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

***Western Australia***

# RECORD OF INVESTIGATION INTO DEATH

*Ref No: 33/2014*

*I, Rosalinda Vincenza Clorinda Fogliani, State Coroner, having investigated the death of* ***Ramaiah MAHENTHIRAN****, with an Inquest held at Perth Coroners Court on 19 September 2014 find that the identity of the deceased person was* ***Ramaiah MAHENTHIRAN*** *and that death occurred on 22 July 2013 at Curtin Immigration Detention Centre, Derby as a result of coronary atherosclerosis in the following circumstances -*

**Counsel Appearing:**

Sergeant Lyle Housiaux assisting the State Coroner

Ms C Holt (Sparke Helmore Lawyers) appeared on behalf of the Department of Immigration and Border Protection

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## INTRODUCTION

On 22 July 2013 Broome Police were advised by a staff member from Derby Hospital that Ramaiah Mahenthiran (the deceased) had passed away at Curtin Immigration Detention Centre (Curtin IDC). The death was reported to the coroner on that date.

The deceased was a 50 year old Sri Lankan male of the Tamil ethnic group. At the time of his death in Western Australia he was an unlawful non-citizen in immigration detention. He had spent approximately two and a half months in Australia after arriving in the Cocos (Keeling) Islands by boat on 5 May 2013, without holding a valid visa. He was initially detained in facilities in Christmas Island and then transferred to Curtin IDC on mainland Australia.

The deceased's death was a Western Australian death that appeared to be a reportable death within the meaning of section 3 of the *Coroners Act* 1996 (the Coroners Act).

Under section 19(1) of the Coroners Act I have jurisdiction to investigate the deceased's death. By reason of section 8A and section 14B of the *Christmas Island Act* 1958 (Cth), I have jurisdiction to investigate the circumstances surrounding the deceased's medical treatment on Christmas Island.

Although the deceased was in detention at Curtin IDC in Western Australia immediately before death, he was not a "person held in care" within the meaning of section 3 of the Coroners Act. I am therefore not required to hold an inquest pursuant to section 22(1) of the Coroners Act.

In the circumstances, given that the deceased died whilst in detention, I decided that an inquest was desirable pursuant to section 22(2) of the Coroners Act. Whilst I am not required to comment on the quality of the supervision, treatment and care of the deceased pursuant to section 25(3) of the Coroners Act, it is desirable that I do make such comments, in light of the deceased's death whilst in detention.

I held an inquest at Perth Coroners Court on 19 September 2014. The issues considered at the inquest comprised the circumstances surrounding the deceased's medical care and treatment from the time that he was taken into immigration detention until his death.

The documentary evidence adduced at the inquest comprised the brief of evidence in two volumes and an additional witness statement. Volume 1, Tabs 1 to 25 was received as Exhibit 1. Volume 2, Tabs 1 to 20 was received as Exhibit 2. The witness statement of Ms Ludwig of the Department of Immigration and Border Protection dated 16 September 2014 was received as Exhibit 3. Two

witnesses gave evidence at the inquest, both by video link and they were Mr Parkinson, formerly Constable Parkinson, who prepared a report on the deceased's death when he was stationed at the Derby Police Station[1] and Mr Troy Crilly Centre Manager for the Curtin IDC (Serco immigration services) at the material time, who prepared a report on the events concerning the deceased's death at the Curtin IDC on 22 July 2013, as part of a post incident review process.[2]

An issue arose at the inquest that required further clarification. Following the hearing through Sergeant Housiaux I sought and received further information. On 3 October 2014 the solicitors for the Department of Immigration and Border Control provided the court with additional information concerning the health assessment process for the deceased when he was taken into immigration detention. On 4 November 2014 the contract manager for International Health and Medical Services provided the court with additional information concerning the emergency medical treatment provided to the deceased on 22 July 2013.

On 26 November 2014, the Department of Immigration and Border Control informed the court, through its solicitors, that it had no comment to make in respect of the further

[1] Exhibit 1, Tab 2
[2] Exhibit 1, Tab 25, attachment D

information provided by International Health and Medical Services on 4 November 2014.

## THE DECEASED

The deceased was born on 15 May 1963 and identified as Sri Lankan when questioned by Australian immigration officers. When the deceased arrived at West Island, Cocos (Keeling) Islands on 5 May 2013, his immediate family members had remained overseas.[3] The deceased was taken into immigration detention following his arrival because he arrived without a valid visa. He sought refuge and protection in Australia.

Formal steps to identify the deceased were undertaken on 14 May 2013. Those records disclose that the deceased required and utilised the services of an interpreter and it was recorded that his language was Tamil.[4] The deceased gave permission for his photograph and fingerprints to be taken pursuant to the Migration Act and he consented to his photograph being disclosed for the purpose of the issue of an identification pass for use whilst in immigration detention.[5]

[3] Exhibit 1, Tab 22
[4] Exhibit 1, Tab 25, attachments D and E
[5] Exhibit 1, Tab 25, attachment E

The records also confirm that by 9 May 2013 the deceased had undergone a security risk assessment, a self-harm risk assessment, and part of a health assessment (the latter is addressed in more detail later in this finding). Also as at that date the deceased had been provided with a Rights and Responsibilities Form and an Induction Booklet in a language that he was able to understand. The deceased neither sought nor received special requirements (for example controlled medication), he was issued with a welfare pack, he had been offered a phone call which was facilitated post his reception and induction, and he was advised of the conditions of use of the computer and internet services and the gymnasium.[6]

I am satisfied that the deceased was properly identified and that he was afforded the use of an interpreter to assist him in understanding the conditions of his detention and how to access medical treatment.

## THE DECEASED'S IMMIGRATION STATUS

On 5 May 2013 when the deceased arrived at West Island, Cocos (Keeling) Islands by suspected irregular entry vessel (SIEV) 689 he did not hold a visa that was in effect. The area was an excised offshore place and the deceased was taken into immigration detention pursuant to section 189(3) of the Migration Act because it was reasonably suspected

[6] Exhibit 1, Tab 25, attachment E

that he was an "unlawful non-citizen" within the meaning of section 14 of the Migration Act. On that same date the deceased was transported to Christmas Island for initial processing. There it was determined that the deceased was in fact an "unlawful non-citizen" within the meaning of section 14 of the Migration Act and as a consequence his detention was continued. The deceased indicated that he was intending to seek protection in Australia.[7]

At the material time there were four different types of immigration detention facilities in Australia, two of which were utilised in respect of the deceased as follows. Alternative Places of Detention (APOD's) are for detainees assessed as being a minimal risk to the Australian community. Immigration Detention Centres (IDC's) accommodate people who have come to Australia without a valid visa and are generally used to detain single adult males as well as medium and high-risk detainees.[8]

From 5 May 2013 the deceased was detained at Phosphate Hill Alternative Place of Detention (Phosphate Hill APOD) on Christmas Island until 16 May 2013, when the deceased was transferred to North West Point Immigration Detention Centre on Christmas Island (Christmas Island IDC).

[7] Exhibit 1, Tabs 2 and 25
[8] Exhibit 3

On 21 July 2013 the deceased was transferred from Christmas Island IDC to Curtin IDC on mainland Australia. That transfer occurred by way of a charter aeroplane from Christmas Island and the deceased arrived at Curtin IDC at 9.45pm on Sunday 21 July 2013.[9] The deceased's nephew was also in detention with the deceased, and they both travelled to Curtin IDC on the same flight.[10]

Curtin IDC was re-opened in June 2010 and is located at the Curtin Royal Australasian Air Force Base approximately 40 kilometres southeast of Derby, Western Australia.[11] On arrival the deceased and his nephew were accommodated in the Echo Compound of Curtin IDC. The Curtin IDC had four accommodation areas known as compounds, and Echo was the phonetic description for the E Compound. Each compound generally comprised of a number of demountable buildings of four rooms each, with two bedrooms in each room and bathroom facilities. At the material time, Curtin IDC held between 180 – 200 detainees.[12]

The deceased's transfer to Curtin IDC had been effected the day before he died. Immediately before his death on 22 July 2013 the deceased was in immigration detention at Curtin

[9] Exhibit 1, Tab 25
[10] Exhibit 1, Tab 11
[11] Exhibit 3. On 9 May 2014 the Minister for Immigration and Border Protection announced the closure of a number of IDC's, including the Curtin IDC by June 2015.
[12] T 13

IDC pursuant to section 189(1) of the Migration Act and he remained an "unlawful non-citizen".

## THE OPERATIONS OF CURTIN IDC

The Department of Immigration and Border Protection (DIBP) contracted and outsourced its management of all Australian IDC's to Serco Australia Pty Ltd (Serco). At the material time, the operations of Curtin IDC were managed by Serco.

The DIBP also contracted and outsourced the provision of health services in the IDC's to International Health and Medical Services Pty Ltd (IHMS). At the material time, IHMS was responsible for the provision of health services to detainees at Christmas Island IDC and Curtin IDC.

Reports and information from the DIBP, Serco and IHMS were before me in evidence at the inquest.

The DIBP provided a report from the Acting Assistant Secretary, Detention Operations Branch (Status Resolution Services Division) attaching specific reports in respect of the deceased and relevant policy and procedure documents.

The specific reports from DIBP comprised a report from IHMS clinical reporting team leader outlining a chronology

of the deceased's health history during his detention (attachment A), a medical report from Dr Rudolph, IHMS Area Medical Director for Western Australia (attachment B), the Serco officer report forms concerning the medical emergency attendances and the death in custody attendances in respect of the deceased (attachment C), the post incident review from Serco's Centre Manager at Curtin IDC (attachment D), and Serco's client dossier in respect of the deceased (attachment E).

The policy and procedure documents from DIBP comprised Curtin IDC's duty phone guidelines (attachment F), DIBP's detention operational procedures (attachment G), DIBP's detention policy documents, relevantly including duty of care to person in immigration detention and general health screening and management (attachment H) and Serco policy documents relevantly including guides on incident reporting and death in detention (attachment I). The DIBP also provided extracts from the Detention Services Manual in respect of health screening and management, and information specific to the deceased's individual "fast track" health assessment.

Serco provided documents similar to the existing Serco material provided by DIBP and additional materials from the deceased's client dossier that are relevant to the identification of the deceased.

IHMS provided information specific to the deceased's medical emergency management and also IHMS' general procedures which relevantly included those related to triage, continuity of care, clinical handover, basic life support, first aid management in a range of specified instances and medical emergency management.

The written policies and procedures of DIBP, Serco and IHMS address the standards relevant to the supervision, treatment and care of detainees. They specifically address standards of medical and emergency care of detainees and they are comprehensive. In the circumstances of the deceased's death, there is no need for me to make any recommendations in respect of them. Those components that are related to the deceased's health assessment are addressed below.

## THE DECEASED'S HEALTH ASSESSMENT

At the time that the deceased arrived at Christmas Island IDC both the detention centre and health service providers were operating beyond standard capacity. To ensure that detainees could be relocated to the Australian mainland as quickly as possible to reduce overcrowding at Christmas Island, a "fast track" health assessment process was

introduced as an interim measure. That process was in place while the deceased was in detention.[13]

## The Health Induction Assessment pursuant to the Detention Services Manual

Before the "fast track" health assessment system was introduced, the usual process regarding health assessments of detainees was as outlined in the Detention Services Manual.[14]

After being taken into immigration detention, detainees were routinely offered a health induction assessment. It was designed to provide a baseline health assessment for the detainee, identify any detainee who might be a risk to public health, identify detainees who were unwell and carry out indicated pathology and x-ray testing. It assisted with determining issues that required immediate attention and those that required ongoing health management.

The health induction assessment comprised an immediate public health screening by a registered nurse (which included a relevant questionnaire and the taking of a chest x-ray), a fitness to travel assessment by a registered nurse (which included relevant pathology tests, a mental state

[13] Exhibit 2, Tab 21
[14] Exhibit 2, Tab 21

examination, the determination of medication requirements and the taking of a basic clinical history) and an examination by a general practitioner (which included the taking of a full clinical history, an appropriate physical examination, a general medical check, and any relevant targeted diagnostic interventions).

In respect of the health induction assessment, the Detention Services Manual[15] sets out that the public health screening component was required to be undertaken as soon as practicable but in any event within 24 hours of arrival, to mitigate the risk of spread of communicable diseases and to facilitate the commencement of required medical treatment. All components of the health induction assessment (save for the universal screening) were to be completed within 72 hours from the time of detainee's entry into immigration detention. Within 10 to 30 days of entry into Australian immigration detention, universal screening was required to be completed, and this was intended to establish a baseline mental health status for the detainee and identify any mental health needs.

Further, at the material time, it was also stipulated that the formal assessment by the general practitioner was to be completed within 30 days of the detainee's entry into immigration detention.[16]

[15] Chapter 5, Health Induction Assessment
[16] Exhibit 2, Tab 21, statement of Ms Little, DIBP dated 2 October 2014

## The introduction of the "fast track" health assessment process

The "fast track" health assessment process was a temporary measure that was put in place to manage a population surge at Christmas Island at the time that the deceased was in detention in 2013. It was designed to deal with the situation at hand at the material time and is no longer being used.[17]

Under the "fast track" health assessment process, detainees would complete the public health screening component of the health induction assessment with a registered nurse shortly after arriving in Australia and this would include clinical observations for the purpose of determining whether the detainee was fit to travel, and relevant pathology tests.

If a detainee was found to be unwell, they would be referred to a general practitioner for further assessment and would not be able to travel until this assessment was completed.

If a detainee was determined to be fit to fly, the detainee's examination by a general practitioner was required to be completed within 10 days of arrival at the receiving site. However, if the detainee was still on Christmas Island at

[17] Exhibit 2, Tab 21, statement of Ms Little, DIBP dated 2 October 2014

10 days, then the examination by the general practitioner would be completed on Christmas Island.[18]

## The deceased's "fast track" health assessment process

Prior to the deceased's transfer to Curtin IDC on 21 July 2013 the deceased had completed a number of components of the health induction assessment. On each occasion, the deceased's health assessments were undertaken by clinicians from IHMS and they occurred at the two facilities on Christmas Island.

Between 5 and 16 May 2013, the deceased was detained at Phosphate Hill APOD on Christmas Island.

The deceased's initial contact with IHMS was on 5 May 2013, being the date of his arrival on Christmas Island. He underwent a health screening questionnaire administered by a registered nurse, he had observations taken and he signed the IHMS consent form. Records disclose he denied having any chest pain or any relevant medical condition that he knew of. That screening did not identify any overt health problems for the deceased.[19]

The deceased's individual management plan dated 9 May 2013 recorded the deceased as appearing to be in good

[18] Exhibit 2, Tab 21, statement of Ms Little, DIBP dated 2 October 2014
[19] Exhibit 1, Tab 22 and Tab 25, attachment B

health.[20] Also on 9 May 2013, the deceased responded to a series of questions required to be administered prior to his use of the gymnasium, and records disclose that he indicated that, to his knowledge, he had no heart conditions, was taking no medication, had no family history of stroke or heart disease, did not smoke and did not have diabetes.[21]

On 14 May 2013 the deceased had a chest x-ray taken, which was checked by a doctor the next day and recorded as normal.[22]

Also on 14 May 2013 the deceased, with the assistance of an interpreter, completed a fitness to travel health questionnaire administered by a registered nurse. The purpose was to determine his health status at that time. That screening did not identify any health problems for the deceased. It was noted that this fitness to travel assessment was valid for 14 days from the date of assessment.[23]

On 16 May 2013 the deceased was transferred to Christmas Island IDC.

[20] Exhibit 2, Tab 13, attachment 5
[21] Exhibit 2, Tab 13, attachment 3
[22] Exhibit 1, Tab 22
[23] Exhibit 1, Tab 22

The deceased's individual management plan dated 17 May 2013 recorded the deceased as indicating that, to his knowledge, he had no medical problems and he confirmed that he knew how to use the medical request form.[24]

On 3 June 2013 the deceased, with the assistance of an interpreter underwent a mental state examination assessment administered by a mental health nurse. No overt psychological issues were identified for the deceased.[25]

On 21 June 2013 whilst detained at Christmas Island IDC, the deceased became unwell and he attended at the IHMS clinic reporting a cough and back pain. Routine observations were carried out on the deceased. The registered nurse assessed the deceased's condition and referred him to the general practitioner, who examined him the same day. The deceased was diagnosed with an upper respiratory tract infection and he was prescribed symptomatic treatment. He was advised to return if the symptoms worsened or persisted. He did not return for any further medical treatment in connection with this illness.[26]

On 20 July 2013 the deceased was still detained at Christmas Island IDC and he again attended at the IHMS clinic, on this occasion for a fitness to travel assessment by the registered nurse. Records disclose that induction blood

[24] Exhibit 2, Tab 13, attachment 5
[25] Exhibit 1, Tab 22 and Tab 25, attachment B
[26] Exhibit 1, Tab 22 and Tab 25, attachments A and B

tests were taken, which later returned as normal. The deceased's clinical file was reviewed and he was deemed fit for transfer to mainland Australia with the proposed transfer date being noted as the next day, 21 July 2013. [27]

## EVENTS LEADING TO DEATH

The deceased arrived at Curtin IDC at 9.45 pm on Sunday 21 July 2013, having travelled from Christmas Island by aeroplane, in company with his nephew who was also in immigration detention. From his nephew's observations the deceased appeared to be well during the travel from Christmas Island to Curtin IDC.[28]

Shortly after the deceased's arrival, just after midnight in the early hours of Monday 22 July 2013, the deceased complained of chest pains to his nephew, who was accommodated with the deceased in a room in the Echo compound. The deceased's nephew sought assistance from a Serco officer outside. The deceased went and sat on the steps of the officer station at the Echo compound and the Serco officer contacted the IHMS clinic. This occurred at approximately 12.15 am on 22 July 2013. The Serco officer was instructed to bring the deceased to the clinic straightaway.[29] As the IHMS clinic was approximately 200

[27] Exhibit 1, Tab 22 and Tab 25, attachments A and B
[28] Exhibit 1, Tab 11
[29] Exhibit 1, Tabs 11, 17 and 18

metres away and the deceased was able to walk with assistance, it was determined to be more efficient for him to be escorted straight to the clinic, rather than to call and wait for an ambulance to take him there.[30]

The deceased arrived at the IHMS clinic of Curtin IDC at 12.20 am, after a short walk. He was clutching his chest and indicted to the nursing staff that he had chest pain. He was examined by a nurse who took observations. He was administered two doses of glyceryl trinitrate spray and aspirin for his chest pain at approximately 12.25 am.

At 12.30 am the nurse attempted to conduct an electrocardiogram, but was unable to do so due to the deceased suddenly losing consciousness. The IHMS nursing staff immediately administered oxygen via mask and commenced cardiopulmonary resuscitation.

When the nurses commenced their resuscitation of the deceased, they gave instructions for an ambulance to be called. The Ambulance Care Record[31] discloses that the call to Derby Hospital was received at 12.43 am, that the ambulance departed immediately and that it arrived at the Curtin IDC at 1.15 am, due to Derby Hospital being some 40 kilometres away.

[30] Exhibit 1, Tabs 2 and 21
[31] Exhibit 1, Tab 16

In the meantime, the IHMS general practitioner on call was contacted. He had instructed that cardiopulmonary resuscitation be continued pending the arrival of the ambulance and this is what occurred. During the resuscitation attempts by the nursing staff of the IHMS clinic, three shocks were given via an automated external defibrillator and four intravenous doses of adrenaline were administered to the deceased. [32]

The ambulance arrived with the registered nurse, orderly and Dr Fisher of the Derby Hospital emergency department. They took over the emergency medical care of the deceased, who was not breathing. They continued the cardiopulmonary resuscitation attempts and administered two further doses of adrenaline.[33]

The deceased's condition continued to deteriorate and the resuscitation attempts, which had been carried out for approximately one hour, were determined to be unsuccessful. At 2.08 am on 22 July 2013 at Curtin IDC, Dr Fisher examined the deceased and found him to be dead.[34]

[32] Exhibit 1, Tab 21 and Tab 25 attachment B
[33] Exhibit 1 Tabs 8 – 10 and 14 - 16
[34] Exhibit 1, Tab 4

The deceased was later identified by his nephew, who had known the deceased for 17 years, by visual means at Derby Hospital.[35]

## CAUSE AND MANNER OF DEATH

On 29 July 2013 Forensic Pathologist Dr J. White made a post mortem examination of the deceased at the State Mortuary and formed the opinion that the cause of death was coronary atherosclerosis. Dr White described the deceased's coronary atherosclerosis as severe and found that his lungs and liver were congested.[36]

I find that the cause of death was coronary atherosclerosis. I find that the manner of death was natural causes.

## QUALITY OF SUPERVISION, TREATMENT AND CARE

Whilst the deceased underwent a "fast track" health screening process which did not incorporate all of the usual components, I am satisfied that the deceased had completed critical elements of the general health screening component, which included a chest x-ray and the collection of specimens for pathological testing and that he also underwent the universal screening component in connection with his mental health.

[35] Exhibit 1, Tab 3
[36] Exhibit 1, Tab 5

That component of the health induction assessment that required the examination by a general practitioner was deferred under the "fast track" system, on the expectation that the deceased would complete the assessment after arriving on the Australian mainland. However, after the fitness to travel questionnaire administered on 14 May 2013, the deceased was not immediately transferred to the Australian mainland, and he remained on Christmas Island, latterly at the Christmas Island IDC until 21 July 2013. There was a second review of the deceased's fitness to travel carried out on 20 July 2013, and he was found fit to travel on that date. The next day, he was transferred to Curtin IDC on the mainland.

The deceased did not undergo a formal assessment by a general practitioner on Christmas Island pursuant to the general health screening component of the health induction assessment within the 30 day timeframe stipulated by the Detention Services Manual.

However, the deceased was in fact examined by a doctor whilst he was detained at Christmas Island IDC on 21 June 2013 when he was diagnosed an upper respiratory tract infection, and treatment was provided.

I am satisfied that the deceased's care was not adversely affected by the application of the "fast track" health

assessment process. That measure was designed to assist with his transfer and to reduce overcrowding.

Clearly the objective of the health induction assessment process be it "fast track" or otherwise, is designed to screen for major or overt medical problems that may require intervention. It is not designed to identify every possible underlying medical condition, nor should it be.

Throughout the deceased's detention, appropriate steps were taken to identify any need for medical intervention. From the various inquiries and assessments, carried out by suitably qualified clinicians, there were no indications of the deceased having specific health risks or health needs, save for his upper respiratory tract infection that was treated.

The deceased went into cardiac arrest as a result of his severe coronary atherosclerosis on 22 July 2013. When this occurred, emergency medical care was made available to him but unfortunately, he was unable to be resuscitated.

In all of the circumstances I am satisfied that the deceased's supervision, treatment and care during the period of his detention were of a proper standard. His medical care was at least equal to what would have been available to him in the community.

## CONCLUSION

The deceased had arrived at Cocos (Keeling) Islands on 5 May 2013, having travelled there by boat (SIEV 689). He sought refuge in Australia. On arrival it was ascertained that he did not hold a valid visa and accordingly he was an unlawful non-citizen and he was taken into immigration detention pursuant to the *Migration Act* 1958.

Between 5 May and 21 July 2013, the deceased was detained at facilities on Christmas Island and on 21 July 2013 he was transferred to Curtin IDC on mainland Australia.

Prior to his arrival on the mainland the deceased had two health screenings carried out by registered nurses and a doctor examined and treated him for a medical ailment. On 20 July 2013 the deceased was found to be fit to travel from Christmas Island to Curtin IDC on mainland Australia.

During his travel from Christmas Island to Curtin IDC on 21 July 2013 the deceased appeared to be well. Shortly after his arrival at Curtin IDC the deceased experienced severe chest pain and he was taken to the medical clinic in the early hours of 22 July 2013. Whilst the nurses were attending to the deceased he lost consciousness and went into cardiac arrest. An ambulance was called for whilst the nurses endeavoured to resuscitate the deceased. An

emergency department doctor arrived with the registered nurse and orderly on the ambulance and they continued the resuscitation attempts. The resuscitation attempts were unsuccessful and the deceased was pronounced dead in the early hours of 22 July 2013.

R V C FOGLIANI
**STATE CORONER**

27 MARCH 2015