Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 33/18

I, Barry Paul King, Coroner, having investigated the death of ***Ali Jaffari*** *with an inquest held at the* ***Perth Coroner's Court*** *on* ***9 October 2018****, find that the identity of the deceased person was* ***Ali Jaffari, also known as Talib Houssain,*** *and that death occurred on* ***16 September 2015*** *at* ***Fiona Stanley Hospital*** *from* ***thermal injuries*** in *the following circumstances:*

Counsel Appearing:

Ms F M Allen assisting the Coroner

Ms E L Blewett (Corrs Chambers Westgarth) appearing for Serco Asia Pacific Pty Ltd

Ms J L Parker (Australian Government Solicitor) appearing for the Department of Home Affairs

Ms A King appearing for International Health and Medical Services

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INTRODUCTION

1. Ali Jaffari (the deceased) entered Australia in October 2010 as an illegal maritime arrival and was granted a protection visa in January 2012. In May 2014 the protection visa was cancelled due to criminal charges and, from 16 December 2014, the deceased was detained at Yongah Hill Immigration Detention Centre (Yongah Hill).

2. Yongah Hill was located in Northam. It could accommodate about 600 detainees in four main accommodation compounds: Eagle, Hawk, Swan and Falcon. Each compound had 18 accommodation modules, with four accommodation units (rooms) in each module. Each room contained two beds and an ensuite bathroom. Each detainee had a swipe card for the compound in which he was accommodated.[1] At the relevant time, Yongah Hill had about 340 detainees.[2]

3. Yongah Hill was managed by the Department of Immigration and Border Protection (DIBP), now the Department of Home Affairs, and the Australian Border Force. Serco Asia Pacific Pty Ltd (Serco) was contracted to provide management and maintenance of immigration detention centres, including catering, cleaning and welfare management. International Health and Medical Services Pty Ltd (IHMS) was contracted to provide primary health care to detainees at Yongah Hill.[3]

4. On 21 August 2015, the deceased made an apparent attempt to end his life by cutting the front of his neck with a razor, and on 11 September 2015 he re-opened the neck wound with a plastic knife.

5. On 16 September 2015 the deceased died from thermal injuries he sustained in a fire which he had started in his room at Yongah Hill.

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[1] Exhibit 1, Volume 1, Tab 31
[2] Exhibit 1, Volume 1, Tab 31- Attachment G
[3] Exhibit 1, Volume 1, Tab 31

6. Under s 19 of the *Coroners Act 1996* (the Act), a coroner has jurisdiction to investigate a death if it appears that the death is or may be a reportable death. As the deceased's death appeared to have been 'unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury', his death was a reportable death as defined in section 3 of the Act. I therefore had jurisdiction to investigate his death.

7. Under section 22(1)(a) of the Act, a coroner who has jurisdiction to investigate a death 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*, the *Young Offenders Act 1994* and the *Mental Health Act 1996*, or by a member of the Police Force.

8. A person held in immigration detention under the *Migration Act 1958* 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, nonetheless, involuntarily detained, it was desirable that an inquest be held in order to provide independent oversight of the circumstances surrounding his death.

9. I held an inquest into the deceased's death on 9 October 2018. The focus of the inquiry was on the supervision, treatment and care provided to the deceased while he was in immigration detention, particularly in relation to treatment for potential mental illness and any associated risk of self-harm or suicide.

10. Oral evidence at the inquest was provided by:

    a. Youssef Fahim Ibrahim Soltan, a detainee at Yongah Hill in September 2015;[4]

[4] ts 37 – 42

b. Ali Rez Hussaini, another detainee at Yongah Hill in September 2015 and an associate of the deceased. He was the last person to see the deceased before the fire;[5]

c. Andrew Mihich, a detainee service officer employed by Serco at Yongah Hill who was the first person to enter the deceased's unit after the fire was discovered;[6]

d. Anthony Vincent, a detainee service officer employed by Serco at Yongah Hill who entered the deceased's unit soon after Mr Mihich, found the deceased on fire in the bathroom of the unit and attempted to extinguish the fire;[7]

e. Tobias Kriss, a detainee service officer employed by Serco at Yongah Hill who entered the deceased's unit after Mr Vincent, attempted to extinguish the fire and tried to remove the deceased from the unit;[8]

f. Valerie Christmass, a detainee service officer employed by Serco at Yongah Hill who had seen the deceased prior to the fire;[9]

g. Michele Fryer-Hornsby, a former welfare officer employed by Serco at Yongah Hill in September 2015 who had ongoing interactions with the deceased;[10]

h. First Class Constable Lucky Moyo, a police officer who attended Yongah Hill shortly after the fire was extinguished;[11]

i. Sergeant Amy Taylor, a detective sergeant at the time of the fire who had attended Yongah Hill to

[5] ts 92 – 101
[6] ts 42 – 55
[7] ts 56 – 65
[8] ts 65 – 84
[9] ts 85 – 92
[10] ts 101 – 115
[11] ts 12 – 16

investigate the incident in order to rule out criminality;[12]

j. Sergeant Mark Harbridge, a forensic officer and the supervisor of a crimes scene unit who had attended Yongah Hill to examine the deceased's unit in order to assist with the investigation;[13] and

k. Professor Aleksandar Janca, a professor of psychiatry and consultant psychiatrist who had seen the deceased twice before his death.[14]

11. The documentary evidence adduced at the inquest primarily comprised a report prepared by Senior Constable Andrew Foster of the Coronial Investigation Squad.[15] In addition, the Court obtained a report by consultant psychiatrist Dr Darryl Bassett on the quality of supervision, care and treatment of the deceased at Yongah Hill.[16]

12. One issue at the inquest was whether the deceased had lit the fire with an intention to cause burns to himself to end his life and, if so, how he had lit it. I have found that he had lit the fire, probably with a contraband lighter, and that he had done so with an intention to end his life.

13. 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 in that care. While that obligation does not apply in relation to the deceased's case, it is desirable that I make such comments. I have found that the supervision, treatment and care provided to the deceased was reasonable in the circumstances.

[12] ts 5 – 12
[13] ts 16 – 24
[14] ts 24 – 33
[15] Exhibit 1, Volumes 1 – 4
[16] Exhibit 1, Volume 1, Tab 36

THE DECEASED

14. On 9 October 2010 the deceased arrived at Christmas Island as an illegal maritime arrival. He had no identity documents, but claimed to be an Afghani national who had lived in Pakistan from 17 years of age after his family had moved there around 1986. He claimed to be persecuted in Pakistan due to his Shia faith and his Hazara ethnicity.[17]

15. On 29 December 2010 the deceased was transferred to Curtin Immigration Detention Centre. Initially, he was not accepted as a bona fide refugee given a lack of evidence of persecution in Afghanistan, where he claimed citizenship. However, following a review, on 14 September 2011 he was found to be owed protection, and on 18 January 2012 he was granted a protection visa and released into the community.[18]

16. In November 2012 the deceased was charged with six counts of indecent acts with a child under 16. He was convicted of the charges on 22 August 2013, was sentenced to a community corrections order and was placed on the sex offender register. After two appeals, the sentence was replaced with a suspended period of imprisonment, but he remained on the sex offender register.[19]

17. On 15 May 2014 the deceased was arrested and charged with accessing child pornography during the period from July 2012 to May 2014. He was released on bail and detained at the Maribyrnong Immigration Detention Centre (Maribyrnong) from 20 May 2014. He was convicted on 2 December 2014 and was sentenced to three months imprisonment and a good behaviour bond. On 16 December 2014 he was transferred to Yongah Hill.[20]

[17] Exhibit 1, Volume 1, Tab 31
[18] Exhibit 1, Volume 1, Tab 31
[19] Exhibit 1, Volume 1, Tab 31
[20] Exhibit 1, Volume 1, Tab 31

18. On 22 December 2014 the deceased's protection order was cancelled and he was detained pending a determination of his removal to Afghanistan.[21]

THE DECEASED'S IDENTITY

19. Under s25(1)(a) of the Act I must find, if possible, the identity of the deceased.

20. In January 2015 another detainee at Yongah Hill alleged to a detention intelligence officer that the deceased was, in fact, a former Pakistani police officer who had been dishonest and had abused his position, especially in targeting Afghani people.[22]

21. Following liaison with Pakistani authorities, fingerprint and photograph records were sent to Pakistani police, who reported that the deceased's identity was Talib Houssain son of Asmat Ali and that he was a former constable of police in Quetta in Pakistan who had been recruited in 2002 and dismissed (presumably in his absence) in 2011.[23]

22. The Pakistani police had been in contact with the deceased's brother in Quetta, who confirmed the details of the deceased's original identity.[24]

23. Under s36 of the *Births, Deaths and Marriages Registration Act 1998*, a change of name by repute or usage is accepted if the change is made after the commencement of that Act so, given that the deceased was known as Ali Jaffari for all of the time he was in Australia, it is appropriate to refer to him by that name, but to note that he was also known as Talib Houssain.

24. On 4 September 2015 the deceased notified case management at Yongah Hill that he wished to return voluntarily to Afghanistan. In the weeks leading up to

[21] Exhibit 1, Volume 1, Tab 31
[22] Exhibit 1, Volume 1, Tab 31
[23] Exhibit 1, Volume 1, Tab 31
[24] Exhibit 1, Volume 1, Tab 31

that notification, he had been in telephone contact with his brother in Quetta, who may have told him that the Australian government were aware of his true identity. If so, that may have contributed to his decision to request voluntary removal to Afghanistan.[25]

25. DIBP officers planned to interview the deceased on 16 September 2015 to give him an opportunity to respond to the allegation that he was Talib Houssain. If he was unable to refute the allegation, he would likely have been subjected to a non-voluntary removal once his actual citizenship had been determined. DIBP officers had not made him aware of the planned interview.[26]

THE DECEASED'S MEDICAL HISTORY

26. In addition to providing primary care, IHMS had a mental health team (IHMS mental health) to provide support and case management to detainees with mental health problems. Support was provided through the Psychological Support Program (PSP), which involved an assessment and, if necessary, a process of monitoring and review called Supportive Monitoring and Engagement (SME).

27. There were three levels of SME, with the most intensive (High Imminent) requiring constant, one-on-one monitoring. The next level (Moderate) involved observations every 30 minutes, and the lowest level (Ongoing) involved an ongoing focus on encouraging normal behaviour, with documentation of progress.

28. During an interview in June 2011 for the review of his refugee status, the deceased threatened self-harm to departmental staff. The interviewer terminated the interview and referred the deceased to Serco, who on-referred him to IHMS mental health. The team

[25] Exhibit 1, Volume 1, Tab 31
[26] Exhibit 1, Volume 1, Tab 31

considered that the deceased did not need psychological support and the matter was closed.[27]

29. On 21 May 2014 the deceased was reviewed by an IHMS psychiatrist in Maribyrnong. He told the psychiatrist that he had no intention of killing himself but said that he could die if kept in detention or sent back to Afghanistan. He seemed distressed about his situation. He was placed on Moderate SME for two weeks.[28]

30. On 9 July 2014 the deceased again saw the psychiatrist. He did not present as depressed or psychotic, but had unrealistic expectations about his future and did not want to be with other detainees.[29]

31. On 6 January 2015 at Yongah Hill, the deceased was referred to IHMS mental health after he had been seen apparently responding to his own thoughts as if he were having auditory hallucinations. When interviewed, he was very guarded with personal questions and just wanted to leave the interview. He said that his only concern was to go back into the community.[30]

32. On 26 January 2015 the deceased was kicked in the face by another detainee, causing loss of consciousness and minor soft tissue injuries. He was sent to Northam Regional Hospital for medical examination in order to rule out head injury.[31]

33. On 25 June 2015 the deceased was seen by IHMS Mental Health. He alleged that all detainees were his enemy and that people were trying to fight with him every day. The mental health nurse who saw him noted a strong paranoid flavour about the allegations.[32]

34. On 6 July 2015 the deceased was referred to IHMS mental health. He was acutely unwell, with paranoid

[27] Exhibit 1, Volume 1, Tab 31
[28] Exhibit 1, Volume 4, Tab 4
[29] Exhibit 1, Volume 4, Tab 4
[30] Exhibit 1, Volume 4, Tab 4
[31] Exhibit 1, Volume 4, Tab 4
[32] Exhibit 1, Volume 4, Tab 4

ideation, persecutory delusions, isolation in his room, poor sleep and poor diet. He had a fixed belief that his own countrymen would attempt to kill him, and he was xenophobic and paranoid of people with dark skin. He was assessed as a high risk of harm to others and a passive risk to himself. He was placed on High Imminent SME.[33]

35. On 7 July 2015 the deceased was kept on High Imminent SME and a doctor was arranged to review him, but he refused to see the doctor who 'had brown skin colour'. That evening the deceased was taken to the emergency department at Swan District Hospital.[34]

36. At the hospital the deceased refused to allow an Indian doctor to assess him. He was returned to Yongah Hill and, on the next day, the SME was down-graded to Moderate after he had been placed in a single room in Swan Compound and provided olanzapine. He was scheduled to see Professor Janca on 13 July 2015 for a first assessment, but he refused to be assessed. Another appointment to see Professor Janca was made for 20 July 2015.

37. Over the week, the deceased generally stayed in his room with his door locked. He refused to take olanzapine and said that he would only speak to an 'Englishman'.

38. On 20 July 2015 the deceased again refused to allow Professor Janca to assess him. He looked anxious and angry, with a hostile and threatening attitude. He shouted that he would only speak with an Englishman.[35]

39. On 23 July 2015 an IHMS mental health nurse assessed the deceased after his mental state appeared to have declined over the preceding week and he had become agitated, aggressive and paranoid. The deceased said

[33] Exhibit 1, Volume 4, Tab 4
[34] Exhibit 1, Volume 4, Tab 4
[35] Exhibit 1, Volume 4, Tab 4

that he had no suicidal ideation but that the detention centre was his problem as it was too big. He wanted to be in the community. He was offered a single room in Eagle compound, but he believed that his enemies were there, too. The mental health nurse up-graded the SME back to High Imminent and the doctor referred him for an off-site psychiatric review.[36]

40. The deceased was taken to Swan District Hospital, where again he refused to speak to the doctor who was not an 'Englishman'. He was returned to Yongah Hill that night.[37] He remained on High Imminent SME until 27 July 2015 because he could not be assessed.[38] On that day, he was openly called a dog and a paedophile by another detainee while walking through Swan compound. A mental health nurse assessed him and down-graded the SME to Moderate.[39]

41. On 29 July 2015 an IHMS mental health nurse assessed the deceased and down-graded the SME to Ongoing. The deceased appeared to be less anxious and agitated when left in a quiet safe environment. By this time, he was agreeable to seeing a psychiatrist. When assessed again on 1 August 2015 the deceased was notably improved but he was kept on Ongoing SME. [40]

42. Over the next three weeks the deceased kept a low profile and had little contact with IHMS. However, on 21 August 2015 he cut the front of his neck with a razor in his room and then walked outside with a bleeding wound. He said that he did not want help and wanted to die.[41] He was taken to Northam Regional Hospital and a dressing was put on the wound before he was transferred to Royal Perth Hospital (RPH).[42]

43. At RPH, the deceased's wound was treated and sutured in the State Trauma Unit, and he was transferred to the

[36] Exhibit 1, Volume 4, Tab 4
[37] Exhibit 1, Volume 3, Tab 2
[38] Exhibit 1, Volume 4, Tab 4
[39] Exhibit 1, Volume 4, Tab 4
[40] Exhibit 1, Volume 4, Tab 4
[41] Exhibit 1, Volume 4, Tab 4
[42] Exhibit 1, Volume 3, Tab 1

psychiatry unit for assessment. There was no evidence of psychotic, depressive or organic illness. His suicide attempt was considered to be the result of the long period in detention and the revocation of his protection visa. It was noted that his risk of self-harm could increase upon returning to an immigration detention centre.[43]

44. On 28 August 2015 the deceased was returned to Yongah Hill and placed on High Imminent SME. On the next day, the SME was down-graded to Moderate. While in RPH he appeared to have gone through a significant shift in his attitude. He was now engaging with other detainees and with non-white detainees and Serco officers with whom he had previously refused to engage, and he was socialising instead of hiding in his room. The Afghani detainee community embraced and supported him once again.[44]

45. On 31 August 2015 the deceased saw Professor Janca, whom he told that he was talking to everyone, regardless of their origin, because he wanted to prove that he was a nice man who wanted a second, new life in Australia. He denied thoughts of self-harm and said that his suicide attempt was the result of a day of intense thinking about his family and the situation at Yongah Hill. Professor Janca diagnosed the deceased with adjustment disorder and recommended that he remain on Moderate SME because he was ambivalent to olanzapine.[45]

46. Due to his improved mood and his guarantee of his own safety, on 1 September 2015 an IHMS psychologist down-graded the SME to Ongoing with hourly observations.[46]

47. On 4 September 2015 the deceased notified case management that he wished to be returned home to

[43] Exhibit 1, Volume 3, Tab 3
[44] Exhibit 1, Volume 4, Tab 4
[45] Exhibit 1, Volume 1, Tab 29; Exhibit 1, Volume 4, Tabs 3 and 4
[46] Exhibit 1, Volume 4, Tab 4

Afghanistan. On 8 September 2015, he formally signed a request for removal. He appeared to be at peace with himself after exhausting all options regarding his immigration status.[47]

48. On 9 September 2015 an IHMS mental health nurse reviewed the deceased and found him settled and showing insight. He denied any risk of self-harm and his request for removal indicated that he was future-focused. The mental health nurse ceased the SME.[48]

49. On 11 September 2015 cleaners in the Swan compound told Serco officers that the deceased was in need of medical attention.[49] He had ingested about 200 ml of shampoo and had re-opened his previous neck wound with a plastic knife. He was taken to the IHMS medical clinic and transferred by ambulance to the emergency department at Northam Hospital, where he said that a voice told him to self-harm.[50]

50. The deceased was on-transferred from Northam Hospital to RPH, and the wound was again sutured. He was assessed by a psychiatry registrar, whom he told that he was awaiting deportation, and that he just wanted to return to Pakistan (sic) after which he would no longer be suicidal because the only reason for his current actions was that he was in a detention centre. He complained of thoughts of self-harm and internal voices telling him not to eat or sleep.[51]

51. The registrar found that the deceased was of sound mind but had decided to self-harm as a political statement related to being in a detention centre. The internal voices were pseudo-hallucinations rather than illusions. The registrar noted that the deceased had received adequate psychiatric input but still self-harmed due to issues associated with being in the detention centre. The deceased was at high risk of

[47] Exhibit 1, Volume 1, Tab 31
[48] Exhibit 1, Volume 4, Tabs 2.4 and 4
[49] Exhibit 1, Volume 4, Tabs 1.5 and 4
[50] Exhibit 1, Volume 3, Tab 1;
[51] Exhibit 1, Volume 3, Tab 3

repeating that behaviour and would require increased 'suicide watch' while being transported and detained. He was discharged that night back to Yongah Hill with a discharge letter recommending regular psychiatric follow-up to assess risk.[52]

52. On 12 and 13 September 2015 the deceased was kept on High Imminent SME with constant one-on-one monitoring as was usual for that level of SME. He attended the IHMS clinic and his wound was re-dressed.

53. On 14 September 2015 Professor Janca reviewed the deceased, who reported feeling anxious and depressed with poor sleep since learning that he had no chance of remaining in Australia. When he thought of his situation, he had thoughts which were like hearing a voice in his brain telling him to harm himself. He said that he had no intention to do that, and that he would like the Serco officer who was monitoring him to be removed so that he could settle his mind and spend more time with his friends in Yongah Hill.[53]

54. Professor Janca found that the deceased was withdrawn and low in mood but without manifest psychotic phenomena. The 'voice' appeared to be a pseudo-hallucination as described in the RPH discharge letter. Professor Janca completed a risk assessment form and recommended that the deceased be placed on Moderate SME with weekly psychiatric reviews.[54] He considered that having an officer at arm's length at all times, as would be the case with High Imminent SME, would have been worse for the deceased's mental health.[55]

55. That night the deceased woke up agitated. He went to the Serco office with his one-on-one monitor and reported auditory hallucinations. He said that he wanted a white female officer or a young boy from Swan

[52] Exhibit 1, Volume 3, Tab 3
[53] Exhibit 1, Volume 1, Tab 29
[54] Exhibit 1, Volume 1, Tab 29; Exhibit 1, Volume 4, Tabs 3 and 4
[55] ts 32 per Janca, A

compound to be in his room and did not want non-Caucasian officers to monitor him. The on-duty detention service manager spoke to him, and he returned to his room. He slept poorly.

56. On 15 September 2015 the deceased's case was discussed in a PSP meeting. The deceased had a consultation with a mental health nurse a short time later, at which time he appeared settled with no thoughts of distress or harm from others. He was unable to explain the events prior to lacerating his neck and said he would not do anything like it again. He requested that the 24 hour watch be removed.[56] The mental health nurse down-graded the deceased's SME level to Moderate with one hourly observations.[57]

EVENTS LEADING UP TO THE FIRE

57. On 12 September 2015 the deceased was moved to Eagle Compound where he would be close to other Hazara detainees, Ali Reza Hussaini and Juma Khan Akbari. His other close associate, Sayed Mohammed Essa Shah, remained in Swan Compound.[58]

58. On 15 September 2015 the deceased spent the morning in his room or a friend's room, walking around the common area in the detention centre or having meals. At 1.30 pm he saw the IHMS mental health nurse, and by 2.00 pm he was sleeping in his room. He again went for walks or socialised with associates in the afternoon, and in the early evening he went for dinner.

59. At 9.20 pm the deceased left Eagle Compound and went to the common area for a walk with Mr Shah. He and Mr Shah returned about 15 minutes later on the way to his room, but the Serco officer at the gate to the compound did not allow Mr Shah to enter the compound.[59]

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[56] Exhibit 1, Volume 4, Tab 4
[57] Exhibit 1, Volume 4, Tab 2.4
[58] Exhibit 1, Volume 2, Tab 6; Exhibit 1, Volume 1, Tabs 7, 8 and 12
[59] Exhibit 1, Volume 2, Tab 6; Exhibit 1, Volume 1, Tab 8

60. The deceased went to Mr Hussaini's room and told him about Mr Shah's exclusion from Eagle Compound. The deceased was angry and upset, but he did not threaten to harm himself. Mr Hussaini told him not to take it seriously because the officer was just doing her duty.[60]

61. Mr Hussaini then walked the deceased back to his room. They went into the deceased's room and Mr Hussaini sat on the bed. He again told the deceased to calm down. After about two minutes, Mr Akbari called for Mr Hussaini to come out to help move some things, so Mr Hussaini stood up and told the deceased that he had to go. The deceased replied that it was okay because he was going to sleep. Mr Hussaini had no concerns about him.[61]

62. Video recording of the door to the deceased's room confirmed that Mr Hussaini remained in the deceased's room for a short time and then left and met Mr Akbari outside the donga. They then walked away with no urgency.[62]

THE FIRE

63. About four or five minutes after Mr Hussaini left the deceased's room, smoke could be seen coming from it. Smoke alarms in nearby detainees' rooms activated, causing the occupants to leave their rooms to investigate. They noticed the smoke and began yelling 'Fire! Fire!'[63]

64. Serco officer Andrew Mihich was on duty in Hawk Compound when he heard the detainees yelling. He saw the smoke coming from the deceased's room, so he ran to Eagle Compound and entered the room after opening the door with his key.[64] He noticed a blanket or floor

[60] Exhibit 1, Volume 1, Tab 7; ts 96 per Interpreter/Hussaini
[61] Exhibit 1, Volume 1, Tab 7; ts 96 and 100 per Interpreter/Hussaini
[62] ts 21 per Harbridge, M; Serco CCTV record 15/09/2015
[63] Exhibit 1, Volume 1, Tab 13
[64] Exhibit 1, Volume 1, Tabs 1 and 9

matting on fire in the middle of the floor of the living area, so he pulled the item out of the room and onto the veranda at the front of the module. He then turned on the light in the room and saw smoke billowing out from under the bathroom door, so he ran to the officer station in Eagle Compound to get a fire extinguisher.[65]

65. While Mr Mihich was obtaining a fire extinguisher, two detainees entered the deceased's room and tried to open the bathroom door, but it was locked.[66] Serco officer Anthony Vincent arrived with a fire extinguisher and used his key to open the bathroom door. He deployed the fire extinguisher into the bathroom but was overcome by the smoke, so he went outside to take some deep breaths of air. Mr Mihich returned, and he and Mr Vincent then went into the room two or three times but were overcome by smoke each time and had to go outside.[67]

66. Serco officer Toby Kriss arrived and found the deceased lying unconscious on the bathroom floor, covered with a burning blanket. Mr Kriss was also overcome by smoke when he attempted to remove the deceased from the bathroom. Serco emergency response team members then arrived and, with Mr Kriss' assistance, pulled the deceased onto the veranda and gave him first aid by covering him with wetted towels and placing him in the recovery position. Mr Kriss removed what appeared to be a piece of ripped sheet from around the deceased's neck. IHMS nurses attended and administered oxygen.[68]

67. Ambulance officers attended and took over treatment of the deceased until a rescue helicopter arrived and transferred the deceased to Fiona Stanley Hospital (FSH), arriving at about midnight.[69]

[65] Exhibit 1, Volume 1, Tab 13
[66] Exhibit 1, Volume 1, Tabs 10 and 11
[67] Exhibit 1, Volume 1, Tab 14
[68] Exhibit 1, Volume 1, Tabs 15 and 16
[69] Exhibit 1, Volume 1, Tab 28; Exhibit 1, Volume 3, Tab 4.1

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68. Upon arrival at the emergency department at FSH the deceased was assessed to have full thickness burns to about 60% of his total body surface area and substantial inhalation injury. He underwent multiple escharotomies and was admitted to the intensive care unit (ICU).

69. Despite full active treatment, the deceased's condition deteriorated rapidly until he died on the evening of 16 September 2015.

CAUSE OF DEATH

70. Chief Forensic Pathologist Dr C T Cooke conducted a post mortem examination of the deceased on 25 September 2015 and found thermal injuries (burns) with medical and surgical treatment, smoke inhalation with black particles in the airways and congestion of the lungs, congestion of the body organs, generalised oedema and a pale liver. There was also early arteriosclerosis and likely fatty change of the liver.[70]

71. Dr Cooke formed the opinion, which I adopt as my finding, that the cause of death was thermal injuries.[71]

HOW DEATH OCCURRED

72. The evidence, particularly the video recording of the deceased's front door prior to the fire commencing, makes clear that the deceased was alone in his room when he was burned in the fire. Mr Hussaini had left the room a couple of minutes before smoke was first visible, and the doors of the room and the bathroom were locked from the inside. No other person had entered the deceased's room until after the fire had been discovered.

[70] Exhibit 1, Volume 1, Tab 4
[71] Exhibit 1, Volume 1, Tab 4

73. Police detectives were able to exclude Mr Hussaini as a suspect in the lighting of the fire on the basis of the consistency of his version of events with the versions of other relevant witnesses, the lack of commotion heard or seen by occupants of the rooms beside the deceased's room, the locked rooms, and the short time-frame involved. In addition, the deceased's mental health and his state of mind was taken into account.[72]

74. Forensic officers from the Crime Scene Unit led by Sergeant Mark Harbridge examined the deceased's room to attempt to identify the cause of the fire and to determine whether there was any evidence to suggest any level of criminality. They were unable to identify an ignition source and did not detect any accelerants.[73]

75. Sergeant Harbridge produced a report in which he concluded that the deceased had been in the bathroom in a sitting or crouched position and had most likely used an ignition source to ignite his clothing in an act of self-harm. He stated that his hypothesis was supported by the lack of a detected accelerant. He said that the fire appeared to be localised to the deceased and his clothing, that the deceased had remained on the bathroom floor until found by Serco officers, and that there was no sign of a struggle occurring in the main room or the bathroom.[74]

76. In oral evidence, Sergeant Harbridge said that the ignition source could have been a match or a cigarette which had been engulfed in the fire. There were so many people going in and out of the room after the fire had started that, if the source was a lighter, it could have been removed by any of them.[75]

77. Sergeant Harbridge also clarified that a lighter or a match would have been sufficient to have ignited the materials which were burned in the fire.[76]

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[72] ts 11 per Taylor, A; Exhibit 1, Volume 1, Tab 1
[73] ts 17 per Harbridge, M
[74] Exhibit 1, Volume 1, Tab 34
[75] ts 20 per Harbridge, M
[76] ts 23 per Harbridge, M

78. There was evidence that lighters were considered contraband at Yongah Hill, so they were confiscated by Serco officers if found during regular searches of the detainees' rooms. However, that evidence was equivocal. A statement obtained from Eddie Davie, a detainee who was in a room in Eagle Compound near the deceased's, said that lighters did exist in Yongah Hill and that if the deceased had wanted to get one, it would not have been difficult for him. In addition, Serco officer Damien Meha provided a statement in which he stated that, in the five years in which he had worked in immigration detention centres, he had had located about 15 lighters, mostly during searches of rooms. There was no evidence about detainees being personally searched for contraband.

79. There are two currently unexplained facts surrounding the deceased's death. The first is the existence of burning material in the living area of the deceased's room when Serco officer Mihich first entered it. Why would the deceased have lit material on fire in the living area and then left it there to go into the bathroom to start another fire? I can only speculate, but it does seem possible that he had lit the first material to see whether it would burn and then, once satisfied that it would, had gone into the bathroom to complete his suicide.

80. The second unexplained fact was the short time between the point when Mr Hussaini left the deceased's room and the point when smoke was first seen coming from the room. That fact throws suspicion on Mr Hussaini, but the locked door and video evidence of his composure when leaving the room appear to rule out the likelihood that he was directly involved in the death. However, his oral evidence that he had been in detention for seven or eight years[77] led me to wonder whether he had any relevant criminal history which had led to the protracted detention.

[77] ts 100 per Interpreter/Houssaini

81. Following the hearing of the inquest, I requested and received information about Mr Hussaini's case from the Department of Home Affairs. It appears that he arrived in Australia as an illegal maritime arrival on 11 August 2011 and has been detained since then. He was convicted of an indecent assault on 7 September 2012 and fined $5000 (later reduced to $2000 on appeal), and as of 31 October 2018 was 'on a removal pathway', which I take to mean a process of deportation. There does not appear to be anything in that information that implicates Mr Hussaini in the death.

82. I am satisfied that Mr Hussaini was not directly involved with the deceased's death. The short period of time between the time when he left the deceased's room and the point at which the deceased lit the fire or fires remains unexplained, but does not affect my conclusion.

83. An important issue relating to the circumstances of the deceased's death was his state of mind. That issue was best addressed by Professor Janca and by consultant psychiatrist Dr Darryl Bassett.

84. Professor Janca gained the impression that the deceased's suicide attempts were demonstrative, impulsive protests due to his frustration with the prolonged detention and the recent loss of hope that his immigration status in Australia would be positively resolved.[78] Professor Janca was surprised by the deceased's actions because he, the deceased, had not presented as being depressed or psychotic and his insight and judgment appeared to be intact. Professor Janca had thought that the deceased had concluded that his immigration status had been decided and that he had been looking forward to being out of Yongah Hill and to returning to some kind of normal life.[79]

85. Dr Bassett, who had not seen or treated the deceased, provided a report to the court. He considered that the deceased was aware that he would be refused residency

[78] Exhibit 1, Volume 1, Tab 29
[79] ts 30 per Janca, A

in Australia, but he would not accept that this would occur. He was determined to avoid deportation and became increasingly desperate, as was reflected in the two suicide attempts, though the first one should be considered a plea for help.[80]

86. Dr Bassett noted that the deceased appeared calm after being told that he would be deported, which could have reflected his determination to complete suicide since he would have relief from his distress over his failure to achieve residency and his fear of return to Pakistan.[81]

87. Dr Bassett suggested that the deceased's choice of burning as a means of suicide may have reflected not only his determination to die, but also his shame and rage at failing to achieve his life goals.

88. It appears to me that, from a layperson's perspective, the deceased had further potential reasons to end his life. One such reason was that, according to Mr Shah, in the time leading up to the fire he had been in touch with his brother in Pakistan about wanting to go home and that his brother had tried to dissuade him because he would be too much of burden on the family.[82]

89. Other possible reasons were that the deceased's brother may have told him that Australian authorities were aware that he was Talib Houssain, and that he now had a criminal record and had been verbally abused by other detainees at Yongah Hill because of the nature of the offences. It is possible, if not likely, that these factors may had added to any sense of despair he may have had about his future.

90. In the foregoing circumstances, I am satisfied that, with an intention to end his life, the deceased ignited flammable material which he was wearing or was near him and caused himself thermal injuries which caused his death.

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[80] Exhibit 1, Volume 1, Tab 36
[81] Exhibit 1, Volume 1, Tab 36
[82] Exhibit 1, Volume 1, Tab 8

91. I find that death occurred by way of suicide.

SUPERVISION, TREATMENT AND CARE OF THE DECEASED

92. The evidence available to me indicates that the deceased was supervised at Yongah Hill with respect and with concern over his propensity to self-harm.

93. The DIPB conducted a 'Post Action Review'[83] in which one of the aims was to identify whether any remedial changes to policies, processes and procedures were required. The review made four findings with associated recommendations. Three of those findings with recommendations, paraphrased as follows, are relevant from a coronial perspective:

    a. there was inconsistent application of rules relating to visits among detainees in the compounds. A set of practices should be established, with flexibility to adopt revised approaches in relation to vulnerable detainees;

    b. as a detainee who had been identified as vulnerable, the deceased may have benefited from extra peer support by Mr Shah, who had been prevented from going with him into his compound. There should be a 'buddy' system of support for vulnerable detainees to allow nominated buddies to move between compounds; and

    c. the deceased's mental health was such that he may have been better managed in a mental health ward. No recommendation was made, given the amount of mental health care the deceased received.

94. In relation to the issue of allowing a buddy to have accompanied the deceased to his room, the evidence does suggest that Mr Shah was the deceased's closest

[83] Exhibit 1, Volume 1, Tab 31

associate and that he had planned to stay with the deceased on the night of 15 September 2015 to look after him. However, the deceased had other associates nearby in Eagle Compound, so it is understandable that, if Serco officers had concerns, they would be comforted by the proximity of those associates to the deceased. They would also have been comforted by the fact that the deceased had been assessed by Professor Janca on 14 September 2015 and an IHMS mental health nurse on the next day before the SME was down-graded.

95. I note too that, in Dr Bassett's opinion, once the deceased had made the firm decision to end his life, it would have been extremely difficult to prevent his death. Frequent observation could have been helpful, but there is a limit to what any intervention could have achieved. The only intervention which could have prevented the deceased's suicide would have been the granting of residency.[84]

96. In those circumstances, while I agree that the deceased would have likely benefited from a system established by Serco which would have allowed Mr Shah to accompany him to his room, I cannot be satisfied that the result would likely have been different. Of relevance is that the deceased did not smoke, so was likely to have obtained a lighter or another ignition source in advance with a plan to use it to start the fire. If that was so, the pre-meditation distinguishes the fire from the earlier, apparently impulsive, acts of self-harm.

97. As to the DIBP finding in relation to the deceased being managed in a mental health facility, Professor Janca did not consider that appropriate. He said that the deceased did not have a severe, serious mental illness such as major depression or psychosis. People with adjustment disorders are not treated in inpatient settings.[85] I accept Professor Janca's evidence.

[84] Exhibit 1, Volume 1, Tab 36
[85] ts 30 per Janca, A

98. Both Dr Bassett and Professor Janca commented on the quality of the treatment and care provided to the deceased at Yongah Hill. Dr Bassett stated that, based on the evidence available to him, it was excellent. He agreed with Professor Janca's diagnosis and considered that the officers and mental health professionals involved with the deceased provided benevolent and attentive care with a high degree of respect for his cultural background and his mental state.[86]

99. Professor Janca also considered that the deceased could not have received better management, in the sense that he was seen by an experienced psychiatrist, a senior psychologist and senior mental health staff at Yongah Hill. Professor Janca did not think that he would have received more care in a public mental health ward.[87]

100. I find that the supervision treatment and care of the deceased at Yongah Hill was reasonable and appropriate in the context of detention.

B P King
Coroner
7 January 2019

[86] Exhibit 1, Volume 1, Tab 36
[87] ts 31 per Janca, A