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

*Western* *Australia*

# RECORD OF INVESTIGATION INTO DEATH

*Ref: 25/16*

*I, Sarah Helen Linton, Coroner, having investigated the death of* ***Anandakumar SELLAKATHIRKGAMAN*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***10 August 2016*** *find that the identity of the deceased person was* ***Anandakumar SELLAKATHIRKGAMAN*** *and that death occurred on* ***4 January 2013*** *at* ***Fremantle Hospital*** *as a result of* ***hypoxic brain injury and organ failure following compression of the neck (hanging)*** *in the following circumstances:*

**Counsel Appearing:**

Mr T Bishop assisting the Coroner.
Ms C Holt (Sparke Helmore Lawyers) appearing on behalf of the Department of Immigration and Border Protection.

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# INTRODUCTION

1. Anandakumar Sellakathirkgaman (the deceased) was a Sri Lankan man of Tamil ethnicity who left Sri Lanka on 22 June 2012, three days before he turned 38 years of age, and travelled to Australia by boat. He arrived at the Australian territory of Christmas Island in early July 2012. He was classified as an Irregular Maritime Arrival and detained as an unlawful non-citizen under s 189 of the *Migration Act 1958* (Cth).[1]

2. The deceased was initially held at the North West Point Immigration Detention Centre on Christmas Island before being transferred to Wickham Point Immigration Detention Centre in the Northern Territory. He was later transferred to the Scherger Immigration Detention Centre, located on the Cape York Peninsula in Queensland, where he remained until he was released into the community on a Bridging Visa on 4 December 2012.

3. Some concerns about the deceased's mental health and ability to manage his own affairs had been raised while he was held in detention so it was arranged that he would be supported by the Australian Red Cross upon his release and he would live with a family member.

4. Upon exiting detention the deceased travelled to Perth, Western Australia, to live with his younger brother in a house in Hamilton Hill. Six other Sri Lankan men also resided in the house. He was allocated a Red Cross caseworker and he was given some initial assistance with orientation and accessing services on 7 and 10 December 2012. On 13 December 2012 the deceased had a face to face meeting with his caseworker and she spoke to him again by telephone on 21 December 2012. The Red Cross support service then closed for the Christmas and New Year period.

5. Over that period the deceased became increasingly disturbed and on 27 December 2012 he made three attempts to harm himself, the last by hanging. He was brought by ambulance to the Armadale Hospital Emergency Department, where he was assessed and not considered to be at acute risk of suicide. He was discharged in the company of his brother that evening for community follow-up.

6. During the afternoon of 2 January 2013 the deceased was found by one of his housemates hanging from a rope in the carport. He was resuscitated by ambulance officers and taken to Fremantle Hospital but he had suffered irreversible brain injury and organ

[1] Exhibit 2, Tab 1, p.3.

failure. On 5 January 2013 medical support was withdrawn and he died a short time later.

7. An inquest hearing was held on 10 August 2016 to explore the medical care and support provided to the deceased while in detention and upon release into the community prior to his death. Evidence was heard from a psychiatrist and Red Cross caseworker directly involved in the deceased's care, as well as witnesses who could speak about the care provided to the deceased in Armadale Hospital and on behalf of the Department of Immigration and Border Protection and Red Cross.

## THE DECEASED'S ARRIVAL IN AUSTRALIAN TERRITORY

8. The deceased was born on 25 June 1974 in Sri Lanka. His family are of Tamil ethnicity, a minority ethnic group in Sri Lanka. The deceased grew up with his parents, two brothers and sister in Sri Lanka. His education did not extend beyond Year 4 and he remained illiterate throughout his life. He worked as a fisherman.

9. The deceased married in 2006 and he and his wife had one daughter together.

10. The deceased's mother borrowed money to arrange for the deceased and his younger brother to journey on a boat to Australia. The total sum was, for the deceased's family, a very significant amount of money. The deceased's younger brother, Rajini Sellakathirkgaman, arrived in Australia in about February 2012 and the deceased completed the same journey four months later. The deceased left Sri Lanka on 22 June 2012, leaving behind his wife and five year old daughter, as well as his parents and other family.

11. The deceased's boat journey took about two weeks and he arrived at the Australian territory of Christmas Island on 8 July 2012. He was classified as an Irregular Maritime Arrival and detained as an unlawful non-citizen under s 189(3) of the *Migration Act* at the North West Point Immigration Detention Centre on Christmas Island.[2]

12. The deceased initially told detention staff at his entry interview on 15 July 2012 that he had experienced economic problems in Sri Lanka as he had been unable to earn enough money to support his family. It was for this reason that he left Sri Lanka to come to Australia, with the plan of working in Australia for five or

[2] Exhibit 2, Tab 1, p. 3.

six years and then returning to live in Sri Lanka.[3] I note that it also seems the deceased gave a different name, or there was some early confusion about his correct name, as many of his case notes are recorded under another name.[4]

13. On 4 August 2012 the deceased was transferred to Wickham Point Immigration Detention Centre in the Northern Territory (Wickham Point IDC) and detained under s 189(1) of the *Migration Act*. On 16 August 2012, during a medical assessment, the deceased indicated that he was missing his family and worried about his family back in Sri Lanka.

14. On 27 August 2012 the deceased informed his Case Manager at the Wickham Point IDC that he was considering returning home to Sri Lanka and wished to speak to the International Office of Migration to gather more information about the process of returning home.[5]

15. On the basis of the earlier information about his reasons for coming to Australia, and also the deceased's indication he was interested in returning home, the deceased was directed towards a removal pathway (ie, removal of unlawful non-citizens who have no basis to remain in Australia) with the potential of voluntarily returning to Sri Lanka.[6]

16. On 25 September 2012 the deceased told his NT Case Manager that he was "100% sure" that he wanted to return to Sri Lanka via the International Office of Migration but later that day he changed his mind.[7]

17. On 9 October 2012 the deceased provided new information to his NT Case Manager about why he left Sri Lanka. Evidence was given at the inquest that this is not uncommon for refugees, who are often distrustful of authority figures due to past experiences. As a result, they may initially withhold information out of fear and it may take individuals a significant amount of time to develop enough trust to actually disclose that they have been subjected to torture and trauma.[8]

18. The deceased stated that when he was about 18 years old he had been on a bus that was stopped by the army and he was questioned and struck. Army personnel later attended his home and questioned his mother and father about his whereabouts.

[3] Exhibit 1, Tab 20.
[4] For example, see Exhibit 2, Tab 1F.
[5] Exhibit 2, Tab 1, p. 3.
[6] Exhibit 2, Tab 1, p. 3.
[7] Exhibit 2, Tab 1, p. 3.
[8] T 61 – 62.

From that time army personnel came looking for him at his house every month. He stated that he was scared to return to Sri Lanka as he might be questioned by members of the army and was scared of what would happen.[9] He later told a friend he was worried he would be tortured if he went home.[10]

19. Based on the additional information provided by the deceased he was no longer on a removal pathway and he was advised by his NT Case Manager that there was no requirement for him to engage with the International Office of Migration unless he wished to engage to voluntarily return home.[11]

20. On 23 October 2012 the deceased was included in a first stage Bridging E Visa (Bridging Visa) submission to the Minister, which preceded a subsequent 2nd stage submission submitted on 3 December 2012.[12]

21. On 28 October 2012 the deceased was transferred to Scherger Immigration Detention Centre in Queensland (Scherger IDC). The main cohort at this facility was single adult males. He remained at the Scherger IDC until he was released into the community on a Bridging Visa on 4 December 2012.[13]

## DECEASED'S MENTAL HEALTH WHILE IN DETENTION

22. On 17 August 2012 the deceased met with his NT Case Manager and told her that he was missing his family and constantly thinking and worrying about his family back in Sri Lanka. He was illiterate and found it hard to motivate himself to participate in any classes and had no friends in the centre. He expressed thoughts of returning to Sri Lanka. He also told his case manager that he had been experiencing dizziness and headaches. He was teary throughout the interaction and requested a referral to mental health services, which was arranged.[14]

23. On 17 September 2012 he was again referred to mental health services by the same case manager after the deceased spoke to her about his confusion about whether he was returning home and told her that he "felt that he was going mad."[15] The following day the case manager met with the deceased and completed a Transitional Support Needs Assessment and Community Link

[9] Exhibit 1, Tab 20.
[10] Exhibit 1, Tab 8 [20].
[11] Exhibit 2, Tab 1, p 4 and Tab 1M.
[12] Exhibit 2, Tab 1, p. 4.
[13] Exhibit 2, Tab 1, pp. 4 – 5.
[14] Exhibit 1, Tab 20, Client Medical Request Form 17.8.2012.
[15] Exhibit 1, Tab 20, General Referral for Mental Health 17.9.2012.

and Information Forms (TSNA Form), which included information that the deceased was vulnerable and had mental health concerns although he coped when visited by a mental health nurse on a regular basis.[16]

24. On 7 October 2012 a Mental Health Nurse completed a Client Preventative and Placement Recommendation form indicating that the deceased was at risk of deterioration of his mental state if he remained in Wickham Point IDC when his cohort was transferred elsewhere and recommended if possible he remain with his cohort. Weekly follow up with a Mental Health Nurse was planned and a psychiatric review scheduled for the following day.[17]

25. On 28 October 2012, on the day that the deceased transferred to Scherger IDC, IHMS staff met with the deceased and observed that he was quite anxious and stressed. It was confirmed that he had been seeing a psychiatrist while in the Northern Territory and noted that the psychiatrist would not have agreed for him to transfer detention centres if he was not fit for travel. The deceased was given medication to assist him with sleeping and he later appeared more engaged and indicated he would like to share accommodation with a friend.[18]

26. On 31 October 2012 Serco staff who managed the Scherger IDC observed that the deceased appeared confused, anxious and stressed. Following on from his earlier request, they advised the deceased they would look for a friend to move in to his accommodation with him. A Sri Lankan male was moved in with the deceased that week.[19]

## Scherger IDC's Case Manager Concerns

27. On 2 November 2012 the deceased's Scherger IDC Case Manager met with the deceased for the first time since his arrival there a few days before. At that time it was anticipated that he would be released on a bridging visa on 8 November 2012. The deceased was allocated a senior case manager due to his documented mental health issues.[20]

28. The case manager was aware that the deceased had significant mental health issues and had experienced difficulty understanding information given to him, particularly complex immigration explanations. The case manager spoke to him with

[16] Exhibit 2, Tab 1, p. 9 and Tab 1K.
[17] Exhibit 2, Tab 1, p. 8 and Tab 1C.
[18] Exhibit 2, Tab 1F.
[19] Exhibit 2, Tab 1, p. 4.
[20] Exhibit 2, Tab 1F, p. 1.

an interpreter and, despite asking the interpreter to explain things to him as simply as possible, it appeared to the case manager that he did not understand much of what was said. She expressed significant concerns about his ability to cope in the community on a bridging visa given his limited understanding. The deceased told his case manager that he had relatives in Perth and it was agreed that he would obtain their contact details in the hope he could be placed with them. The deceased still seemed to be talking in that meeting about the possibility of returning home voluntarily but wanted to see if he got a bridging visa.[21]

29. The case manager asked in an email on the same date to the Director of Case Management that the relevant service provider and case manager and IAAAS agent be made aware of his issues so that he was provided with sufficient support should he be granted a bridging visa.[22]

30. On 5 November 2012 the deceased's case worker again expressed concern about the deceased's ability to cope if released on a bridging visa. He had still not provided any contact details of family members, although it was known that he had a brother who had been released into the community, and he still seemed to be wavering about whether he wanted to return home. It remained apparent that he found it difficult to understand information he was told and the interpreters used also had great difficulty understanding him. The case worker reiterated her concerns about the level of support he would be able to be provided on a bridging visa and his ability to comply with visa conditions. She suggested that community detention would be more suitable to provide the deceased "with a greater amount of support" and ensure "he would not suffer"[23]. However, if he was granted a bridging visa then she again wanted to make sure that appropriate support was provided in the community.[24]

31. After his case manager sent that email she was provided with a psychiatric report by the Mental Health Team Leader at Scherger IDC prepared by Dr Nick Argyle, an IHMS Psychiatrist, who had seen the deceased that day. The report presented a contrasting position to the case manager's concerns about a bridging visa.

## Dr Argyle's Psychiatric Assessment

32. Dr Nick Argyle is a very experienced Consultant Psychiatrist who works for International Health and Medical Services Pty Ltd,

[21] Exhibit 2, Tab 1, p. 4.
[22] Exhibit 1, Tab 20.
[23] Exhibit 1, Tab 20, Email 5.11.2012 Donna Schaarschmidt.
[24] Exhibit 1, Tab 20, Email 5.11.2012 Donna Schaarschmidt.

which is contracted to provide health services to the Immigration Detention Centres.[25]

33. Dr Argyle saw the deceased for the first time on 5 November 2012. He was, however, aware of his medical history since he had been in detention and had spoken with the mental health nurse and psychologist who had seen the deceased.[26] Dr Argyle noted that the deceased had been seen many times while in detention by mental health clinicians appearing either anxious or depressed.[27]

34. The deceased had no prior history of mental illness or addiction problems but had been somewhat anxious, tending to rely on his family and finding working away from home difficult. He had relatives in Queensland but had not been in direct contact with them while in detention. The deceased's father-in-law had died while he was in Australia, which had distressed him.[28] Dr Argyle found that the deceased had not been well prepared for coming to Australia. He had expressed surprise at being detained. He had been told that his case for asylum was not strong and he was missing home. He was also isolated and lonely in detention.[29]

35. The deceased had been tried on different anti-depressants (partly for their anti-anxiety effects) while in detention but had either not tolerated them or been ambivalent about taking them. He had gained some benefit from taking diazepam at night for sleep.[30]

36. At the interview with Dr Argyle the deceased appeared anxious and somewhat restless. His mood was reactive and not clearly depressed. There was no evidence of psychosis or ideas of self harm. He was oriented to time and place but he had poor abstract thinking and it was clear he found it hard to understand the immigration process and his options.[31] Dr Argyle's assessment was that he was of low average intelligence, low educational level and possessed anxiety traits, all of which contributed to his difficulty coping in detention, which increased his anxiety.[32] Although Dr Argyle accepted that many people he saw at the detention centres had anxiety, Dr Argyle considered the deceased had "more anxiety than most."[33] Dr Argyle did not, however, form the impression that the deceased had a consistent depressive state while at Scherger IDC.[34]

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[25] T 6.
[26] T 7.
[27] Exhibit 1, Tab 19, Report 5.11.12, p. 1.
[28] Exhibit 1, Tab 19, Report 5.11.12, p. 1.
[29] Exhibit 1, Tab 19, Report 5.11.12, p. 1.
[30] Exhibit 1, Tab 19, Report 5.11.12, p. 1.
[31] Exhibit 1, Tab 19, Report 5.11.12, p. 1.
[32] T 8.
[33] T 20.
[34] T 9.

37. The deceased had previously relied on his family to manage. On his own he found it very hard to cope with the uncertainties of the immigration process but he was clear that if he was able to get a bridging visa he wanted to remain in Australia and stay with relatives.[35]

38. The deceased expressed to Dr Argyle a clear desire to leave detention and was aware that his mental state was at risk of worsening if he was detained longer.[36]

39. Dr Argyle felt that the main thing the deceased needed was social support.[37] He recommended that the deceased would be much better supported emotionally if he were to be released from the camp on a bridging visa, provided he had a definite plan about a person with whom he could stay. Dr Argyle indicated in his report that the deceased could be provided with adequate support in the community by a GP and psychologist, if required. If the deceased was able to stay with relatives who were sufficiently supportive then Dr Argyle considered the deceased's need for additional help might be minimal as most of his problems likely stemmed from being alone.[38] If the deceased's relatives could not be located then Dr Argyle thought community detention, with some level of support to orient himself in Australia, would be appropriate.[39]

40. Other than social support, hopefully provided by his family and a non-government support provider (such as Red Cross),[40] Dr Argyle did not consider the deceased needed specific treatments or any ongoing medication.[41] Dr Argyle had seen the deceased the day after his first assessment to clarify for the deceased that he was not required to take the prescribed medication (diazepam) unless he felt he required it.[42] Dr Argyle saw the deceased again on 12 November 2012. At that time the deceased seemed significantly improved and he reported sleeping better, even though he had not been taking any medication.[43] That information reinforced Dr Argyle's view that the deceased did not need to be medicated.

41. Dr Argyle did think it was important that the deceased be medically assessed once he was living in the community, in order

[35] Exhibit 1, Tab 19, Report 5.11.12, p. 1.
[36] Exhibit 1, Tab 19, Report 5.11.12, p. 2.
[37] T 9.
[38] T 13; Exhibit 1, Tab 19, Report 5.11.12, p. 2.
[39] T 9.
[40] T 17.
[41] T 9, 11.
[42] T 7, 11.
[43] T 11 – 12.

to see how he was reacting to the new environment. However, he did not consider the assessment was required urgently and was of that view that it was reasonable if it occurred within a month, provided the deceased's family were not expressing any concerns about him.[44]

42. Dr Argyle confirmed at the inquest that the deceased had not disclosed to him any thoughts of self-harm or shown any signs of being at risk of suicide. Dr Argyle indicated he was surprised to hear that the deceased had ended his life.[45]

## Efforts to locate the deceased's relatives before release

43. On 2 November 2012 the deceased had met with his Scherger IDC Case Manager and told her he had relatives in Perth but no exact details were known.

44. When the deceased saw Dr Argyle on 5 November 2012 the details of the deceased's relatives in Australia, if any, were still unclear.[46]

45. On 7 November 2012 the deceased's case was considered at a Client Placement and Preventative Meeting. His Case Manager had provided information that she had met with him on two occasions and noted that on the first occasion he presented as incoherent and the interpreter could not understand him. On the second occasion (which was the same day he was seen by Dr Argyle) the deceased was very clear. The deceased was expressing competing feelings during the second meeting, wavering between wanting to go home and feeling a sense of responsibility to stay in Australia.[47] There was also information that the deceased now had a supportive roommate and had been engaging with Serco officers and other detainees. At the conclusion of the meeting it was agreed to monitor and follow up on the deceased's commitment to going home and await a second psychiatric review.[48]

46. As noted above, Dr Argyle saw the deceased again on 12 November 2012 and at that time the deceased's mood had significantly improved. He appeared less anxious and more positive about the future.[49]

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[44] T 13.
[45] T 12, 18 – 19.
[46] T 9.
[47] Exhibit 2, Tab 1F, p. 1.
[48] Exhibit 2, Tab 1F, p. 1.
[49] T 9, 20.

47. On 14 November 2012 the deceased informed Dr Argyle he had a younger brother in Darwin, but it was eventually confirmed on 16 November 2012 that his brother was residing in Perth. The deceased advised his case manager that he had been in contact with his brother, who had indicated that the deceased could stay with him. The deceased's Scherger IDC case manager requested that the deceased contact his brother and obtain his address and phone details. The deceased provided these to his case manager on 21 November 2012.[50] It seems from his case manager's account of their conversation that even at that time the deceased was still keen to go home but possibly felt pressure from his family to stay.[51]

## Community Detention vs Bridging Visa

48. During the period when the exact details of the deceased's relatives in Australia were unclear, there was some suggestion by Dr Argyle and the deceased's Scherger IDC Case Manager that community detention might be the best option for the deceased, if his relatives could not be found.

49. Ms Robyn Miller, who at the time of the inquest held the position of Commander, Field Compliance and Removals in the Australian Border Force,[52] gave evidence at the inquest about the difference between community detention and a bridging visa. There is a difference under migration law in relation to the status of the individual, as a person released on a bridging visa is lawful in the Australian community whereas a person released into community detention is officially still detained. However, Ms Miller explained that there is little practical difference other than for community detention the Department sources and provides the accommodation for the individual. In either case the person is allowed to live in the community and is free to engage in normal community activity.[53] People released into community detention are also provided with a higher level of support and supervision by the community service providers, such as the Red Cross.[54]

50. Ms Miller explained that a person who had a significant vulnerability due to significant mental health issues or significant physical health issues, which might mean that they were unable to support themselves, would be likely to be placed in community detention. Ms Alenka Jeram, who gave evidence on behalf of the Red Cross at the inquest, agreed that the community detention clients were often people with complex medical and psychosocial

[50] Exhibit 2, Tab 1, p. 4.
[51] Exhibit 2, Tab 1, p. 10.
[52] Australian Border Force is part of the Department of Immigration and Border Protection.
[53] T 57 – 58.
[54] T 58.

needs.[55] Families with children would also be given preference for community detention, and at the time of the deceased's release into the community there were many families with children requiring assistance.[56]

51. Ms Jeram explained that, unlike when a person was released on a bridging visa, in the case of a person being released on community detention there would be discussions between IHMS and detention centre staff and Red Cross staff, so that the Red Cross staff were prepared to assist the person properly with essential medical referrals upon their release.[57] That pre-planning did not occur with people released on bridging visas, who were generally expected to have less complex, and less urgent, needs.

52. Ms Jeram also explained that for community detention clients the way they access medical services in the community is different, as they still access medical services through IHMS via a 24 hour service and then liaise through them with services available in the community, as compared to bridging visa clients who access normal Medicare services.[58]

53. Although community detention had been considered for the deceased if he had no family support available, his brother was eventually located in Perth and the deceased's case manager made contact with him to ensure that he would be in a position to accommodate and care for the deceased and provide him with support.[59] After those arrangements had been confirmed, it was decided that he would be an appropriate candidate to be released on a bridging visa and did not require community detention. The submission to the Minister for the deceased's release on a bridging visa was then progressed.[60]

## RELEASE ON BRIDGING VISA

54. The deceased was granted a bridging visa on 4 December 2012. The visa was valid for six weeks to allow him to live in the Australian community while he made arrangements to lodge a protection visa application. He was required to lodge the protection visa application within the six weeks, as once that paperwork was lodged he would then be eligible for a further bridging visa.[61]

[55] T 73.
[56] T 60.
[57] T 73.
[58] T 78.
[59] T 68.
[60] T 60.
[61] Exhibit 2, Tab 1, p. 5.

55. While on the bridging visa the deceased had permission to work.[62] He was also notified that he was eligible for inclusion on the Commonwealth Community Assistance Support (CAS) transitional support program, which could provide him with up to six weeks of transitional support, including:

- 89% of the equivalent Centrelink Special Benefit payment;
- Emergency accommodation;
- Assistance in sourcing long term accommodation;
- Orientation into the community;
- Medicare;
- Medical services; and
- Mental Health/Counselling services (including torture and trauma).[63]

56. When the deceased was advised by his case manager that his bridging visa had been granted and that he was going to live with his brother he doubted the validity of the information and required reassurance that he was not actually being returned to Sri Lanka or sent to a Mental Hospital. The interpreter conveyed to the case manager that the deceased remained very worried and no reassurance seemed to comfort him.[64]

57. Despite his distrust, the deceased signed the relevant bridging visa paperwork and accepted inclusion in the CAS transitional support program. He was released from detention and transferred to Perth on 5 December 2012. His flights to Perth were arranged and paid for by the Department.[65] He was met by Red Cross staff at the airport, given some funds to tide him over until his first fortnightly payment was received, advised of upcoming appointments with Red Cross and then delivered to his brother's house in Hamilton Hill.[66]

## SUPPORT PROVIDED BY RED CROSS

58. The Australian Red Cross provides a range of humanitarian services for refugees and asylum seekers. The Red Cross is one of the service providers funded by the Department of Immigration and Border Protection (previously the Department of Immigration and Citizenship) to carry out the CAS program on behalf of the Federal Government.[67] As noted above, the CAS transitional support program was established to provide six weeks of

[62] Exhibit 2, ab 1, p. 5.
[63] Exhibit 2, Tab 1, p. 6.
[64] Exhibit 2, Tab 1, p. 10.
[65] T 69.
[66] Exhibit 2, Tab 1, p. 10 and Tab 13.
[67] Exhibit 1, Tab 11.

intensive support to people released from detention centres and help to orientate them in the community.[68]

59. The deceased was referred to the Red Cross for inclusion in the CAS transitional support program on 4 December 2012. The presence of mental health issues was recorded on the deceased's TSNA Form that was given to Red Cross. The deceased's medical records were not forwarded to the Red Cross directly by the Department for privacy reasons.[69] However, the deceased was given a copy of his medical records upon his release to take with him to appointments.

60. After his arrival in Perth the deceased attended a Red Cross group Welcome Seminar on 7 December 2012 to have the CAS program explained to him and be assisted to sign up with Medicare. He was also provided with a welcome pack. The welcome pack included information on emergency numbers, 24 hour counselling and crisis services, translating and interpreting services, available English classes and general information on Perth.[70]

61. The deceased attended a Walking Orientation of the city on 10 December 2012. The deceased was assisted to open a bank account, obtain a library card and shown where to buy food items and low cost clothing.[71]

62. On 13 December 2012 the deceased had his first face to face meeting with his Red Cross Worker, Dominique Ombrasine. Ms Ombrasine had not been alerted to any concerns about the deceased prior to the meeting.[72] The deceased brought with him some information, including the psychiatric report prepared by Dr Argyle, which she used to inform herself about his needs.[73] The role of the deceased's caseworker was not a clinical role, so the report was not for her to make some assessment of his mental health at the time she saw him, but to enable her to make arrangements for him to receive appropriate medical care.[74]

63. The deceased attended the meeting with his brother. The deceased appeared "a bit distressed and anxious"[75] so Ms Ombrasine asked the deceased's brother to join the meeting in the hope that it would make him feel at ease.[76] Ms Ombrasine

[68] T 72.
[69] T 63.
[70] T 77; Exhibit 1, Tab 13.
[71] Exhibit 1, Tab 11 and Tab 13.
[72] T 34.
[73] T 34, 36 – 37.
[74] T 72 – 73.
[75] T 39.
[76] T 37; Exhibit 1, Tab 10 [18].

observed during the meeting that the deceased appeared comfortable with his brother and his brother seemed quite supportive; so it appeared to her that they had a good relationship.[77]

64. Based on the information provided as to his mental health care in prison, which had included psychiatric care and counselling, Ms Ombrasine wanted to continue some mental health support for the deceased in the community. The deceased's brother was also keen for the deceased to have treatment for his foot injury, although the deceased himself seemed somewhat disinterested.[78]

65. Ms Ombrasine's plan was to arrange for the deceased to be assessed by a general practitioner, both for his ongoing foot injury and for his mental health needs. The GP could then refer the deceased to a psychologist or any other specialist appointments he required. The GP referral would enable the deceased to access the relevant services via Medicare.[79]

66. Ms Ombrasine spoke to the deceased by telephone (using an interpreter service) on Friday, 21 December 2012 (Red Cross' final business day for 2012). Ms Ombrasine informed the deceased she had arranged a doctor's appointment for him on 28 December 2012 for the purposes of treating his foot injury and obtaining a referral to a counsellor. Ms Ombrasine had arranged the appointment with a GP practice that had a psychologist based in the same surgery, as she thought that would provide the fastest option for the deceased to start receiving counselling services.[80] Ms Ombrasine had also considered the ASeTTS, an organisation that provides services, including counselling, to survivors of trauma and torture, but she was aware that there was a long waitlist for their services at that time (up to 12 weeks) and thought the GP appointment would be quicker.[81] She would have organised for the deceased to be assessed by ASeTTS in the new year in addition to any other counselling that was arranged, as that was the normal practice.[82]

67. The deceased told Ms Ombrasine that his brother was working and no one else could accompany him to the appointment. He asked her to reschedule the appointment for another time when he could be accompanied. In that regard, he indicated that he would be happy for Ms Ombrasine to accompany him to an appointment in the new year.[83]

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[77] T 45.
[78] T 38, 45.
[79] T 38, 75.
[80] T 41.
[81] T 41.
[82] T 46.
[83] T 42.

68. During the telephone call Ms Ombrasine informed the deceased of Red Cross' closing dates over the Christmas and New Year period (24 December 2012 – 1 January 2013 inclusive). The entire WA Red Cross office was closed over this period. Although the Red Cross was not funded to provide an afterhours on-call service as part of the CAS program, the Red Cross CAS program in WA implemented a 24 hour on-call service for this period for clients on the transitional support stream of the CAS program. Ms Ombrasine advised the deceased of the process for contacting triple zero and provided the on-call number for the Red Cross CAS program over the break. Ms Ombrasine also sent this information to the deceased in a text message, even though he told her he didn't need it.[84]

69. Nothing about the deceased's behaviour in the times that she had contact with him raised any concerns for Ms Ombrasine that he required urgent psychiatric treatment and she had no indication from either the deceased or his brother that he was experiencing any suicidal thoughts. Ms Ombrasine understood that the deceased was living in a nice home environment with a supportive brother and other Sri Lankan men and believed that he did not require a high level of attention. He was, however provided with emergency contacts in case that position changed.[85]

70. The deceased's younger brother, Rajini Sellakathirkgaman, provided a statement in Tamil and his friend translated the statement into English for the police.[86] The statement was given in July 2013. Mr Sellakathirkgaman had left Australia by the time of the inquest hearing in August 2016 so the only evidence available from him was his statement.

71. Mr Sellakathirkgaman states that he had arrived in Australia four months prior to the deceased arriving. He spoke to the deceased by telephone two to three times a week while he was in detention and the deceased always appeared very disturbed and indicated he was missing his family and anxious about being sent back to Sri Lanka. He was aware the deceased also kept in daily telephone contact with his wife and child in Sri Lanka over this time.[87] The deceased reportedly told his brother he had some razor blades within him in the camp and intended to cut himself with the blade if he was sent back to Sri Lanka.[88] I note in that regard there was a reported incident at Scherger IDC on

[84] T 42 – 43; Exhibit 1, Tab 10 [28].
[85] T 52; Exhibit 1, Tab 10.
[86] Exhibit 1, Tab 9.
[87] Exhibit 1, Tab 9.
[88] Exhibit 1, Tab 11.

29 November 2012 (shortly before his release from detention) when the deceased was found to have removed a blade from a disposable razor and could give no explanation to Serco staff for why he had done so. This had prompted a psychologist's review but it does not seem that the matter was taken further.[89]

72. Mr Sellakathirkgaman does not describe the deceased's behaviour when he first moved in with him in Perth. His account of the deceased's behaviour around that time begins in the days closer to Christmas.

## ARMADALE HOSPITAL

73. Sometime over the Christmas period the deceased and his brother went to stay with friends in Kenwick. For the first two days of their visit the deceased seemed fine but then his brother noticed that the deceased became very quiet.[90] He did not articulate any suicidal thoughts to his brother or friends but on 27 December 2012 the deceased repeatedly attempted to harm himself.

74. According to the medical records the deceased attempted to harm himself three times that day, although only the details of two attempts are known. One attempt occurred when the deceased went for a walk. When he came back he was found to have a six inch knife and some wire in his pocket and he admitted to having inflicted a wound to the inside of his right foot. He was later found tying a rope around his neck, which prompted his brother to call the police.[91] Police attended and took the deceased and his brother to hospital.

75. The deceased was brought to the Emergency Department of Armadale Hospital at 7.58 pm on 27 December 2012. He was noted during triage to have a small abrasion to his right foot, which was consistent with the account of events that day.[92]

76. The deceased was assessed by a psychiatric liaison nurse with the assistance of an interpreter over the telephone. The deceased admitted that he had attempted to self-harm with a knife and a rope that day. He said that he had made a mistake and wouldn't do it again. The deceased's younger brother also described the deceased engaging in strange behaviour and indicated the deceased had been carrying a knife in his pocket and had

[89] Exhibit 1, Tab 20, Consolidated Activity Report.
[90] Exhibit 1, Tab 9 [23] – [27].
[91] Exhibit 1, Tab 15; Exhibit 2, Tab 3.
[92] Exhibit 2, Tab 3, Nursing Triage Assessment.

deliberately self-harmed by inflicting an injury to his left leg below the knee.[93]

77. The deceased indicated that he had been stressed and depressed and was having problems sleeping, but at the time he was in the ED he claimed that his mood was "good" and "happy."[94] He rated his mood as 8/10 although the nurse noted that he appeared depressed and anxious.[95] The deceased denied having any current suicidal or homicidal thoughts, plans or intent while in the ED.[96]

78. The nurses' impression was that the deceased had an Adjustment Disorder (a type of reactive depression)[97] with the presence of depressive symptoms, sleep disturbance. After completing a risk assessment the nurse deemed the deceased to be at low risk of further suicidal attempts.[98] The nurse discussed a plan with the Emergency Department Registrar, Dr Zhou, and it was decided that the deceased could be discharged home in the company of his brother as he was currently expressing nil suicidal ideations. Follow up was to be organised with the deceased's Red Cross worker, who could organise a GP appointment if the deceased's symptoms persisted. The discharge summary suggested that Red Cross could make a referral to outpatient psychiatry and psychology services. Emergency numbers were provided to the deceased before he left the ED and he was told to talk to his family or return to the ED if he had any further thoughts of self-harm.[99]

## EVENTS AROUND 2 JANUARY 2013

79. Following his discharge the deceased and his brother returned to their Hamilton Hill home. After they returned home the deceased's brother recalled that the deceased continued to be quiet and would sit on his own all the time. Mr Sellakathirkgaman described the deceased at that time as "mentally very disturbed."[100] The deceased would do nothing without prompting and Mr Sellakathirgaman had to prompt him to do everything from brushing his teeth, eating food and even going to the toilet.[101] Mr Sellakathirkgaman states that he felt that he needed to stay with his brother all the time to ensure that

[93] Exhibit 2, Tab 3, Psychiatric Assessment and Service Plan.
[94] Exhibit 2, Tab 3, Psychiatric Assessment and Service Plan.
[95] Exhibit 2, Tab 3, Psychiatric Assessment and Service Plan.
[96] Exhibit 2, Tab 3, Psychiatric Assessment and Service Plan.
[97] As explained at T 22.
[98] T 22.
[99] Exhibit 1, Tab 15; Exhibit 2, Tab 3, Discharge Summary.
[100] Exhibit 1, Tab 9 [29].
[101] Exhibit 1, Tab 9 [30].

he did not do anything to hurt himself.[102] Mr Sellakathirkgaman indicates in his statement that he tried to send the deceased back to Sri Lanka as he felt that it would have been better for him to return home given he was missing his family so much. He also states he attempted to contact the Red Cross for assistance, but he does not explain how he attempted to do this.[103]

80. A housemate of the deceased, Pratheesan Kandasamy, also gave a statement to police.[104] Like the deceased, Mr Kandasamy had also come to Australia from Sri Lanka by boat and been detained in detention centres before being released into the community on a bridging visa in December 2012. Mr Kandasamy had left Australia by the time of the inquest hearing, so only his statement was available.

81. Mr Kandasamy described the deceased as a "quiet person who kept to himself."[105] The deceased would usually stay in his room. The deceased's brother had asked Mr Kandasamy to talk to the deceased, as the deceased would not talk to his brother. Accordingly, when Mr Kandasamy was not at work he would take the deceased outside and they would do activities such as fishing or going to the park. While together Mr Kandasamy would talk to the deceased about his immigration case and even though the deceased did not want to talk, he told Mr Kandasamy that he was worried about his case, because he came to Australia illegally. He also mentioned missing his family. In effect, the deceased told Mr Kandasamy that he was always thinking about his family and his immigration case. He thought about being sent home and was concerned he would be tortured if he did go home.[106]

82. Mr Kandasamy had been told by the deceased's brother that the deceased had hurt himself with a knife about a month after being released from detention, although he did not know the details. He also noticed that the deceased stopped eating and took steps to prepare food for the deceased and encourage him to eat. However, two days before he hanged himself the deceased stopped eating again.[107]

83. Mr Kandasamy mentions in his statement that he tried to contact the deceased's Red Cross caseworker by telephone as he wanted the deceased to see a doctor about his mental health. He states that he rang a number of times and left messages, but did not hear back.[108] It would appear from the evidence that he was

[102] Exhibit 1, Tab 9 [31].
[103] Exhibit 1, Tab 9 [32] – [33].
[104] Exhibit 1, Tab 8.
[105] Exhibit 1, Tab 8 [8].
[106] Exhibit 1, Tab 8.
[107] Exhibit 1, Tab 8.
[108] Exhibit 1, Tab 8 [34].

ringing Ms Ombrasine's number while she was on leave, rather than the emergency contact number, which would explain why no contact was made.

84. On 2 January 2013 Mr Kandasamy did not speak to the deceased but was aware that the deceased was in his bedroom with the door closed during the day. Mr Kandasamy left for work in the early afternoon so he was not present when the deceased was found hanging.[109]

85. The deceased's brother describes 2 January 2013 as a "normal day's routine."[110] At 4.00 pm that day the deceased's brother left the house and went with a friend, Mr Pathmaseelon, to a local shopping centre. At the time he left the house the deceased was sitting on a chair and assured his brother he was going to be fine. Mr Pathmaseelon returned to the house on his own at 5.15 pm as he had forgotten some documentation. When he arrived home Mr Pathmaseelon saw the deceased hanging in the carport, with a rope around his neck and attached to a hook. Mr Pathmaseelon called the deceased's brother, who was still at the shopping centre, to tell him what had happened. He then reported the matter to police and ambulance services.[111]

86. Two police officers attended the deceased's Hamilton Hill home at about 5.51 pm. St John Ambulance officers were already in attendance. The police officers attempted to talk to the residents of the house but the conversation was limited due to the language barrier. The police officers searched the house and noted that the living conditions were good and tidy, although slightly overcrowded. No medication or suicide notes related to the deceased were found in the house.

87. Later that day one of the police officers utilised a telephone interpreter service to interview the deceased's brother at Fremantle Hospital. At that time the deceased's brother indicated that the deceased had seemed happy at home, despite the fact that he had attempted to hang himself the week before.[112] The deceased's brother explained that the deceased could not read or write, so he would not have expected him to leave a suicide note.[113]

88. The Acting National MSP Manager of the Australian Red Cross advised that a records check confirmed that the deceased did not contact the 24 on-call service provided by the Red Cross during

[109] Exhibit 1, Tab 8.
[110] Exhibit 1, Tab 9 [34].
[111] Exhibit 1, Tab 9 [35] – [40].
[112] Exhibit 1, Tab 5.
[113] Exhibit 1, Tab 9 [42].

the Christmas/New Year break and the service was also not contacted on the deceased's behalf.[114] It is possible that the deceased's brother and friend tried to call Ms Ombrasine's number (contrary to the instructions she had given) but that number was not monitored while she was on leave and the messages she found on her phone on her return were not in English and difficult to hear, so it could not be confirmed.[115]

## FREMANTLE HOSPITAL

89. After being discovered in the carport the deceased had been cut down by his friends. When ambulance officers arrived they followed a full resuscitation protocol and managed to get some response from the deceased. He was then taken by ambulance to Fremantle Hospital.[116]

90. The deceased arrived at Fremantle hospital at 6.11 pm. He had spontaneous return of circulation with a heart rate of 105bpm in sinus rhythm. An adrenaline infusion was commenced. The deceased had a second cardiac arrest while in the Emergency Department but there was a spontaneous return of circulation again after five minutes. When assessed the deceased's Glasgow Coma Scale was only 3/15 and his pupils were noted to be fixed and dilated. The deceased was admitted to ICU and on initial assessment he was assessed as having a prolonged hypoxic brain injury with uncertain down time secondary to the hanging attempt. The deceased's brother was told on 3 January 2013 that the deceased was unlikely to survive.[117]

91. Ms Ombrasine, the deceased's Red Cross caseworker, was informed of the incident by the deceased's brother when she called the deceased's telephone on 3 January 2013. She attended the hospital and spoke to the deceased's brother and friend and provided support and assistance over the following days.[118]

92. The deceased underwent brain death testing on 4 January 2013, which was repeated twice during the day and he was then declared deceased at 3.33 pm that day, although he was not extubated until the following day.[119]

93. Red Cross staff and the Department's staff assisted the deceased's brother with the funeral arrangements, which was

[114] T 79 – 80; Exhibit 1, Tab 11.
[115] T 43, 81.
[116] Exhibit 1, Tab 17.
[117] Exhibit 1, Tab 14.
[118] Exhibit 1, Tab 13.
[119] Exhibit 1, Tab 14.

paid for by the Department. The funeral took place on 16 January 2013 with a qualified Tamil priest present.[120]

## CAUSE AND MANNER OF DEATH

94. On 9 January 2013 the Chief Forensic Pathologist, Dr C.T. Cooke, conducted a post mortem examination of the deceased. Dr Cooke noted changes of medical treatment. Dr Cooke also observed signs consistent with a hanging death, namely a 'ligature-type' marking to the skin of the deceased's neck and fractures of the superior horns of the thyroid cartilage. The deceased's lungs were congested and there was some softening and congestion of other body organs, consistent with multiple organ failure. Likewise, the deceased's brain was softened and swollen, consistent with hypoxic brain injury.[121]

95. At the conclusion of the examination Dr Cooke formed the opinion that the cause of death was hypoxic brain injury and organ failure following compression of the neck (hanging).[122]

96. I accept and adopt the conclusion of Dr Cooke as to the cause of death.

97. Given the known circumstances of the death, I find that the manner of death was suicide.

## QUALITY OF SUPERVISION, TREATMENT AND CARE

98. Under s 25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

### Care provided by Department of Immigration and Border Protection

99. I raised the question at the end of the inquest whether the Department accepted, in hindsight, that community detention might have been the preferable alternative for the deceased. Ms Holt, on behalf of the Department, accepted that in hindsight the Department conceded that perhaps something different should have been done. It was acknowledged, in that regard, that it would have been possible for the deceased to be placed in

[120] Exhibit 1, Tab 11.
[121] Exhibit 1, Tab 2.
[122] Exhibit 1, Tab 2.

community detention and still live with his brother, provided his brother agreed to the arrangement, but it would have placed some extra security measures on the household where the deceased resided.[123]

100. It is clear that the Department had given considerable thought to what was the best placement option for the deceased. The deceased's Scherger IDC case manager documented her concerns about the deceased's ability to manage in the community, which prompted a further review by Dr Argyle.[124] The main concern seems to have been about his ability to cope without family support, so the Department staff were reassured when his younger brother was located and indicated he was willing to accommodate the deceased. All the evidence indicates the deceased's brother was appropriately supportive and caring and had some experience already living in Australia, so in that sense he was an ideal person for the deceased to live with while transitioning into the Australian community. It was anticipated that with that level of support, and once the pressures of living in a detention centre were removed, the deceased's mental health would significantly improve.

101. Unfortunately, that did not prove to be the case and, for whatever reason, the deceased's mental health deteriorated significantly over the Christmas period of 2013, a few weeks after his release into the community. If the Department had become aware of his deterioration, they would have taken steps to ensure that the Red Cross were aware of his additional needs.[125]

102. Ms Miller advised the court that since the deceased's death there has been a general improvement across the many organisations involved to try and address mental health issues. Ms Miller indicated that the Department acknowledged that many of the individuals taken into detention and managed under the *Migration Act 1958* (Cth) are very vulnerable as a result of their traumatic life experiences and they also find the length of time it takes to processes their asylum claims exacerbates their distress. As a result, the Department has seen mental health issues arise in people being managed in the community, as well as in persons managed in detention centres.[126]

103. Ms Miller explained that this has prompted a greater emphasis on general mental health concerns and efforts have been made to put in place extra supports. For example, greater access to torture and trauma counselling services are available as people

[123] T 87 – 89.
[124] T 87.
[125] T 68.
[126] T 70 – 71.

have been out in the community longer and feel more comfortable in their settings, which allows a greater degree of disclosure.[127] In addition, in 2015 a Chief Medical Officer was appointed to the Department, Dr John Brayley. Dr Brayley is a trained psychiatrist and one of his key roles is to try and improve the Department's processes and practices around mental health.[128] Regular communication with the service providers to alert them to possibly adverse news in advance is also prioritised.[129]

104. I am satisfied that the Department is aware of the need for a high level of mental health care to be provided both to detainees in detention centres and to persons released into the Australian community under the Department's care. I'm also satisfied that there are appropriate services available to people when a need for a higher degree of care is identified.

105. What occurred in this case is more a product of a difficulty in predicting how the deceased's mental health needs would be affected by being in the community. It was anticipated that being out of the detention centre and in a supportive environment, with some ongoing care provided by a general practitioner and perhaps a psychologist or other mental health practitioner would be sufficient to meet the deceased's psychological needs. However, in hindsight, his needs once in the community were actually higher and community detention may have been a better option to satisfy those needs, given the higher level of monitoring provided. Nevertheless, even in those circumstances it does not follow that the deceased's death would have been prevented. It just may have meant that the Red Cross would have become aware sooner of his deteriorating mental health, which would have allowed them to take some action.

## Care provided by the Red Cross

106. I have outlined above the level of support provided to the deceased by the Red Cross under the CAS program. There is no suggestion that Red Cross staff were anything other than supportive and welcoming to the deceased and they did their best to ensure he transitioned quickly into the Australian community.

107. At the time Ms Ombrasine met with the deceased it does not appear that his mental health had begun to decline, and certainly his brother did not take that opportunity to raise any particular concerns. That is consistent with the fact that the deceased's brother does not mention in his statement any real concerns about the deceased's mental health from the time of his release

[127] T 65.
[128] T 65.
[129] T 71.

until the period near Christmas when the first suicide attempt occurred.

108. The main difficulty with the Red Cross' care has arisen simply because of the unfortunate timing of events, in that the deceased could not attend the initial GP appointment Ms Ombrasine had arranged and due to the office-wide shut down, no one from Red Cross was available to take him until after her return from leave. It would have been ideal if the deceased had been able to attend the appointment on 28 December 2012, given that was the day after he had attended Armadale Hospital and if that information had been relayed to the doctor, it would most likely have prompted the doctor to do a full mental health assessment and take some urgent action to arrange counselling. However, as that appointment was postponed at the deceased's request, it did not occur.

109. I am satisfied that the deceased's brother and friend did try to contact the Red Cross in the ensuing days, given the deceased's continued to appear depressed and exhibit concerning behaviour, but I am also satisfied that they did not use the emergency contact information Ms Ombrasine provided and were inadvertently ringing an unmonitored number. It is not clear, in those circumstances, why they did not take him back to hospital when they became worried about him, as suggested by the hospital staff when he was discharged on 27 January 2012.[130]

110. The timing of events is unfortunate. I have no doubt that Ms Ombrasine or any other Red Cross case worker would have taken appropriate action to get the deceased seen quickly if they had spoken to the deceased's brother or friend and been advised of their concerns. Sadly, due to the intervening Christmas break and miscommunication, the Red Cross were not aware of the deceased's situation and hence were not in a position to take any action.

111. Ms Miller was asked whether the Department considered the Red Cross staff handled the deceased's care appropriately. Ms Miller agreed that they did and that the Red Cross staff had done everything that would have been expected by the Department at the time, and what was reasonably practicable in the circumstances.[131]

112. Dr Argyle was also asked what was the minimal amount of care he had expected to be provided for the deceased in the community. He indicated that contact with a GP, within a month

[130] Exhibit 1, Tab 16.
[131] T 65, 70.

of release, would have been sufficient if it was thought the deceased was coping well with his new environment.[132] Therefore, until it became apparent to the deceased's brother that he was not coping over the Christmas break, the arrangements made by Ms Ombrasine were in line with what Dr Argyle had expected.

113. It is apparent from material on the brief of evidence that the Red Cross took the news of the deceased's hanging very seriously and were actively involved in supporting the deceased's brother during the deceased's last days in hospital and in arranging the funeral. They also provided support to staff involved in the case and conducted an internal review to consider the circumstances of the death and propose steps to improve processes and communication with the Department.[133]

114. Ms Jeram, who is a Senior Manager of Migrations Support Services, advised that since the deceased's death there have been a lot of changes at the Red Cross due to the escalation in client numbers and the complexities of the clients. They have developed a casework model with guidance on how to work with people who are feeling suicidal. They also sought additional funding from the Department for suicide prevention training of CAS caseworkers, which was granted and remains in place to be offered to new staff members and as a refresher course every two years.[134]

115. I am satisfied that the Red Cross provides a valuable service to new arrivals into the Australian community and the Red Cross staff did their best to provide the deceased with an appropriate level of support upon his release in early December 2012.

## Care at Armadale Hospital

116. Dr Peter Morton, who is currently a consultant psychiatrist at the Alma Street Psychiatric Centre at Fremantle Hospital, prepared a report in 2013 in his position at that time as the Acting Clinical Director of Psychiatry at the Armadale Mental Health Service. The report was compiled from the deceased's Armadale Hospital file as Dr Morton did not have any personal involvement in the deceased's medical care.[135] Dr Morton also gave oral evidence at the inquest. During his evidence Dr Morton indicated that, with the benefit of hindsight and his far greater psychiatric experience, he had identified aspects of the deceased's care that could have been improved. His frankness was appreciated and I did not take his evidence overall to be a criticism of the care provided at Armadale Hospital, but rather an explanation of how

[132] Exhibit 1, Tab 19.
[133] Exhibit 1, Tab 13.
[134] T 81 – 82.
[135] Exhibit 1, Tab 15.

the deceased's care might have been managed better with the benefit of hindsight.

117. Dr Morton described the psychiatric assessment as "limited"[136] and the documentation was also limited, partly due to the fact that the deceased had only recently arrived in Australia so there was little "collateral history" available.[137] Dr Morton noted that much of the information available at the inquest in relation to the deceased's anxiety and treatment with anti-depressants in detention was not known to the ED staff. Dr Morton explained that, based upon what was known, the diagnosis of Adjustment Disorder was made, which is "a very serious, stress related disorder which produces psychological symptoms," but it is not clear what the reactive depression was in reaction to.[138] Dr Morton indicated there was "a whole lot of missing information which would have added an awful lot to the assessment"[139] but unfortunately, due to the deceased's personal circumstances not all of that was available that evening.

118. Dr Morton agreed that the fact that the deceased was an asylum seeker would raise a red flag for him and raised his index of suspicion that there was something more going on with the deceased.[140] This was in the context that Dr Morton had personal experience working for IHMS visiting detention centres, in a similar role to Dr Argyle, as well as being a very experienced consultant psychiatrist in mainstream medical care.[141] He also agreed that the report that the deceased had reportedly made three self-harm attempts that day was also a significant concern as there was "a sense of escalating behaviour."[142]

119. Based on the information that was available, Dr Morton expressed the opinion that the deceased's case should have been escalated, at least to the extent of a call being made to a psychiatric doctor on call, rather than simply a discussion with the emergency department doctor.[143] Despite the fact that these events were occurring around Christmas time, Dr Morton indicated that an appropriately experienced doctor would have been on call, if required.[144]

120. In this case, the deceased's assurances that he was not at risk of further suicidal behaviour was "taken at face value."[145]

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[136] T 22.
[137] T 22.
[138] T 22.
[139] T 26.
[140] T 23.
[141] T 22.
[142] T 26.
[143] T 24.
[144] T 24 – 25.
[145] T 27.

Dr Morton indicated that while the deceased may have been completely genuine in his assertions, but there were a range of possibilities for why he might not admit to having suicidal thoughts, including cultural reasons and a reluctance to discuss personal distress with strangers, as well as the difficulties of using a telephone interpreter, that would make it difficult to make that assessment.[146] Dr Morton described the situation fairly simply, in that the deceased was "just out of immigration detention and he's presenting in quite a distressed way and there's talk about suicide" and that history should have been given more weight and "a more cautious approach should have been taken to managing him."[147]

121. As noted above, Dr Morton prefaced all of these comments with an acknowledgment that he has far more experience, both as a psychiatrist and in particular, with refugees, than the staff involved on the night. He also explained some of the statistics as to how many presentations of psychiatric patients the Armadale ED receives, which he explained worked out to about 3 people a day presenting following a suicide attempt and requiring a risk assessment and a plan to be formulated.[148] To manage that number of people, standardised risk assessments are used in the hospital, based on past history and situational events, and Dr Morton acknowledged that on both scales the deceased scored quite low.[149] Nevertheless, based on the known history, in Dr Morton's opinion there was enough information to warrant escalating his case for a psychiatric opinion.

122. However, even if that had occurred, and the deceased had been admitted, Dr Morton acknowledged that there is a high chance that the deceased would not have been kept in hospital for a very long time. If he had continued to maintain his position that he was feeling all right and was no longer at risk and was not contemplating self-harm, there is a very high likelihood he would have been discharged in a short space of time.[150] In those circumstances, he would most likely have been back in the community on 2 January 2013 in any event.

123. What might have been done differently, if it had been communicated to the ED staff that the Red Cross was closed until the new year, is that the deceased could have been referred to Community Mental Health Services connected with Fremantle Hospital. That service would have been operating over the Christmas/New Year service and Dr Morton believes there would

[146] T 25, 27.
[147] T 28.
[148] T 23.
[149] T 23.
[150] T 28.

have been a greater likelihood that the deceased might have been seen by a community mental health nurse close to the date of his discharge.[151] Unfortunately, it seems from the medical records that the ED staff were unaware of the immediate unavailability of the Red Cross case worker and that information was not conveyed to them by the deceased or his brother.

124. The events at Armadale Hospital can perhaps best be described as a missed opportunity to have the deceased more comprehensively psychiatrically assessed, which would have been the best option given the particularly stressful issues he faced as a newly released detainee going through the asylum seeking process.

## CONCLUSION

125. The deceased was a Sri Lankan man who came to Australia by boat with the hope that it would lead to a better life for him and his family. The evidence indicates that he was an unsophisticated and mentally vulnerable man who was ill-prepared for the reality of the immigration process that applies to irregular maritime arrivals to Australia. He and his family also underestimated the severe level of distress he would experience as a result of being separated from his wife and child.

126. While being held in various detention centres the deceased was able to regularly access care from mental health professionals. After the deceased satisfied the requirements for a bridging visa, he was assessed by a psychiatrist as a person who would psychologically benefit from being released from detention into the community, provided he had some family support in the community. That family support was available in the form of the deceased's younger brother, who was already living in Perth subject to a bridging visa, as well as transitional support provided by the Red Cross. Accordingly, the deceased was released from detention.

127. Upon release the deceased's mental health did not improve as anticipated, but instead slowly deteriorated further until he became actively suicidal. Just after Christmas 2012 the deceased acted on his thoughts and was found trying to hang himself, which resulted in him being taken to Armadale Hospital for psychiatric assessment. During the assessment the deceased reported that he was no longer feeling suicidal. He was assessed as being no longer acutely suicidal and deemed suitable for discharge with community follow-up. In hindsight, this hospital

[151] T 29.

presentation could have been an opportunity for greater psychiatric review of the deceased, given the build-up of events that had led to his suicide attempt. However, given the lack of information available to the hospital staff about his prior history and the deceased's unwillingness to disclose this information, that opportunity was missed.

128. The deceased did not receive any further medical treatment or care after his discharge from Armadale Hospital and on 2 January 2013, while left alone for a period, the deceased took the opportunity to complete the act he had attempted days before and hanged himself. By the time he was discovered and resuscitated he had sustained severe hypoxic brain injury and as a result he died a few days later.

129. Sadly, I understand that the deceased's case is not an isolated event. I am advised the Department is aware of other similar incidents of self-harm by people engaged in the asylum seeking process while living in the community. Given the vulnerability of such people, who have often experienced extreme trauma prior to coming to Australia, it is not surprising that some of them find their mental health adversely affected by the pressures of starting life in a new country and the uncertainty of their position while engaged in a protracted immigration process.

130. I am advised by the Department that since the death of the deceased they have actively taken steps to improve mental health services, both within the Department and in conjunction with their service providers, and this is an ongoing process. None of the parties submitted that any particular recommendations might arise from this inquest that would add to what is already being done. In those circumstances, I make no recommendations.

S H Linton
Coroner
8 September 2016