is resisting his or her removal and is threatening self-harm or suicide; and

   (b) Its policies on use of force to provide guidance to DIAC officers as to what matters should be taken into account when they are requested to give a use of force authorisation in order to effect a removal.

   (c) The Detention Services Manual should be amended to prohibit notification of negative decisions including removals on a Thursday or Friday.

Case Management

2. In relation to case management of detainees, DIAC should:

   (a) Direct Case Managers that they are responsible for making referrals for risk assessments to IHMS as soon as risk factors become apparent;

   (b) Implement a policy that all referrals for risk assessment be made to IHMS in writing; that there be periodic follow up of the results of risk assessment in writing and that the results of the risk assessment be documented in writing and recorded in Portal;

   (c) Direct all staff with responsibilities towards detainees to make contemporaneous notes in Portal regarding their dealings with respect to the detainees, and to specifically record any observations made in relation to risk factors and any information received from DIAC, IHMS or Serco regarding the mental health or well-being of a detainee;

   (d) Implement a procedure whereby when information is obtained by DIAC suggesting that a detainee is at risk of self-harm or suicide the DIAC Case Manager is required to seek all information held by DIAC on the detainee and also obtain corroborative/clarifying information to the extent that that is reasonably practicable to do so in the circumstances.

To Serco Australia Pty Ltd:

3. Serco should develop procedures for:

   (a) Encouraging Serco officers to proactively seek information on the outcome of risk assessments where Serco is aware that risk factors have been identified with respect to a detainee and/or a detainee has been referred to IHMS for a risk assessment risk;

   (b) Documenting in detainee files the presence of risk factors; the referral of risk assessments to IHMS and the outcomes of risk assessments;

   (c) Ensuring that where there is a need for additional vigilance with respect to a detainee, that need is effectively communicated to all Serco officers in the compound in which the detainee is accommodated.

   (d) That Serco formulate a policy on the basis upon which authority to use force is to be used, including the assessment of risk, appropriate planning to reduce risk and the consideration of de-escalation techniques.

To International Health and Medical Services Pty Ltd:

4. In relation to assessing a detainee's risk of self harm or suicide, IHMS should:

   (a) Develop a standard procedure for such an assessment which *inter alia* provides clear guidance as to what topics should be canvassed with the detainee; what instruments/risk assessment tools should be used to guide clinical judgment; stresses the importance of seeking corroborative information where it is available; provides for the documentation of corroborative information obtained; and provides clear guidance as to what must be documented by the clinician;

   (b) Periodically train its mental health staff on the above procedure and on the minimum requirements to be satisfied in documenting their consultations with and assessments of clients; and

   (c) notify DIAC and Serco on the outcome of its risk assessments in writing.

To the Honourable Chris Bowen MP, Minister for Immigration and Citizenship, to Serco Australia Pty Ltd and to International Health and Medical Services Pty Ltd:

Detainee Mental Health – collaboration between DIAC, Serco and IHMS:

5. DIAC, IHMS and Serco should work together to develop policy guidance on what information about a detainee's mental health can be provided by IHMS to DIAC and Serco officers and in what circumstances on the basis of the "need to know", without having to first consult via Detention Health Services.

To the Honourable Chris Bowen MP, Minister for Immigration and Citizenship and to Serco Australia Pty Ltd:

6. That DIAC and Serco formulate a policy with the NSW Police or the Federal Police to permit the police to provide timely assistance, including trained negotiators, for high risk situations.

To the Honourable Chris Bowen MP, Minister for Immigration and Citizenship and to International Health and Medical Services Pty Ltd:

7. DIAC and IHMS give consideration to changing the clinical governance structure at VIDC in relation to the provision of mental health services so that they are overseen by a consultant psychiatrist

Magistrate M Jerram

NSW State Coroner 19th December 2011

Note: An order has been made under section 75(5) of the Coroners Act 2009 permitting the publication of these findings.