FINDINGS and COMMENTS of Coroner Olivia McTaggart following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Saeed Hassanloo

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Saeed Hassanloo, with an inquest held at Hobart in Tasmania, make the following findings:

Hearing Dates

9, 10, and 11 February 2021

Representation

Counsel Assisting the Coroner: C Lee

Counsel for Department of Home Affairs: J Forsaith and E Evagorou

Counsel for Tasmanian Health Service: J Rudolf

Counsel for Dr Reddy: T Cox

Counsel for Australian Red Cross: J Sawyer

Preliminary matters

Introduction

1. Saeed Hassanloo, aged 27 years, died on 27 August 2016 when he jumped from the Tasman Bridge in Hobart. While his body was never recovered, I am satisfied, for the reasons stated in this finding, that Mr Hassanloo died as a result of his injuries and/or drowning, and that his actions were his alone and taken with the intention of ending his own life.

2. Mr Hassanloo was an asylum seeker from Iran, who had arrived in Australia by boat in 2010 and subsequently spent periods of time in both immigration and community detention on the mainland of Australia. He elected to move to Tasmania in early 2016, almost 8 months before his death, having been granted a Bridging Visa by that stage. Support and case management was provided to him by the Department of Home Affairs ("the department").

3. During his time in Australia, he suffered significant mental health issues and ongoing distress and was often extremely challenging in his behaviours. He had undergone mental health inpatient admissions on the mainland following self-harm and two mental health inpatient admissions in Tasmania. His discharge from the second inpatient admission in Tasmania occurred the day before his death. Apart from the circumstances of his death, the coronial investigation focused upon the provision of information and support by the department in various aspects, Mr Hassanloo's hospital treatment in Hobart, and whether there were opportunities to have reasonably prevented his suicide.

Coroner's jurisdiction and functions

4. In Tasmania, the coroner's functions are set out in section 28(1) of the *Coroners Act* 1995 ("the Act"). By this section, the coroner is required to find the identity of the deceased, how death occurred, the cause of death and when and where death occurred. By section 28(2), a coroner may make comment on any matter connected with the death; and by section 28(3), a coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.

5. Coroners complete their written findings pursuant to section 28(1) into a reportable death after receiving documentary evidence in the investigation. In a small proportion of reportable deaths, the coroner will hold a public inquest, which almost always involves the calling of oral testimony to further assist the coroner in his or her investigation function and subsequently, findings. Many of the public inquests held by the coroners in Tasmania are made mandatory by the Act.[1] The remaining inquests are held because the coroner considers that a public inquest is desirable in the particular circumstances of the investigation. [2] In the case of the death of Mr Hassanloo, an inquest was not made mandatory by the Act. However, in light of the issues to be ventilated in the investigation (as listed below) and the particular vulnerability of Mr Hassanloo as an asylum seeker newly arrived in Tasmania, I considered that a public inquest was desirable.

[1] Section 24(1) of the Act.
[2] Section 24(2) of the Act.

Issues at inquest

6. Within section 28 of the Act, the inquest focused upon the following matters:

    a) Whether Mr Hassanloo is deceased and the circumstances of his suspected death;

    b) The adequacy of communication between the department, the Red Cross, Royal Hobart Hospital (RHH), and Tasmanian Health Service (THS); and in particular, whether the department provided to the THS/RHH adequate information to enable correct diagnosis and treatment of Mr Hassanloo; and whether it provided to the Red Cross, being the organisation charged with his care, sufficient information to enable it to support Mr Hassanloo and develop effective strategies for his well-being;

    c) The adequacy of treatment and care at the RHH, including appropriateness of diagnosis, assessment as to capacity and discharge on 26 August 2016; and

    d) The ability of medical staff at the RHH, in this case and generally, to deal with presentations by asylum seekers.

Evidence in the investigation

7. The documentary evidence at inquest comprised exhibits C1 to C45A. The exhibit list is annexed to this finding.

8. At inquest, the following witnesses provided oral testimony:

    - Sergeant Gavin White, who had a prior dealing with Mr Hassanloo;
    - Joshua Taylor-Dawson, Joshua Eastwood, Judy Scott and Peter Black, who witnessed Mr Hassanloo on the Tasman Bridge before his death;
    - Sergeant Damian Bidgood and Constable Benjamin Cunningham, search and rescue officers, regarding the search for Mr Hassanloo after he jumped from the Tasman Bridge;
    - Sergeant Leah Adams, attending and investigating officer;

- Dean Barker and Alison Dugan, employees of the Australian Red Cross;
- Dr Ian Sale, consultant psychiatrist, who independently reviewed Mr Hassanloo's psychiatric care;
- Dr Anil Reddy, psychiatrist, who treated Mr Hassanloo;
- Professor Leonard Lambeth, Clinical Director (Mental Health) at the Royal Hobart Hospital;
- Bradley Creevey, Director of Case and Incident Management Systems for the department;
- Ann-Clare Fitzgerald, Director of Status Resolution Support Services Program Management Section for the department; and
- Judy Lazaro, Community Liaison Officer for the department.

Arrival into Australia and time on mainland

9. Saeed Hassanloo was born in Tehran, Iran on 6 December 1988. He was Farsi Persian and his religion was Shia Muslim. He was the youngest of six children. Along with his brother, Majid, he travelled to Indonesia via Dubai. After spending three weeks in Indonesia, he boarded the boat 'Alina' and arrived at Christmas Island on or about 21 November 2010. As he did not hold a visa, he was an 'unlawful non-citizen.'[3] Accordingly, he was detained in custody under section 189(3) of the *Migration Act* 1958 (Cth) while applications were made for him to be considered as a refugee. He came to be in the care of the International Health and Medical Service (IHMS), a service provider contracted by the department to provide health and medical services to persons in immigration detention.

10. Shortly after his arrival, Mr Hassanloo completed an Entry Interview with the assistance of a Farsi interpreter.[4] When asked why he left Iran, he replied:[5]

[3] Section 14 of the *Migration Act 1958* (Cth).
[4] DHA.0001.0004.2239.
[5] DHA.0001.0004.2239, per 2248 at 2257.

> *I was just tired of ridiculous rules and conditions there. If I wanted a job you had to be a member of the Basij or family of a Martyr. When I was working as a courier (motorbike) I had problems getting stopped and accidents so I decided to get a car and work as a driver. I was getting stopped and picked on by the traffic police for example because of my helmet or insurance. So they would confiscate my motorbike for a few months. The majority of people in Tehran had these problems. This was part of the problem.*
>
> *I was also not able to go out. The majority of the young people could not drink and have a good time on the weekend. Why? Because after Ahmadi became president the country got run by Basij and Sepah and there are lots of check points. For example I could not just go out freely with my girlfriend. A few times we were stopped by the Basij who were going to take us to their base (because we were not married) but let us go. We have no safety or lifestyle in Iran. We were not happy. I was picked up all the time because of my clothes and music. The Basij just wanted us to dress like old people. In general I was just tired of all these issues and lack of freedom.*

11. When asked if he had any reasons for not wishing to return to Iran, he replied:[6]

> *Yes, there are ridiculous rules and picking up on people in Iran as explained about my clothes and car. We are just alive, but don't enjoy life at all. Lots of young people become drug addicts and in my view Iran is not a place for living. As I mentioned, there is no freedom in Iran. The majority of the people, especially young people, could not have a good life. For example, everything is forced on us, we cannot make a decision. We can't wear brand clothes or even drink alcohol.*

12. In early 2011, Mr Hassanloo participated in a Refugee Status Assessment interview. He said that he was easily identified as a "modern young person" and claimed to fear "that he would be identified as an anti-government supporter simply on the basis of his appearance and age, leading to harm or even death at the hands of security forces."[7]

13. This application was declined. He made further applications but they appear to have been declined on a number of grounds, including that he may have embellished his claims after his initial application was declined. He claimed that he and his brother, Majid, had suffered significant harm in Iran and would continue to do so if returned. He said he had suffered psychological harm as a result of encounters with the Basij (a

[6] DHA.0001.0004.2239 at 2256.
[7] DHA.0001.0004.2209 at 2217.

paramilitary volunteer militia) and had been beaten on a number of occasions. He also stated that he suffered psychological issues which lead to his hospitalisation on more than one occasion.

14. In this finding, I am not required to, and am not able to, determine the veracity of Mr Hassanloo's stated claims concerning his life in Iran and reasons for travelling to Australia to seek asylum. However, it is clear that from the outset, that he was a particularly troubled young man with significant mental health difficulties.

15. On 22 February 2011, Mr Hassanloo's asylum claims were rejected.

16. On 9 September 2011, he was transferred to Melbourne Immigration Transit Accommodation.

17. On or about 4 November 2011, Mr Hassanloo was admitted to the Northern Hospital, Victoria, after swallowing between 50 and 60 tablets. He threatened self-harm unless he was placed in community detention. He was diagnosed with anxiety and depression with agitation and sleep disturbance.

18. It appears he was then re-admitted to Northern Hospital from 10 to 24 November 2011 and entered a voluntary starvation protest, refusing to eat and drink. He spoke of cutting himself unless placed in community detention. He was subsequently diagnosed with major depressive disorder.

19. On 9 January 2012, the Minister made a determination that Mr Hassanloo be placed in community detention in Melbourne pursuant to a residence determination. Such determination enabled Mr Hassanloo to live in the community with the stipulation that he resided at the specified address.[8] It appears that this determination arose due to the efforts of IHMS in seeking a less restrictive detainment due to mental health concerns.

20. On 18 July 2012, he was found not to be a refugee under the Independent Merits Review process.

21. On or about 26 August 2012, he was accused of sexually assaulting an intellectually disabled female at a train station in Footscray.

[8] Transcript p 28, lines 37-44.

22. In October 2012, an organisation assisting him reported an incident alleging that Mr Hassanloo had stalked and attempted to "chat up" his case worker.

23. Victoria Police concluded that there was insufficient evidence to lay criminal charges in respect to allegations of criminal offending by Mr Hassanloo.

24. On 1 November 2012, Mr Hassanloo's community detention was revoked by the Minister and he and Majid were transferred to the Maribyrnong Immigration Detention Centre. On 4 November 2012 he again attempted self-harm and/or suicide. Mr Hassanloo made a claim during his time in the Maribyrnong Immigration Detention Centre that he was sexually assaulted and was hospitalised on 5 January 2013.

25. On or about 16 January 2013, he and Majid were again transferred to the Melbourne Immigration Transit Accommodation (MITA).

26. On 24 July 2013, Mr Hassanloo and his brother were transferred to Villawood Immigration Detention Facility in Sydney after a meeting between departmental officers, IHMS and Serco (a company assisting the department in the management of detention centres), had concluded that they were unable to be appropriately managed in a low security setting such as MITA following various incidents there including 'repeated intimidation of female clients in the family compound' and a recent assault. The consensus view was that the continued presence of the brothers at MITA posed 'a significant risk' to other clients and, in particular, single adult females.

27. On 11 April 2014, Mr Hassanloo and his brother were transferred to the Northern Immigration Detention Centre in Darwin. Shortly thereafter, there was an alleged threat made against another person by Mr Hassanloo which was referred to Australian Federal Police. However, the alleged victim did not wish to pursue the complaint.

28. On 5 May 2014, he was transferred to Curtin Immigration Detention Centre in the far north of Western Australia. Mr Hassanloo then requested that he be separated from his brother.

29. On or about 26 August 2014, he was transferred to Yongah Hill Immigration Detention Centre in Perth.

30. On 2 and 3 March 2015, Mr Hassanloo was engaged in rooftop demonstrations and then threatened self-harm to IHMS staff.

31. On 10 March 2015, he was transferred to the Royal Perth Hospital (RPH) under the provisions of the *Mental Health Act,* having been diagnosed with acute renal failure due to five days voluntary starvation and major depressive disorder.

32. Between April and May 2015, Mr Hassanloo underwent 40 days of self-imposed starvation in apparent protest of his treatment in Australian detention. This episode attracted global protests and led to a vigil outside the RPH. At this point in the narrative, I observe that this inquest did not extend to any detailed consideration of Mr Hassanloo's treatment in Australian detention. However, the evidence in this investigation did not suggest irregularities in processes.

33. On 5 May 2015, Mr Hassanloo was made the subject of a mental health order, having been diagnosed as severely depressed and suffering an anxiety disorder.

34. On 13 May 2015, he was re-admitted to the RPH from Redcliffe Detention Centre suffering renal failure following his self-imposed starvation. He stated if he was not granted a visa, he was prepared to die. It appears he was close to death and a chaplain had attended at the hospital.

35. On 21 May 2015, the Minister for Immigration and Border Protection intervened to make a residence determination that Mr Hassanloo was permitted to reside in community detention at an address in Victoria Park, Western Australia.[9]

36. On 22 May 2015, Mr Hassanloo received a positive International Treaties Obligation Assessment (ITOA) based upon a new and different asylum claim recently advanced on his behalf by his migration agent, Associate Professor Mary Anne Kenny. The essence of this new claim was that Mr Hassanloo had converted to Christianity whilst in immigration detention and that his asylum claim (including his claimed conversion to Christianity) had been published in Iran in the context of his recent episode of voluntary starvation.[10]

37. The positive ITOA meant that Mr Hassanloo would not have been removed to Iran, even if that were practicable.[11]This was explained to him in a letter sent to him on 29 May via A/Prof Kenny. I accept the submission of counsel for the department that Mr Hassanloo would have been well aware of the effect of the positive ITOA - a very

[9] Exhibit C40.
[10]Exhibit C31.
[11] Transcript, p 287 (evidence of Ann-Clare Fitzgerald).

significant and positive development for him.[12] At this time, Mr Hassanloo remained in community detention and began to receive services under the Status Resolution Support Services (SRSS) program. This program is administered by the department to provide support to individuals seeking to engage Australia's protection obligations while they are in the process of resolving their immigration status in Australia.[13] As explained in the relevant Operational Procedures Manual, the services available to an individual depend on which 'band' of SRSS services they are receiving. [14] The following is a summary of the categories of SRSS services;

a) Individuals in community detention receive band 3 services.

b) Individuals such as Mr Hassanloo who have been granted a visa and are transitioning from detention into the community receive band 4 services for a limited period of time.

c) A higher level of support is available to vulnerable individuals living in the community through band 5 services.

d) Individuals who are living in the community with lower needs may receive band 6 services.

38. SRSS services are delivered by service providers under contract. Mr Hassanloo's SRSS service provider in community detention was the Australian Red Cross ("Red Cross") in Western Australia.

39. On or about 21 December 2015, Mr Hassanloo expressed the wish to move to Tasmania.[15]

40. On 22 December 2015, the Minister granted him a Bridging Visa which operated for a period of six months. It enabled him to live lawfully in the community, work and register with Medicare.[16] As he was no longer in community detention, he was moved into band 4 SRSS support.

[12] The letter is amongst the documents tendered through Ann-Clare Fitzgerald as Exhibit C40D.
[13] Transcript, p. 293 (evidence of Ann-Clare Fitzgerald).
[14] Exhibit C25C, 40B, pp 224-26. See also Transcript, pp 293-94 (evidence of Ann-Clare Fitzgerald, the Director of the SRSS program).
[15] Exhibit C37, par 21.
[16] Exhibit C37, par 22.

41. In her evidence at inquest, Ms Fitzgerald, Director of SRSS, explained that *"A bridging visa enables a person to live lawfully in the Australian community while they are seeking to resolve their immigration status, so through the grant of a substantive visa or through departure from Australia."*[17] She further explained that whilst on a bridging visa, a person is able to move freely and lawfully within Australia.[18]Thus, under a bridging visa, the department could not have prevented Mr Hassanloo relocating to Tasmania as he wished, although he would be obliged to report his change of address or other conditions required by the visa. [19]

42. On 23 December 2015, Mr Hassanloo signed a letter requesting a move to Tasmania.[20] It appears that he may have requested relocation in order to distance himself from his brother. The other reasons are not clear, except that it was his choice. He had no known connections in Tasmania. The department facilitated his request by agreeing to transfer his SRSS services to Red Cross (Tasmania) at band 4.

43. Red Cross (Western Australia) updated Mr Hassanloo's SRSS plan before moving to Tasmania. His history of resistance to complying with essential regulations and the fact that he had not yet registered for Medicare were noted, as was his refusal to see a psychiatrist or attend a general practitioner. It was also noted that he was involved in a personal dispute with his brother and did not wish to engage with him.[21]

44. Moreover, Ms Lazaro, Community Liaison Officer for the department responsible for case-managing Mr Hassanloo, undertook a comprehensive review of departmental records before Mr Hassanloo relocated to Hobart. She particularly noted his history of mental health issues and non-engagement with medical and mental health services.[22]

Time in Tasmania

Arrival in Tasmania

45. On 5 January 2016 Mr Hassanloo arrived in Hobart.[23] Temporary accommodation was provided at a backpacker's hostel in the city. Ms Alison Dugan, Mr Hassanloo's allocated Red Cross case worker, described how he wanted to make new start, find a

[17] Transcript, p 288, lines 20-24.
[18] Transcript, p 288, lines 29-35.
[19] Transcript, p 303, lines 29-34.
[20] Exhibit C37, par 25.
[21] Exhibit C37, par 28.
[22] Exhibit C37, par 32.
[23] Exhibit C37, par 37.

job and earn money. She said he undertook fruit picking work until around 18 January 2016 (when the season ended) and then became disillusioned with the process of finding work. She described him as having retreated into himself but remained focussed on obtaining a visa.

46. On 26 February, Mr Hassanloo moved into his own residence, a unit at Queens Walk, New Town. Although he did not obtain work, he acquired his learner driver's licence, participated in a motorcycle course, attended training for a "White Card"[24] and organised his Centrelink payments and Medicare. However, as time went by, Ms Dugan was concerned about his paranoia, social isolation and resistance to mental health and general practitioner support. It seems that she was particularly concerned at the impact of A/Prof Kenny being unable to continue as his agent, as notified to him in June 2016.

47. Ms Dugan was also concerned that Mr Hassanloo had become inappropriately attached to her.[25] In regards to this point, I find that her concerns were well-founded, although Red Cross managed the situation well by implementing protective measures, including ensuring that Ms Dugan had the support of a fellow staff member in her meetings with Mr Hassanloo. There can be no valid criticism of Ms Dugan or Red Cross in this respect.

48. On 26 April 2016, Mr Hassanloo was invited to apply for a temporary protection visa following a decision by the Minister acting under s 46A(2) of the *Migration Act*. Ms Lazaro hand-delivered the letter to him on 28 April 2016 at their scheduled case management appointment.[26] Again, this was a most positive development for Mr Hassanloo.[27] Ms Fitzgerald confirmed this was the next major step following after his positive ITOA assessment.[28]

49. When it became apparent that A/Prof Kenny would no longer be representing him, Mr Hassanloo was offered assistance through the 'PAIS' program, whereby the department would fund a registered migration agent to assist him to prepare his application.[29] Unfortunately, Mr Hassanloo declined to participate and refused to

[24] Induction training for work in the construction industry.
[25] Exhibit C24, pp 2-3.
[26] Exhibit C37, par 60.
[27] Transcript p 158 (evidence of Ms Dugan).
[28] Transcript, p290, lines 1-2
[29] Statement of Ms Lazaro, par 67.

progress his visa application without the assistance of A/Prof Kenny.[30] This remained the case until Mr Hassanloo's death. In an exchange of emails on 8 August,[31] Mr Dean Barker of Red Cross wrote to Ms Lazaro:[32]

> *"…as you know he can have PAIS support but refuses to sign the paperwork to accept PAIS – we believe that losing Maryanne as one of a very limited support team has really rattled him.*
>
> *I've let Tas Police know that it is likely that he is still in his unit and simply refusing to respond to door knocking etc. We were supposed to get an agreement from him on behalf of Housing Choices (the property managers) around allowing access to tradespeople when required and answering calls from and allowing regular access to the property manager. We haven't been able to have this discussion with Mr Hassanloo and certainly haven't been able to garner any sort of agreement with him about anything since the initial incident where police executed forced entry.*
>
> *I'm not sure where all this leaves his band 5 participation – until advised otherwise will continue to try to make contact with him and will keep you updated."*

50. In her reply, Ms Lazaro continued to explore options aimed at encouraging Mr Hassanloo to engage with the process. She also emphasised *"that the application process is generally not complex in cases where a person has already been found to engage Australia's protection obligations."*[33] The emails exemplify both the dedication and perseverance of his support personnel and the persistent refusal of Mr Hassanloo to utilise most avenues of assistance to help himself.

51. Between May and June 2016, Ms Lazaro sighted Mr Hassanloo in the community on two occasions. She said he appeared well dressed, carrying what appeared to be a shopping bag and walking alone. Her second sighting was the last time she saw him.[34]

52. Ms Lazaro said that in June 2016 she conducted a case review and completed a report in relation to Mr Hassanloo. She outlined his continued non-engagement with medical and mental health services and explained that she had made available the

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[30] Statement of Ms Lazaro, par 69-70.
[31] See statement of Ms Lazaro, par 90.
[32] Exhibit JAL-1 to the statement of Judy Lazaro dated 26 February 2020, tab 14, p 270. See also Transcript, p 230 (evidence of Dr Sale).
[33] Exhibit JAL-1 to the statement of Judy Lazaro dated 26 February 2020, tab 14, p 270.
[34] Exhibit C37, par 66.

higher level band 5 services for him for a further period of three months. She noted that Ms Dugan's Monthly Case Review had identified no critical issues.[35]

53. On 24 June 2016 and 29 June 2016, Mr Hassanloo refused to attend appointments with Ms Lazaro.[36] Ms Dugan told Ms Lazaro on about 30 June 2016 that Mr Hassanloo was still refusing to engage with mental health services.[37] Ms Lazaro put in place a plan to him engage.

54. It should be noted that on 5 July 2016 Ms Dugan went on leave and another support worker was allocated to Mr Hassanloo. It is noted that, before her leave, Mr Hassanloo stated to Ms Dugan he was down and depressed. She offered him medical services but the offer was declined.[38] It is clear from the affidavit of Mr Barker that Red Cross experienced great difficulties attempting to make contact with Mr Hassanloo and two welfare check notifications were made to Tasmania Police.[39]

55. Ms Dugan returned to work on 14 July 2016.[40]

First incident at Queens Walk – 15 July 2016

56. On 15 July 2016, Ms Dugan emailed Ms Lazaro stating she was concerned for Mr Hassanloo's welfare as he was not answering his phone.[41] Mr Hassanloo's landlord had wanted to enter his unit in order to fix his door buzzer and hot water cylinder. This upset Mr Hassanloo and he would not permit entry. Red Cross asked Tasmania Police to conduct a welfare check.[42]

57. Tasmania Police officers arrived at Mr Hassanloo's unit at 3.15pm in response to welfare concerns raised by Ms Dugan. Attempts were made throughout the incident to try and negotiate with Mr Hassanloo with a view to him allowing the officers inside the property. He had barricaded himself inside his unit by using a fridge and key chain across the front door. A master key was obtained and access was gained to the unit through the back door, although it appears there had been an attempt to barricade

[35] Exhibit C37, par 68.
[36] Exhibit C37, par 70.
[37] Exhibit C37, par 72.
[38] Exhibit C24, p 3.
[39] Exhibit C23, p 1.
[40] Exhibit C24, p 3.
[41] Exhibit C37, par 73.
[42] Exhibit C24, p 4.

that door as well. When police entered the unit they found that Mr Hassanloo was in the bathroom. He was holding the door handle to prevent police access and said he wanted to be left alone. The officers were unable to sight Mr Hassanloo. Due to concerns that he may engage in self-harm, police used a door ram to gain entry to the bathroom. In the circumstances, the officers chose to deploy capsicum spray around the door area. Mr Hassanloo did not receive any of the spray directly and therefore no after-care was required.

58. Sergeant Gavin White, one of the officers at the incident, was clear in his evidence that Mr Hassanloo understood what police were saying to him and he could gauge this by how Mr Hassanloo reacted to comments. He described his English as being "manageable." Ms Dugan also attended the incident. She said that Mr Hassanloo stated *"go away and leave me alone"* and *"do you really want me to hurt myself."*[43] It was clear that significant mental health concerns existed at that time. I comment that the actions of Tasmania Police were entirely reasonable in managing this difficult incident. No other options were available to them given his imminent risk of self-harm.

First hospital admission 15- 22 July 2016

59. Mr Hassanloo was immediately conveyed by police to the Emergency Department of the RHH, arriving at 4.36pm. He was admitted as a patient for 7 days before being discharged on 22 July 2016.[44]

60. A doctor in the Emergency Department, Dr Yogendra Tikare, saw him initially and believed he was suffering a situational crisis and awaited a psychiatric emergency nurse (PEN) to assess him. Registered Nurse (RN) Cooper conducted such an assessment at 6.45pm and considered that Mr Hassanloo required further assessment and admission. He was admitted to the Department of Psychiatric Medicine (DPM) in the RHH at 10.10pm,[45] and Ms Dugan said that Mr Hassanloo did so voluntarily.[46]

61. The following day, 16 July 2016, Mr Hassanloo saw consultant psychiatrist, Dr Anil Reddy. Dr Reddy is a senior specialised psychiatrist with over 20 years of experience in the field of psychiatry.[47] As Mr Hassanloo's principal treating psychiatrist, he

[43] Exhibit C24, p 4.
[44] Exhibit C28, p 14.
[45] Exhibit C28, pp 19-22.
[46] Exhibit C24, p 4.
[47] Exhibit C38; Transcript, pp 247-274.

provided a detailed and helpful affidavit for the inquest and gave oral testimony. He said that his impression was that Mr Hassanloo may have been suffering from psychotic and depressive ideas. He also thought it possible that Mr Hassanloo was suffering from post-traumatic stress disorder (PTSD). It is important to note that Dr Reddy did not diagnose him with a personality disorder at this time or at any point during his treatment of Mr Hassanloo.[48]

62. An assessment order under section 25 of the *Mental Health Act* 2013 was made by Dr K Sivasankaran at 12.15pm.[49] Dr Reddy agreed with the conclusions about the need for Urgent Circumstances Treatment (UCT) noting he was satisfied that a reasonable attempt to have Mr Hassanloo assessed with informed consent had failed, and noting that he was a self-harm risk and an asylum seeker on a Bridging Visa.[50]

63. The criteria for an assessment order under section 25 of the *Mental Health Act* are satisfied where:

> *(a) the person has, or appears to have, a mental illness that requires or is likely to require treatment for –*
>
> *(i) the person's health or safety; or*
>
> *(ii) the safety of other persons; and*
>
> *(b) the person cannot be properly assessed with regard to the mental illness or the making of a treatment order except under the authority of the assessment order; and*
>
> *(c) the person does not have decision-making capacity.*

64. Section 7 defines decision making capacity as follows:

> *For the purposes of this Act, an adult is taken to have the capacity to make a decision about his or her own assessment or treatment (decision-making capacity) unless a person or body considering that capacity under this Act is satisfied that –*

[48]Exhibit C38, par 29.
[49] Exhibit C28, p 122.
[50] Exhibit C38, par 39.

(a) he or she is unable to make the decision because of an impairment of, or disturbance in, the functioning of the mind or brain; and

(b) he or she is unable to –

(i) understand information relevant to the decision; or

(ii) retain information relevant to the decision; or

(iii) use or weigh information relevant to the decision; or

(iv) communicate the decision (whether by speech, gesture or other means).

(2) …[omitted as it relates to children].

(3) For the purposes of this section –

(a) an adult or child may be taken to understand information relevant to a decision if it reasonably appears that he or she is able to understand an explanation of the nature and consequences of the decision given in a way that is appropriate to his or her circumstances (whether by words, signs or other means); and

(b) an adult or child may be taken to be able to retain information relevant to a decision even if he or she may only be able to retain the information briefly.

(4) In this section –

information relevant to a decision includes information on the consequences of –

(a) making the decision one way or the other; and

(b) deferring the making of the decision; and

(c) failing to make the decision.

65. On 17 July 2016 the assessment order was extended for 72 hours until 20 July 2016.[51] Dr Reddy confirmed he was satisfied that Mr Hassanloo met the assessment criteria

[51] Exhibit C28, p 123.

and, in particular, that he appeared to have a mental illness that required or was likely to require treatment for his own health and safety or the safety of other persons.[52]

66. Early on 18 July, Mr Hassanloo refused to participate in an interview which necessitated the hospital asking Ms Dugan if she could assist. He expressed a desire to go home but he was not willing to give access to his house. He then changed his mind and wanted to stay in hospital. Dr Reddy notes that he did appear a little more accepting that being in hospital was a good idea and Dr Reddy believed that he had the capacity to make the decision to stay in hospital. He formed the impression that Mr Hassanloo had PTSD and visa-related situational stress. Dr Reddy held a meeting with a psychologist, an occupational therapist, and Ms Dugan. He then proceeded to discharge the assessment order as he was of the view that Mr Hassanloo had capacity and that he would stay in hospital and seek help.[53]

67. On 20 July, the multi-disciplinary team met to discuss Mr Hassanloo's case. There was discussion regarding the best way to proceed as he was not engaging with treatment recommendations.[54] He was seen by clinical psychologist, Dr Philippa Cannan, upon referral by Dr Reddy. While Mr Hassanloo was apparently adamant in wanting to remain in hospital, he was reluctant to answer questions, disclose symptoms and was generally uncooperative. Hospital staff described him as hiding under the covers and refusing eye contact.[55] A plan was developed about how Mr Hassanloo's hospital admission would be managed. Dr Reddy said that if Mr Hassanloo cooperated with Ms Dugan and explained why he wanted to remain in hospital, he could stay; otherwise, he would need to be discharged. Mr Hassanloo was aware of the plan.[56] That evening he was still refusing to cooperate, returned his food to the nursing station and refused evening medications.[57]

68. On 21 July, Mr Hassanloo's conduct of refusing to cooperate continued. He refused routine observations and was considered by hospital staff to be displaying passive aggressive behaviour. However, he refused to leave. [58] He denied suicidal thoughts and depression. Hospital staff could have properly discharged Mr Hassanloo at this point. However, it appears that he was given a further chance because of possible

[52] Exhibit C38, par 52.
[53] Exhibit C38, pars 59-62.
[54] Exhibit C38, par 76.
[55] Exhibit C38, par 81.
[56] Exhibit C38, par 82.
[57] Exhibit C38, pars 83-84.
[58] Exhibit C38, par 87.

accommodation issues post-discharge, with discharge due to occur the following day.[59] Ms Dugan visited him again that evening and he refused his evening meal.

69. On 22 July, being the seventh and final day of his admission, he was refusing to engage with hospital staff, to eat his meals and was described as being *"selectively mute."* He declined to attend a meeting.[60] Dr Reddy stated that given there was no observed evidence of Mr Hassanloo having acute symptoms of mental illness and given that he was a voluntary patient on the unit, there was an expectation that he would engage in some form of treatment.[61] I agree with the submission of counsel assisting that the evidence of Mr Hassanloo's inpatient admission indicated a general refusal to engage and it is difficult to see what more Dr Reddy could have done to treat Mr Hassanloo's poor mental health. The hospital file reveals no significant evidence of paranoia or thought disorder. There was no evidence of psychosis or suicidal thoughts. Mr Hassanloo's defiant and oppositional attitude generally was exemplified by his statement to hospital staff, *"You guys forced me here initially and I will refuse to leave the hospital at present because I am so comfortable here."*[62]

70. On 22 July 2016, Mr Hassanloo agreed to leave the hospital and did so accompanied by Ms Dugan and Mr Barker. They all returned to the offices of Red Cross but when Ms Dugan was inside, Mr Hassanloo left the area. He later sent her a text message stating he would meet and look at accommodation options. She transported him to his unit at Queen's Walk. He then did not wish to stay there but agreed to go to a hostel. Upon arrival at the hostel, he then declined to stay there and left without taking his wallet or belongings.[63]

71. Mr Hassanloo spent the next week living on the streets and refused to look at his proposed accommodation.[64] Ms Dugan met with him on 29 July 2016 after Mr Hassanloo had contacted her asking for his keys. She met with him at 4.30pm and returned his keys and wallet. That evening Ms Dugan received a message from Mr Hassanloo asking if he could come to her place. She replied that it was not possible.[65] It goes without saying that her response was entirely appropriate.

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[59] Exhibit C38, par 88.
[60] Exhibit C38, par 102.
[61] Exhibit C38, par 104.
[62] Exhibit C38, par 116.
[63] Exhibit C24, pp 4-5.
[64] Exhibit C24, p 5.
[65] Exhibit C24, p 5.

72. Over the next three weeks Mr Hassanloo was uncontactable by Red Cross. Red Cross made contact with Tasmania Police and Mental Health Services during this time, although the assumption was that Mr Hassanloo was deliberately avoiding contact with support services.[66]

Second incident at Queens Walk – 24 August 2016

73. On 24 August 2016, a police welfare check on Mr Hassanloo was requested by the Red Cross Program Manager (in conjunction with the local Red Cross team, Housing Choices, and Mental Health Services).[67] Police officers attended Mr Hassanloo's unit on 24 August pursuant to the request.

74. Police officers arrived at Mr Hassanloo's unit at 10.10am that morning and observed a collection of notes and letters untouched around the front door area. A fridge had been used to block the front door and a couch and dinning were blocking the rear door. The officers attempted to rouse Mr Hassanloo without reply. Concerned for Mr Hassanloo's welfare, the officers gained entry to the unit by breaking down the back door. They observed band aids placed on blinds and saw Mr Hassanloo sitting on his bed. It was clear that significant mental health concerns existed at that time. He was generally silent but unco-operative in terms of going to hospital. On observation by police, Mr Hassanloo appeared to be extremely depressed and he stated he had not been eating. After unsuccessful attempts to engage Mr Hassanloo further, and after having spoken with the mental health team, the police officers determined that hospitalisation and a mental health assessment was necessary due to concerns for his health and apparent refusal to eat.[68] They then conveyed him to the RHH. Again, the actions of the police officers were appropriate in managing this incident.

Second hospital admission

75. At 11.23am on 24 August 2016, Mr Hassanloo arrived at the RHH. He refused observations and a chest examination. He did not appear to be distressed or agitated.[69]

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[66] Exhibit C24, p 5.
[67] Exhibit C24, p 5.
[68] Exhibit 8, p 3.
[69] Exhibit C28, pp 4-11.

76. At 2.58am Dr Gayathiri Pathmanathan, junior psychiatric registrar, noted that Mr Hassanloo did not respond to any questions whatsoever and later refused the PEN's attempt to obtain vital signs. The PEN had been unable to assess his capacity due to his *"elective mutism."* After discussion with Dr Reddy, Dr Pathmanathan recorded that he was *"not for admission to the Department of Psychiatric Medicine. The problem at hand here is not related to mental health (likely a strong personality component at play here – refusal to cooperate with medical/nursing staff precludes any benefit to be gleaned from an admission)."*

77. However, based upon advice from Dr Reddy, the following was later recorded:

> *Plan: (1) reasonable to apply for new assessment order.*
>
> *(2) Will aim for admission no longer than 48 hours. Must set reasonable, realistic goals for care plan post-discharge."*[70]

78. In formulating the plan for admission, Dr Reddy had clearly given great weight to representations made by Ms Dugan to have him remain in hospital.[71]

79. At 3.30pm an assessment order was made by Dr Pathmanathan who determined that he lacked decision-making capacity on the basis that such was unable to be assessed due to his mutism.[72] He was then admitted to the DPM at 8.50pm. [73]

80. The following day, 25 August 2016, there were further difficulties with Mr Hassanloo refusing to allow vital observations and to be interviewed by Dr Reddy, Dr Ed Elcock, a psychiatric registrar, and RN Salt. He said he wanted to go and did not want anyone to touch him.[74]

81. At about 10.30am, Dr Reddy spoke with Mr Hassanloo and told him that he would shortly be reviewed by the Clinical Director. He advised him of treating team's intention to either discharge him if it was deemed that he did not have a mental illness or, alternatively, if his behaviour was assessed being driven by mental illness, assertive management would be required, possibly involving intravenous intubation and electroconvulsive therapy (ECT).[75] In the medical notes, Dr Reddy wrote that Mr

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[70] C28, p 12.
[71] C28, p 10.
[72] Exhibit C28, p 70.
[73] Exhibit C28, p 53.
[74] Exhibit C28, pp 54, 47, 48 and 49; Exhibit C38, pars 153-154.
[75] Exhibit C28, p 48; Exhibit C38, par 157.

Hassanloo was *"patiently entreated to craft a lucid, informing response for Dr Lambeth's ears (David seemed slightly alarmed that assertive treatment may be an option)."*[76]

82. Dr Reddy's evidence was that at this time, he was seriously contemplating the possibility of imposing a new assessment order with a view to a treatment order in due course, and instigating treatment for depression, including medication and ECT.[77] He said it was a very significant step to take and he wished to have a second opinion.

83. At 11.45am Mr Hassanloo met with Professor Leonard Lambeth, Clinical Director, as Dr Reddy had requested a second opinion regarding capacity, diagnosis, and treatment. Mr Hassanloo told Professor Lambeth that he was not unwell, not sad, and had no physical problems. He said that he had no friends and did not want friends. He declined blood tests and said that he just wished to leave.[78] The notes indicate that no clear mental illness was seen, that there was no overt psychosis and that Mr Hassanloo denied depression and thoughts of harm to himself and others.[79]

84. Dr Reddy and Professor Lambeth then discussed their observations and interactions with Mr Hassanloo and reached the conclusion that the use of physical restraints, intravenous access, potential ECT and significant medication might re-traumatise Mr Hassanloo. They considered, therefore, that the risk outweighed the potential benefits of intervention. They agreed that Mr Hassanloo may well be depressed. As such, the plan was for continued management, motivational interviews in respect to blood tests and to try and ascertain an accommodation location for him.[80]

85. Importantly, Professor Lambeth and Dr Reddy were of the opinion that Mr Hassanloo *did* possess decision-making capacity regarding his medical treatment.[81] As such, he was entitled to refuse any suggested treatment.

86. Later that afternoon there was continued refusal by Mr Hassanloo to engage and refusal to request assistance or treatment. The assessment order, which had been

[76] Exhibit C28, p 48.
[77] A longer term order under Division 2 of the *Mental Health Act* mandating treatment.
[78] Exhibit C28, p 49.
[79] Exhibit C28, p 50.
[80] Exhibit C28, p 50; Exhibit C38, pars 163-165.
[81] Exhibit C43, par 4.

made, was discharged at 3.15pm.[82] That night, Mr Hassanloo was noted to sit in his room with the light off, refused to communicate and told people to go away.[83]

87. On 26 August 2016, the third and final day of his admission, there was a continued refusal by Mr Hassanloo to engage, to answer questions relating to his psychopathology and to explain why he would not sign the lease form for his unit. [84] Efforts by staff were focussed upon securing his accommodation, even if it was a short-term option. He was told by members of his treating team that if he refused to accept accommodation options presented, he would be escorted from the hospital by police or security staff.[85] However, the primary objective of the treating team was to discharge him only *after* accommodation had been found.[86]

88. Dr Reddy denied there were any bed shortage pressures which may have necessitated the need for discharge.[87] He also denied any staffing pressures. I fully accept his evidence and find that such issues played no part whatsoever in the treatment and care of Mr Hassanloo at any time.

89. A nursing note at 3.00pm states he had been eating and drinking but did not wish to engage. He was, however, able to make his needs known and requested Panadol, which was given to him.[88]

90. At 4.00pm a meeting at the hospital took place between Dr Pathmanathan, David Magor-Hemple (a social worker), Ms Dugan and Mr Barker.[89] There were comprehensive notes made of the discussion, which centred around Mr Hassanloo's situation, attempts at treatment options and attempting to find a way forward for him. The meeting notes convey the real difficulties encountered by the treating team in effective treatment options in light of his refusal to engage.

91. In the meeting, Ms Dugan expressed grave concerns for Mr Hassanloo's safety and mental health if he was not kept in hospital on an involuntary basis. She was advised that, as he possessed decision-making capacity, an order could not be lawfully made. She also expressed concerns about him being discharged without accommodation. Dr

[82] Exhibit C28, p 74.
[83] Exhibit C28, p 56.
[84] Exhibit C28, pp 187-190.
[85] Exhibit C38, par 189.
[86] Exhibit C38, par 189.
[87] Transcript, p 252, lines 10-11.
[88] Exhibit C28, p 57.
[89] Exhibit C28 pp 57-58.

Pathmanathan communicated (and recorded in the notes) that the two goals for Mr Hassanloo remained as firstly, ensuring that he was not medically compromised and secondly, sourcing accommodation for him.

92. Upon leaving the hospital that afternoon, Ms Dugan and Mr Barker attempted to locate Mr Hassanloo's phone which they eventually located at the hospital's security desk. She made a decision to return to her office to charge the phone and to return it to Mr Hassanloo in hospital later in the day.[90]

93. At about 4.30pm RN Salt was informed by the Resident Medical Officer that Mr Hassanloo had approached her at the nursing station, stating that he wanted to leave the hospital and that he wanted to be taken to backpacker's accommodation.[91]

94. RN Salt then telephoned Ms Dugan. Ms Dugan said she would confirm whether Red Cross could fund backpacker's accommodation and would call RN Salt back. Shortly thereafter, Ms Dugan called back and said that there was no funding, that something would try to be done and that she would come to the ward and see Mr Hassanloo.[92]

95. Just after the time of this conversation, Mr Hassanloo approached the nursing station again and said that he wanted to leave *"now."* RN Salt advised him that Ms Dugan was on her way and when asked if he wanted to wait for her, he said *"No, I want to leave now."* RN Salt then walked Mr Hassanloo off the ward at 4.40pm in accordance with his wishes. [93]

96. RN Salt then attempted to phone Ms Dugan who did not answer, so she left a message letting her know that Mr Hassanloo had left the ward.[94]

97. RN Salt noted that Ms Dugan arrived on the ward at 4.50pm. She explained to Ms Dugan what had occurred. Ms Dugan left shortly afterwards, taking the two backpacks Mr Hassanloo had left behind.[95]

98. Ms Dugan then commenced searching for Mr Hassanloo. She drove around the city trying to find him without success. Later that night, at about 7.30pm, she drove past

[90] Exhibit C24, p 7.
[91] Exhibit C28, p 60.
[92] Exhibit C28, p 60.
[93] Exhibit C28, p 60.
[94] Exhibit C28, p 60.
[95] Exhibit C28, p 60.

the Red Cross Office again to see if he was outside the building.[96] She could not find him.

99. After Mr Hassanloo discharged himself from hospital there is no evidence of his movements at all until about 12.30pm the following day, 27 August 2016.

Immediate circumstances surrounding death

100. At 12.30pm on 27 August 2016, Joshua Taylor-Dawson was driving his car across the Tasman Bridge towards the Eastern Shore.[97] He described seeing a male person walking on the southern side of the bridge towards the Eastern Shore who began to climb the bridge railing. Mr Taylor- Dawson said *"he got to the top of the railing and just jumped."* He described the male as being around 30-40 years old, wearing all grey clothing and having dark facial hair. He described stopping his car and crossing the bridge. He was able to observe the male person *"come to the top of the water, struggle for a bit and then go back under."* At that point he was talking to ambulance officers (who had stopped behind his car) to tell them that the man had disappeared again.[98] Mr Taylor-Dawson continued to observe the water, but did not see the man re-appear. Mr Taylor-Dawson was the last person to see Mr Hassanloo alive.

101. Sergeant Leah Adams, investigating officer present at the scene, collected details from Mr Taylor-Dawson. On 14 September 2016, Mr Taylor-Dawson was shown a photograph of Mr Hassanloo and identified him with certainty as the person he observed on the bridge.

102. Joshua Eastwood also gave evidence of witnessing a male person jump from the bridge.[99] He stated *"As I drove up over the bridge I saw a male standing on the outside of the rail on the southern side of the bridge. He was on the outside of the bridge, holding on with his hands behind him, facing outwards. I only saw him at the last minute and then he let go and jumped from the bridge."*[100] Mr Eastwood described being about 20 metres away, stating in evidence that he could see him *"pretty directly, it was clear. There was no traffic in between me and the person."*[101] Mr Eastwood did not exit his vehicle. Mr Eastwood gave a similar description of the male person as that given by Mr Taylor-Dawson, and

[96] Exhibit C24, p 7.
[97] Exhibit C12; Transcript, pp 33-37.
[98] Exhibit C12, p 1.
[99] Exhibit C13; Transcript pp 39-42.
[100] Exhibit C13.
[101] Transcript, p 40, lines 2-3.

was later shown a photograph of Mr Hassanloo. He confirmed that the male person he saw on the bridge was the same as in the photograph.[102]

103. Peter Black gave evidence that he was driving over the bridge in a westerly direction in the second lane. [103] He did not see any person jump from the bridge but did witness a male person climbing up the outer high railing on the southern side of the bridge just off the apex on the western side. Mr Black was about 10-20 metres away at the time of witnessing this event. After he drove past he looked into his wing mirror and saw the male person standing fully upright on the high railing.[104] He said he believed the action of climbing and standing on the railing gave him the distinct impression that it was the person's intention to jump. He heard his wife say *"he's jumped."*[105] He provided a description of this male person in his affidavit. He was also shown a photo of Mr Hassanloo at inquest and he said the person in that photo matched his recollection of the male person he saw on the bridge railing.[106]

104. Mr Black's wife, Judy Scott, was the final witness to give evidence about what occurred on the bridge.[107] She described seeing a male person standing on the lower rails. When she next looked he was on top of the railing. She said he then stepped off the top rail, appearing very determined to take his own life.[108]

105. None of the four witnesses who gave evidence about the male person on the bridge identified anyone else as being present with him.

106. Sergeant Adams was the first police officer to arrive at the bridge following a number of calls made to police. She stopped the traffic on the bridge and asked Mr Taylor-Dawson and another potential witnesses to meet her on the other side of the bridge so that she could obtain details. She then requested other police units in the area to assist in locating the male person. The officers in those units searched foreshore areas on both the western and eastern side of the Derwent River. Sergeant Adams tasked a further police unit to contact the hospital to ascertain if anyone had recently been discharged matching the description of the male person. She obtained approval from

[102] Transcript, p 41, lines 1-9; C13.
[103] Exhibit C14; Transcript pp 42-46.
[104] Transcript, p 42, lines 38-39.
[105] Transcript, p 46, line 18.
[106] Transcript, p 46, line 8.
[107] Exhibit C15; Transcript, pp 48-52.
[108] Exhibit C15.

an Inspector to dispatch the helicopter for the search. Sergeant Adams also requested Radio Dispatch Services to contact marine police and the Port Authority.

107. Constable Benjamin Cunningham gave evidence about searching the river aboard the police vessel 'Dauntless.'[109] Constable Cunningham is experienced in search and rescue and is also a qualified police search controller. He arrived under the bridge at 12.50pm having been provided with information concerning the circumstances and location of the incident. He gave evidence at inquest concerning the capabilities of the vessel to conduct the search, calculating the optimal search area and conducting the search itself. He described visibility and weather conditions as being good. The search area, conducted in "sweeps," extended 1.2 nautical miles south of the bridge to a line across the river between Bellerive and Battery Point. A number of similar sweeps were conducted north of the bridge. He said at inquest that the vessel's depth sounder (which has some limited "photographic" capacity) could show a rough outline of the bottom of the river but would not detect an object the size of a body on the bottom.

108. Constable Cunningham also contacted TasPorts to ask if vessels on the water could keep a look out for a person in the water and, as a consequence, a number of other vessels also assisted in the search.

109. At 3.05pm that day, 'Dauntless' concluded its search with no result. Constable Cunningham said in evidence that if the male person had remained on the surface of the water after jumping from the bridge then he would have been located in the search.

110. Sergeant Damian Bidgood, a very experienced search and rescue officer, also gave evidence. He was on duty for the police rescue helicopter, which arrived at the bridge at 1.00pm to conduct an air search. The immediate area north and south of the bridge line was searched and subsequently the search was extended north to Self's Point and south to Howrah and Sandy Bay. He said that the search exceeded 90 minutes and was conducted at an altitude of 500 feet. He described conditions of good visibility. The air search was unsuccessful.

111. At 11.30am the following day, 28 August 2016, Mr Taylor-Dawson returned to the bridge with Sergeant Bidgood to identify the particular spot where he believed the

[109] Exhibit C21; Transcript, pp 53-61.

male person had jumped the previous day. He said he was 90 percent confident he had identified the correct position and was able to give detailed evidence as to how he had calculated that position. As a result, Sergeant Bidgood was confident that the correct location of the jump had been identified and that there would be a good chance of finding the deceased if he had gone directly to the bottom. Sergeant Bidgood then organised a dive team for the following day, it being difficult to assemble such a team quickly.

112. On 28 August Mr Hassanloo was reported missing by Mr Barker who had seen no evidence of him having returned to his Queens Walk unit. Mr Barker and Ms Dugan were unaware of the incident at the bridge the previous day.[110]

113. On 28 and 29 August, Constable Cunningham and another police officer conducted further searching aboard the 'Dauntless' in the shoreline area between Geilston Bay and Little Howrah Beach. The search was without result.

114. On 29 August 2016, Sergeant Bidgood attended the bridge in the Police Dive Platform accompanied by three police divers. Sergeant Bidgood himself has been a police diver for 29 years and gave evidence in respect to the dive. He has conducted about 10 dives in that particular area of the bridge and "a couple of hundred" in the centre span area which was much deeper with less visibility. In his evidence at inquest, Sergeant Bidgood described the methodology (including the use of a side-scan sonar system), used for the dive. I have no hesitation in accepting that the dive search for Mr Hassanloo was well-planned and thorough. Unfortunately, no body was located in the water within the dive radius.

115. On 28 and 29 August, Sergeant Adams made numerous enquiries regarding Mr Hassanloo. These initially included making contact with and receiving information from the Red Cross, confirming his hospital admission and discharge, and obtaining CCTV footage of him leaving hospital at 4.40pm on 26 August in clothing matching the description provided by witnesses.

116. Sergeant Adams also requested a triangulation of Mr Hassanloo's phone and checks of his bank records for any activity on his accounts. A search of his unit did not reveal any matter of interest. Sergeant Adams reviewed available footage from the bridge which revealed a male person walking on the southern side of the bridge and she

[110] Exhibit C22.

submitted a copy to forensics for enhancement. At that time, footage was not available for the location of the jump. Mr Barker advised Sergeant Adams that the male person in the footage from the hospital and bridge appeared to be Mr Hassanloo.

117. There is no evidence available to assist me with his movements between his leaving hospital in the late afternoon of 26 August and his entry onto the bridge the following day.

118. On 2 September 2016, Sergeant Adams received advice from the Commonwealth Bank that there had been no activity on Mr Hassanloo's bank accounts. She also ascertained that there had been no travel bookings made by or on behalf of Mr Hassanloo. She submitted Mr Hassanloo's toothbrush and Commonwealth Bank Card for DNA analysis.

119. Following the disappearance of Mr Hassanloo, Red Cross and Tasmania Police made contact with Mr Hassanloo's brother, Majid. On 15 September 2016, Majid travelled to Hobart from the mainland and met with police and a number of support persons who had been involved with his brother.[111]

120. There was no further indication from the many avenues of investigation at that time that Mr Hassanloo was alive. Similarly, in the years since his death there has been no information received in the investigation consistent with him being alive.

121. I have had regard to the high quality and consistent evidence from witnesses regarding the description of the male person and the incident generally. I have also taken into account the evidence of the search and rescue officers regarding this incident and their experience with similar incidents on the bridge, particularly in regards to the significant proportion of bodies that cannot be subsequently located due to factors such as currents and tides.

122. I find that the person who was seen to jump from the railing of the Tasman Bridge into the water of the River Derwent on 27 August 2016 was Saeed Hassanloo. I further find that Mr Hassanloo died of traumatic injuries and/or drowned as a consequence of the 20-25 metre fall from the bridge into the water shortly after impact. He was submerged after impact and not able to be located. I am satisfied that an extensive and methodical air and sea search conducted by experienced police

[111] Transcript, p 74, line 34; p 75, line 30.

officers took place. No more could reasonably have been done to try and find his body, which was likely carried quickly away with the tide and current.

Comments

a) The provision of information by the department to the Red Cross and Royal Hobart Hospital

Information held by the department

123. An issue arose at inquest as to whether the department should have provided more comprehensive or more timely information from its records both to Red Cross (Tasmania) and to the RHH to enable better informed treatment, care and support of Mr Hassanloo. This issue was raised in the investigation initially by the investigating officer and also Ms Dugan, and, subsequently, by Dr Sale in his independent report. It was unclear prior to inquest whether such concerns were valid or whether a greater degree of information sharing by the department may have resulted in any different outcome for Mr Hassanloo.

124. The evidence during the inquest and subsequent submissions by counsel for the department have considerably assisted in resolving these issues. The summary below regarding the setting of information-sharing relies significantly upon counsel's helpful submissions on this topic.

125. The department held personal information regarding Mr Hassanloo including, but not limited to, his medical records since arriving in Australia as a result of him having spent time in immigration detention. As noted earlier in this finding, the department provides health and medical services to persons in immigration detention through a contracted service provider, IHMS. This results in the accumulation of medical records whilst a person is held in detention or community detention. Upon being granted a visa (including a Bridging Visa), the person is released from detention and IHMS no longer provides health and medical services. Instead, the person is expected to register with Medicare (if eligible) and a general practitioner, as well as other services available to them as a member of the Australian community. In aid of this, IHMS provides a 'discharge summary' that outlines any health issues and relevant

information. The person is also able to request access to their IHMS medical records at any time to assist in their care or treatment.[112]

126. It was therefore always the case that Mr Hassanloo could have provided his consent to enable any treating doctors or support persons to have access to any particular information held by the department that they considered would be helpful in his care. It was, however, patently clear upon the evidence that at all material times Mr Hassanloo did not and would not provide such consent.

127. As submitted by counsel for the department, the absence of consent therefore gave rise to the need for the department to comply strictly with the provisions of the *Privacy Act 1988 (Cth).* I accept counsel's analysis of the relevant provisions of the Act as they pertain to this matter.[113] I further accept that Mr Hassanloo's consent for the release of his personal information by the department in May 2015 in the context of his placement into community detention was limited in its scope and did not permit the department to disclose his medical records to treating doctors without consent during future hospitalisations. I also accept that the relevant exceptions to the consent requirement provided by the *Privacy Act* did not apply to disclosure of Mr Hassanloo's personal information at any relevant stage. In this regard, I am satisfied for the reasons contained in this finding, that Mr Hassanloo had capacity to consent to release of his information if he wished to do so. No issue was taken by any other interested party regarding the submissions of counsel for the department concerning applicable privacy principles.

128. I note that Ms Lazaro was a significant point of contact regarding provision of information when Mr Hassanloo arrived in Tasmania. She became his departmental case manager following his move to Tasmania. Ms Lazaro provided an affidavit and was cross examined by counsel.[114] Ms Lazaro has been a senior case manager since 2007 and over time became a supervisor of case management. Her case load is between 5 and 15 clients.[115] She said she has managed thousands of cases including a large number of asylum seekers. She also said that Red Cross had been a key stakeholder and partner in several departmental contracts across the community.[116] I found her evidence knowledgeable, credible and of assistance, particularly in relation to the

[112] Transcript, pp 294-95 (evidence of Ann-Clare Fitzgerald).
[113] Closing submissions of James Forsaith, Counsel for the department, 21 April 2021.
[114] Exhibits C37; 37A.
[115] Transcript, p 308, lines 39-40.
[116] Transcript, p 305, lines 23-44.

liaison between the department and Red Cross as well as information sharing practices. It was apparent that she was extremely helpful in facilitating the provision of information to enable the support of Mr Hassanloo to the extent permitted by law.

129. It is within this context that I make further comments below regarding the sufficiency of information concerning Mr Hassanloo held by the RHH and Red Cross in Tasmania.

Whether the department provided to the RHH adequate information to enable correct diagnosis and treatment of Mr Hassanloo

130. On 20 July 2016, during Mr Hassanloo's first period of hospitalisation, Ms Dugan enquired of Ms Lazaro about whether there were any other records her department were able to provide. Ms Lazaro forwarded the request to IHMS and the Department and advised Ms Dugan she had done so and that the records would relate to services provided by IHMS. [117]

131. The following day, on 21 July 2016, Ms Dugan suggested to Ms Lazaro that the hospital might benefit from having Mr Hassanloo's records from the RPH. On 23 July 2016, Ms Lazaro informed Ms Dugan that records held by RPH could be sought directly by RHH or Mr Hassanloo.[118]

132. On 28 July 2016, IHMS advised Ms Lazaro that it was unable to supply Mr Hassanloo's medical records directly to the RHH without his consent. The department therefore requested the RHH to seek that consent. That fact was conveyed to Ms Dugan.[119]

133. Ms Lazaro's handling of the information request by Ms Dugan was proper and considered in light of the need for compliance with privacy laws and the ongoing lack of consent by Mr Hassanloo to release of his records held by the department.

134. Dr Reddy gave evidence at inquest about the nature of information that he considered necessary and desirable for diagnosis and treatment of Mr Hassanloo. He said that that, for the most part, he found the information provided by Ms Dugan assisted in his treatment of Mr Hassanloo.[120] I readily accept that that was the case, given the degree

[117] Exhibit C37, par 76.
[118] Exhibit C37, pars 77-78.
[117] Exhibit C37, par 79.
[120] Transcript, p 263, lines 21-22.

of her involvement and provision of information, both of which are reflected in the medical records.

135. Dr Reddy gave evidence that he had a copy of Mr Hassanloo's discharge summary from the RPH. He said that he *possibly* might have been assisted by Mr Hassanloo's whole medical file from the RPH but his standard practice was to rely only on the discharge summary, which normally provided sufficient information for his purposes. Dr Reddy said that he would generally not receive the full file due to privacy issues.[121] I note that neither Dr Reddy nor any other staff member at the RHH made an application to the department to obtain Mr Hassanloo's records, a fact indicative of there being no clinical need to do so.

136. Dr Sale considered the discharge summary as far more succinct than other materials.[122] He agreed with what Dr Reddy stated in that little can be done to obtain patient records without patient consent.[123]

137. I am satisfied, having regard to all the evidence, that Dr Reddy would not have been greatly assisted in having access to additional records held by the department in relation to his treatment and care interstate. In particular, and assessment of capacity significantly involves consideration and analysis of a patient's current presentation.

Whether the department provided to the Red Cross (in Tasmania) being the organization charged with his care, sufficient information to enable it to support Mr Hassanloo and develop strategies for his well-being.

138. The department shares information with its SRSS service providers through an online 'portal' ("the Portal") to which caseworkers and their supervisors have remote access.

139. In the context of Mr Hassanloo being discharged from RPH into community detention, the Red Cross in Western Australia was given access to information about his case in the Portal. Mr Bradley Creevey, responsible for the Portal within the department, provided a statement exhibiting the information that was made available by the department to Red Cross users in this way.[124] In his oral evidence he said that, in addition to this information, Red Cross Tasmania users would also have been able to

[121] Transcript, p 262, lines 27-38.
[122] Transcript, p 215, lines 3-4.
[123] Transcript, p 125, lines 22-25.
[124] Exhibit C41.

see whatever information had been uploaded into the Portal by their Western Australian colleagues during Mr Hassanloo's time in community detention in Perth.[125]

140. Red Cross in Tasmania also had access to information otherwise obtained or recorded by Red Cross in Perth during Mr Hassanloo's stay in community detention. This included a spreadsheet containing various case notes and attachments.[126] Within the spreadsheet is a reference on 22 May 2015 to Mr Hassanloo's discharge summary from RPH of same date, and likely provided to the Red Cross on the same date, when Mr Hassanloo first moved into community detention in Perth.[127] Ms Dugan recalled seeing the discharge summary within the case notes when she first took on Mr Hassanloo's case and said that she may have provided the document to the RHH (as it appeared in those records).[128]

141. In her oral evidence, Ms Dugan spoke of the support that she received from Ms Lazaro:[129]

> *"Judy's always been very supportive around case work and clients. So, I felt as though that was a rapport and a relationship that we had that I could always contact if I – if I needed to."*

142. Ms Dugan agreed that it was open to her, on an ongoing basis, to seek further information from Ms Lazaro if she considered that Red Cross had been provided with inadequate information about Mr Hassanloo.[130] She was asked about an occasion when she sought Mr Hassanloo's medical records and another occasion when she requested further information from Ms Lazaro regarding an incident that she had read about in the Portal.[131] She was asked whether she could recall any other occasions where she had gone back to the department and sought further information.[132] She could not recall any other such occasions.[133]

143. Moreover, Ms Lazaro explained in her evidence that she did not consider that the support of a person such as Mr Hassanloo was hampered by privacy laws as there was

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[125] Transcript, p 283.
[126] Exhibit C25A
[127] See Transcript, p 126 (evidence of Alison Dugan).
[128] Transcript, pp 123-24 (evidence of Alison Dugan).
[129] Transcript, p 161.
[130] Transcript, p 160.
[131] Transcript, pp 160-61.
[132] Transcript, p 161.
[133] Transcript, p 195.

significant information available to enable good support. Further, she indicated that she tried to facilitate the provision of as much information as possible if a request was made. Having heard her give evidence, I can readily accept that this was the case.[134]

144. It was clear from her comprehensive affidavit and oral testimony that Ms Lazaro did a very good job managing the case and overseeing the Red Cross in providing support to Mr Hassanloo. She fostered a good working relationship with Ms Dugan. She was an experienced case manager and had many clients over the years who she perceived to be at a higher risk of self-harm than Mr Hassanloo. She did not foresee that he would take his own life at any point - a view consistent with that of his treating health professionals.

145. I am satisfied there was sufficient information available to Red Cross in the Portal to enable them to effectively case manage Mr Hassanloo. There was no cogent evidence of the unavailability of any particular pieces of information that were critical or necessary for his care or support. Any personal information not available by virtue of privacy laws would not have altered in any significant way how he was supported and managed by the Red Cross in the period before his death.

146. I comment that Ms Dugan's efforts to help Mr Hassanloo exceeded what might reasonably have been expected of her. She worked tirelessly to advocate on his behalf to give him the best possible opportunities for his future.

b) Adequacy of treatment and care at the Royal Hobart Hospital

Decision-making capacity

147. One matter arising inquest was whether Mr Hassanloo should have been the subject of an involuntary order under the *Mental Health Act* 2013 at the time of his departure from hospital on 26 August, which would have prevented him leaving.

148. Mr Hassanloo had been the subject of continuous assessment for decision-making capacity throughout his admissions. The short-term assessment orders that were made reflected significant concern about his ability to make decisions in light of his presentation, and the need to hold him involuntarily to adequately determine capacity,

[134] Transcript, p 315, lines 1-12.

diagnosis and treatment. The assessment orders that were made were appropriate in the difficult circumstances presented to the treating team.

149. In the finding of P*eck, Edward Paisley 2019 TASCD 386,* I dealt with the meaning and principles applicable to "decision-making capacity." I stated as follows:[135]

> "In Australia, in *Hunter and New England Area Health Services v A*, McDougall J considered that there is not a dichotomy between 'capacity' on one hand and 'lack of capacity' on the other, rather that capacity is a scale. His Honour went on to say that the issue of capacity is relative to the transaction in question and that an assessment of an individual's capacity must be issue, or 'transaction' specific, as an individual may be capable of making some simpler decisions that arise from a situation, but not more complex ones.
>
> In *Re MB*, Butler-Sloss LJ held that, in deciding whether a person has capacity to make a particular decision, the ultimate question is whether that person suffers from some impairment or disturbance of mental functioning so as to render him or her incapable of making the decision. That will occur if the person is unable to comprehend and retain the information which is material to the decision, in particular as to the consequences of the decision; or is unable to use and weigh the information as part of the process of making the decision.
>
> If a patient understands their condition, and the consequences of refusing treatment, the reasons for refusing that decision – whether they be irrational, rational, unknown or non-existent – are irrelevant."

150. I was impressed by the evidence of Dr Reddy and Professor Lambeth at inquest on the subject of Mr Hassanloo's decision-making capacity. Both were fully cognisant of the legislative presumption of capacity as expressed in section 7 of the *Mental Health Act* 2013 and were, quite properly, conscious that holding Mr Hassanloo on an involuntary order would be contrary to law unless they could be positively satisfied that he did not have capacity to use and weigh information given to him regarding treatment decisions.[136]

151. Both Dr Reddy and Dr Lambeth were also cognisant of the fact that assessment of capacity must be made at the time point in question and that a prior assessment of

[135] *Peck, Edward Paisley 2019 TASCD 386*, para 90.
[136] Transcript, p 144.

incapacity is not a determinative factor in any future assessment. Decision-making capacity may fluctuate, as recognised by the authorities cited above.

152. Relevantly, in relation to the assessment of Mr Hassanloo's decision-making capacity on 25 August, Professor Lambeth said in evidence that Mr Hassanloo was brief, polite and specific in his responses and had the ability to convey his wishes, and express his desires. His behaviour was not abnormal and was not psychotic or delusional.[137] It was clear that Professor Lambeth considered that he had the ability to use and weigh information at the time of his assessment. I have no hesitation in finding that his opinion in this regard, and that of Dr Reddy, were correct.

153. Despite his behaviour, the evidence indicates that Mr Hassanloo remained with capacity the following day – a fact discussed by the treating doctor at the meeting just before he voluntarily left the hospital. As a voluntary patient with capacity, he could not be forcibly kept against his wishes under any circumstances.

154. To the extent that Dr Sale, in his report, criticised the assessment of Mr Hassanloo's decision making capacity by those involved the time, I do not agree with such criticism. The members of the treating team were required to deal with the complexities of Mr Hassanloo's condition and lack of engagement as those difficulties arose. They did so appropriately, having had the benefit of observing, interacting with and treating Mr Hassanloo.

Diagnosis

155. The question of Mr Hassanloo's diagnosis was ventilated in this inquest, the issue having been highlighted by Dr Sale in his reports. Dr Sale stated that *"the term personality disorder can be pejorative and carries stigma. It implies that a person is unlikely to respond to treatment, can be difficult and would not benefit from hospital admission*."[138] He emphasised that such a diagnosis was not possible given the lack of confirmation that it was enduring, exhibited over many contexts, deviated from his own culture and had developed early. Dr Sale was of the view that the incorrect diagnosis influenced the decision making of the treatment team, reflected in their reluctance to admit Mr

[137] Transcript, p 155.
[138] Exhibit C33, p 10.

Hassanloo on the second occasion, reluctance to allow more than a brief admission and a conclusion that there was no lack of capacity.

156. As may have been apparent from the narrative concerning his hospitalisation earlier in this finding, Mr Hassanloo had not, either on the mainland or in Tasmania, been given a formal diagnosis of personality disorder after considered assessment. His long term treatment was based upon him suffering a depressive disorder and/or an adjustment disorder. For instance, the RPH Discharge Summary of 21 May 2015 refers to Mr Hassanloo as having a current moderate episode of his *"major recurrent depressive disorder, with deliberate self-harm by starvation."*[139] There is no reference within the document to a personality disorder. The RHH discharge summary compiled by Dr Elcock after Mr Hassanloo's second admission notes a principal diagnosis of adjustment disorder.[140]

157. Dr Reddy also pointed out, seemingly correctly, that the described 'Welborn email' appearing in the hospital notes[141] is not an email but a note of a telephone call between Dr Elcock and Dr Alexandra Welborn, one of Mr Hassanloo's treating psychiatrists in Western Australia. Although Dr Welborn offered a diagnosis of severe personality disorder, she told Dr Elcock that the diagnosis and management was "confounded." Further, she told Dr Elcock that, if there was to be a formal diagnosis, it would be that of chronic adjustment disorder with depressed mood.

158. Further, Dr Reddy in his affidavit dealt with the notes of the meeting at 4.00pm on 26 August, signed by Dr Pathmanathan, which referred to (and adopted, to a degree) Dr Welborn's postulation of Mr Hassanloo having a severe personality disorder. Dr Reddy said that this was the first occasion that the possibility of such a diagnosis had been raised by any member of the treating team. He said that the assessment contained in the notes of that meeting did not reflect his nor Professor Lambeth's assessment of Mr Hassanloo.[142]

159. Dr Reddy was firm in his evidence that he was *not* of the opinion that Mr Hassanloo was suffering from a personality disorder.[143] Dr Reddy also validly stated that any discussion between Drs Elcock and Welborn could only have been for the collection

[139] Exhibit C28, pp 29-33.
[140] Exhibit C28, p 35.
[141] Exhibit C28, p 28.
[142] Exhibit C38, par 209.
[143] Exhibit C38, par 213.

of collateral information and not to make a diagnosis.[144] There is no evidence that Mr Hassanloo's care, treatment or management for his mental health in Tasmania was based upon a diagnosis of a personality disorder.

160. Additionally, a diagnosis of borderline personality requires seven of nine diagnostic criteria to be present.[145] Dr Reddy said that such a diagnosis could not be made, predominantly because the required persistent patterns of behaviour over many years could not be ascertained, and there was no sufficient evidence of longitudinal, collateral and family history. His opinion in this regard accords with that of Dr Lambeth and Dr Sale.

161. Certainly, the diagnosis of personality disorder was mentioned in the notes as a possibility, and even noted as an initial diagnosis upon his second admission.[146] There can be no doubt that Mr Hassanloo's mental illness, regardless of any formal diagnosis, presented as a very difficult and complex treatment challenge with personality vulnerabilities being present. Dr Reddy stated in his affidavit that Mr Hassanloo displayed Axis 2 traits of: *"negativity, hostility, defiance or oppositional positioning against authority figures and society generally and a pervasive distrust and suspicion that people were trying to harm or deceive him. These vulnerabilities had formed into rigid patterns of thinking, functioning and behaving."*[147] In the case of Mr Hassanloo's presentation and behaviour, it is not altogether surprising that, on occasions, discussions between various treating staff and notes considered the issue and possible diagnosis of personality disorder. I accept Dr Sale's opinion, however, that entertaining an unavailable diagnosis may have significant consequences for treatment decisions. However, I do not accept that there were such consequences in this case.

162. I accept the helpful analysis contained in the submissions of Dr Reddy's counsel of Dr Reddy's evolving consideration of Mr Hassanloo's condition and diagnosis over the period of treating him. Dr Reddy considered the possibilities of Mr Hassanloo suffering from PTSD, depression and an adjustment disorder (or a combination thereof), ultimately concluding that the appropriate diagnosis was that of an adjustment disorder. In evidence at inquest, Dr Reddy said that an adjustment disorder differs from major depression in that it can be linked to an external (exogenous) causes whereas a diagnosis solely of major depression is inherent in the

[144] Exhibit C38, par 215.
[145] Transcript, p 142 (evidence of Professor Leonard Lambeth).
[146] Exhibit C28, p 34.
[147] Exhibit C38, para 216.

patient and arises endogenously.[148] Dr Reddy gave evidence that Mr Hassanloo's mental health difficulties were psychosocial in nature and surrounded his visa issues.[149]

163. That his residency and visa status were a significant focus of his stress and distress was confirmed by Ms Dugan and the documentary evidence. His prospects for remaining in Australia were effectively assured before his death, although he was, sadly, unable to perceive the situation positively or rationally – no doubt for complex reasons, including his life experiences and/or trauma as well as personality issues.

164. Having regard to all the evidence, Dr Reddy was very patient and thorough in his treatment of Mr Hassanloo over the period of both hospital admissions. Assessment orders were made under the *Mental Health Act* 2013 in the best interests of Mr Hassanloo within both admissions with a view to understanding his condition and treating it effectively, notwithstanding his lack of co-operation. Consideration was given during Mr Hassanloo's second admission to a more extensive treatment order. ECT therapy was contemplated by Dr Reddy. In this regard, I fully accept his evidence that proposed ECT treatment was a genuine attempt to progress towards available treatment options in a very difficult case rather than being an unnecessarily aggressive approach to deal with his behaviour.

165. Dr Reddy displayed sound judgment in seeking a second opinion from the Clinical Director, Professor Lambeth, in light of the treatment dilemma associated with Mr Hassanloo. Dr Lambeth agreed with the diagnosis of adjustment disorder. Moreover, he said in his affidavit: *"It is difficult to believe that anything further could have been done to clarify the diagnosis and facilitate further treatment and care given Mr Hassanloo's reluctance to engage in any treatment."*[150]

166. I find that the diagnosis was appropriate, as was the treatment and decision-making in respect of Mr Hassanloo.

Discharge

167. I have described in this finding the circumstances of Mr Hassanloo's sudden self-discharge and departure from the hospital on the afternoon of 26 August.

[148] Transcript, p 148 (evidence of Professor Leonard Lambeth).
[149] Transcript, p 254 (evidence of Dr Anil Reddy).
[150] Exhibit C43, p 5.

168. Dr Reddy gave evidence that he instructed the registrars that Mr Hassanloo should not be discharged without first discussing it with him. However, he said that if Mr Hassanloo elected to discharge himself, he was free to do so because he was a voluntary patient. This was despite the discharge being unwise.[151]

169. Dr Reddy said he was not on the ward at that time because he was seeing another patient, perhaps in the Emergency Department. He said that generally he would be called when such a situation occurred but he was not sure if hospital staff knew where he was.[152]

170. Dr Sale was of the opinion that the circumstances surrounding Mr Hassanloo's self-discharge were concerning. He said in evidence:

> *"But if I was there as a member of staff, I'd be alarmed by this development, particularly that he left without his possessions. That would cause me considerable concern. I'd probably get on the phone to the case worker to alert them of that development and also perhaps in liaison with them, seek their advice as to whether we should alert Tasmania Police about a man who's a potential risk."*[153]

171. When questioned in evidence about the circumstances of Mr Hassanloo leaving hospital, Dr Reddy said that he was told (after the event) that the nurses pleaded with Mr Hassanloo to stay at least until his caseworkers returned. He also confirmed that, as the discharge was planned for Monday, Mr Hassanloo's leaving without his possessions, likely caught staff "off guard." His evidence was, however, that nothing more could have been done to keep him in hospital apart from pleading that he remain, at least temporarily.[154] As I have previously discussed, hospital staff had no power to compel a patient to remain in hospital if they were deemed to have capacity and therefore ineligible for an involuntary order under the *Mental Health Act* 2013.

172. The only hospital staff member who has provided direct evidence about these final events is Dr Reddy, who was not present at the time. I did not have evidence from RN Salt and other relevant hospital staff members. However, the reality is that Mr Hassanloo had decision-making capacity and that treatment options and suggestions had been exhausted with his refusal to cooperate. The intention of the treating team

[151] Transcript, p 255, lines 18-33.
[152] Transcript, p 265, lines 1-45.
[153] Transcript, p 218, lines 27-33.
[154] Transcript, p 265, lines 13-33.

was to have him remain as an inpatient over the weekend solely to allow him time to obtain accommodation was a reasonable and compassionate decision in the circumstances.

173. At the conclusion of the inquest, I received THS Protocols applicable to the situation of a mental health patient *Missing or Absent Without Leave (AWOL).*[155] This was said by the Medical Director for Mental Health State-Wide Service to be the Protocol applicable to Mr Hassanloo leaving without permission from a clinical staff member.[156] Technically, permission was neither granted nor refused, although his departure was unexpected and unscheduled. RN Salt asked him to wait until Ms Dugan arrived - a sensible request in the circumstances and one that may have been attractive to him. At the time, the Protocol required that actions for search and notification be jointly decided by the nurse in charge with the "Registrar/Duty Doctor/senior staff member." It required a decision to be made based upon the individual patient's circumstances, known risk factors and staff safety. There is no evidence that such a joint decision occurred. The Protocol also provided for a range of discretionary responses depending upon the level of assessed risk, including contacting the missing patient's carer or the police.

174. I observe that in hindsight, knowing of Mr Hassanloo's death the following day, it is not difficult to envisage that a different response should have been adopted. In fact, Ms Dugan was contacted and arrived at the hospital 10 minutes after he left, likely giving comfort to the hospital staff that Ms Dugan would locate him. In any event, the time frame was so short that the staff members seeing him would well have been entitled to allow what is described in the protocol as a "period of grace" to actually confirm his AWOL/missing status. There was no indication that Mr Hassanloo was suicidal or at risk of self-harm at the time, which may explain why the hospital staff and Ms Dugan did not call the police at that time. I do not consider in the circumstances that the ultimate outcome could have reasonably been predicted or prevented.

175. I also add that, upon the evidence as it stands, I cannot be confident to the requisite degree that the *Missing or Absent Without Leave (AWOL)* Protocol dated March 2017 was in force in August 2016. The Medical Director provided evidence that it was likely to be in force as it had been uploaded on the systems in March 2016. Even if that is

[155] Exhibits 44A and 44C.
[156] Exhibit C44.

the case, I do not have evidence that staff had been trained in its application. I therefore make no further comment regarding this issue.

176. The current protocol requires a mandatory set of actions and notifications once a patient is confirmed as missing/AWOL. These include the requirement to notify various medical staff, family members/guardian, police and the CAT team and to make continuing enquiries and communications regarding the patient's whereabouts. The current protocol also requires a system of documentation of the situation and actions taken. The protocol appears to be appropriately responsive to patient risk, and the THS should ensure on an ongoing basis that relevant staff are familiar with its terms.

c) The ability of medical staff at the RHH to deal with presentations by asylum seekers

177. An important issue at inquest was Mr Hassanloo's ability to understand and use the English language and whether additional assistance in this area could have enhanced his care and treatment. It will be noted from the narrative in foregoing sections of this finding that Mr Hassanloo had a reasonable comprehension of the English language and was able to make himself understood. I add the following further comments.

178. Ms Lazaro gave evidence that Mr Hassanloo declined the offer of the Translating and Interpreting Service (TIS) stating that his preferred language was English. She said that she offered him TIS at the beginning of every face to face meeting with him but he always declined.[157] In her evidence at inquest, she indicated that Mr Hassanloo *"had a fair grasp of conversational English. He conversed well, was always very polite, very clean and exhibited no behavioural or mood related issues or concerns. No concerns with speech or anything."*[158] Further, she said that Mr Hassanloo was polite and engaged well during the meetings with her.[159]

179. Ms Dugan said that he had a good understanding of the English language. She also noted in her affidavit that *"We could not get David* [Mr Hassanloo] *to engage with interpreters at any stage while we were dealing with him."*[160]

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[157] Exhibit C37, par 42.
[158] Transcript, p 311, lines 8-11.
[159] Exhibit C37, par 43.
[160] Exhibit C25, p 1.

180. Dr Reddy acknowledged that Mr Hassanloo did not have excellent English *"but said he was able to understand simple comments and he was able to articulate that he had problems with his visa and problems in the past."*[161] Dr Reddy was also of the view that Mr Hassanloo would have rejected the use of an interpreter.[162]

181. Similarly, Professor Lambeth could not see the need for an interpreter, considering that there was *"ample evidence that Mr Hassanloo had a good understanding of the English language."*[163]

182. I find that, upon the evidence, Mr Hassanloo had a sufficient knowledge of the English language and did not require an interpreter.

183. Dr Sale, in his reports and oral evidence, expressed that the main issue for Mr Hassanloo's hospital treating team was the lack of familiarity in dealing with challenging presentations of asylum-seeker patients, such as Mr Hassanloo, who required a specialised approach to treatment. He indicated that specialist psychiatrists in the transcultural field from interstate should have been contacted to assist in understanding how best to communicate with and treat Mr Hassanloo, who presented as particularly challenging in his lack of engagement.[164]

184. Upon hearing from Dr Reddy and Professor Lambeth at inquest, I was impressed with the level of professional consideration given to Mr Hassanloo's treatment. Having regard to all of the evidence concerning Mr Hassanloo's psychiatric history and behavioural patterns whilst in Australia, I do not consider that any more could have been done to assist him reduce his level of distress, which presumably contributed to his decision to end his life. Further, as submitted by counsel assisting, Mr Hassanloo had a very strong desire to distance himself from his Iranian background and therefore the introduction of an interpreter or cultural liaison personnel would likely have been ineffective and may well have exacerbated his issues.

185. I accept Dr Sale's view, however, that specialist psychiatrist's advice in this area may be of great assistance in particular cases. The inquest did not explore in any detail the number of cases of presentations of asylum seekers to the THS. I make no formal recommendations on this particular matter, although the THS might consider the

[161] Transcript, p 268, line 45 to p 269, line 3.
[162] Exhibit C38, par 250.
[163] Exhibit C43, par 9.
[164] Transcript, p 216.

desirability of compiling for the use of relevant health professionals within the Service a list of available medical practitioners across Australia with particular expertise in treating asylum seekers.

Recommendations

186. I do not consider that it is appropriate in this investigation to make recommendations pursuant to section 28(2) of the Act.

Response to previous recommendations regarding suicide from the Tasman Bridge

187. In November 2016, I handed down findings in *Deaths from a Public Place 2016 TASCD 385-390(Tasman Bridge findings)* involving six suicides from the Tasman Bridge. In those findings, I observed that the current outer railing of the bridge is 1.59 metres in height. This is relatively easy to scale and provides a direct drop into the river at a height that will almost always cause death. I commented that, further, maintenance and lighting gantries and electrical connection boxes are installed at regular intervals along the inside of the fence. These provide an opportunity for footholds for those intending to effect suicide. The evidence in this case does not permit me to find whether Mr Hassanloo used one of these installations as a foothold – only that he was able to scale the railing without great difficulty. It is impossible to say whether, had he not been able to effect his purpose on the bridge, he would have ended his life using other means. Research indicates that, on many occasions, there is no substitution of means in the context of an impulsive state of mind.[165]

188. The grief of Mr Hassanloo's death can only have been heightened for his family members by his body never having been found. In such a case, as with many cases of suicide from the Tasman Bridge, his family have been unable to bury him. The fact that his remaining family members live in Iran has no doubt presented further difficulty in coming to terms with their loss.

189. In the Tasman Bridge findings I made various recommendations with the aim of eliminating the Tasman Bridge as a well-known and frequent method of suicide.

190. For this finding, I requested that the Chief Psychiatrist, Dr Aaron Groves, provide a report regarding the responses to the recommendations made. Dr Groves is the

[165] *Deaths from a Public Place 2016 TASCD,* p 11.

Chair of the Cross Agency Working Group (CAWG) for the Tasman Bridge. He provided that report on 23 April 2021, and an updated report on 23 February 2022. The reports are exhibits in this inquest.[166]

191. Below, I set out the recommendations made in the Tasman Bridge findings and summarise the responses by Dr Groves.

192. ***Recommendation 1*****:** *That the government formulates a plan for the implementation of structural modifications to the Tasman Bridge, such structural modifications having a key aim of eliminating the Tasman Bridge as a method of suicide.*

193. Implementation of this recommendation is stated to be "ongoing". The Department of State Growth has worked with the Department of Health to apply for funding from the *Australian* Government's *Prioritising Mental Health - Suicide Prevention Support Programs 2017-18 Budget Initiative,* seeking funding to remove/relocate electrical boxes and to remove potential hand/footholds. The application was successful, and the removal/relocation of the boxes was completed in June 2020.

194. The construction of safety barriers has been the subject of a major works feasibility and planning study inthe Department of State Growth, including external consultant reports.

195. In 2020, $130M in matched funding was secured from the Tasmanian ($65M) and Australian Governments ($65M) to widen the pathways and increase the height of the barriers. This will mitigate the risk of suicide and provide a safer access for pedestrians and cyclists. Design for improvements to the pathways and associated strengthening required to meet the future transport task will now be progressed with the intention of commencing construction in the 2022-23 financial year, and completion expected in 2025. Consultants have been engaged and concept planning is underway, with preliminary design and development expected to be complete in 2022. There will be broad community consultation through the development of the project.

[166] Exhibit C45 and C45A.

196. ***Recommendation 2*:** *That the Department of State Growth install additional and enhanced camera surveillance on the Tasman Bridge to provide improved quality footage and complete coverage of all pedestrian areas.*

197. Implementation of this recommendation is complete.

198. ***Recommendation 3*:** *That Tasmania Police continues the operation with respect to the reporting of incidents involving suicide, attempted suicide of persons in crisis on the Tasman Bridge and, further, Tasmania Police review the accuracy of the current reporting and implement necessary measures to reinforce to police officers the requirement for complete and accurate reporting of such incidents.*

199. Implementation of this recommendation is complete.

200. Tasmania Police has completed a review of its current reporting databases with the following outcome that Operation Cormorant will remain the main source of comprehensive intelligence reporting for attempted suicides and threats of suicide to inform operational responses and indicate the frequency of these incidents. All Cormorant reports will be contained in the new Atlas database. Emergency Services Computer Aided Despatch (ESCAD) provides the best high-level statistical data relating to threats of, or attempted suicide, on the Tasman Bridge. Operational procedures have been revised through an amendment to the Tasmania Police Manual, ensuring that all attempts or threats of suicide are recorded for operational and statistical purposes. Further, a microwave connection from the new high definition Tasman Bridge Cameras was completed in March 2019, enabling real time viewing of incidents.

201. ***Recommendation 4*:** *That the government continue its commitment as expressed in the Tasmania Suicide Prevention Strategy to pursue the development of a Tasmania Suicide Register, so as to accurately inform suicide prevention strategies, including strategies for suicide prevention at the Tasman Bridge.*

202. Implementation of this recommendation is complete.

203. The Tasmanian Suicide Register (TSR) was established within the Coronial Division of the Magistrates Court of Tasmania in Hobart in November 2017. The first *Report to the Tasmanian Government on Suicide in Tasmania, 2012-2016,* was released in October 2020 and the second *Report to the Tasmanian Government on Suicide in Tasmania, 2012-2018* was released December 2021. The report is available publicly. The TSR will considerably

assist in understanding suicide in Tasmania and enabling suicide prevention policies and initiatives based upon the best available information.

204. ***Recommendation 5*:** *That the Department of Health and Human Services implement a system for the ongoing monitoring of the use of the telephones and signage on the Tasman Bridge, assess the efficacy of those telephones and that signage at regular intervals and report result to the relevant ministers and the cross agency working group.*

205. Implementation of this recommendation is ongoing.

206. The Department of State Growth is responsible for maintaining the crisis telephones and signage on the Tasman Bridge, which are tested every week as per the *Lifeline Tasman Bridge Hot Spot Emergency Phones Protocols for Phone Maintenance and Fault Rectification.*

207. The Tasmanian Government, through the Department of Health, has a service level agreement with Lifeline Australia, the provider of the crisis telephone service. Lifeline Australia provides a six-monthly data report to the Department of Health which includes data on the use of the telephones on the Tasman Bridge. This data report is discussed at the Cross Agency Working Group – Tasman Bridge (CAWG) meetings.

208. ***Recommendation 6*:** *That the cross agency working group continues to operate in accordance with its terms of reference as a principal source of advice to government regarding suicide prevention at the Tasman Bridge.*

209. Implementation of this recommendation is complete.

210. ***Recommendation 7*:** *That the cross agency working group considers the findings, comments and recommendations in executing its functions in accordance with its terms of reference.*

211. Implementation of this recommendation is complete. Further, Professor Ken Kirkby, a member of the CAWG and a specialist clinical adviser to the Office of the Chief Psychiatrist, is currently completing a detailed report on the progress of the suicide prevention measures relating to the Tasman Bridge.

212. I comment that the government, through the CAWG, has made very significant progress towards preventing suicides from the Tasman Bridge and such progress

should continue without undue delay. The funding for the structural modifications is a critically important development.

Formal findings required by section 28(1) of the *Coroner's Act* 1995:

213. I find that:

a) The identity of the deceased is Saeed Hassanloo;

b) Mr Hassanloo died as a result of jumping from the Tasman Bridge into the River Derwent, an action taken by himself alone and done with the specific intention of ending his life, the circumstances of his death being set out in this finding;

c) The cause of Mr Hassanloo's death was traumatic injuries and/or drowning; and

d) Mr Hassanloo died on 27 August 2016 at Hobart in Tasmania.

Acknowledgements

214. I appreciate the considerable assistance of Mr Cameron Lee, counsel assisting. I also thank all counsel for their most helpful written submissions.

215. I also extend my appreciation to Sergeant Leah Adams for her thorough investigation and to Josephine Burbury, Coronial Division intern, for her valuable assistance in the preparation of the inquest.

216. Sadly, Majid died in 2017 whilst he was living interstate, and both of Mr Hassanloo's parents passed away due to natural causes after Majid's death. Mr Hassanloo's brother, Mahmoud Hassanloo, then fulfilled the role of senior next of kin under the Act and represents the family. I convey my sincere condolences to the family and loved ones of Saeed Hassanloo.

Dated 28 February 2022 at Hobart in the State of Tasmania

Olivia McTaggart
CORONER