**Coroners Act 1996**
**[Section 26(1)]**

*Western* *Australia*

# RECORD OF INVESTIGATION INTO DEATH

*Ref: 39 /18*

*I, Sarah Helen Linton, Coroner, having investigated the death of* ***Mohammad Nasim NAJAFI*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***6 November 2018*** *find that the identity of the deceased person was* ***Mohammad Nasim NAJAFI*** *and that death occurred on* ***31 July 2015*** *at* ***Yongah Hill Detention Centre, Northam****, in circumstances* ***consistent with seizure (epileptic)****:*

**Counsel Appearing:**

Sgt L Houisaux assisting the Coroner.
Mr N Van Hattem (Mr D Vijayakumar Wotton Kearney) appearing on behalf of Serco.
Mr A Berger (AGS) appearing on behalf of the Department of Home Affairs.
Ms J Thornton (Mr P Keays Moray & Agnew) appearing on behalf of IHMS.
Mr D Stojanoski appearing on behalf of the family of the deceased.

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# INTRODUCTION

1. Mohammad Nasim Najafi (the deceased) was born in Afghanistan. According to information provided by the deceased to Australian authorities, he left Afghanistan because he was afraid he would be killed if he stayed. He went first to Pakistan, but the situation there was not good so he went to some other countries and then to Indonesia. From Indonesia the deceased made his way to Australia by boat in 2012. The deceased landed at Christmas Island on 1 November 2012 and was classified as an illegal maritime arrival. He was subsequently detained by the Australian government as an unlawful non-citizen pursuant to s 189(3) of the *Migration Act 1958* (Cth).[1]

2. The deceased was initially detained at the Christmas Island Detention Centre and shortly afterwards was transferred to the Curtin Immigration Detention Centre. He was transferred again on 24 July 2013, this time to Yongah Hill Immigration Detention Centre in Northam, Western Australia, where he remained until his unexpected death on 31 July 2015.[2]

3. At no time after arriving in Australia had the deceased been released into the community, so at the time of his death he had spent over two and a half years in detention.[3]

4. Under s 22(1)(a) of the *Coroner's Act 1996* (WA) a coroner who has jurisdiction to investigate a reportable death[4] must hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death 'a person held in care.' A person held in care is defined to mean, effectively, a person involuntarily detained under certain Western Australian legislation, including the *Prisons Act 1981* (WA).

5. A person held in immigration detention under the *Migration Act* does not come within the definition of a person held in care, so there was no requirement for me to hold an inquest. However, given that the deceased was involuntarily detained at the time of his death, it was considered desirable that an inquest be held, pursuant to s 22(2) of the Act. Accordingly, I held an inquest at the Perth Coroner's Court on 6 November 2018.

6. The deceased was known from the time he went into detention to have epilepsy and he was prescribed anti-epileptic seizure medication. All the evidence indicated he died as a result of an epileptic seizure.

7. The inquest focused primarily on an issue regarding the dispensing of the deceased's essential medication for his epilepsy. I indicated at the conclusion of the inquest that I considered there had been a failing in the medication dispensing system in place at Yongah Hill Detention Centre at the time, as the processes in place did not identify to staff that the deceased was not receiving his essential medication consistently in the days prior to his death. I heard expert evidence that the failure to take his medication as prescribed would have greatly increased the deceased's risk of having a seizure.

[1] Exhibit 3, Tab 20.
[2] Exhibit 3, Tab 20.
[3] Exhibit 3, Tab 20.
[4] As defined in s 19 of the Act.

8. Following the deceased's death a review of the medication dispensing procedures at Yongah Hill IDC identified the gap in the system for following-up detainees who miss essential medication. Evidence was provided at the inquest of a new system now in place at Yongah Hill IDC, and other detention centres, that ensures there is follow-up by medical and nursing staff when a detainee fails to receive their essential medication.

## DETENTION HISTORY

9. As noted above, following the deceased's arrival on Christmas Island in November 2012 he was initially held in a detention centre on the island and then spent approximately 18 months at Curtin IDC before being moved to his final destination of Yongah Hill IDC.[5]

10. The deceased was ineligible to apply for a substantive visa because of a legislative bar on applications by illegal maritime arrival. This meant he could not apply for a Temporary Protection Visa. After his death other illegal maritime arrivals in a similar situation to the deceased had their legislative bars lifted so his circumstances may have changed in the future, but at the time of his death the deceased's only option to a visa was through Ministerial intervention to granting a Bridging Visa E. At the time of the deceased's death the Minister had not been asked by the Department to exercise his power to grant a Bridging Visa E to the deceased. Accordingly, the deceased remained in prolonged detention.[6]

11. Various reasons have been given by the Department for not recommending to the Minister that a Bridging Visa E be granted. They included information provided by the deceased in his initial 'Entry Interview' that raised the possibility that the deceased had engaged in offshore criminality prior to his arrival on Australian shores in an incident where he allegedly stabbed a man while protecting his younger brother and that his identity had still not been conclusively established. He also did not meet other criteria, such as providing evidence that he had health issues that could not be properly cared for in immigration detention or that there were strong compassionate circumstances involving an Australian citizen.[7]

12. However, shortly prior to his death the Department had reassessed the deceased's case. It had been concluded that the length of time the deceased had spent in immigration detention and the fact that there was likely to be a further protracted delay in resolving his case meant the deceased's case should be referred to the Minister for consideration of the grant of a Bridging Visa E. In June 2015 the Department had begun drafting a submission to the Minister to that effect but unfortunately the submission had not been sent to the Minister at the time of the deceased's death.[8]

[5] Exhibit 3, Tab 20.
[6] Exhibit 3, Tab 20.
[7] Exhibit 3, Tabs 20 and 20D.
[8] Exhibit 3, Tabs 20 and 20E.

## THE DECEASED'S MEDICAL CARE

13. The evidence indicates the deceased had a past history of epilepsy when he arrived in Australia.[9] He had reportedly been diagnosed with epilepsy at the age of 21 years. His epileptic seizures were described as loss of consciousness with tongue biting, foaming at the mouth, jerking movements and slow recovery to normal consciousness, consistent with generalised tonic-clonic seizures. There is reference in the deceased's records to the deceased travelling to Iran and having had brain scanning and EEG with treatment then recommended.[10]

14. The deceased raised his epilepsy as a reason for why there may have been a miscommunication during his entry interview, as he asserted he had a seizure prior to the interview.[11] He had been witnessed to have a probable tonic-clonic seizure on 11 November 2012 after missing four days of his anti-seizure medication.

15. The deceased was said to speak a good level of English and did not require an interpreter for medical or other consultations. In his entry interview on Christmas Island he had indicated that he had attended a 3 year English course and spoke both English and Pashto. He declined the use of an interpreter when it was offered.[12]

16. The deceased had not been diagnosed with any mental health disorders but he was seen intermittently for mental health reviews in relation to the impact that long term detention was having on his mood. No doubt the prolonged detention had a negative effect at times, and there was mention of possible 'detention fatigue' affecting his behaviour.[13] The deceased also described periods of low mood in relation to news of events in Afghanistan, which is understandable. However, generally he appeared to manage reasonably well while in detention and did not receive any ongoing treatment for mental health issues and declined ongoing mental health support.

17. The deceased was prescribed the anti-seizure medication carbamazepine 300mg (1.5 tablets) twice daily to manage his epilepsy. He usually received this medication in a Webster-pak, which is a multi-dose medication administration aid designed to assist people to take their medication as prescribed. It is often used in care facilities such as nursing homes and prisons. It is sometimes referred to as a blister pack. The deceased had to be approved as a suitable patient for self-administration of his medication, which was done by an IHMS general practitioner.

18. While taking his carbamazepine as prescribed the deceased's epilepsy was well-managed. It is noted in the materials that the deceased had expressed concern in the past that his epilepsy might be a reason for the delay in his visa, so it is possible the deceased did not fully report any seizure activity, but generally the evidence suggests that he was largely seizure free while on

[9] Exhibit 3, Tabs 20C and 20D.
[10] Exhibit 1, Tab 32.
[11] Exhibit 3, Tab 20.
[12] Exhibit 2; Exhibit 3, Tab 20B.
[13] Exhibit 1, Tab 31, Clinical Review, pp. 3 – 4; Exhibit 2.

his medication.[14] There had not generally been any concerns with the deceased being compliant with taking his medication when he had access to his Webster-pak.

19. At the end of October 2014 there was an issue with the deceased's Webster-pak and he ultimately ended up missing two doses of his medication. He was witnessed to have a tonic-clonic seizure after the missed doses. This was the only recent seizure recorded.

20. The deceased had been referred to the Department of Neurology at Royal Perth Hospital for review in the Neurology clinic on 1 September 2014. In the referral request it was queried whether the deceased should have any investigations for his epilepsy or consider stopping his medications. I note this was written before he had the seizure the following month, and I speculate that this additional information might have changed that request.

21. In any event, Royal Perth Hospital declined the referral on 31 December 2014. It is not entirely clear from the letter itself the reason for the refusal but evidence was given at the inquest that it was because the deceased's condition was not considered to be acute enough to warrant review by the neurology team in the context of the large volume of patient referrals they had received. It was open to the IHMS GP's to consider making another referral if something changed further down the track.[15]

22. It would seem that not all IHMS staff understood that the referral had been declined, as in April 2015 the deceased raised with a general practitioner the possibility that he might cease taking his medication as he had been seizure free for a long period. He was told at that time that he should continue to take his medication until he had undergone specialist neurology review, presumably in anticipation of the RPH review.[16] Similarly, in May 2015 a note was made that the deceased was still awaiting a neurology appointment.[17] This does not raise any issue as I accept that the deceased required the medication and the misunderstanding that there was a review still pending did not affect his ongoing medical management.

## ISSUES WITH DISPENSING THE CARBAMAZEPINE

23. An issue was raised at the start of the inquest in relation to the dispensing of the deceased's carbamazepine and whether he was compliant with his medication at the time of his death. As noted above, he had been known to experience seizures in the past very shortly after he had missed doses of his carbamazepine.

24. The medical services at Yongah Hill IDC were provided by International Health & Medical Services (IHMS) pursuant to a contract between that service and the Commonwealth. At the time IHMS provided an onsite medical clinic operating between 9.00 am and 5.00 pm on weekdays and a

[14] Exhibit 2.
[15] T 61 – 62; Exhibit 4.
[16] Exhibit 1, Tab 31, Clinical Review p. 2; Exhibit 2, Clinical Records, 23.4.2015.
[17] Exhibit 2, Clinical Notes, 22.5.2015.

pharmacy dispensary service for dispensing medications every day in the morning, afternoon and evening. Once a week, on a Friday, there was also a Webster-pak clinic for exchange of Webster-paks for detainees who were approved to self-administer their medications via this method. The night before a detainee would be given a designated appointment time between 8.30 am and 3.00 pm to come and return their old pack and receive a new one.[18]

25. As noted above, the deceased usually received his carbamazepine via a weekly Webster-pak. The Webster-paks for Yongah Hill IDC are prepared off site by a local pharmacist and delivered a few days before the weekly clinic to allow them to be checked and any errors or missing packs rectified.[19]

26. For much of the time while the deceased was at Yongah Hill IDC his receipt of Webster-paks occurred without incident. In the year of his death there is a regular record of Webster-pak exchange throughout January to May 2015.

27. Problems began to arise from early May. On 8 May 2015 the deceased attended late for his Webster-pak exchange. Nurse Anita Nugara made a note that it was explained to the deceased that he would not get a Webster-pak that late on a Friday and he needed to attend at his designated appointment time during the day. Nevertheless, a note was made that the deceased was still given a new Webster-pak at 10.00 pm that evening. It was due to be replaced at the next Webster-pak clinic on 15 May 2015.[20]

28. One week later, on 15 May 2015, Nurse Nugara made a note at 9.42 pm that the deceased had not come to collect his weekly Webster-pak in the morning. He was spoken to by Nurse Nugara that evening at about 10.27 pm and it was explained to him that he would not be given a Webster-pak and he would need to present daily for one week to receive his medication. The notes record that he walked out of the clinic in anger and refused his medications.[21]

29. The following day Nurse Nugara documented that the deceased did not present to the clinic for his daily medication dose in the morning. At 11.50 am Nurse Nugara telephoned the compound where the deceased was held but was advised the deceased was sleeping. A request was made that he be sent to medical when he awoke to receive his medications. He eventually turned up at approximately 4.30 pm that afternoon and after a discussion with the Health Services Manager the deceased was given his Webster-pak, although it was contrary to the normal process.[22]

30. A note made at 4.38 pm by Nurse Nugara recording that, whilst the deceased was given the Webster-pak, it was,[23]

[18] T 68; Exhibit 1, Tab 30.
[19] T 38 – 39.
[20] Exhibit 2, Clinical Records, 8.5.2015.
[21] Exhibit 1, Clinical Review, p.3; Exhibit 2, Clinical Records, 15.5.2015.
[22] T 68 – 69; Exhibit 2, Clinical Records, 16.5.2015.
[23] Exhibit 2, Clinical Records, 16.5.2015.

*[e]xplained to the detainee that if he does not present at the right time and day for weekly Webster he will be denied this privilege. Detainee has promised to comply.*

31. There was evidence this was not the only occasion on which the deceased had been given his Webster-pak outside the designated clinic hours of 8.30 am and 3.00 pm on a Friday. He would often come in late at night and the IHMS staff would give him his evening's medication and then permit him to take the Webster-pak.[24] This flexibility in the practice perhaps led the deceased to pay less regard to the instructions from Nurse Nugara to attend within the set hours than he should have.

32. The deceased had an after-hours Health Assistance Service (HAS) call to get some Panadol for a headache on 21 May 2015.

33. The following day the deceased was seen for a GP appointment. They had a discussion about his medications and he indicated he had been taking his medication and was happy to keep taking it. He maintained he was still seizure free. The deceased mentioned to the doctor that he had previously requested that his appointment with the nurse be made in the afternoon because he sleeps late in the morning. It was mistakenly thought by the doctor that the deceased was still waiting for a neurology appointment and the plan was for the deceased to continue taking carbamazepine in the interim.[25]

34. On 25 May 2015 the deceased was referred to a psychologist due to reported escalation in verbal aggression that had resulted in the implementation of a Behaviour Management Plan. The deceased reported frustration at having been placed on the plan and denied the incidents had occurred. His mood presented as normal and he did not report thoughts of suicide or self-harm. A scaled assessment indicated moderate stress, which the psychologist thought might be associated with ongoing detention and possible detention fatigue, as well as a reaction to the Behaviour Management Plan. The deceased declined further mental health support and no follow-up appointment was scheduled.[26]

35. From 29 May 2015 to 17 July 2015 there appear to be no major issues with the deceased receiving his medication. The deceased received his last Webster-pak on 17 July 2015 at 2.23 pm.

36. The deceased had an after-hours HAS call with a report of a headache the next day. An entry in the medical record on 18 July 2015 indicated that the deceased was compliant with his epilepsy medication at that time and the headache was not felt to be related to any seizure activity.[27]

37. The deceased was due to attend for a replacement Webster-pak on Friday 24 July 2015 but he did not attend his appointment.

[24] T 69.
[25] Exhibit 2, Clinical Records, 22.5.2015.
[26] Exhibit 2, Clinical Records, 25.5.2015.
[27] T 71; Exhibit 2, Clinical Records, 18.7.2015.

38. On 25 July 2015 a mental health nurse made a note that the deceased brought his empty Webster-pak to the clinic for a refill; which was a day late. He was advised that he had to come on Fridays for Webster-paks. He reportedly then walked off [28]

39. The medical records show the deceased received a dose of carbamazepine on the evening of 25 July 2015 and both his scheduled doses the following day.

40. From 27 July 2015 the deceased's attendance for medication became sporadic, set out as follows:

- 27 July 2015 – *morning dose missed*, evening dose dispensed; (1/2)
- 28 July 2015 – morning dose dispensed, *evening dose missed*; (1/2)
- 29 July 2015 – morning dose dispensed, *evening dose missed*; (1/2
- 30 July 2015 – *no dose received.* (0/2)
- 31 July 2015 – *no dose received.* (0/2).[29]

Depicted in Table Form it shows quite clearly the gaps in medication doses increases as it leads up to his death.


Screenshot of IHMS clinical notes

41. Despite his erratic attendance for medication, when the deceased saw a mental health nurse for review on 28 July 2015 there appears to have been no discussion about his reason for non-attendance and the effect that might have on his health. He appeared mentally settled and scored normally on the mental health assessment at that time. He was pleasant and cooperative during the interview and indicated at the time that he was still hopeful of being discharged into the community to start his life in Australia.[30]

42. The deceased did not attend a further mental health assessment on 31 July 2015. A note was made that the appointment had been cancelled at the deceased's request as he did not desire mental health follow-up. His main focus was immigration issues and he was aware that this should be followed up through his case manager.[31] It appears from later information that no one from IHMS actually spoke to the deceased on this day.[32] Again,

[28] T 71; Exhibit 2, Medical Note 25.7.2015.
[29] Exhibit 1, Tab 31, p. 2 and Tab 31A.
[30] Exhibit 1, Clinical Review, p. 7; Exhibit 2, Clinical Records, 28.7.2015.
[31] Exhibit 2, Clinical Records, 31.7.2015.
[32] Exhibit 1, Clinical Review, p. 8.

no one appears to have considered raising his erratic medication attendance at that time.

43. Unlike in the past, the deceased himself did not bring up with IHMS or Serco staff concerns about not receiving his medication regularly, even though he had opportunity to do so. He was due to collect his new Webster-pak on 31 July 2015, the day of his death, and there was evidence he had been sent an appointment slip to remind him,[33] but it appears from the Clinical Records that he did not attend and there was no Webster-pak in his room after his death.

## OTHER EVENTS LEADING UP TO THE DEATH

44. On 12 July 2015 the deceased reported that his mobile telephone had been stolen from his room by New Zealand detainees. The deceased feared he would be targeted for retribution for disclosing the offence.[34]

45. On 14 July 2015 the deceased requested to see the mental health nurse as he had been placed on 'Keepsafe'. There had reportedly been an incident where the deceased's room had been 'smashed up'. The deceased had reported the incident to Serco and allegedly received threats from the perpetrators. After discussion with the deceased a change of room and compound was authorised by the Department. The deceased was moved to a single room, Room S4, in Eagle Compound on 27 July 2015 and placed onto security watch. Once placed on security watch there was a requirement that Serco staff maintain direct observations of the deceased. To facilitate this supervision, the room the deceased was placed in was located directly opposite the Eagle compound staff office and he could also be monitored by way of closed circuit television, as a CCTV camera was pointed directly at the deceased's door. Access to the deceased's room was restricted to the deceased and staff of the Yongah Hill IDC.[35]

46. As noted above, the deceased saw a mental health nurse again on 28 July 2015 and he was not indicating any symptoms of psychological distress following the compound change. He had obviously been going through some turmoil in terms of interactions with other detainees, and the evidence was that he had understandably been keeping to himself to avoid contact with those people. There was nothing to suggest he might wish to harm himself or was experiencing any suicidal thoughts.

## DISCOVERY OF DECEASED

47. On 31 July 2015 the deceased appeared to have largely kept to his room. He did not attend his medical appointment that morning. The only clear evidence of a sign of life is recorded at approximately noon when he was

[33] Exhibit 1, Tab 33, Photograph 28.
[34] T 9 – 10.
[35] T 10.

checked by the day shift officer in Eagle Compound and heard to 'pass wind" as the door opened. He was lying in bed at that time.[36]

48. Serco Detainee Services Officer Stuart Barron was working on shift in the Eagle Compound on the evening of 31 July 2015. At that time he knew of the deceased but did not know him closely as he had only recently moved into the compound where DSO Barron worked.[37]

49. DSO Barron went to the deceased's room at about 6.30 pm to deliver a letter to the deceased. He knocked on the door of Room S4 and then unlocked the door. Upon entering the room DSO Barron noticed that the deceased was lying on his bed face down. He assumed the deceased was sleeping so he did not disturb him. The deceased was known to have abnormal sleeping habits so there did not appear to be any cause for alarm that he was sleeping at such an early hour in the evening.[38]

50. DSO Barron left the room without delivering the letter. DSO Barron relocked the door to the room as he left.[39] DSO Barron returned to the Eagle compound officers' station and from there he had a clear, unobstructed view of the deceased's room, which was secure.[40]

51. There is a suggestion in the St John Ambulance notes that the deceased was also delivered his dinner at 7.10 pm and he was seen face down so he was presumed to be asleep and left undisturbed.[41] An uneaten meal on a chair at the foot of his bed was visible in photographs of the deceased's room taken after his death.[42] The Serco notes suggest this dinner was perhaps delivered earlier, as the deceased was checked for the 'dinner head count' and was in his room and sleeping on his side between 4.30 and 5.30 pm.[43]

52. At around 8.40 pm DSO Barron returned to the deceased's room to again attempt to deliver the letter. He unlocked the door to the room and turned on the light. DSO Barron saw the deceased was still lying on his bed in the same position he had been seen earlier; namely, with his head facing the far wall and his body tucked under the blanket with his feet sticking out.[44]

53. DSO Barron called out to the deceased but he did not respond. DSO Barron then tried to wake the deceased by touching his pen to the sole of his foot and then shaking him on the shoulder, but the deceased did not respond to either contact. DSO Barron called out to DSO Valerie Christmas for help. DSO Christmas entered the room and also touched the deceased on the shoulder but received no response. It was then apparent to both officers that the deceased required urgent medical attention.[45]

[36] Exhibit 1, Tab 30F, p. 7.
[37] T 13.
[38] T 14.
[39] T 14.
[40] T 14.
[41] Exhibit 1, Tab 23.
[42] Exhibit 1, Tab 33.
[43] Exhibit 1, Tab 30F, p. 7.
[44] T 15.
[45] T 15.

54. A Code Black was called over the radio by DSO Christmas. It was heard by IHMS staff. The IHMS staff were on site in the pharmacy dispensing area conducting a medication round.

55. Detainee Service Manager Michael Brooks heard the Code Black and came to the deceased's room. After assessing the situation he called a Code Blue over the radio, which is a call for a medical emergency. This radio message was also heard by the IHMS staff who were still on site.

56. DSM Brooks and DSO Barron began performing cardiopulmonary resuscitation on the deceased while they waited for medical assistance. DSO Barron noticed that the deceased was cold to the touch and his limbs felt stiff when they moved him to perform CPR.[46]

57. Registered Nurse Cecil Stone was working for IHMS at the time and was on duty in the medical clinic that night. At that time the medical clinic at Yongah Hill IDC was open between 9.00 am and 5.00 pm, during which two medication rounds were conducted and detainees attended for appointments. After the clinic closed the IHMS staff conducted a third medication round from the pharmacy dispensing area that ordinarily commenced at around 7.30 pm. Nurse Stone advised that the IHMS staff had been directed that they were only to attend medical emergencies during clinic hours (between 9.00 am and 5.00 pm), in contrast to a previous policy that provided a 24-hour service[47] If a medical emergency occurred outside clinic hours, the Serco staff could call after-hours HAS and speak to a nurse and/or doctor to determine if the person needs to be sent to hospital or can be dealt with through instruction over the telephone.[48] In an emergency an ambulance would be called.

58. However, when Nurse Stone and his colleague on duty heard the Code Blue called some minutes after the Code Black, Nurse Stone recalled hearing desperation in the voice of the person making the radio call and thought that the situation sounded urgent. Based upon what he had heard, Nurse Stone and his colleague believed that it sounded like a 'cry for help' and they decided to stop the medication round and go and provide what assistance.[49] Nurse Stone explained that he considered the Serco staff were in a difficult situation and it was incumbent on them to help if they could, despite the formal processes for 'after-hours' medical events.[50] This was also noted in a Serco post-incident review, noting the difficulties the limited hours for emergency attendance placed on both the Serco staff and the IHMS staff, and a recommendation was made that the contractual arrangement be reviewed.[51]

59. They apologised to the waiting clients and closed the pharmacy dispensing area, before collecting the medical responder bag and arranging to be escorted by a Serco officer to the relevant Eagle compound.[52]

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[46] T 15 – 16.
[47] T 21, 42.
[48] T 41.
[49] T 42.
[50] T 42 – 43.
[51] Exhibit 1, Tab 21 and Tab 26C, pp. 3 - 4.
[52] T 21.

60. Nurse Stone gave evidence that he and his colleague ran to the compound. When they entered the deceased's room they saw some Serco officers performing CPR on the deceased. Nurse Stone observed that the deceased's right hand and arm were completely stiff in an upright position. He assessed the deceased for any signs of life and noted that the deceased felt ice cold and had clinical signs of rigor mortis. Although he had observed an officer performing chest compressions on the deceased, Nurse Stone had also observed that the deceased's chest was not moving in response to the compression. The deceased's eyes were fixed, he was not breathing and he had no palpable carotid pulse. From all of these observations Nurse Stone concluded the deceased showed no signs of life and had clearly died. Nurse Stone's impression, based upon his experience, was that the deceased had in fact been dead for a while and probably for a couple of hours.[53]

61. Nurse Stone considered that further CPR would be futile and advised the Serco officers to cease performing CPR. There was pooling of blood consistent with the deceased being face down prior to death, consistent with the description given by a Serco officer of the position in which the deceased was found.[54]

62. After resuscitation was ceased Nurse Stone told the Serco officers not to touch the deceased and further that they should all leave the room and inform the police of the death. Nurse Stone then left the deceased's room and returned to the health centre where he called his manager to inform them of the death.[55]

63. St John Ambulance officers attended Yongah Hill IDC and examined the deceased. Similarly to Nurse Stone, they noted there was evident rigor mortis present and significant lividity on the front of the deceased's body. There was also evidence of urinary incontinence. The deceased was certified life extinct by a St John Ambulance officer at 9.10 pm.[56]

64. Consistent with Nurse Stone's belief that the deceased had probably died a couple of hours before he assessed him, DSO Barron gave evidence at the inquest that after reflecting upon these events he had come to the view that the deceased may have already died at the time he first went in to the deceased's room earlier in the evening.[57]

65. Police officers from the Coronial Investigation Squad Northam Detectives' Office, Northam Police Station, Regional Operations Group, K9 section and Forensic Field Operations attended Yongah Hill IDC while the St John Ambulance Officers were still in attendance. The attending officers assessed the deceased and the incident scene. The deceased was in a single room, which appeared relatively clean and contained person effects belonging to the deceased. There no signs of a disturbance. A review of the CCTV footage

[53] T 31 – 32.
[54] T 22; Exhibit 2, Medical note 1.8.2015.
[55] T 22; Exhibit 2, Medical note 1.8.2015.
[56] Exhibit 1, Tab 4 and Tab 23.
[57] T 16.

of the deceased's doorway showed nothing to indicate the criminal involvement of another person in the deceased's death.[58]

66. After viewing the scene and a brief discussion with witnesses the attending officers determined there was no criminality involved in the death of the deceased. Following this assessment the ongoing investigation into the death became the responsibility of officers from the Coronial Investigation Squad.[59]

67. Photographs of the deceased and his room were taken and the deceased was formally identified by detention centre staff member. Medication consisting of carbamazepine 200 milligram tablets in the name of the deceased was seized by police, and it was noted the box contained 24 and a half tablets from a 100 tablet box. The box of remaining tablets were recorded as having been transferred to the State Mortuary with the body of the deceased. They were logged into the mortuary on 14 August 2015 and recorded as being later disposed of on 6 May 2016.[60]

68. There was no record of a Webster-pak of medication being found in the deceased's room at the time of his death.[61]

69. While police officers were still in attendance it became apparent that the atmosphere in the detention centre was becoming tense as other detainees became agitated upon hearing news of the death and were inciting violence towards detention centre staff. This was said to have hampered the ability of police officers to continue to investigate at the scene and it was maintained that this was the reason why no photographs were taken of the box of medication that was seized and no video recording was made.[62] It does not, however, explain why no attempt was made to take a photograph of the medication at the mortuary.

## CAUSE AND MANNER OF DEATH

70. On 5 August 2015 forensic pathologist, Dr Jodi White, performed a post mortem examination of the deceased. The examination showed no obvious injuries. The lungs were congested and there was a frothy plume extending from the nose and mouth area, with a lightly blood stained froth in the upper airway and oral cavity.[63]

71. Microscopy of the lungs showed gross oedema but no additional pathology. Toxicology analysis was completed, which showed low therapeutic amounts of carbamazepine, the antiepileptic medication prescribed to the deceased.[64]

72. Gross neuropathology of the brain concluded autolysis (from decomposition) with no other abnormalities detected. It was noted by the Neuropathologist

[58] T 9 – 10.
[59] T 7.
[60] T 7.
[61] T 10.
[62] T 7 – 9.
[63] Exhibit 1, Tab 5.
[64] Exhibit 1, Tab 5 and Tab 7.

that a CT scan of the deceased's brain completed at Northam Hospital on 11 November 2014 also showed a normal brain.[65]

73. Dr White noted she had received some limited information from IHMS outlining a history of epilepsy and, given her other findings, found that the cause of death was consistent with seizure (epileptic). Dr White noted that given the deceased's position when he was found, she could not exclude a contribution to the death by positional asphyxia, although I understand this would have occurred in the context of the seizure and its aftermath where the deceased would have been unable to protect himself.[66]

74. I note that an epilepsy specialist, Clinical Professor John Dunne, whose evidence I refer to below, reviewed the autopsy findings and found that the lung fluid was consistent with a seizure being the ultimate cause of death. Professor Dunne explained that in the vast majority of patients who suddenly die with epilepsy the data supports it being a seizure that somehow produces a cardiac arrhythmia or reflex fluid in the lungs, which causes poor oxygenation. Professor Dunne therefore agreed that the deceased's death was probably seizure related.

75. I accept and adopt the opinions of Dr White and Professor Dunne as to the cause of death and find the cause of death was due to seizure (epileptic).

76. It follows that I find that the manner of death was natural causes.

## QUALITY OF SUPERVISION, TREATMENT AND CARE

77. Under s 25(3) of the Act, where the death is of a person held in care, the coroner investigating the death must comment on the quality of the supervision, treatment and care of the person while held in that care. That obligation does not apply in relation to the deceased's case, but it is desirable that I make such comments.

78. To assist me in considering the quality of the medical care provided to the deceased, Professor Dunne reviewed the deceased's medical records and other relevant evidence and provided an expert opinion to the court, both in a written report and in oral evidence. Professor Dunne is a Consultant Neurologist and Physician with a particular specialist expertise in epilepsy.

79. After reviewing all of the data provided, Professor Dunne concluded the deceased had a clear diagnosis of epilepsy from the age of 21 for which he had been commenced on the commonly used epilepsy medicine carbamazepine. Professor Dunne considered carbamazepine to be appropriate for the seizure type that the deceased had, which was occasional convulsions without warning and with no other episodes. Once started on the medication the deceased remained seizure free, save for breakthrough seizures when he missed his medication. Therefore, when the deceased was compliant with his medication he was effectively safe from seizures and

[65] Exhibit 1, Tab 5 and Tab 6.
[66] Exhibit 1, Tab 5.

could continue living his life as normal. This is a common outcome for patients with this type of epilepsy.[67]

80. Professor Dunne considered the materials showed the deceased was generally committed to his treatment and noted that he appeared distressed at times when there were issues accessing his medication.[68]

81. An example was an occasion in October 2014 when the deceased was only given a five day supply of his medication in his Webster-pak. A note recorded that the deceased attended the night medication round on 29 October 2014 when his medication ran out and was very agitated. He demanded that his Webster-pak be changed immediately, and was unhappy when he was told that this was not possible and was offered a single dose of his medication instead, which he refused. He had a seizure the following day.[69]

82. The deceased later lodged a complaint about the issuing of the incomplete Webster-pak and the events that followed. He explained that his medication was very important, indicating an understanding of the essential nature of the medication to manage his condition.[70]

83. Professor Dunne considered that the evidence showed the change to single doses being dispensed twice daily created important problems for the deceased as his longstanding sleep disorder meant that attending regularly was difficult. It also showed that he became very distressed when he did not have control over consistent access to his medication.[71] Professor Dunne emphasised that a Webster-pak is a way of ensuring that a full week's supply of medication is accessible to a patient. In his opinion replacing it with a twice daily round to obtain a single dose was not a reasonable or practical approach in the circumstances.[72]

84. Professor Dunne noted that the record of missed doses of carbamazepine accords with the fact he had a low blood level of carbamazepine in his post-mortem toxicology results. His blood level was consistent with the deceased having missed "at least a number of doses."[73]

85. The significance of the lapse in medication doses is that it made the deceased vulnerable to seizures. Professor Dunne explained in his evidence that the primary risk factor for sudden unexpected death in epilepsy is convulsions/tonic-clonic seizures, which is the seizure type that the deceased exhibited. The statistics indicate that the risk of a seizure-related death in someone with well-controlled epilepsy is 1:2,500 whereas the risk is 1:200 in a person who experiences regular seizures.[74] As seizure frequency dictates the risk of sudden unexpected death in epilepsy, prevention of seizures is key and that is achieved by medication.[75]

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[67] T 74; Exhibit 1, Tab 32, p. 7.
[68] T 74 – 75.
[69] T 87 – 88.
[70] T 89, 92.
[71] T 92.
[72] T 93.
[73] T 75.
[74] T 76.
[75] T 76.

86. Professor Dunne acknowledged that, even for a person taking their medication regularly, there is a still a risk of seizure, which can lead to unexpected death in epilepsy or seizure-related accident. However, regular medication can drastically reduce the risk of that occurring. When the deceased had tried to be off his medicine in the past, prior to his arrival at Christmas Island, he had experienced a recurrence of seizures and he also had documented seizures in detention when there were dispensing issues. This evidence reinforced Professor Dunne's opinion that the deceased's carbamazepine medication was "absolutely essential for his well-being."[76] Professor Dunne noted that there was evidence in the materials that the deceased understood this, as on a number of occasions he had emphasised to various staff that it was essential he maintain his regular medication.[77]

87. Professor Dunne explained that having a tonic-clonic seizure will generally involve the person losing consciousness and then waking up sore, perhaps with a bitten tongue and having been incontinent. Understandably, it doesn't usually take long after a person experiences such events for them to become committed to a regular treatment to prevent them.[78]

88. With that in mind, Professor Dunne was worried that the available evidence might suggest that the deceased had "given up"[79] when he failed to attend for his medication doses in the days leading up to his death. He had already shown a level of distress the week before his death when he was not given the Webster-pak after turning up a day late and his behaviour afterwards was not reassuring.

89. Professor Dunne expressed concern that the deceased's failure to attend for his essential medication was not followed up, despite his attendance at the clinic for other matters. Based upon his review of the records, Professor Dunne concluded the deceased had missed at least half of his medication doses in the days leading up to his death, which was out of character for him as he was usually very compliant. Therefore, his behaviour should have triggered some investigation to establish why he was not attending and consideration given to implementing a process that ensured his essential medication was reliably dispensed.[80] As Professor Dunne noted, in a place of detention there is a responsibility that falls on those in charge to ensure that essential medicine is actually being provided and dispensed and taken.[81] As Professor Dunne put it, his failure to attend should have been a red flag to assess the deceased and investigate further his reason for not attending in order to try to remedy the problem.[82]

90. It was noted that the deceased was reliable when self-administering via a Webster-pak, so Professor Dunne suggested that more flexibility in providing the deceased with a Webster-pak might have resolved the problem. In that

[76] T 77.
[77] T 77.
[78] T 78.
[79] T 78.
[80] T 78 – 79.
[81] T 93.
[82] T 95, 97.

regard, Professor Dunne took exception to the use of the term 'privilege' in reference to providing the deceased with his essential medication.[83]

91. There was some discussion during the inquest about whether the 'privilege' referred to was receiving his medication or receiving it in the form of a self-administered Webster-pak. I am satisfied the reference to a privilege is a reference to being allowed to self-administer the medication via a weekly Webster-pak. Nevertheless, in circumstances where the alternative method of dispensing was difficult for the deceased to maintain given his sleep disorder, the lines do unfortunately start to blur in relation to the deceased, although this would not have been apparent to the nurse at the time the comment was made.

92. Professor Dunne was not concerned that the deceased was not reviewed as an outpatient by the RPH Neurology Department in terms of any impact upon his death. Professor Dunne did express his own particular view that ideally all patients with epilepsy should be seen in a timely manner in specialist clinics but he accepted the reality is that this is not always practical given the demands on the public hospital clinics. Professor Dunne agreed that the deceased was not a patient who required prioritising as his epilepsy was well-controlled on regular medicine and he had previously had a CT scan. Therefore, it is likely if he had been reviewed he would have continued with the same carbamazepine treatment unaltered.[84]

93. Nurse Stone has worked at various IHMS sites since 2013, including Yongah Hill IDC.[85] Nurse Stone has been involved in the exchange of Webster-paks as part of his duties. Nurse Stone explained that in his experience a detainee is given an appointment slip the evening before to remind them to present to the clinic to receive their Webster-pak. An appointment time is stated on the slip but if the person comes outside that time on the relevant day they will still be given the Webster-pak, and this was borne out in most of the medical history for the deceased.[86]

94. Nurse Stone gave evidence that if a detainee failed to attend to collect a Webster-pak he would be aware of this fact at the end of the clinic as he would have the Webster-pak still there at the clinic. Nurse Stone's evidence was that it was his practice to try his utmost to get in touch with that person to see where they were and, if they were still at that detention centre, to get them to come and collect the Webster-pak. Nurse Stone explained that his concern would be that otherwise this person will not have access to their Webster-pak for another seven days, which was why he would do his best to try and track the person down and pass on the medication. He would often ask a Serco officer for assistance in doing so.[87]

95. If his attempts to track down the detainee were unsuccessful, Nurse Stone said he would usually hand it on as part of the handover and indicate that

[83] T 83.
[84] T 80.
[85] T 19.
[86] T 32 – 33.
[87] T 24 – 25, 34

the person did not present for their Webster-pak so they would need to be followed up.[88]

96. As to the practice of whether a detainee would be followed up if they didn't attend a daily medication dispensing round, Nurse Stone's evidence was that, at the time of this incident, there "wasn't a black and white process"[89] for follow up in those circumstances. If he knew the particular person as a regular attendee Nurse Stone said he might become concerned and follow them up, but it might otherwise not be apparent to a particular nurse that a person had not attended. The situation was, therefore, quite different to a person failing to collect a Webster-pak, where it would be quite obvious they had failed to attend.[90]

97. Nurse Stone's evidence was that if it was brought to his attention that a detainee had failed to attend a medication round he would be concerned if the medication was anything other than pain medication, as he would assume it was important for the person to take the medication as prescribed for whatever condition it was intended to manage.[91] In those circumstances, if the failure to attend was brought to his attention then Nurse Stone said his practice would be to either phone their compound and request that the person be sent down to the clinic to see him or else book an appointment for the person so the issue can be followed up.[92] However, as indicated earlier, he would often not be aware of the failure to attend.[93]

98. Dr Deky Souvannavong is an Area Medical Director for IHMS. He is based in Canberra and has an oversight, clinical governance role over the IHMS services in a designated region. At the relevant time of the deceased's death Dr Souvannavong was the Area Medical Director for the west region, which included Yongah Hill IDC.

99. Dr Souvannavong was aware that after the death of the deceased the Department of Immigration and Border Protection and IHMS reviewed the circumstances of his death and identified "an absence of a trigger point for active follow up in addressing [the deceased's] medication management as a result of his non-compliance during the days preceding his death on 31 July 2015."[94] It was noted that the risk this presented was that "if the medication is for serious or life-threatening conditions, health may deteriorate without proper medication."[95] That is what the evidence of Professor Dunne supports occurred in this case.

100. Dr Souvannavong gave evidence that following these findings IHMS put in place a procedure to provide a trigger where people on critical medications do not receive that medication. The procedure varies amongst the different sites where IHMS provides services, as the size of the sites varies considerably.

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[88] T 25.
[89] T 25.
[90] T 25 – 26.
[91] T 26.
[92] T 26.
[93] T 27.
[94] T 52.
[95] T 52.

101. For the larger sites in the eastern states IHMS now uses a critical register list that can be displayed at the medication round so that the nurse doing the round can review who they have seen and identify if someone on the critical register list has not attended. This person can then be followed up to identify why they did not attend and attempts made to ensure they receive their critical medication.

102. In Western Australia at Yongah Hill IDC there are currently only 15 clients for IHMS so the nursing staff generally know all of the patients individually. This makes it easier for the nursing staff to be aware of which detainees are on critical medication and that information is also handed over between shifts. Given the much smaller number of patients involved, the nursing staff simply use a list of all of the people who receive medications, which they cross off as the medication is dispensed. At the end of the round if any person has not turned up to receive their medication they will be flagged for appropriate follow-up to establish why the client did not attend and to encourage them to take their medication as prescribed.[96]

103. Dr Souvannavong's evidence was that this new system would ensure that any critical medication would be reliably dispensed to a person in detention, provided the person was willing to take the medication.[97] That is because, like any other patient, a person in detention is entitled to decline to take their medication unless it is mandated under legislation.[98]

104. The protocol that sets out this new process was provided to Court and is described as IHMS guideline 312.2.1, documentation and administration of medication. It was most recently revised in February 2018.[99] The procedure is identified in paragraph 3.6, Critical Medications, which requires each site to have a means of following up clients who miss their critical medication.[100] Relevantly to this case, critical medications are defined to include anti-epileptics.[101]

105. The updated guideline also formally provides more flexibility in respect of Webster-paks for critical medication (rather than simply leaving it up to the discretion of individual staff), which addresses the other concern raised by Professor Dunne.

106. I am satisfied that IHMS has been proactive in identifying, and rectifying, the concerning issues raised by the death of the deceased. I am satisfied that the concerns properly raised by Professor Dunne in relation to the failure to ensure that there was a reliable system for dispensing the deceased's essential medication and monitoring where this did not occur, has been addressed by the new procedures implemented by IHMS.

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[96] T 53 – 54.
[97] T 59.
[98] For example under the *Mental Health Act 2014* (WA).
[99] T 63.
[100] Exhibit 3, Tab 21B, p. 10 [3.6].
[101] T 65; Exhibit 3, Tab 21A.

107. It is not entirely clear how the deceased managed to access an unauthorised box of carbamazepine, which was not issued by IHMS, and unfortunately the evidence available at the inquest does not allow me to take the matter any further. I am advised that the WA Police are aware of the concerns raised by the failure to properly document the box of medication in this case and that the shortcomings in this investigation have been addressed.[102] The evidence suggests that this medication was not likely to have assisted the deceased in managing his epilepsy, so other than noting that it was unusual for him to have an alternate source of medication, I do not make any further comment about it.

## CONCLUSION

108. The deceased came to Australia by boat in 2012. Because he did not come through authorised channels, he was detained by the Australian Government and held in various detention centres while steps were taken to try to process his application to remain in Australia on a visa. Sadly, that process had not been finalised prior to his death, so he never had the opportunity to live in the Australian community as he had hoped.

109. The deceased had disclosed that he had epilepsy when he first came into contact with Australian authorities and he was given appropriate medical management for that condition, including appropriate medication. This meant that for most of his time in detention his epilepsy was successfully managed so that he could remain seizure free.

110. However, in order to run any kind of facility like a detention centre, it is inevitable that rules and procedures are put in place so that the needs of individuals are managed on a day to day basis in a practical way. Unfortunately for the deceased, the procedures for the delivery of his medication did not suit his particular sleeping habits, which meant that he did not always comply with the procedures. This meant that the most convenient way for him to receive his medication, namely by Webster-pak, was not always achieved. I accept that generally he was given some flexibility, so that the Webster-pak was still made available, but prior to his death it appears that a decision was made that the deceased had passed the point where a Webster-pak could be provided for a particular week and he was told that he would have to attend twice daily for his medication dose until the following week's Webster-pak was available.

111. The evidence indicates the deceased either could not, or chose not to, comply with this alternative method for receiving his essential medication. This was despite the fact that he had always shown a good understanding of the need to take his medication as prescribed. There is no dispute that the effect of the deceased not taking his essential medication twice daily was that it made him susceptible to break-through seizures, and I have found that it was a seizure that ultimately caused his death.

[102] T 99.

112. Looking back on the events leading up to the death, the most concerning feature is that, when the deceased stopped attending for his essential medication, there was no attempt by any member of IHMS to follow up with the deceased and find out why he was not attending and to try to find a solution to the problem so that he returned to compliance with his medication regime.

113. I am satisfied that, following the death of the deceased, this problem was identified by IHMS and has been properly addressed by the implementation of a new regime for critical medications that ensures that IHMS nursing staff are aware when a detainee fails to attend a medication round for critical medication and will appropriately follow-up with the detainee on each occasion.

S H Linton
Coroner
27 December 2018