[2022] WACOR 32

JURISDICTION	**:** CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:** CORONERS ACT 1996
CORONER	**:** SARAH HELEN LINTON, DEPUTY STATE CORONER
HEARD	**:** 18 - 22 OCTOBER 2021
DELIVERED	**:** 14 JULY 2022
FILE NO/S	**:** CORC 1095 of 2018
DECEASED	**:** AL JHELIE, SARWAN HEKMAT SALMAN

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms R Collins assisted the Coroner.
Mr F Merenda (Mitry Lawyers) appeared for the family of the deceased.
Ms P Giles SC with Ms C Taggart (AGS) appeared for the Commonwealth Department Home Affairs.
Ms B Burke (ANF) appeared for Ms Cheema.
Mr D Johnson (Corrs Chambers Westgarth) appeared for Serco Australia Pty Ltd.
Mr B Tomasi appeared for Ms Paterson.
Ms J Thornton (Moray Agnew) appeared for International Health and Medical Services (IHMS)

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of ***Sarwan Hekmat Salman AL JHELIE*** *with an inquest held at the* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth*** *on 18 to 22 October 2021, find that the identity of the deceased person was* ***Sarwan Hekmat Salman AL JHELIE*** *and that death occurred on 5 September 2018 at Royal Perth Hospital from complications of ligature compression of the neck (hanging) in the following circumstances:*

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SUPPRESSION ORDER

Made on 20 October 2021

THIS ORDER REPLACES THE ORDER PREVIOUSLY MADE BY THE CORONER ON 19 OCTOBER 2021.

WITH THE EXCEPTION OF THE DECEASED, THE NAME OF ANY PERSON MENTIONED IN THE PROCEEDINGS, OR ANY IDENTIFYING DETAILS, EITHER IN OPEN COURT, OR IN DOCUMENTS, FILES OR TENDERED IN THE PROCEEDINGS, WHO IS OR HAS BEEN DETAINED UNDER THE *MIGRATION ACT 1958* (Cth) MUST NOT BE PUBLISHED, IN ELECTRONIC FORM OR OTHERWISE.

EXCEPT THOSE PARTIES APPEARING AT THE INQUEST WHICH HAVE A STATUTORY DUTY TO PRESERVE ALL RECORDS, THE PARTIES ARE DIRECTED TO DESTROY COPIES OF EXHIBIT 13A IN THESE PROCEEDINGS AT THE CONCLUSION OF THE INQUEST, AND ANY APPEAL OR REVIEW.

INTRODUCTION

1. Sarwan Al Jhelie was born in Iraq and moved to Jordan with his family when he was a very young child, due to his family being targeted by the authorities in Iraq. He spent his early years in Jordan before coming to Australia with his family on a Global Special Humanitarian visa in 2010, when he was 13 years of age. The family settled in New South Wales.[1]

2. Unfortunately, Mr Al Jhelie found it difficult to settle into a new life in a new country, including living with a father he had not seen for many years. He fell in with the wrong crowd, started using drugs and got into trouble with the law. His story, to that extent, is not that unusual. Many other young men in Australia head down the wrong path in their teenage years before they mature. However, for Mr Al Jhelie that conduct had very significant consequences as he was not an Australian citizen.

3. In 2016, after he had been sentenced to serve a lengthy term of imprisonment, Mr Al Jhelie's visa was automatically cancelled under s 501 of the *Migration Act* 1958 (Cth). When Mr Al Jhelie was released from prison in late 2016, he was immediately taken into detention at Villawood Immigration Detention Centre in NSW (Villawood).

4. The decision to revoke Mr Al Jhelie's visa was eventually set aside in January 2017, his visa was re-enlivened, and he was released from immigration detention. However, only a short time later, on 27 March 2017, Mr Al Jhelie's visa was cancelled again after he was sentenced to another term of imprisonment.[2] Mr Al Jhelie sought revocation of the cancellation decision, which was refused by a delegate of the Minister for Immigration (Minister) on 28 September 2017.[3]

[1] Exhibit 1, Tab 12.
[2] Exhibit 1, Tab 15 and Tab 53.
[3] Exhibit 17, Tab 4.

5. Mr Al Jhelie sought a review of this decision in the Administrative Appeals Tribunal (AAT), with the hope that he would be permitted to remain living in Australia with the rest of his family. On 24 January 2018, the AAT set aside the decision not to revoke cancellation of Mr Al Jhelie's visa (or in effect set aside the decision to deport Mr Al Jhelie) and ordered that the Minister re-assess the revocation after obtaining a psychiatric report on Mr Al Jhelie's prospects of successful rehabilitation. The Department of Home Affairs (the Department) began discussions about what needed to be done the following day. There appeared to be some ongoing confusion as to whether the responsibility for obtaining the report rested with Mr Al Jhelie or the Department, although it was made clear by the Tribunal that it was the Department's responsibility to facilitate the obtaining of the report.[4]

6. Mr Al Jhelie was released from prison on 1 March 2018, and he returned to immigration detention at Villawood that same day.[5]

7. On 8 July 2018, and again on 25 July 2018, Mr Al Jhelie suffered two drug overdoses while being held at Villawood. Concerns were raised by Australian Border Force (ABF) staff that he might overdose again, and possibly die, if he remained at Villawood. Accordingly, on 7 August 2018, Mr Al Jhelie was transferred to Yongah Hill Immigration Detention Centre in Western Australia (Yongah Hill). The transfer was arranged largely for the purpose of disrupting his supply and access to drugs and thereby preventing another overdose.[6]

8. At the time the transfer was initiated by ABF staff, they were unaware that Mr Al Jhelie had been receiving support from mental health and drug and alcohol services within the detention centre. When he was transferred to Yongah Hill, for some unknown reason these services stopped. Mr Al Jhelie did receive some medical treatment for an ongoing chronic bowel condition, but nothing more was offered.

9. Mr Al Jhelie was still awaiting assessment by a psychiatrist, as ordered by the AAT, at the time he was moved. Mr Al Jhelie was finally booked in to see the psychiatrist for this assessment on 3 September 2018, although it's unclear if Mr Al Jhelie was aware of the appointment.

10. On 2 September 2018, six months after Mr Al Jhelie entered detention for the second time, eight months after the AAT decision was delivered and the day prior to the psychiatric review occurring, Mr Al Jhelie self-harmed by cutting his left wrist several times. The evidence indicates this act of self-harm followed a break-up with his girlfriend that morning, and some issues with accessing his telephone as a result. Serco staff were notified, and they went to check on Mr Al Jhelie.

11. On the weekends, the International Health and Medical Services (IHMS) nurses at the Yongah Hills were only contracted to dispense medications and Serco staff were supposed to call a staffed helpline for any medical matters relating to detainees. However, knowing there were two nurses on site, Serco staff brought Mr Al Jhelie to

[4] Exhibit 6, Tab 2; Exhibit 17, Tab 2 – Tab 4.
[5] Exhibit 1, Tab 13 and Tab 53.
[6] Exhibit 1, Tab 53.

the dispensary to see if Mr Al Jhelie could be reviewed by the nurses in the dispensary.

12. According to protocol, the nurses should have refused and turned Mr Al Jhelie away, but it seems they took the humane and practical approach and did what they could to help. One of the nurses, Nurse Mariam Cheema, looked briefly at his cuts and confirmed they were only superficial and did not require medical attention. The other nurse, Nurse Bernadette Paterson, also spoke briefly to Mr Al Jhelie to see if he wanted to talk about what was bothering him, but he declined. Nurse Paterson made a note for someone to review Mr Al Jhelie on the next business day, as she felt he still required following up for his possible mental health issues.

13. Serco staff returned Mr Al Jhelie to his room. Later that afternoon, after Mr Al Jhelie's roommate left the room for a period of time, Mr Al Jhelie was found hanging in his cell by a torn bedsheet tied to a bunk bed. He was resuscitated by Serco staff and transferred by ambulance first to Northam Hospital, and then on to Royal Perth Hospital, where he was admitted to the Intensive Care Unit for treatment. Sadly, Mr Al Jhelie had suffered an unsurvivable brain injury. He remained in hospital on life support long enough for some of his family to fly from the eastern states to be by his bedside, before he died on 5 September 2018.

JURISDICTION

14. Mr Al Jhelie's death was a reportable death within the meaning of s 3 of the *Coroners Act 1996* (WA) (the Act) as it was an unexpected and unnatural death that occurred in this State. A person held in immigration detention does not come within the definition of a 'person held in care' within the meaning of s 3 of the Act, so there was no mandatory requirement to hold an inquest into the death. However, given the circumstances of the death, which are in many ways akin to a death in care under the Act, it was determined that an inquest was desirable pursuant to s 22(2) of the Act.

15. Under the Act, I am required (if possible) to find the identity of the deceased, how the death occurred, the cause of death and the particulars needed to register the death.[7]

16. Where a death is of a person held in care, the coroner investigating the death must also comment on the quality of the supervision, treatment and care of that person while in that care. That mandatory obligation does not apply to Mr Al Jhelie, as he does not meet the definition of a person held in care under the Act.

17. However, it does not follow that the care, treatment and supervision given to Mr Al Jhelie prior to his death is irrelevant to my enquiry. As has been noted in other inquests into self-inflicted deaths of detainees at immigration detention centres in Australia, the Department has "a non-delegable duty of care to all immigration detainees which is essentially a duty to ensure that reasonable care is taken for

[7] Section 25(1) *Coroners Act 1996* (WA).

persons over exercises control and authority."[8] It is appropriate, in considering the circumstances of the death of a detainee, who does not have the ability to leave a facility to seek medical treatment on their own behalf, to consider whether the Department has provided reasonable care akin to what is available within the community. That is particularly so in the case of Mr Al Jhelie, who had drug abuse and mental health issues for which he had received treatment in prison, prior to being taken into detention on both occasions.

18. In any event, I also accept the submission made on behalf of Mr Al Jhelie's family[9] that there were a number of issues relating to the care of Mr Al Jhelie that are 'connected to' his death, thus enlivening my discretion to make comments pursuant to s 25(2) of the Act. In that regard, I am not limited by the relevant terms of the legislation to comments on public health, safety or the administration of justice and "may comment on any matter connected with the death". In my view, the issues arise within the context of how Mr Al Jhelie's death occurred, namely by way of suicide.

19. There is some complexity arising in this case from the fact that there were a number of agencies responsible for Mr Al Jhelie's general care and safety in the sense of ensuring he was kept housed, fed and clothed appropriately, his health care, his security and his legal case resolution at the time. The Commonwealth as represented by the Department of Home Affairs (known as the Department of Immigration and Border Protection at the relevant time) has overarching responsibility for the management of the country's immigration detention facilities and the care of the people detained in those facilities. The Department incorporates within it the Australian Border Force.

20. However, in terms of the day-to-day responsibility for caring for and managing detainees, Serco Asia Pacific Pty Ltd (Serco) is contracted to staff and manage the detention facility and IHMS is contracted to provide primary health care services. It was submitted that the level of health care contracted to be provided is largely similar to a GP service and is provided in conjunction with the public health system in whichever State or Territory the facility is located.[10]

21. Concerns arose in the coronial investigation as to how each of these agencies performed their roles and responsibilities in relation to Mr Al Jhelie and they were each advised of the potential for adverse findings or comments to be made against them. Accordingly, all three parties were represented at the inquest by counsel, who were able to question the witnesses and make submissions at the conclusion of the inquest, along with counsel for the family. Nurses Cheema and Paterson, who saw Mr Al Jhelie at the medical centre, were individually represented as both nurses no longer worked for IHMS at the time of the inquest and were not covered by IHMS' representation.

22. It was apparent from the evidence adduced during the inquest that at various times, these different stakeholders had little understanding of what the others were doing in

[8] *Inquests into the deaths of Josefa Rauluni, Ahmed Obeid al-Akabi and David Saunders* delivered 19 December 2011 (NSW State Coroner Magistrate M Jerram), p. 2.
[9] Closing Submissions filed on behalf of the family of the late Mr Al Jhelie, filed 30 November 2021.
[10] IHMS Submissions filed 26.11.2021.

terms of the care and management of Mr Al Jhelie, which led to confusion, delays and at times decisions being made without all the relevant facts, which I consider contributed to Mr Al Jhelie's untimely death.

23. I note at this stage that the Court faced significant issues in preparing for this inquest due to a lack of documentation, which also made it difficult to understand what role each party played in decision-making, and why decisions were made. A lot of relevant material was only provided on the eve of the inquest, or even in some cases, during it. In an earlier inquest involving the suicide of a young woman who died while living in the community, but after a long period of time being held in detention, I raised with counsel appearing for the Department of Home Affairs in that inquest my concerns about the difficulty the Coroners Court faced obtaining information from the Department. I emphasised the importance in future cases of the Department providing at an early stage an overarching report about the treatment, care and supervision provided to a detainee. I was assured by the Department's counsel at that time (who was not the same counsel as at this inquest) that the message had been received and understood by the Department.[11] Despite this assurance, the Court faced the same obstacles in this inquest as it did in the previous inquest in regard to obtaining the necessary information from the Department.

24. While the same counsel was not briefed by the Department to appear at this inquest, the instructing solicitors remained the Australian Government Solicitor in both. I also provided a copy of the relevant portion of transcript to counsel appearing for the Department at a case management hearing held on 29 September 2021, although Senior Counsel was not present at that hearing. I'm unaware as to what instructions were provided to counsel to explain the position that had been reached by that stage.

25. What I do know is that it was not until 14 October 2021, two business days before the commencement of the inquest, that the Court was provided with a copy of the Detention Assurance Review conducted into the death of Mr Al Jhelie.[12] The report, completed in August 2019, was precisely the kind of information I had requested the Department provide. I note it was only provided to the Court after Counsel Assisting, Ms Collins, identified the existence of the report during some last-minute research prior to the inquest, and a specific request was made for its provision on 13 October 2021. After this report was provided on the Thursday before the inquest, a flood of further materials was provided to the Court from various parties, including the Department, IHMS and Serco. No compelling reasons were offered as to why this was the case.

26. A simple example is the request for information as to why Mr Al Jhelie was transferred from Villawood to Yongah Hill a few weeks prior to his death:

- The investigating officer, Det Sgt Tanya Tidey, began asking the Department for all relevant documentation relating to Mr Al Jhelie's death from as early as November 2018;
- Follow up requests were made by other police officers in 2019 and 2020;

[11] Inquest into the death of FJ, 10.9.2020, T 277 – 281.
[12] Exhibit 6, Tab 2.

- On 10 August 2020, then Counsel Assisting, Ms Kathryn Heslop, emailed the Australian Government Solicitor to request specific information about why Mr Al Jhelie was transferred, amongst other things;
- The request was followed up by another Counsel Assisting, Mr Will Stops, who was eventually told by AGS on 16 March 2021 that the Department had provided the WA Police with the reasons as to why the transfer occurred;
- The Court made enquiries and confirmed with the WA Police that the information had not been provided to police;
- On 15 July 2021, a solicitor from AGS conceded that the relevant information about the transfer had not, in fact, been provided to the WA Police, nor the Court. At that stage, AGS then indicated it was its preference to supply the materials following a formal warrant. A warrant was duly issued that day;
- In late July and early August 2021, an AGS solicitor advised that there were issues with the wording of the warrant and that it was incorrectly addressed to AGS, rather than the Department. A new warrant was immediately issued on 10 August 2021;
- Some of the information relating to the transfer was finally provided to the Court on 17 September 2021;
- At the commencement of the inquest hearing on 18 October 2021, a further hard copy bundle of materials relating to the warrant was tendered by Senior Counsel appearing for the Department and instructed by AGS, after being provided electronically to the Court approximately four minutes before the inquest was due to commence.

27. It hardly needs to be said that this put the Court, and all counsel as well, in the unenviable position of trying to read and digest large volumes of material at the last minute.

28. I note the submission made on behalf of the Department that it would be unfair to make an adverse finding about the Department in relation to the lack of assistance on the basis that by "the time the perceived inadequacies were raised, the Department had little opportunity to remedy them." I accept that is true for Senior Counsel, who only came into this matter at a very late stage. I do not accept that submission on behalf of the Department. The Department must be assumed to have been well aware of submissions made on its behalf on 10 October 2020, urging me not to make an adverse finding against it for a similar course of conduct in another inquest. Nevertheless, there was no improvement in this matter. As I have set out above, it is not for want of trying on the part of the Court.

29. It was submitted by the family that the Department, who should conduct itself as a model litigant in proceedings such as this, has failed in its obligations to the Court and disadvantaged the family in these proceedings.[13] I accept that submission. I am reluctant to make a finding that it was a deliberate tactic by the Department to subvert the inquest process, as that is a very serious allegation. However, it certainly has a tendency to give that unfortunate impression to the objective observer. I am willing at this stage to accept the failings might be attributed to other factors, such as the layers of bureaucracy of a large unwieldy government department, as alluded to

[13] T 654.

by senior counsel, a lack of understanding of the Western Australian coronial process and late briefing of counsel. However, there is only so long that such excuses can be accepted. It is very important that these matters proceed in a more orderly fashion in the future and that all of the parties take active steps to provide relevant information to the Court, rather than adopting the current passive and reactive approach, with lengthy delays and late disclosure the inevitable result.

30. There needs to be greater cooperation by the relevant agencies (being the Department, IHMS and Serco) with any Western Australian coronial investigation in the future at an early stage if another such death of a person in detention occurs, so that everyone is put in the best position to understand the full history of events. This allows consideration to be properly given to whether any meaningful changes to bring about death prevention can arise out of the coronial inquiry. When there is a last-minute scramble to compile the evidence, that purpose is not best served. Senior Counsel for the Department suggested that the Court might benefit from some consultation with the Department and its instructors to perhaps create a practice direction for future matters. I indicated at the inquest that this might have some practical benefit, so I have referred the matter to the State Coroner, who administers this jurisdiction for her consideration. I assume the Department will also proactively approach the Court to offer up its cooperation to ensure this proposal proceeds in a timely manner.

31. I note that IHMS has also indicated in submissions that it regrets that active involvement was not commenced at an earlier time in this case and, if future inquests arise, it is "committed to improving its participation and assisting the Court from an earlier point in time."[14]

32. I can only express the hope that all of this discussion will lead to improved communication and earlier provision of relevant materials in any future matters.

33. In any event, I wish to make it very clear that further failures will be met with a much less understanding approach from this Court, as this inquest finding will act as a record of the Court's clear expectations.

BACKGROUND

34. As noted above, Mr Al Jhelie was born in Iraq. He left Iraq with his family when he was only three years old. They fled to Jordan in 1998 to escape persecution by the Saddam Hussein regime.[15] While the rest of the family stayed in Jordan, Mr Al Jhelie's father left his family behind and eventually made his way to Australia as a refugee.[16] Meanwhile, Mr Al Jhelie grew up in Jordan with his mother and siblings. After many years, his family were granted Global Special Humanitarian visas to move to Australia to reunite with Mr Al Jhelie's father. Mr Al Jhelie moved to

[14] Submissions of IHMS filed 26.11.2021 [125].
[15] *Re JSQF and minister for Immigration and Border Protection* [2018] AATA 305.
[16] Exhibit 1, Tab 15 and Tab 18.

Australia on 22 June 2010 and the family settled in Liverpool, New South Wales. Mr Al Jhelie was 13 years and 7 months' old at the time.[17]

35. When he moved to Australia, Mr Al Jhelie spoke Arabic as his main language. He was enrolled in high school in Liverpool, where he learnt the English language. Unfortunately, Mr Al Jhelie experienced bullying at his new school due to his limited language skills and he began fighting with other students. He was suspended after only a few weeks at school and was eventually expelled after only a year.[18]

36. After being expelled from school, Mr Al Jhelie's relationship with his father broke down. In a letter written by Mr Al Jhelie, he described being assaulted by his father, who was angry about his expulsion. Mr Al Jhelie obtained an apprehended violence order against his father and decided to leave home.[19] He was homeless for a time, and while living on the streets he started using illicit drugs, in particular cannabis and methamphetamine (or 'ice'). He also became depressed and began self-harming by cutting himself to relieve his emotional pain.[20]

37. Mr Al Jhelie formed a relationship with a woman, and they had a son together when he was only 15 years of age. The relationship eventually ended, and Mr Al Jhelie formed another relationship, from which he had two more children, both daughters. That relationship also ended. His two daughters were eventually taken into State care and placed with foster carers, as neither Mr Al Jhelie nor their mother was able to care for them.[21]

38. Mr Al Jhelie was still using drugs and had attracted the attention of authorities as a juvenile. In March 2015, shortly after he had turned 18 years, he was convicted of possession of a prohibited drug and other offences and was sentenced to an aggregate sentence of 5 years' imprisonment, with a non-parole period of 30 months. Following a successful appeal, his total sentence was reduced to 3 years' imprisonment, with his parole period to commence on 30 September 2016.[22]

39. Mr Al Jhelie was released from prison on parole on 30 September 2016 and was immediately taken into detention and placed at Villawood as his visa had been mandatorily cancelled by operation of s 501(3A) of the *Migration Act*. Mr Al Jhelie had already sought revocation of the decision to cancel his visa, and this was eventually successful. He spent 101 days in detention until his visa was reinstated and he was released on 9 January 2017.[23] He was 20 years old by this time.

40. On 2 March 2017 Mr Al Jhelie was sentenced to another 12 months' imprisonment and returned to prison. On 28 March 2017 Mr Al Jhelie's visa was again mandatorily cancelled and on 31 March 2017 Mr Al Jhelie lodged another application for

[17] Exhibit 1, Tab 15 and Tab 18; Exhibit 6, Tab 1.
[18] Exhibit 1, Tab 15 and Tab 18.
[19] Exhibit 1, Tab 12.
[20] Exhibit 1, Tab 12 and Tab 15.
[21] Exhibit 1, Tab 18.
[22] Exhibit 1, Tab 11.
[23] Exhibit 1, Tab 15.

revocation of the mandatory decision to cancel his visa. Mr Al Jhelie served a further 12 month term of imprisonment from 2 March 2017 until 1 March 2018.[24]

41. While serving that term of imprisonment, Mr Al Jhelie had been advised on 28 September 2017 that a delegate for the Minister had refused his application to revoke the second cancellation decision. On 8 November 2017 Mr Al Jhelie sought a review of his visa cancellation by the AAT.[25]

42. While still in prison, Mr Al Jhelie wrote a letter dated 8 January 2018 in support of his application to have his visa re-instated. He referred to his three children from two relationships, all born in Australia, and the personal difficulties he had been through over the years. He expressed his remorse for letting everyone down by returning to offending. He expressed his fear of being deported to Iraq, a country where he had no family and had not lived after the age of two years old. He indicated he no longer spoke the local language fluently and believed his life in Iraq would be very difficult. He asked for one more chance to prove himself and show that he had changed. Mr Al Jhelie had reunited with his parents and siblings and Mr Al Jhelie spoke of wanting to be a better father for his own children.[26]

43. On 24 January 2018, after a hearing before the AAT, the Deputy President set aside the delegate's decision not to revoke the visa cancellation and remitted the matter to the Department with the direction that the Department obtain a report on Mr Al Jhelie's prospects of successful rehabilitation, with the view that the report would be part of the materials before the decision maker when the matter was being determined afresh.[27] It was also suggested that Mr Al Jhelie might be a person in respect of whom Australia owes non-refoulement obligations, which had not been examined in detail but might be explored by Mr Al Jhelie after seeking legal advice, noting he had not been legally represented in the AAT proceedings.[28]

44. It was suggested in the Department's submission that this order for an expert psychiatric report was "novel,"[29] although I note that the decision referred to something not dissimilar occurring in another case.[30]

45. As noted above, there seemed to be some ongoing misunderstanding by the Department's staff as to whether it was Mr Al Jhelie or the Department's responsibility to obtain the report, although the decision of the Deputy President was clear that it was for the Department (as the Respondent) to obtain the report. Mr Al Jhelie was incorrectly told that he would need to obtain the report, and it seems he continued to try to do so over the following months and was getting frustrated as his appointments were being cancelled and he was unable to arrange it.[31]

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[24] Exhibit 1, Tab 11 and Tab 13 and Tab 15.
[25] Exhibit 1, Tab 15; Exhibit 17, Tab 4.
[26] Exhibit 1, Tab 12 and Tab 15.
[27] Exhibit 17, Tab 4.
[28] *Re JSQF v Minister for IBP*,[16].
[29] Written Closing Submission of the Commonwealth of Australia, filed 26 November 2021.
[30] *WKCG and Minister for Immigration and Citizenship* [2009] AATA 512 heard by Deputy President Tamberlin,
[31] Exhibit 17, Tab 2 to Tab 4.

46. After being released from prison on parole on 1 March 2018, Mr Al Jhelie was immediately detained again and taken to Villawood.

47. Ms Sandra Ishak (who is now married and known as Sandra Todd) became Mr Al Jhelie's Status Resolution Officer (SRO) at this time. Ms Ishak first met Mr Al Jhelie in March 2018 and thereafter she had ongoing contact with him, primarily by telephone but also sometimes face-to-face.[32]

MEDICAL HISTORY

48. Mr Al Jhelie was known to have suffered from asthma since childhood, but his condition was generally well controlled and he did not take regular asthma medications. His last known asthma attack was in 2015, when he was exposed to a prison cell fire that triggered an attack.[33]

49. I note that in his NSW Justice health records, which I acknowledge were not part of the IHMS records,[34] Mr Al Jhelie was noted to have a history of depression and anxiety and had mental health concerns on his health intake screening. He also disclosed multiple previous attempts to self-harm by cutting, and multiple suicide attempts by overdose. His Kessler 10 score suggested he may be experiencing severe levels of distress consistent with a diagnosis of severe depression and/or anxiety disorder. He also admitted using diazepam and methamphetamine.

50. A mental health review took place in prison on 9 April 2015. Mr Al Jhelie had been referred to the mental health nurse due to reported 'bizarre behaviour', after telling someone he believed "his heart stopped for 10 minutes."[35] Mr Al Jhelie denied thoughts of self-harm and showed no evidence of major mood disorder or psychosis. He was referred to the Intensive Drug and Alcohol Treatment Programme, which he engaged with while serving his sentence.[36] Mr Al Jhelie indicated he participated in the program so he could "get something out of prison."[37] He later said in a letter that he learnt many things from the program, in particular not to use drugs to get away from everything. Mr Al Jhelie believed he was ready for the outside when he was eventually released from detention and had a plan to do rehabilitation in the community.[38]

51. On 8 November 2015, Mr Al Jhelie was reviewed by a mental health nurse and again was assessed as exhibiting symptoms of Post Traumatic Stress Disorder (PTSD) with associated depression and anxiety. It was noted he had been significantly affected by past events in his childhood in Jordan and his relationships with his father and partner.[39]

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[32] Exhibit 6, Tab 13.
[33] Exhibit 1, Tab 15.
[34] Exhibit 2, Tabs 2 & 3.
[35] Exhibit 2, Tab 2, Progress Notes.
[36] Exhibit 2, Tab 2, RSA Clinical Summary, 4.4.2015, Reception Screen Assessment 4.4. 2015 and Chronic Disease Screen, 30.8.2015.
[37] Exhibit 1, Tab 12, p. 3.
[38] Exhibit 1, Tab 12.
[39] Exhibit 2, Tab 2, Progress Notes.

52. Mr Al Jhelie underwent another mental health assessment on 8 January 2016, while still serving his first prison term. He reported he had been having trouble sleeping and was thinking about traumatic experiences he had witnessed in the past. He admitted to using cannabis and 'ice' daily in the past, as well as engaging in self-harming behaviour. He reported he had been prescribed anti-psychotic medication by a GP at the age of 17 years for anger and sleep issues but said he had only taken the medication for a few days. Mr Al Jhelie appeared significantly affected by childhood events, his relationship with his father and the breakdown of his relationships with the mothers of his children. He was suffering anger problems and was felt to be vulnerable to drug abuse. The nurse conducting the mental health assessment suggested a provisional diagnosis of PTSD, characterised by angry outbursts, not sleeping, and dwelling on his past, as well as depression.[40]

53. Mr Al Jhelie was then reviewed by a psychiatrist on 21 January 2016. The psychiatrist documented Mr Al Jhelie's accounts of witnessing killings in Jordan as a child, as well as the difficult experiences with his father. The psychiatrist noted Mr Al Jhelie's significant history of trauma and considered he showed "features of, but probably not "full blown" PTSD."[41] He also presented as depressed. Mr Al Jhelie was commenced on the antidepressant mirtazapine and advised to continue seeing the psychologist. The mental health nurse was instructed to monitor his progress. According to the prison medical charts, Mr Al Jhelie stopped taking the antidepressant after a few weeks and when he was reviewed on 30 January 2016 by a nurse, he denied any mental health issues.[42]

54. Mr Al Jhelie was supposed to be seen by a mental health nurse in the prison on 9 September 2016, but his appointment was pushed back to 30 September 2016, the day he moved to immigration detention.[43]

55. When Mr Al Jhelie was released from prison and moved to detention at Villawood, he had a health induction assessment on 30 September 2016 with a primary health nurse. Mr Al Jhelie indicated he had a history of asthma and described being a heavy user of methamphetamine/ice and regular cocaine and alcohol use until going into prison and undertaking a drug rehabilitation programme. He declined to see a GP or to receive any immunisations. Mr Al Jhelie did not disclose any history of mental health concerns during this initial review, despite his history in custody.[44]

56. A request was sent by IHMS to NSW Justice Health Services requesting Mr Al Jhelie's medical records/health summary and medication charts from his time in custody, which should have shed light on Mr Al Jhelie's mental health issues in 2016.[45] Unfortunately, on 5 October 2016, IHMS received only two pages from NSW Justice Health from John Moroney Corrections Centre, one being his medication chart and the other the most recent page from his progress notes. His 2016 mental health assessment and psychiatrist's notes were not provided.[46]

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[40] Exhibit 2, Tab 2, Mental Health Assessment 8.1.2016.
[41] Exhibit 2, Tab 2, Progress Notes.
[42] Exhibit 2, Tab 2, Progress Notes.
[43] Exhibit 2, Tab 2, Progress Notes.
[44] Exhibit 2, Tab 3, p. 69.
[45] Exhibit 2, Tab 3, p.210.
[46] Exhibit 2, Tab 3, pp. 236 – 237.

57. Evidence was given by a witness from IHMS that there continues to be ongoing and significant issues getting adequate documentation from corrections health, so it was not an unusual event for only some of the relevant documentation to be provided.[47]

58. While the failure to receive the comprehensive documentation does make the task of the IHMS staff more difficult, I do note that it was apparent to an IHMS doctor who looked at the medication chart that Mr Al Jhelie was prescribed the antidepressant mirtazapine and the dose had been increased.[48] There is no mention in the progress notes provided by NSW Justice Health Services as to who had prescribed this medication to Mr Al Jhelie or when. This obvious gap in the medical information should have prompted either a follow-up request with NSW Justice Health (as it is quite clear his full relevant medical history had not been provided) or alternatively, prompted a discussion by an IHMS health professional with Mr Al Jhelie to see if he could shed any light on the issue, given he had not mentioned it in his initial health screening. Neither of these options was done, which meant that potentially important information about Mr Al Jhelie's tentative diagnosis of PTSD was not on the radar of the health staff caring for him in detention.[49]

59. I note at this juncture that it was conceded by a witness for IHMS at the inquest that the information that was provided by Corrections Health to IHMS was obviously inadequate and she would expect follow-up by staff if a similar event occurred today. I was advised that a recent change by IHMS has been implemented requiring IHMS staff to document the outcome of an attempt to obtain records from Corrections Health. When documentation is received a doctor will physically sign the corner of the documents before it is uploaded. All staff can be confident that the information provided has been actually reviewed by a doctor.[50]

60. Mr Al Jhelie did not attend his planned mental health screening with a psychologist on 12 October 2016 and did not attend his rescheduled appointments in the following days.[51] This was another missed opportunity for some information to be obtained from Mr Al Jhelie about his mental health history, but unfortunately it seems he did not want to discuss it with a psychologist. His focus appeared to be more geared towards his drug use and obtaining medication assistance for his withdrawal symptoms at that time.

61. Mr Al Jhelie submitted a medical request on 12 November 2016 asking to see a doctor to discuss developing a medication regime to help with his medical conditions, both "physically and mentally."[52] He was seen by a primary health nurse on 16 November 2016 and explained he wished to see a specialist regarding buprenorphine treatment as he had been using and experiencing withdrawal symptoms. A urinary drug screen was negative, suggesting he had not been using drugs recently.[53]

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[47] T 546.
[48] Exhibit 2, Tab 3, p. 68.
[49] T 547.
[50] T 547 - 548.
[51] Exhibit 2, Tab 3, p. 85.
[52] Exhibit 2, Tab 3, p. 256.
[53] Exhibit 2, Tab 3, pp. 66 – 67, 232.

62. On 17 November 2016 Mr Al Jhelie presented to the medical centre for assessment of his withdrawal symptoms. He underwent a mental health consultation with a primary health nurse, who confirmed he was a smoker and user of ice and cocaine. Mr Al Jhelie also disclosed he had been using buprenorphine while in prison and had only stopped when he left prison. There is nothing to suggest he had been prescribed buprenorphine, so it seems he was accessing it illicitly while in custody. His expressed aim was to be formally put on buprenorphine treatment while in Villawood. He was booked with Dr Needham, the addiction specialist, the following week for further review and encouraged to try to distract himself with sports and other activities to reduce his cravings in the meantime.[54]

63. Mr Al Jhelie also saw a doctor on 17 November 2016. He disclosed during this consultation that he had a history of depression and was on Avanza (mirtazapine) in jail but did not like it so he voluntarily stopped taking it. He admitted to smoking ice, cocaine and buprenorphine, his last use being 8 days ago while in detention. The doctor confirmed his appointment with Dr Needham and gave Mr Al Jhelie advice about adopting a healthy lifestyle.[55]

64. Mr Al Jhelie saw Dr Needham on 25 November 2016 and was deemed unfit to commence on opioid replacement therapy (buprenorphine). It was recommended he see a psychologist to manage his cravings and the mental health team were notified.[56]

65. Mr Al Jhelie attended an appointment with a psychologist on 28 November 2016, in response to the internal referral. Mr Al Jhelie discussed his personal history and indicated he was reconciled with his immediate family and received visits from them. Two of his children were in care and he did not have contact. He denied any current mental health concerns and said he did not need mental health support, so it was left on the basis Mr Al Jhelie would initiate contact if his circumstances changed.[57] Mr Al Jhelie was released from immigration detention soon after, on 9 January 2017.

66. Mr Al Jhelie returned to prison on 2 March 2017. Like his previous prison medical history, I note that the next portion of medical information was not known to IHMS staff when he later returned to detention. On this occasion there is no evidence to indicate that IHMS staff even made the request to Justice Health.[58] No explanation was provided by IHMS as to why this omission occurred.

67. On 7 March 2017, Mr Al Jhelie had a mental health assessment. His prior diagnosis of possible PTSD by a Justice Health psychiatrist and transient use of mirtazapine 'for sleep' was noted. He was not presenting as depressed or psychotic during the assessment, and he denied any drug or alcohol issues, so he was felt to not present any risk to himself at that time. However, on 9 March 2017, Mr Al Jhelie took another prisoner's medication and collapsed. He said he had taken it as he wanted to

[54] Exhibit 2, Tab 3, p. 65.
[55] Exhibit 2, Tab 3, p. 64.
[56] Exhibit 2, Tab 3, p. 63.
[57] Exhibit 2, Tab 3, p. 62.
[58] Submissions of IHMS filed 26.11.2021 [12].

sleep. Mr Al Jhelie was reviewed a couple of weeks later and denied any acute mental health issues or thoughts of suicide.[59]

68. On 19 May 2017 Mr Al Jhelie complained of abdominal pain and passing blood in his stools. He was transferred to Wellington Hospital, NSW, for medical review. He was discharged back to prison the same day on paracetamol for the pain and advised to try to eat a good fibre diet and drink fluids to avoid constipation.[60] He reported ongoing issues with rectal bleeding and in August 2017 he was diagnosed with bleeding haemorrhoids. Blood tests and stool samples were ordered. His stool sample was found to be positive for blood, so Mr Al Jhelie was referred for an abdominal CT scan and colonoscopy in September 2017.[61] He went to hospital in October 2017 for investigations of his possible inflammatory bowel disease.[62]

69. After returning to detention at Villawood on 1 March 2018, Mr Al Jhelie underwent a brief health induction assessment with a nurse. He admitted to previous illicit drug use and previously being prescribed medication for depression. He denied any current drug use. His recent history of rectal bleeding was noted.[63]

70. A more extensive health indication assessment was then performed on 7 March 2018 by a doctor. Better management of his asthma was discussed, and further information was sought about his rectal bleeding and abdominal pain. He was referred for an abdominal CT scan and blood tests to further investigate this issue. He admitted to the doctor he was still abusing drugs, and had used buprenorphine in jail, with the last time being on 1 March 2018 when he moved to detention. He reported his mood as okay and denied any suicidal ideation.[64]

71. The following day Mr Al Jhelie underwent a drug and alcohol assessment. During the assessment he indicated he had been an illicit drug user for many years but had never injected or overdosed. At this assessment, and at further assessments on 13 and 27 July 2018, he was not deemed appropriate for opioid replacement therapy. He was referred for a mental health assessment.[65]

72. On 10 March 2018 Mr Al Jhelie suffered chest pains while at the gym and was transferred to hospital. The impression was muscle injury secondary to strenuous exercise. He was quickly discharged and when he was reviewed on 11 and 16 March 2018 he reported he was fine and had simply reduced his exercise.[66]

73. On 20 March 2018 a CT scan of Mr Al Jhelie's abdomen and pelvis showed a subtle wall thickening in the rectum, inferior portions of the sigmoid colon and right portion of the transverse colon, suggestive of inflammatory bowel disease. Referral to a gastroenterologist was recommended.[67]

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[59] Exhibit 2, Tab 2, Progress Notes and Mental Health Assessment 7.3.2017.
[60] Exhibit 2, Tab 2, Progress Notes and Wellington Hospital Progress Notes.
[61] Exhibit 2, Tab 2, Progress Notes.
[62] Exhibit 2, Tab 2, Progress Notes.
[63] Exhibit 2, Tab 3, p. 60.
[64] Exhibit 2, Tab 3, p. 59.
[65] Exhibit 2, Tab 3, p. 58.
[66] Exhibit 2, Tab 3, pp. 54, 57 - 58, 275 - 277.
[67] Exhibit 2, Tab 3, p. 262.

74. On 21 March 2018 Mr Al Jhelie was reviewed by the psychologist for his scheduled mental health review. He described his family fleeing Iraq to Jordan and then coming to Australia as a 13 year old. He said he was bullied at school and exposed to violence at home, leading to him becoming suspended from school and homeless at 14 years of age. He provided a history of being prescribed Avanza in the community and in prison and engaging in substance abuse. The psychologist, Ms Emma McMillan, had no independent recollection of Mr Al Jhelie, so there are only her notes to go on, which do not record a risk assessment, impression or plan at that time.[68]

75. On 8 April 2018 Mr Al Jhelie was transferred to Liverpool Hospital, NSW, due to abdominal pain and rectal bleeding, which he indicated he had been experiencing intermittently for some time. Internal haemorrhoids were believed to be the cause of the bleeding and GP follow-up was recommended. He was also advised to avoid constipation, although he denied this was the cause. The following day Mr Al Jhelie was seen by an IHMS GP and referred to a specialist for colonoscopy due to a suspicion he had irritable bowel syndrome.[69]

76. Mr Al Jhelie had an Individual Management Plan Review on 14 April 2018 and he mentioned that he had psychiatric issues and that he was supposed to see the psychiatric nurse but the appointment had been cancelled. He also mentioned he had been told to see the psychologist as soon as possible.[70]

77. Mr Al Jhelie saw the psychologist, Ms McMillan, again on 18 April 2018. The previous consultation had largely been about obtaining background. During this consultation, Mr Al Jhelie completed the Beck Depression Inventory questionnaire, and his score was indicative of moderate to severe depression. Mr Al Jhelie denied thoughts of self-harm or suicide and Ms McMillan assessed him as at low risk of self harm or harm to others, but he also had low protective factors. Ms McMillan planned to follow him up for further appointments. However, her follow up appointment was rescheduled a number of times and then cancelled. Ms McMillan then took leave for an extended period, so Mr Al Jhelie saw other mental health staff in her absence.[71]

78. Mr Al Jhelie returned to Liverpool Hospital on 29 April 2018 with further abdominal pain. Two Health Advisory Service (HAS) calls were made overnight before an ambulance was arranged. At the hospital, an abdominal x-ray showed he was very constipated. He was reviewed by a nurse on return from hospital and then reviewed by a GP review the following day, who confirmed he had an upcoming specialist appointment.[72]

79. Mr AL Jhelie was still unwell with abdominal pain on 1 May 2018, when a HAS call was made on his behalf overnight. He attended the clinic in the morning where he was given some medication to ease his pain and discomfort.[73]

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[68] T 417 – 426; Exhibit 2, Tab 3, p. 53; Exhibit 15.
[69] Exhibit 2, Tab 3, pp. 51 - 52, 251 – 253.
[70] Exhibit 2, Tab 1, IMP Review 14.4.2018.
[71] Exhibit 15.
[72] Exhibit 2, Tab 3, pp. 46 – 49, 147 – 150, 238 - 240.
[73] Exhibit 2, Tab 3, pp. 44 – 45.

80. He had another episode of abdominal pain and rectal bleeding on 8 May 2018 and was again transferred to Liverpool Hospital. On this occasion he was reviewed by the gastroenterology team and outpatient endoscopy was recommended. Mr Al Jhelie's gastroscopy and colonoscopy was performed on 21 May 2018. However, due to poor bowel preparation there was only a limited view of the bowel. It was suggested he would need supervision of his preparation in order for the colonoscopy procedure to be successful when repeated. The gastroscopy showed mild gastritis.[74]

81. The evidence indicates that Mr Al Jhelie was continuing to use illicit drugs whilst in prison and after his move to detention in 2018. Mr Al Jhelie would telephone his sister and ask her to send him money every two to three weeks. He gave his sister a lot of bank accounts to put money in and would change his mobile phone number frequently. His sister understood that he was using the money to purchase 'ice' for himself whilst in prison and in detention.

82. Mr Al Jhelie saw a different IHMS psychologist, Geoffrey Fox, on 25 May 2018. Mr Al Jhelie indicated he did not wish to see a psychologist but said he was hoping to see a psychiatrist. Mr Fox indicated he would arrange a psychiatric referral.[75]

83. Mr Al Jhelie was seen by the IHMS psychiatrist, Dr David Lienert, on 13 June 2018. It appears Mr Al Jhelie had requested the psychiatric review as he knew he needed such a review for his AAT proceedings, and he was still under the impression it was his responsibility to arrange it. Dr Lienert's note indicates Mr Al Jhelie "expressed gratitude at being seen because reportedly he needs a psychiatrist review for immigration proceedings."[76] Dr Lienert clarified that he was not undertaking that psychiatric review at the time he consulted with Mr Al Jhelie, but he acknowledged that there is sometimes a misunderstanding around that and is very common for him to have to begin the session with an explanation that he can't write a report for the purpose of immigration proceedings. However, Dr Lienert said that he believes he would have suggested to Mr Al Jhelie that he could access his medical records, and the record of his session, if his lawyer found that helpful.[77]

84. Dr Lienert had not seen Mr Al Jhelie previously and he did not have any further consultations with him. Dr Lienert did not have an independent recollection of Mr Al Jhelie, so his statement and evidence were based on his notes taken at the time of the consultation and his general practice, as well as any review of Mr Al Jhelie's previous records.[78]

85. During his review with Dr Lienert, Mr Al Jhelie reported a long history of methamphetamine abuse. He indicated he believed substance abuse had ruined his life, so he was motivated to remain abstinent from drugs in the future. He admitted to feeling depressed and previous episodes of self-harm but said he was not currently suicidal and was not accepting of medication or psychological therapy. Mr Al Jhelie

[74] Exhibit 2, Tab 3, pp. 36, 265.
[75] Exhibit 2, Tab 3, p. 37.
[76] Exhibit 2, Tab 3, pp. 6-7, 35.
[77] T 383.
[78] T 374; Exhibit 9.

told Dr Lienert he had experienced trauma in Jordan and when living on the streets in Australia, and said he felt "on edge and tense"[79] with a recurring dream of being on a cliff edge. Mr Al Jhelie also told Dr Lienert that when he had been in prison eight months ago, he had been hearing auditory command hallucinations telling him to kill himself. He was worried about the officers watching him at Villawood and felt distrustful of others, although he had no frank persecutory delusions. Dr Lienert observed no formal thought disorder or current psychosis and assessed Mr Al Jhelie's risk to himself as low at that point in time. Dr Lienert's diagnosis was a substance use disorder, but he noted that it was in sustained remission[80] (although later events would suggest that probably was not the case). Dr Lienert considered Mr Al Jhelie's symptoms were mild and mainly reactive to his current environment. The plan was for further psychiatric review as required, with no follow up appointment scheduled at that time.[81]

86. Mr Al Jhelie attended a follow up hospital outpatient review on 4 July 2018 in relation to his recent colonoscopy. It was uncertain whether he had underlying inflammatory bowel disease due to the incomplete preparation and a further repeat colonoscopy was recommended, with Mr Al Jhelie given detailed instructions on how to prepare.[82] IHMS had not been notified of a date for Mr Al Jhelie's repeat colonoscopy at the time Mr Al Jhelie was transferred to Yongah Hill.[83]

DRUG OVERDOSES IN JULY 2018

87. There was an incident in June 2018 when Mr Al Jhelie's sister received an email asking her to give cash to a specialist doctor so that he could review Mr Al Jhelie. She thought the request was odd and asked Mr Al Jhelie about it, who became angry with her. Mr Al Jhelie's sister suggested she send the money directly to the medical clinic, but he became angry again. She did not pay the money in the end.[84] Information was passed on to Serco staff about the request, which found no doctor associated with the personal details given.[85] It was suggested that this request might have related to Mr Al Jhelie's drug use, but I also note below that he was incorrectly told in May 2018 that he would probably need to fund an independent psychiatric report himself, so it is possible his request was genuine. However, it is clear that Mr Al Jhelie was still involved in illicit drug use, as there were two major drug-related incidents in July 2018.

88. Mr Al Jhelie was still reporting abdominal pain and rectal bleeding on 7 July 2018, but he declined a GP appointment.[86] The next day, being 8 July 2018, Serco officers conducting a welfare check found Mr Al Jhelie collapsed in a sitting position in his bathroom, with his back against the wall. A Code Blue medical emergency was called.[87]

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[79] Exhibit 2, Tab 3, p. 35.
[80] T 373.
[81] Exhibit 2, Tab 3, p. 35.
[82] Exhibit 2, Tab 3, pp. 34, 241.
[83] Exhibit 8, [36].
[84] Exhibit 1, Tab 18 and Tab 19.
[85] Exhibit 1, Tab 15 and Tab 18.
[86] Exhibit 2, Tab 3, p. 33.
[87] Exhibit 2, Tab 3, p. 32.

89. Paramedics attended and began treating Mr Al Jhelie. While treating him, the paramedics smelt an odour coming from Mr Al Jhelie's groin region. An emergency response team officer searched Mr Al Jhelie and found two small sachets containing a white crystal substance in the front pocket of his shorts, together with a smoking implement. In addition, a search of Mr Al Jhelie's room located a home-made 'shiv' or weapon. Mr Al Jhelie was taken by ambulance to Bankstown Hospital in NSW for further medical treatment.[88]

90. Mr Al Jhelie regained consciousness just after 4.00 am on 9 July 2018 while in hospital. When asked how he had become unconscious, he admitted he had consumed 10 mg of the liquid drug gamma hydroxybutyrate (GHB), which he said he had obtained free from another detainee. He was diagnosed with acute GHB intoxication. Mr Al Jhelie was medically cleared and discharged back to detention from hospital at 4.50 am with a plan for follow up with a GP.[89]

91. The Serco officers suspected Mr Al Jhelie had attempted self-harm by overdosing due to information provided by another detainee. The mother of Mr Al Jhelie's girlfriend had approached the Facilities Operations Manager and said her daughter had told her that Mr Al Jhelie would be ending his life as he was suffering from several forms of cancer. He had told her daughter that he would be taking 7 – 10 mg of liquid ecstasy to end his life.[90]

92. A progress note indicates that Mr Al Jhelie was transferred on his return to Villawood to the Hotham observation area on 'Keep SAFE' due to this suspected suicide attempt. He was reviewed by a mental health nurse and he was said to have appeared in good spirits. He stated to the nurse that he did not intend to kill himself and that the drug he ingested was simply stronger than usual. He denied any thoughts of self-harm and guaranteed his safety, so he was removed from Keep SAFE and referred to the drug and alcohol team. Mr Al Jhelie was also informed of how to contact the mental health team if required.[91]

93. Mr Al Jhelie was reviewed by a nurse from the drug and alcohol team later that day. He stated that this was the first time he had tried GHB and indicated he had also used 'ice' an hour earlier, which was his drug of choice. He did not recall the events that followed and only recalled waking up in hospital. The nurse discussed the risks with him of using the two drugs together and he stated he regretted using the GHB and would not do it again. He was also reviewed by a doctor, who performed a physical assessment and discussed drug use and its risks with him.[92]

94. A Behavioural Management Plan (BMP) was put in place. It was indicated that Mr Al Jhelie was to meet regularly with the drug and alcohol clinical nurse at IHMS, as well as the counselling or mental health team, for support while he transitioned through the BMP. Mr Al Jhelie was also relocated to a different compound at the

[88] Exhibit 1, Tab 15; Exhibit 2, Tab 3, pp. 32, 156 – 157.
[89] Exhibit 1, Tab 15; Exhibit 2, Tab 3, pp. 242 - 244.
[90] Exhibit 17, Tab 21, p. 101.
[91] Exhibit 2, Tab 3, p. 31.
[92] Exhibit 2, Tab 3, pp. 28 – 29.

centre and restrictions were put in place (such as escorts by Serco staff to and from the visits section, pat searches after seeing visitors and extra room searches) as part of a plan to reduce his access to illicit drugs. The BMP was put in place for four weeks initially and was subject to ongoing review. Mr Al Jhelie was required to be incident free for four weeks before he could be moved back to a less restrictive compound.[93]

95. Mr Al Jhelie was seen by Dr Needham from the drug and alcohol team on 13 July 2018. He denied any drug use since the overdose and said he would not do it again. He denied any physical or mental health issues and maintained he had no thoughts of harming himself.[94]

96. Mr Al Jhelie saw a GP on 19 July 2018 who advised him to stop smoking and using drugs. He indicated he was happy to stop using drugs but wanted time to consider stopping smoking.[95]

97. Despite the extra restrictions and counselling from health staff, on 25 July 2018 Mr Al Jhelie took another unknown illicit substance and suffered another medical episode. He developed difficulty breathing, abdominal pain and chest pain. He was taken to Bankstown Hospital for monitoring and then discharged back to Villawood the same day. A contraband substance and nine unidentified tablets were found in Mr Al Jhelie's accommodation. Mr Al Jhelie accepted ownership of the items and said he wasn't sure what he had smoked, but thought it was heroin. The hospital discharge summary described his admission as following an "accidental drug overdose"[96] and he said he took the substance with no suicidal intent.

98. Attempts were made for Mr Al Jhelie to be reviewed by IHMS staff on 26 July 2018, after his return from hospital, but he refused to come to the clinic. Eventually, a psychologist and primary health nurse went to see Mr Al Jhelie in the compound. He told them he didn't know what the substance was that he took, but he had been told it was 'ice'. After he took it, he felt drowsy and nearly collapsed. Mr Al Jhelie maintained it was an unintentional drug overdose. He was educated again on the risks of using drugs and provided with drug abuse related reading material.[97]

99. As a result of the medical episode and discovery of unauthorised substances, Mr Al Jhelie was relocated to the Blaxland High Security Centre, the highest security compound within Villawood. The BMP remained in place and Mr Al Jhelie was monitored even more closely, with regular room searches conducted. His BMP started again for another four weeks.[98]

100. Mr Al Jhelie was seen by Dr Needham for drug and alcohol counselling on 27 July 2018 and indicated he was angry about the move to Blaxland. He told the drug and alcohol nurse that there were still a lot of drugs in Blaxland compound, and he believed moving him there would make him worse, not better. He continued to

[93] Exhibit 1, Tab 15.
[94] Exhibit 2, Tab 3, pp. 27, 254.
[95] Exhibit 2, Tab 3, p. 26.
[96] Exhibit 2, Tab 3, p. 214.
[97] Exhibit 2, Tab 3, pp. 23 - 24.
[98] Exhibit 1, Tab 15; Exhibit 2, Tab 1 and Tab 3, pp. 25, 214 – 217.

maintain that he did not know what drug he had taken. Dr Needham discussed some possible treatment options, but Mr Al Jhelie indicated he wanted "Suboxone or nothing."[99] He was booked for a drug and alcohol assessment with urinalysis.

101. Mr Al Jhelie had a mental health assessment with the psychologist Ms McMillan, who had returned from leave, that afternoon. This was the third and last time she saw him. A drug and alcohol nurse were also present during the consultation. Ms McMillan's note records that Mr Al Jhelie had lost a significant amount of weight since she had seen him last, and he reported his mood was "very stressed."[100] He admitted using an unknown substance that led to him being hospitalised but denied an intentional overdose and said he had no thoughts of self-harm or suicide. He was, however, agreeable to engaging in further sessions in the clinic with Ms McMillan moving forward and a follow-up appointment was booked. Ms McMillan indicated that it was important that any substance use issues were addressed in order to be able to treat any underlying mental health issues, and this was being addressed by the drug and alcohol team at the same time.[101]

102. Mr Al Jhelie was reviewed again on 31 July 2018, this time by a GP. The doctor discussed with him the two overdoses. Mr Al Jhelie stated that "he did both as a way of desperation,"[102] describing himself as someone who give up easily after he finds himself in trouble. He stated that the ABF had rejected his visits and he felt that they were "punishing him too hard."[103] They discussed how he was going backward in his life and Mr Al Jhelie indicated he understood the consequences of his risky behaviours, which included potential death. It was recommended that Mr Al Jhelie receive regular mental health counselling and close observation from the drug and alcohol team, with GP follow up in a couple of weeks. He also had some dental issues, and he was given information about the process to see the dentist.[104]

103. Mr Al Jhelie was seen by the same GP and a member of the drug and alcohol team again on 31 July 2018. He denied any drug use since the last overdose and indicated he was regretful about both overdose incidents. He stated that his partner and family were very upset with him as well. He said he had no thoughts of harming himself in the future. Mr Al Jhelie indicated he liked talking to the drug and alcohol nurse and was happy to continue to see the drug and alcohol team for support. It was noted that he would be booked in for weekly sessions for follow-up.[105] However, plans were then made to move Mr Al Jhelie to another immigration detention facility, so that follow-up did not occur.

DECISION TO TRANSFER MR AL JHELIE

104. Mr Al Jhelie was transferred from Villawood in New South Wales to Yongah Hill Detention Centre in Western Australia on 7 August 2018. Detainee movements and

[99] Exhibit 2, Tab 3, pp. 22, 231.
[100] Exhibit 2, Tab 3, p. 21.
[101] Exhibit 1, Tab 15, p. 37; Exhibit 2, Tab 3, p. 21; Exhibit 15.
[102] Exhibit 2, Tab 3, p. 19.
[103] Exhibit 2, Tab 3, p. 19.
[104] Exhibit 2, Tab 3, pp. 17 - 19.
[105] Exhibit 2, Tab 3, p. 17.

placements are said to assess the needs of the detainee and the management and good order of an immigration detention facility. In Mr Al Jhelie's case, it was officially said that he was moved for 'operational reasons'. Prior to the inquest, the Department provided additional information indicating that a primary reason for moving Mr Al Jhelie was to try to break his drug connections and limit his access to illicit substances, given his repeated drug overdoses despite increased surveillance.[106] I set out some of the history of that decision-making process below.

105. On 9 July 2018, Ms Lyjelle Tinsley, who was the ABF Acting Inspector of Detention Operations at Villawood at the relevant time, became aware of Mr Al Jhelie's first overdose. The matter was raised at the daily morning stakeholder meeting at Villawood. Ms Tinsley recalled the information from Serco included that Mr Al Jhelie had apparently rung his girlfriend and said he had cancer and intended to fatally overdose, prior to the overdose occurring.[107]

106. Ms Tinsley recalled that Serco were asking IHMS at the meeting for more information about his health status and IHMS staff advised that Mr Al Jhelie did not have cancer and his overdose was accidental.[108] Ms Tinsley gave evidence that she felt "a little taken back" by the way the information was delivered by the IHMS staff and she felt that it raised questions as to why Mr Al Jhelie would have mentioned cancer to his girlfriend if he didn't have it. Ms Tinsley said there was also information provided that Serco had found a shiv and some additional drugs in Mr Al Jhelie's room, so a security emphasis arose, which turned to the BMP aspect of managing him. After the meeting, Ms Tinsley rang the AFP detention health team in Canberra to raise her concerns with them that she did not believe Mr Al Jhelie's overdose was being taken seriously by IHMS staff and indicated she wanted them to look into it further and have a conversation with IHMS staff about it.[109]

107. An email sent by Ms Tinsley to Ms Jenny Bartley, an ABF Inspector in Canberra on the morning of 9 July 2018 indicates that Ms Tinsley made it clear she wished to escalate concerns about the IHMS "response and management of the self-harm element"[110] of Mr Al Jhelie's overdose. As Ms Tinsley explained in her email, her concern (and that of other ABF staff members) was that Mr Al Jhelie had "stated his intention to fatally self-harm, and then immediately proceeded to go through with these threats and overdose,"[111] which suggested that despite his denial, there was a self-harm element to his act. It was Ms Tinsley's impression from the meeting that IHMS staff did not propose to provide any further follow-up medical support to Mr Al Jhelie as they considered the overdose to be accidental. There is other evidence to indicate this was not the case, but unfortunately the additional services IHMS proposed to provide to Mr Al Jhelie were not disclosed to Ms Tinsley. Ms Tinsley told investigating police she had expressed her concerns higher up the chain as she wanted to ensure that her concerns were properly recorded.[112] It is clear

[106] Exhibit 1, Tab 15 and Tab 53.
[107] Exhibit 6, Tab 12; T 439.
[108] T 440.
[109] T 440 – 441.
[110] Exhibit 6, Tab 12, LT3, pp. 138 – 139s.
[111] T 139.
[112] Exhibit 1, Tab 20.

Ms Tinsley felt there was a real, ongoing risk to Mr Al Jhelie's safety at the time and she did not feel that she had all the information she needed to ensure his safety.[113]

108. The response provided to Ms Tinsley by Ms Bartley, as communicated to her by the IHMS mental health team, did not provide Ms Tinsley with much reassurance. It was suggested that Mr Al Jhelie had no mental health issues noted and his issues were drug-related.[114] Ms Tinsley had no ability to access Mr Al Jhelie's health records herself, as the information was held by IHMS 'in-confidence' for patient confidentiality reasons, so there was no other way for her to obtain additional information.[115] The information provided to Ms Tinsley by IHMS was that "assuring Mr Al Jhelie's safety required his access to drugs to be prevented to reduce the chance of a similar incident occurring again."[116]

109. Accordingly, Ms Tinsley set about finding a way to reduce Mr Al Jhelie's access to illicit drugs. As part of the BMP, Serco staff had recommended consideration be given to moving Mr Al Jhelie to a different compound within Villawood, with a smaller staff to detainee ratio. ABF was responsible for making that decision, following advice from Serco and IHMS. Based upon what she had been told, Ms Tinsley endorsed Mr Al Jhelie being moved to the Mackenzie Compound, subject to IHMS feedback. This was a very separate compound to his previous compound, and had a separate visitor centre, which she believed would be helpful in limiting his access to drugs. It was Ms Tinsley's recollection that IHMS did not provide any further feedback about the decision to move Mr Al Jhelie between compounds, which she found disappointing as she did not feel that she could take a holistic approach to managing his safety and had to approach his case solely from a security perspective.[117] After considering the options, Mr Al Jhelie was moved to the Mackenzie compound.

110. On 19 July 2019 Mr Al Jhelie telephoned his SRO, Ms Ishak, to enquire about the progress of his application. Ms Ishak indicated in her statement he expressed his frustration to her about the time being taken for the psychiatric review process to be completed. She told him that she had no new information and once again referred him to the National Character Consideration Centre (NCCC) for further information. Ms Ishak made a note that she conducted a well-being check at that time and enquired about his visits and involvement in activities. Mr Al Jhelie told her he was receiving visits from family but wasn't attending activities as he had been unwell. Ms Ishak encouraged him to keep engaging with the relevant services and indicated that he would be notified when there was an update to his case.[118]

111. Not long after, he overdosed again on 25 July 2018. Ms Tinsley became aware of Mr Al Jhelie's second overdose at the morning meeting the following day when Serco staff read out the related incident report. Ms Tinsley understood from the incident report that Mr Al Jhelie had reported to Serco staff having difficulty breathing and he had then been allowed to return to his room unaccompanied while

[113] Exhibit 6, Tab 12, [61].
[114] Exhibit 6, Tab 12, LT3, p. 138.
[115] Exhibit 6, Tab 12.
[116] Exhibit 6, Tab 12, [51].
[117] T 441 - 442; Exhibit 6, Tab 12, [67].
[118] Exhibit 6, Tab 13, [35], ST-3.

the Facilities Operations Manager (FOM) was notified. Shortly after he was found unconscious in his room and was taken to hospital. Ms Tinsley indicated she was concerned at how Serco staff had dealt with the incident, by allowing Mr Al Jhelie to go to his room when he was in difficulties, and she was also concerned that Mr Al Jhelie was obviously still able to access illicit drugs despite the move.[119]

112. Ms Tinsley recalled that IHMS staff indicated at the meeting that this overdose was also an accidental overdose, with no self-harm intention, and "they didn't believe the incident warranted a health response."[120] It was suggested by the IHMS staff member that limiting his access to drugs needed to be the primary focus.[121]

113. Ms Tinsley gave evidence at the inquest that she was concerned that IHMS did not seem to give any consideration to placing Mr Al Jhelie on a high level of monitoring on the Psychological Support Program (PSP), despite the possibility he had self-harmed. Ms Tinsley believed the additional monitoring and ongoing mental health appointments available on PSP might have been appropriate for Mr Al Jhelie at that time. However, she said it was not for the ABF to refer him to that process.[122]

114. In response to the second overdose, Serco recommended that Mr Al Jhelie be moved again, this time to Blaxland compound. This was apparently proposed as a Serco Intelligence Officer had intelligence that suggested that Mr Al Jhelie might be obtaining drugs passed through the fence from neighbouring compounds. Blaxland was a standalone facility and had a much smaller visitor centre, a higher officer to detainee ratio and only three dorms with no interactions between the dorms except at the visitor centre, so again the option appeared to reduce the opportunity for Mr Al Jhelie. Accordingly, Ms Tinsley accepted that recommendation and Mr Al Jhelie was moved to a dorm in the Blaxland compound.[123]

115. However, after he was moved, Ms Tinsley became aware through the BMP meetings that the dorm room in which Mr Al Jhelie was placed at Blaxland housed detainees who were known by Serco to be bringing drugs into Blaxland, and possibly selling drugs. Ms Tinsley was angry when she heard this, as she felt it was a significant oversight by Serco and she was worried the consequences of placing Mr Al Jhelie in that dorm could potentially be catastrophic if it enabled him to make new connections within Blaxland and access more drugs.[124]

116. Ms Tinsley gave evidence she was concerned at this stage that neither stakeholder, namely IHMS nor Serco, were in a position to help the ABF keep Mr Al Jhelie safe within Villawood. Accordingly, she requested that all of the information about his situation be referred to the National Placements Team for their consideration as to where Mr Al Jhelie might be best placed within the immigration detention network.[125]

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[119] T 443; Exhibit 6, Tab 12.
[120] T 444.
[121] Exhibit 6, Tab 12, [74] – [75].
[122] T 447 - 448.
[123] T 444 – 445; Exhibit 6, Tab 12, [76].
[124] T 445; Exhibit 6, Tab 12, [79] – [83].
[125] T 445; Exhibit 6, Tab 12, [88].

117. Ms Tinsley said that she initiated the transfer from Villawood to another facility as she feared for Mr Al Jhelie's safety/life if he remained at Villawood. She believed that if he stayed at Villawood he would definitely overdose again, and he might not survive it a third time. Ms Tinsley gave evidence she felt she needed more involvement from IHMS from a health perspective to manage Mr Al Jhelie more safely, but it was not forthcoming. Ms Tinsley therefore felt his drug connections needed to be broken and she believed the transfer might achieve this aim.[126]

118. Ms Tinsley was aware that by managing Mr Al Jhelie from a security perspective only, it would have felt to Mr Al Jhelie that he was being punished for overdosing, which concerned her. However, she felt there was no alternative at the time.[127] If he was not moved to another immigration detention facility, Ms Tinsley had explored the possibility of Mr Al Jhelie being locked down or placed in a hotel but noted that these options were "quite restrictive and historically not supported."[128]

119. Ms Tinsley was unaware that IHMS had planned for Mr Al Jhelie to receive regular mental health counselling and close observation from the drug and alcohol team at the time she was making her decisions. She received no information from IHMS to indicate that they would be providing follow-up or "any support whatsoever to him after he returned"[129] from hospital.

120. Ms Tinsley gave evidence at the inquest that "there were a number of opportunities where IHMS could have shared information that would have changed the direction of how Mr Al Jhelie was being managed."[130] Ms Tinsley indicated she had not expected to receive personal and confidential medical information but would have been assisted by knowing that IHMS staff were treating the overdoses as more than simply 'accidental'. She would have been reassured to know that they considered it warranted additional health follow-up. Ms Tinsley said that if she had been informed by IHMS staff at the stakeholder meetings that Mr Al Jhelie was going to receive ongoing support from general practitioners, counsellors and drug and alcohol staff, it would have definitely influenced the way that she felt he was being managed and whether or not she would have even proposed or referred him to the national placements team.[131] Ms Tinsley said that when she discussed the matter later with her superintendent, they became aware that IHMS had in fact been offering some support to Mr Al Jhelie after the second overdose, and they agreed that "maybe we would have made other decisions if we knew he was receiving care from IHMS on site."[132]

121. Ms Tinsley understood that as part of the National Placement Team's decision-making process, they would reach out to the SRO to see if there was any issue in relation to Mr Al Jhelie's visa progress, as well as the NCCC to see if there was anything upcoming in relation to Mr Al Jhelie's cancellation review that might be a

[126] T 449; Exhibit 1, Tab 20.
[127] T 465, 468.
[128] Exhibit 7, Tab 30, p. 187.
[129] T 456.
[130] T 467.
[131] T 457.
[132] T 463; Exhibit 6, Tab 13, p. 144.

reason why he shouldn't leave the state.[133] This procedure was not followed and Mr Al Jhelie's SRO and the NCCC were not consulted. Ms Ishak was on leave at the relevant time, but in any event, Ms Ishak gave evidence that in her experience it was not unusual for her not to be informed about transfers until after the fact. She assumed this was for security reasons.[134]

122. At the same time it was proposed that Mr Al Jhelie be transferred out of Villawood, and Yongah Hill had sought a transfer of another detainee, so it was proposed that Mr Al Jhelie swap places with the detainee from Yongah Hill.[135] No one raised any impediments to the swap, so the National Placements Team allowed the swap of detainees between the two facilities to proceed without the need for it to go through a formal approval process.[136] After the approval had been given for the transfer, Detention Operations were then responsible for coordinating Mr Al Jhelie's travel to Yongah Hill.[137]

123. Ms Tinsley was aware that this required IHMS to conduct a fitness to travel assessment, which included looking at whether Mr Al Jhelie had any upcoming health appointments that might be impeded by the transfer.

124. An IHMS primary health nurse completed a Fitness to Travel for Mr Al Jhelie on 2 August 2018, indicating that based on his health information, he was fit to travel and did not require a medical escort. A clinical handover summary accompanied him.[138] Ms Tinsley recalled that there were no concerns about any upcoming health appointments listed on the fitness to travel form.[139]

125. It was noted in the Detention Assurance Review that the Department's decision-makers were not aware of Mr Al Jhelie's impending psychiatry appointment, in part because the two business areas that might have provided this information, namely his SRO or the NCCC were not consulted. They only became aware when an SRO went to Villawood on the afternoon of 7 August 2018 to provide a procedural fairness letter to Mr Al Jhelie and was told by Serco staff that Mr Al Jhelie had been transferred to Yongah Hill that morning.[140]

TRANSFER TO YONGAH HILL IDC

126. Mr Al Jhelie was transferred to Yongah Hill on 7 August 2018. I gather he was moved out of Villawood sometime during the previous evening or early hours of the morning and he boarded a flight to Perth that departed at 8.25 am.[141] He arrived at the Yongah Hill facility at 1.37 pm that day and began his reception/induction process at around 3.00 pm.[142]

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[133] T 446.
[134] T 482.
[135] T 600; Exhibit 7, Tab 29, pp. 182 - 184.
[136] T 600, 604; Exhibit 6, Tab 16.
[137] Exhibit 2, Tab 12, p. 127.
[138] Exhibit 2, Tab 3, pp. 88, 106 - 110.
[139] T 446.
[140] Exhibit 6, Tab 2, p. 35; Exhibit 7, Tab 18.
[141] Exhibit 7, Tab 18, p. 116.
[142] Exhibit 7, Tab 20, p. 120.

127. On 7 August 2018, when he underwent a self-harm assessment interview as part of his admission to Yongah Hill, he was asked how he felt and he said, "Shit - but alright" and indicated he was not happy to be in Perth as all his family were in Sydney. However, he didn't appear agitated and presented as calm.[143]

128. Mr Al Jhelie's family expressed concern that they were not advised of the move, before he was relocated. The first time they became aware Mr Al Jhelie was being transferred out of the state was when Mr Al Jhelie's brother, Fadee, received a video on his phone from Mr Al Jhelie advising that he was on a plane and he did not know where he was going.[144]

129. Mr Al Jhelie spoke to his brother Fadee the next day and told him that he was at Yongah Hill. He told his brother he was scared to be there and had been put in a double bunk room with another person. Mr Al Jhelie said he had requested to be put alone in a single room, as he had heard rumours about people being homosexuals at Yongah Hill and being preyed upon, but his request was refused. It seems he had expressed some reservations about the person he was placed with, although other evidence suggests Mr Al Jhelie quickly became comfortable with his roommate.[145]

INITIAL PERIOD OF AT YONGAH HILL

130. Yongah Hill Immigration Detention Centre is a high security detention facility that accommodates only single men. It is divided into a number of compounds, with each compound comprised of bunk rooms with an ensuite bathroom, as well as shared facilities such as a laundry and common room area. Mr Al Jhelie was placed in the Falcon compound in a shared bunk room with another detainee, Mr D. Mr D had the bottom bunk and Mr Al Jhelie had the top bunk. Mr D described Mr Al Jhelie as 'not much of a talker', although he had mentioned he had come from Villawood and this appeared to be because of his use of 'ice' and drug overdose. Mr D indicated that Mr Al Jhelie spent a lot of his time on his mobile phone. At other times, he would simply sit and do nothing and appeared sad,[146] although Mr D also gave evidence at the inquest that Mr Al Jhelie was "a normal person – happy and active."[147]

131. The healthcare services provided by IHMS at Yongah Hill at the relevant time and now (which I understand are the same for all onshore detention facilities) are:[148]

- an onsite primary health clinic including a general practitioner, primary health nurses and mental health nurses on weekdays during business hours;
- external referral to drug and alcohol programs, psychologists and psychiatrists, and
- a morning, lunchtime and evening medication dispensary service on weekends.

[143] Exhibit 2, Tab 1, Self Harm Assessment Interview 7.8.2018.
[144] Exhibit 1, Tabs 15, 18 and 53.
[145] Exhibit 1, Tabs 15, 18, 19 and 53.
[146] Exhibit 1, Tab 15.
[147] T 93.
[148] Exhibit 8, p. 12 [38] – [42]; IHMS Submissions filed 21.11.2021.

132. Evidence was given at the inquest that these more limited services came into effect with the signing of a new contract between the Department and IHMS in December 2014. Prior to that, on shore detention facilities received 24 hour cover with clinicians on site, but now it is a primary health care service only, akin to a general practice.[149]

133. If medical assistance is required after hours or on the weekends then detainees are able to access the 24-hour telephone HAS, which is staffed by nurses with access to an on-call doctor. They can assist with a level of advice and facilitate medication prescriptions. In the event that a detainee requires additional assistance or in an emergency, detainees must be taken to hospital by Serco or an ambulance, although if nurses happen to be on site in the dispensary they will also respond to a code blue or life threatening emergency and assist with emergency first aid and CPR until the ambulance arrives.[150] If the issue can wait, then IHMS HAS staff advise the onsite IHMS staff of the telephone contact by way of an internal referral, to ensure that the patient is subsequently followed up during clinic hours. A detainee would also be reviewed by IHMS staff on return from hospital.[151]

134. Although the level of health service available is apparently the same at Villawood and Yongah Hill, there is a marked difference in Mr Al Jhelie's health appointments after his transfer to Yongah Hill. Despite the health transfer summary including the information from his GP reviewed on 31 July 2018, where it was recommended, he have regular mental health counselling and close observation from the drug and alcohol team,[152] no such follow-up or observation was provided at Yongah Hill. It was explained at the inquest that the IHMS Apollo medical records system is seamless across the entire immigration detention network. Mr Al Jhelie's medical records would also have been available to the health staff at Yongah Hill immediately after he arrived there and accessible in sequential order, so the GP review would have been near the top.[153] There was evidence at the inquest that there should also have been a verbal clinical handover of Mr Al Jhelie's case between the health service managers of the two immigration detention facility's once he was moved, but this does not appear to have occurred.[154]

135. A Case Officer from the NCCC sent an email on the afternoon of 7 August 2018, after the letter was unable to be delivered, indicating she was very concerned that ABF Detention Operations had transferred Mr Al Jhelie to Yongah Hill without the knowledge of the SRO or any input from the NCCC. She noted the transfer occurred after months of effort by Departmental staff to escalate arrangements for the AAT directed psychiatric report. The ABF's National Detention Placements team was informed of the pending psychiatric appointment and it was requested that he be returned to Villawood to facilitate the mental health assessment and avoid further delay.

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[149] T 519 – 520.
[150] T 520 – 522, 558 - 559.
[151] Exhibit 8, p. 12 [38] – [42]; IHMS Submissions filed 21.11.2021.
[152] Exhibit 2, Tab 3, p. 108.
[153] T 528 - 530.
[154] T 544 – 545.

136. It's clear that some of the Department's staff were well aware that this was being arranged and was urgent, but the problem is that the Department is so enormous, with so many different components, that one part of the Department is unaware of what the other is doing. This is apparent from the email of the Senior Legal Officer who had been attempting to facilitate the report's preparation. He expressed his surprise to hear that Mr Al Jhelie had been moved to Yongah Hill, without any prior advice, and emphasised the need to return him to Villawood so the psychiatric assessment could be completed. At that stage, IHMS were advising that the security check was expected to be finalised around 11 to 13 August 2018.[155]

137. Ms Tinsley gave evidence that when she was advised that there was a discussion around the need for Mr Al Jhelie to be returned to Villawood to see a forensic psychiatrist, she advised the National Placements Team that she did not support Mr Al Jhelie being placed in Villawood again as she believed he was at high risk of a third overdose if he returned. She said at the inquest that her main concern was that neither IHMS nor Serco had demonstrated they were in a position to keep him safe at Villawood.[156]

138. As a result, the Department queried with IHMS whether the assessment could be completed in Western Australia instead. On 15 August 2018, it appears that suggestion succeeded, and it was agreed that the psychiatric assessment would take place at Yongah Hill. However, this inevitably led to a further delay in the psychiatric assessment taking place.[157]

139. On 15 August 2018, a week after Mr Al Jhelie had been transferred to Yongah Hills, Detention Health Operations had confirmation that IHMS had been able to engage a psychiatrist in Western Australia to undertake the required external psychiatric review of Mr Al Jhelie. However, the new psychiatrist was required to lodge paperwork (such as a police clearance) before the review could take place. It was anticipated that everything would be completed in two to six weeks.[158]

140. I note that Mr Al Jhelie had been allocated a new SRO following his move to Yongah Hill. Ms Maria Parise became Mr Al Jhelie's SRO from the date of his transfer on 7 August 2018. Ms Parise had scheduled a meeting with Mr Al Jhelie for 8 August 2018, the day after he arrived, with the intention of introducing herself to Mr Al Jhelie and also to provide him with the 'Procedural Fairness' letter that had been unable to be given to him in Villawood the previous day. Mr Al Jhelie did not attend the appointment on the 8 August, nor another appointment Ms Parise made for 10 August 2018, so she had the letter delivered to him through the internal mail system. Ms Parise did not try to contact Mr Al Jhelie by phone or email, after the failed appointments, and simply decided to wait another month and try to make another appointment.[159]

[155] Exhibit 7, Tab 17, pp. 103 - 104.
[156] T 447; Exhibit 6, Tab 12, [92] – [93].
[157] Exhibit 7, Tab 12, pp. 81 - 87.
[158] Exhibit 1, Tab 15.
[159] Exhibit 6, Tab 14 [18].

141. Ms Parise gave evidence that she was not aware during the period she was Mr Al Jhelie's SRO that Mr Al Jhelie required a psychiatric report to be prepared for his immigration case to proceed.[160] This seems to be another example of the disconnect between the many different people involved in Mr Al Jhelie's immigration case management.

142. The letter delivered to Mr Al Jhelie, which was dated 6 August 2018, referred to his two recent drug overdoses and indicated that the information about those incidents might be taking into account when the Department considered whether to revoke the decision to cancel his visa. Mr Al Jhelie was invited to provide a response.[161] There was no mention in this letter of the steps still being taken to arrange Mr Al Jhelie's psychiatric review, so he was not given any new information about that process and was presumably unaware that an appointment was hopefully being scheduled in the near future. It is possible that at this stage Mr Al Jhelie still thought his appointment with Dr Lienert had been this review, although he had not heard anything about it since.

143. I note Ms Parise's evidence that the Procedural Fairness letter given to Mr Al Jhelie was not a negative sign and simply suggested that a decision was likely to be made soon.[162] Having looked at the letter myself, it certainly isn't obvious to me that there was not any negative connotation to it. Indeed, it would be easy to infer that the drug overdoses were likely to negatively impact upon the decision-making. It is unfortunate that Mr Al Jhelie did not have any contact with the SRO before or after receiving the letter, so that he could have been given some reassurance that it was a fairly standard part of the process.

144. Ms Parise became aware that Mr Al Jhelie had received the letter and she was informed he had provided a response on 22 August 2018. In his response, Mr Al Jhelie offered a sincere apology to the officers and detainees who were on site when the overdoses occurred. He admitted that he had relapsed into drug use and said that the first overdose was his way of dealing with his stomach pains and when he was moved to McKenzie compound, there was more access to drugs, which made them harder to avoid. Mr Al Jhelie wrote that he was disappointed in himself, as he had been on a clean road to recovery, and that the last incident had been a wake-up call. He indicated he was willing to make a change and begin the process of rehabilitation, with the support of his mother, siblings, partner and children.[163]

145. Mr Al Jhelie's roommate, Mr D, gave evidence that Mr Al Jhelie had been experiencing "excruciating pain in his stomach"[164] for at least a few days, and up to a week or two before 2 September 2018. Mr Al Jhelie had been requesting help from Serco and the medical officers for his pain, but he was not given anything that helped. Mr D became aware that Mr Al Jhelie was struggling to sleep at night due to the pain in his stomach, and he remained in pain until the events on 2 September 2018. Mr D said Mr Al Jhelie was also feeling down and he was clearly unhappy

[160] T 498 – 499.
[161] Exhibit 7, Tab 26, pp. 154 – 155.
[162] T 494 – 495.
[163] Exhibit 3, Tab 8.
[164] T 93.

about being moved to Yongah Hill. Mr D recalled that Mr Al Jhelie told him he believed he had been moved to Yongah Hill from Villawood because of his drug use and overdoses. As far as Mr D was aware, Mr Al Jhelie had no access to illicit drugs in Yongah Hill.[165]

146. On 29 August 2018, Mr Al Jhelie was reviewed by a GP. This was the first time he had seen a health practitioner since his initial arrival at Yongah Hill. Mr Al Jhelie complained of a 16 month history of rectal bleeding with abdominal pain. His investigations while in NSW, indicating some lesions and wall thickening, were noted. He was said to be pale with a mildly tender abdomen on examination. Blood tests were ordered with a view to arrange a repeat colonoscopy and the features of ulcerative colitis (a presumptive diagnosis) which was explained to Mr Al Jhelie.[166]

147. Two days later, during the late evening of 31 August 2018, Mr Al Jhelie complained of abdominal pains and rectal bleeding and was transferred to Northam Hospital after a HAS call. He was triaged at 11.16 pm. Mr Al Jhelie said he had suffered abdominal pain and passed blood for two days and reported he had a previous CT scan in Sydney, which had shown thickened bowel. He said he had been booked in for a colonoscopy but had moved to Yongah Hill before this could occur. His abdomen was reported to be normal, and he looked well, and his pain had settled, so he was discharged with advice to organise a colonoscopy through his GP. He returned to Yongah Hill in the early hours of 1 September 2018, one day prior to his death.[167]

148. Mr Al Jhelie spoke to his brother via a Facebook messenger phone call on 1 September 2018, after he had returned to Yongah Hill. Mr Al Jhelie was talking about a PlayStation and seemed positive and excited about it. He was laughing and joking during the conversation and Fadee did not sense there were any issues or that Mr Al Jhelie might be thinking of hurting himself.[168]

149. It appears Mr Al Jhelie also had an individual management plan review on the evening of 1 September 2018. It was noted that he suffered irritable bowel disease and, accordingly, could not participate in any sport or exercises, or even art classes, due to discomfort. He had frequent bouts of illness, and it was noted he had gone to hospital the night before due to blood in his stools. The Detainee Services Officer (DSO) noted he was often seen in the company of other middle eastern detainees and he apparently reported he spoke to his partner and three children in Sydney every day.[169]

150. Mr Al Jhelie's new SRO, Ms Parise, did not have any interactions with him at any stage prior to 2 September 2018, and his case was re-allocated to a more senior officer on that day after the events detailed below.[170]

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[165] T 94 – 95; Exhibit 1, Tab 15, Statement signed 19.12.2018.
[166] Exhibit 2, Tab 3, pp. 16, 183.
[167] Exhibit 2, Tab 3, pp. 15, 159 – 160 and Tab 4.
[168] Exhibit 1, Tab 18.
[169] Exhibit 2, Tab 1, Individual Management Plan Review 1.9.2018.
[170] T 494; Exhibit 6, Tab 14.

EVENTS ON 2 SEPTEMBER 2018

151. There is evidence that during this second time in Villawood, Mr Al Jhelie had been befriended by a female detainee, Ms S, who introduced Mr Al Jhelie to her daughter.[171] The daughter was not in detention but would visit her mother in detention and began to also visit Mr Al Jhelie in detention regularly. Their relationship developed and they had apparently become boyfriend and girlfriend by the start of June 2018 and Ms S believed they became engaged in mid-August 2018. Ms S tried to support Mr Al Jhelie in detention and described him as polite and well-spoken. She approved of his relationship with her daughter as they both appeared happy. Ms S believed Mr Al Jhelie was a 'good kid' with a 'big heart' but also said he was stubborn and needed a lot of encouragement to comply with his medication regime.[172] It appears Mr Al Jhelie's new relationship had been a significant positive in his life, so when he had relationship issues, he reacted strongly.

152. On 2 September 2018 at lunchtime, between 12.30 and 1.00 pm, Mr D and Mr Al Jhelie were in their room, both located on their respective beds. Mr D had been sleeping and when he woke up, Mr Al Jhelie showed him some cuts on his left wrist that he had made apparently using a razor they had for shaving. There was a small amount of blood coming out, but it appeared to have dried up, which suggested Mr Al Jhelie had done it some time ago. Mr D asked him how he was doing, and Mr Al Jhelie told him that he had broken up with his girlfriend and she had locked up his phones. Mr Al Jhelie had two phones at that time and his girlfriend had apparently locked both as the Apple ID for both was in her name. As a result, Mr Al Jhelie said he was feeling annoyed and depressed.[173]

153. Mr Al Jhelie asked Mr D if he could use Mr D's phone to take a photograph of Mr Al Jhelie's wrist to send to his girlfriend. Mr D did as ask, and Mr Al Jhelie then wrote a message on Mr D's phone to his girlfriend and sent the photograph to her.[174] Mr D also sent a message to her, saying that he had seen Mr Al Jhelie's wrists cut.[175]

154. Mr Al Jhelie's girlfriend's mother became aware of the message and photograph shortly after it was sent. She became concerned and approached Serco staff at Villawood. She told them of the message and photograph and expressed concern that her daughter was being blamed for Mr Al Jhelie's conduct. A Serco officer relayed this information to the Facility Operations Manager at Villawood, who in turn notified Serco staff at Yongah Hill that there was a detainee who had either harmed himself or was threatening to harm himself and asked them to check on Mr Al Jhelie.[176]

155. DSO Scott Walker and DSO Michael Bamber were in the Falcon compound officers' station at the time. They were contacted and asked to go and check on Mr Al Jhelie, who was housed in their compound. At approximately 2.17 pm they made their way

[171] I have not included her surname for her privacy.
[172] Exhibit 1, Tab 15.
[173] Exhibit 1, Tab 15.
[174] T 96; Exhibit 1, Tab 15.
[175] T 96.
[176] T 208; Exhibit 1, Tab 15.

to Mr Al Jhelie's room. They could hear a conversation in another language taking place between Mr Al Jhelie and Mr D, which appeared by its tone to be unconcerning. The Serco officers knocked on the door and Mr D answered it. He seemed surprised to see them. DSO Walker looked into the room and could see Mr Al Jhelie sitting on his bunk with his back against the wall. Neither officer knew Mr Al Jhelie, as he only recently arrived at Yongah Hill, but from first appearances he seemed relaxed. Mr Al Jhelie was not wearing a shirt but was sitting up on the top bunk, so it was difficult for them to see if he had any visible injuries.[177]

156. For the privacy of Mr Al Jhelie, the officers did not wish to raise their concerns in front of Mr D, so they asked Mr Al Jhelie to come outside. When he asked why, they told Mr Al Jhelie he had a phone call. Mr Al Jhelie asked if he could put on a shirt, so they waited outside while Mr Al Jhelie put on a long-sleeved shirt. He then came outside the room, where the two officers were waiting. They asked him to walk with them and have a chat. They walked together towards the Falcon compound officers' station. DSO Walker asked Mr Al Jhelie how he was, and he said he was "a bit stressed at the time."[178] DSO Walker then asked him if he had done anything, to which he replied, "Yes'. DSO Walker asked Mr Al Jhelie if he would show him what he had done, but Mr Al Jhelie declined, and they could not see his arms otherwise as they were covered by his shirt.[179]

157. DSO Walker asked Mr Al Jhelie if he would be willing to be seen at the medical centre, to which he agreed. DSO Walker and DSO Bamber started walking with Mr Al Jhelie towards the medical centre. DSO Walker asked DSO Bamber to go to the officers' station and advise Facility Operations Manager (FOM) Dion Goodall that Mr Al Jhelie was going to the medical centre and also to ring ahead to the medical dispensary and advise the nurses that they were coming. DSO Walker assumed DSO Bamber followed his instructions and made the calls. Certainly, FOM Goodall, was notified as he joined them at the medication dispensary.[180]

158. While they were gone, Mr D believes he sent another message to Mr Al Jhelie's girlfriend asking her to please unlock Mr Al Jhelie's phone so that he could keep busy. Mr D also said he would talk to Mr Al Jhelie and help him. Mr D said he sent the message because he saw how down Mr Al Jhelie was feeling.[181]

159. DSO Walker and Mr Al Jhelie were joined at the breezeway, a location between the four compounds, by DSO Samuel Hicks. DSO Hicks accompanied DSO Walker and Mr Al Jhelie to the medical dispensary. Whilst walking, DSO Walker asked Mr Al Jhelie about his family and things in general. Mr Al Jhelie told DSO Walker he had three children. He also mentioned he had a partner who was outside and not in detention but did not provide any more details about his partner.[182]

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[177] T 209; Exhibit 1, Tab 15.
[178] T 211.
[179] T 211; Exhibit 1, Tab 15.
[180] T 212; Exhibit 1, Tab 15 and Tab 34.
[181] T 97.
[182] T 212; Exhibit 1, Tab 15 and Tab 34.

160. DSO Walker also asked Mr Al Jhelie about his roommate, Mr D, as he wanted to make sure there were no problems between them. Mr Al Jhelie advised that Mr D had been helping him and was supportive.[183]

161. DSO Hicks recalled that during the walk, DSO Walker also asked Mr Al Jhelie again about the cuts and if he would show them the injuries. DSO Hicks recalled Mr Al Jhelie did show them the cuts and they did not appear life-threatening or require any significant first aid.[184] DSO Hicks recalled they asked Mr Al Jhelie why he did it and Mr Al Jhelie indicated it was Father's Day and he was missing his kids and feeling stressed out. Mr Al Jhelie was very apologetic and embarrassed about the incident. The Serco officers asked him if he was thinking of harming himself again and he indicated that he wasn't.[185]

162. DSO Hicks understood they were taking Mr Al Jhelie to the medical dispensary so that the IHMS staff could provide a second opinion as to whether he needed first aid for the cuts and also to advise if Mr Al Jhelie needed to be put on the IHMS SME monitoring, given it appeared to be a self-harm incident. DSO Hicks believed the Serco officers had already unofficially started the Serco Keep SAFE process at this stage. They were going to stay with Mr Al Jhelie and take him to medical centre so he could be assessed by the IHMS nurses, and as part of that process to determine if he required ongoing monitoring under the IHMS procedure, whether continuously or intermittently. Until then, the Serco officers would keep him in sight.[186]

163. DSO Hicks gave evidence he understood that the nurses were primarily there to dispense medication and could turn them away if they didn't have time to see Mr Al Jhelie. It was not uncommon at that time for Serco officers to take detainees to the dispensary on weekends if there was a medical issue and the nurses were on site, rather than make a HAS call. DSO Hicks gave evidence they usually reserved the HAS calls for when no IHMS were on site or if the IHMS staff indicated they didn't have time to see the detainee. In those circumstances, if it was a mental health issue, they would keep the detainee on Keep SAFE until they had been assessed.[187] I note that DSO Hicks ceased employment with Serco in 2019, so he was not able to give evidence about more recent practices.[188]

164. At 4.28 pm they arrived at the medical dispensary. They were met by FOM Goodall and DSO Gary Varley. At the time they arrived, the nurses were busy doing a medication round with other detainees, so the Serco staff and Mr Al Jhelie waited outside.[189] DSO Hicks recalled they briefed the two Serco managers, who seemed supportive of their actions thus far.[190]

165. While they waited, FOM Goodall spoke to Mr Al Jhelie and asked to see his injuries. Mr Al Jhelie presented one of his wrists. Several superficial scratches or light cuts

[183] T 213; Exhibit 1, Tab 15 and Tab 34.
[184] T 113.
[185] T 113.
[186] T 110 – 112, 127, 142.
[187] T 125, 131- 132.
[188] T 112.
[189] Exhibit 1, Tab 15.
[190] T 114.

could be seen across the wrist area. Mr Al Jhelie said he was stressed and mentioned missing his children as it was Father's Day. He apologised for the inconvenience.[191]

166. Mr Al Jhelie was told that he was at the medical room to see the nurses. He was said to have replied, "I'm fine, I'm fine. It's nothing. I know I shouldn't have done it."[192] He appeared to the officers to be embarrassed and uncomfortable about the attention.[193] They waited outside for just under 10 minutes before the nursing staff became available.

167. There were two IHMS nurses on duty that afternoon, Primary Health Nurse Mariam Cheema and Mental Health Nurse Bernadette Paterson. Both nurses were new to Yongah Hill, although Nurse Paterson had previous experience working in an offshore immigration detention facility on Manus Island and Nurse Cheema had some limited experience at Villawood. Nurse Paterson gave evidence that the health services provided at Yongah Hill were different to the seven day a week health service that had operated at Manus Island. At Yongah Hill, during the weekdays, there were other IHMS staff on duty in addition to the primary health nurse and mental health nurse, which allowed her time to conduct mental health consultations (which was her primary role), in addition to assisting with administering medications. However, on the weekends, the two nurses on shift were working unassisted, and on a split shift, with the sole duty of administering medications.[194]

168. This was the first Sunday either Nurse Cheema or Nurse Paterson had worked at Yongah Hill, so it was also the first Sunday they had worked together. Nevertheless, they both understood from their orientation that their primary task during the shift was to dispense medications to the detainees and that Serco officers were supposed to make a HAS call if a detainee required medical attention on the weekend. The nurses gave evidence doing the job of dispensing medications on weekends without assistance meant they were both very busy.[195]

169. Although there was evidence from DSO Walker that he had asked DSO Bamber to call ahead to the dispensary to tell the nurses they were coming, the nurses' evidence was that they had not received the notification and were not expecting Mr Al Jhelie to arrive.[196]

170. At 2.37 pm, Mr Al Jhelie and FOM Goodall entered the medical room and approached the counter. Neither nurse had prior knowledge of why they were there. Nurse Cheema said she asked FOM Goodall what he needed, and he then told Nurse Cheema that Mr Al Jhelie had some lacerations to his wrist and asked her to look at them to see if he needed a dressing. Nurse Cheema recalled FOM Goodall told her that Mr Al Jhelie had "been angry earlier, causing damage to his wrist,"[197] although FOM Goodall denied he used those words.[198] Nurse Paterson was also present behind

[191] Exhibit 1, Tab 25.
[192] Exhibit 1, Tab 25, [55].
[193] T 170 – 172.
[194] T 233 – 235; Exhibit 1, Tab 27.
[195] T 235 - 238; Exhibit 1, Tab 26 and Tab 27.
[196] T 239, 266.
[197] Exhibit 1, Tab 26, [24].
[198] T 267l

the counter during this conversation, but she said she was not listening closely and only overheard something about a cut or scrape.[199]

171. FOM Goodall said that he asked the nurses if Mr Al Jhelie could be seen by them as he had self-harmed. FOM Goodall gave evidence he was expecting the nurses to conduct a mental health assessment as well as to look at his cuts. FOM Goodall remained present while Nurse Cheema tended to Mr Al Jhelie, in order to ensure the safety of Mr Al Jhelie and the nurses. He said he was not asked by the nurses to leave, as he would have done so if requested.[200]

172. Nurse Cheema looked at Mr Al Jhelie's left wrist and observed four or five horizontal slash marks. They had broken the skin but were not actively bleeding at that time. She deemed the cuts to be superficial and considered they did not require urgent medical attention. Nurse Cheema provided Mr Al Jhelie with advice on how to keep the wounds clean and handed him some dressings for his wrist.[201]

173. Nurse Cheema then asked Mr Al Jhelie if he wanted to speak to a mental health professional. Mr Al Jhelie appeared embarrassed by the incident and declined the offer. She then asked him a second time, and he again declined. Nurse Cheema explained that at this time she was not proposing to conduct a mental health assessment herself, as she was only a primary health nurse, and she did not expect that Nurse Paterson would do so either on a weekend. Rather, she was thinking that either a HAS call could then be initiated, if it was urgent, or else a follow-up appointment could be made for Mr Al Jhelie to see a mental health nurse the following day.[202] She later made a comment to Nurse Paterson that she might need to follow up Mr Al Jhelie later, with that in mind.

174. At 2.38 pm Mr Al Jhelie left the medical dispensary. Nurse Paterson recalled that after he had left, she had a brief conversation with Nurse Cheema about Mr Al Jhelie, Nurse Paterson recalled that Nurse Cheema said to her, "You may need to see him later."[203] Nurse Paterson took that comment to mean that Mr Al Jhelie had a self-inflicted injury or mental health matter. She asked Nurse Cheema if she had got the detainee's name, and she said she had not. Nurse Paterson then left the dispensary and went outside in order to speak to Mr Al Jhelie herself and get his details.[204]

175. While this was Nurse Paterson's recollection, the CCTV footage showed a slightly different chronology of events, which Nurse Paterson conceded must be correct. The CCTV footage shows that after Mr Al Jhelie left the dispensary, Nurse Paterson had a conversation with FOM Goodall.[205] The CCTV footage shows FOM Goodall speaking to Nurse Paterson and making a cutting motion against his wrist.

176. After that brief conversation, Nurse Paterson went outside. She said she spoke directly to Mr Al Jhelie through a fence in the presence of a Serco officer. Nurse

[199] T 239.
[200] T 170 – 175, 189; Exhibit 1, Tab 25, [70].
[201] Exhibit 1, Tab 15 and Tab 26.
[202] T 277.
[203] Exhibit 1, Tab 27, [45].
[204] Exhibit 1, Tab 27.
[205] Exhibit 1, Tab 15.

Paterson identified herself as the mental health nurse and asked Mr Al Jhelie several times if he was okay or if he wanted to talk to her. He declined each time. Nurse Paterson described Mr Al Jhelie's demeanour at this time as relaxed, with his hands in his pockets, and she did not think he appeared distressed. When she asked if he wanted to speak to her, he told her, "I'm okay Miss. I just got angry. I just want to go back and talk to my friend."[206] He seemed calm and was clear that he would not do it again. She did not see any injuries on him, although the Serco officer with him mentioned he had old scars from previous acts of self-harm a long time ago.[207]

177. Mr Al Jhelie said more than once that he just wanted to go back to his room, have a cup of tea and talk to his friend, who one would assume was Mr D. Nurse Paterson thought Mr Al Jhelie might be reluctant to talk to her in that public area, as there were a number of other detainees around collecting their medicine, so she offered to talk to him privately in the clinic. He again declined. Nurse Paterson then desisted and allowed Mr Al Jhelie to leave as she felt it was clear "he was rejecting any mental health assistance at that time."[208] Nurse Paterson planned to see Mr Al Jhelie the following day instead.[209] The CCTV footage indicates Nurse Paterson was outside the dispensary for just under 30 seconds.

178. Despite the acknowledged act of self-harm, Mr Al Jhelie was not put on Keep SAFE or the Support Monitoring Engagement (SME) part of PSP, which can include closer monitoring and observation. [210] Nurse Paterson said she did ask the Serco officers to keep an eye on him and to let her know if there were any further concerns or bring him back when the medication round was finished if required.[211] Nurse Paterson did not, by this, mean that he was to be formally monitored as she had formed the opinion he was not at high risk at that time, based on what she knew.[212]

179. Nurse Paterson gave evidence that if the incident had occurred on a weekday, she definitely would have persisted further in encouraging Mr Al Jhelie to undergo a full mental health assessment with her, but on this Sunday, she was under pressure to get back into the pharmacy and help her colleague, who was having to dispense the medications on her own.[213]

180. Nurse Paterson gave evidence that although some of her recollection was a little unclear, she did remember clearly speaking to Mr Al Jhelie and noting he was calm, he had good eye contact and was not agitated or distressed at the time she spoke to him. He said it wasn't going to happen again and although she asked him three times if he wanted to talk to her privately, he made it clear he wanted to return to his room. Nurse Paterson, an experienced mental health nurse, had a sense that there "was no imminent risk"[214] although she certainly felt that there must have been something that triggered his behaviour and she wanted him to be followed up the next day.[215]

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[206] Exhibit 1, Tab 27, [62].
[207] T 260; Exhibit 1, Tab 27.
[208] Exhibit 1, Tab 27, [73].
[209] Exhibit 1, Tab 15.
[210] T 523 - 524; Exhibit 1, Tab 15.
[211] T 241, 248 - 249; Exhibit 1, Tab 27.
[212] T 249.
[213] T 248.
[214] T 242.
[215] T 242.

Nurse Paterson was still unsure of Mr Al Jhelie's details at that stage, so she asked one of the Serco officers to find out who he was, which he did. Between giving out medications, Nurse Paterson then checked the Apollo system for any alerts against Mr Al Jhelie's name, that might tell her if he had a suicidal history or a history of mental illness or depression. Nurse Paterson found only a reference to an accidental overdose and a note that Mr Al Jhelie was adamant it was not done with an intent to self-harm.[216] Nurse Paterson was not in a position at that time to do the kind of full file review of Mr Al Jhelie's medical history that she would normally do before a mental health review, so she simply used the alerts "to hopefully flag anything major."[217]

181. Nurse Paterson agreed that if she had seen the information available in the medical transfer form that referred to a recommendation at Villawood that Mr Al Jhelie receive regular mental health counselling, that would have changed how she assessed Mr Al Jhelie's risk on the day.[218]

182. Within the hour after Mr Al Jhelie had left, Nurse Paterson made an entry in the IHMS Apollo Records, which she recorded as a mental health consultation from the drop-down box. Nurse Paterson entered that Mr Al Jhelie had attended the pharmacy with Serco staff at 2.00 pm with self-inflicted superficial scratches to his left wrist, no dressing was required, and he was encouraged to keep the area clean and dry. He was reporting "to have got angry and scratched himself." [219] Nurse Paterson recorded that Mr Al Jhelie declined mental health input at that time and said he had spoken to a friend and was now "feeling a lot better." [220] Nurse Paterson also recorded that Mr Al Jhelie was encouraged to request a mental health appointment or advise Serco staff if further support or assistance was required.[221]

183. Nurse Paterson said that after making the entry in the Apollo notes, she then sent an email to her team leader to say that Mr Al Jhelie had presented that day and she wanted him followed up the next day to make sure he was supported. Nurse Paterson said she sent the email as a safeguard in case the team leader did not get the information easily from Apollo. Nurse Paterson agreed in questioning that at the time she made the entry and sent the email, she had some general concerns about Mr Al Jhelie's wellbeing but no imminent or immediate safety concerns. Nurse Paterson explained that it is common for people to commit an act of self-harm when feeling overwhelmed or distressed, and then feel a relief of pressure from that act, before the pressure builds up again in a cyclical way. Therefore, she wanted to ensure he was followed up to make sure that the process did not repeat itself.[222]

184. After Mr Al Jhelie left with the Serco officers, FOM Goodall and Nurse Cheema reportedly spoke about the incident. FOM Goodall mentioned that Mr Al Jhelie was not happy with his living arrangements and accommodation and acted out as a

[216] T 243,
[217] T 244.
[218] T 261.
[219] Exhibit 2, Tab 3, p. 14.
[220] Exhibit 2, Tab 3, p. 14.
[221] Exhibit 2, Tab 3, p. 14.
[222] T 245.

result.[223] FOM Goodall had understood from the conversation Nurse Paterson had with Mr Al Jhelie that she was going to see him the next day, and he believed there was nothing more the Serco officers needed to do with Mr Al Jhelie at that stage and there was no need to do any kind of formal referral to IHMS. FOM Goodall also gave evidence he did not recall Nurse Paterson asking him to ensure that someone kept an eye on Mr Al Jhelie. He gave evidence that if she had said that to him, it would have prompted him to query with her why Mr Al Jhelie was not then being put on some form of SME monitoring.[224] If the Serco officers had reported any more concerning behaviour to him, FOM Goodall said he would have reviewed the matter and potentially taken Mr Al Jhelie back to the nurses again, but nothing of that nature was raised with him before he finished his shift.[225]

185. DSO Walker and DSO Hicks walked Mr Al Jhelie back to Falcon compound, but DSO Walker indicated in his evidence that this was because they were walking back to the same compound, rather than performing a role of escort at this stage.[226] DSO Hicks recalled that they had been told Mr Al Jhelie had been cleared, was "good to go"[227] and there was no need for monitoring or observations.[228] On the journey Mr Al Jhelie spoke about Mr D some more and said they were getting on well, but was generally quiet. At 2.20 pm they all walked through the main metal gate back to the Falcon compound. DSO Walker and Hicks then stopped walking alongside Mr Al Jhelie and Mr Al Jhelie continued walking on his own to his room. He knocked on the door, opened it and went inside at 2.43 pm.

186. Mr D said that after Mr Al Jhelie returned to his room, Mr Al Jhelie simply lay down on his bed.[229] Mr D sent another text message to Mr Al Jhelie's girlfriend so he could try to help Mr Al Jhelie as he "felt for the guy,"[230] as it was apparent to him that Mr Al Jhelie was feeling very low.[231] There was some evidence that Mr D also understood from Mr Al Jhelie that his girlfriend had agreed to unlock his phone, so he was feeling a bit happier by this stage.[232]

187. Mr D said he didn't try to raise any concerns about Mr Al Jhelie with the Serco officers as he understood that Mr Al Jhelie had been taken to the medical centre and then returned. Mr D did say one of the Serco officers had asked him to look after Mr Al Jhelie, without telling him anything in particular about what to look out for.[233] DSO Hicks recalled there was a conversation with Mr D, in which he asked whether Mr Al Jhelie was on any watches and he was told that Mr Al Jhelie was not. Mr D then said something like he would look after him. DSO Hicks did not believe the Serco staff specifically asked Mr D to keep an eye on Mr Al Jhelie during that

[223] T 189, 267; Exhibit 1, Tab 15.
[224] T 203, 207.
[225] T 183, 188, 201 - 202.
[226] T 215,
[227] T 127
[228] T 115.
[229] T 98.
[230] T 97.
[231] T 100.
[232] T 104 – 105.
[233] T 98, 100, 108.

conversation, rather Mr D indicated he would do so of his own accord, as it appeared they were good friends.[234]

188. DSO Walker gave evidence that he was performing standard welfare checks in the Falcon compound at about 4.30 pm. Mr Al Jhelie was not in the blocks allocated to DSO Walker to check, but after completing his allocated blocks, he went to Mr Al Jhelie's room "just to see how things were going"[235] and have a chat with Mr Al Jhelie. DSO Walker said he was finishing his shift soon and he "didn't want to just leave without … visually seeing him one more time"[236] to make sure everything was okay. DSO Walker gave evidence that he asked Mr Al Jhelie if he was okay, and Mr Al Jhelie agreed that he was. DSO Walker recalled Mr D was also present and said, "He is okay, and I will look after him."[237] DSO Walker clarified that he did not ask Mr D to keep an eye on Mr Al Jhelie at this stage, but rather Mr D volunteered that he would do so.[238]

189. There was a change of shift commencing at around 5.30 pm and FOM Goodall handed over to his night shift replacement, FOM Alex Howell. FOM Howell gave evidence that FOM Goodall "was a bit blasé"[239] about the incident. He told FOM Howell that Mr Al Jhelie had been spoken to by IHMS and he appeared embarrassed about it and the cuts to his arms were only superficial. FOM Goodall was said to have suggested that Mr Al Jhelie was "attention seeking."[240] FOM Howell said he asked if Mr Al Jhelie was on constant Keep SAFE, which is their standard process after someone has self-harmed, and FOM Goodall told him that Mr Al Jhelie had been removed after he had been assessed by IHMS earlier that day. FOM Howell gave evidence at the inquest that he wasn't certain FOM Goodall specifically used the term Keep SAFE at that time, despite the question, or simply said that Mr Al Jhelie had been on constant observations until he had been assessed by IHMS.[241]

190. FOM Howell recalled that FOM Goodall told him that he did not believe it was a very serious attempt by Mr Al Jhelie and he wasn't concerned about it.[242] FMO Howell gave evidence that in his experience, self-harm is generally more of a cry for help than an attention seeking behaviour, so he had some reservations about what FOM Goodall was telling him.[243]

191. FMO Goodall, who no longer works for Serco, was asked about this conversation during his evidence. He maintained that he was taking the incident seriously at the time, noting he chose to personally attend the dispensary,[244] but he was also following the guidance of the IHMS nurses. FOM Goodall said he did expect the Serco officers were going to do some more checks on Mr Al Jhelie and if there was

[234] T 129.
[235] T 216.
[236] T 231.
[237] T 217.
[238] T 217, 230.
[239] T 179; Exhibit 1, Tab 44, [50] – [52].
[240] Exhibit 1, Tab 44, [50] – [52].
[241] T 364 - 365.
[242] T 347.
[243] T 362.
[244] T 189.

an escalation of his behaviour and any other reason for concern, then he would have been placed on Keep SAFE.[245]

192. FOM Howell had only met Mr Al Jhelie a couple of times prior to this day, the last being on his return from hospital in the early hours of 1 September 2018. FOM Howell spoke to him briefly and formed the impression Mr Al Jhelie "seemed a bit down",[246] but nothing to cause major concern within the context that most detainees are not really in a good mood most of the time.[247] However, this extra information about the self-harm incident obviously was additional information to add to his own impression.

193. After being given the handover from FOM Goodall, FOM Howell said that he took the opportunity to advise his team about the incident with Mr Al Jhelie and specifically told them that although the cuts were superficial, "it was something to be concerned about".[248] He wanted them to watch Mr Al Jhelie closely and be vigilant and have a monitoring regime every couple of hours, even though Mr Al Jhelie was not on official observations.[249] FOM Howell also said in evidence that his intent was either to talk to Mr Al Jhelie himself, or have one of his staff members speak to him to try and gauge how we was feeling, so how often he was monitored would have depended on the outcome of that engagement.[250] However, this did not come to pass as events overtook it. The briefing took place between 5.45 pm and 6.00 pm, and the night shift Serco officers were then to be deployed out into the facility at 6.00 pm. As we know now, at about the same time, Mr Al Jhelie was discovered hanging in his cell. Before the briefing had finished, FOM Howell heard the Code Blue in relation to Mr Al Jhelie called over the radio at 5.51 pm.

194. There is CCTV footage that indicates Mr Al Jhelie's roommate, Mr D left their shared room at 5.29 pm. Mr D left the room to get some dinner. At the time Mr D left the room, Mr Al Jhelie appeared to be asleep on his top bunk.[251] Mr D closed the door as he left but did not lock it. Mr Al Jhelie was alone in the room after Mr D left.[252]

195. Mr D returned to the room at 5.47 pm and found the door was locked, which was unusual. He knocked on the door and called out but did not receive any response from Mr Al Jhelie. Mr D then tried to look through the window next to the door, before trying the door again, but still did not receive any response from Mr Al Jhelie. As he could not get into the room and was worried about Mr Al Jhelie, Mr D went and asked for help from a Serco officer, DSO Muhammad Ali.[253] DSO Ali was with another detainee, Mr Z. Mr Z, was a long-term detainee with a history of self-harm attempts,[254] and he was on a hunger strike at the time, so he was required to be kept under constant observation by staff. DSO Ali was performing that task at the time.

[245] T 179.
[246] Exhibit 1, Tab 44, [38].
[247] T 343.
[248] Exhibit 1, Tab 44, [55].
[249] T 344, 347.
[250] T 354.
[251] T 100.
[252] T 98; Exhibit 1, Tab 15 and Tab 28.
[253] Exhibit 1, Tab 15.
[254] Exhibit 5.

Initially DSO Ali made a radio call to request another officer come to assist. They waited for a few minutes, but the other officer didn't arrive, and Mr Z then offered to go with them so that DSO Ali could open Mr D's door.[255]

196. Mr D then returned to his room with DSO Muhammad Ali and Mr Z.[256] Mr Z had known Mr Al Jhelie only four days and did not know him well, although he was aware from other detainees that Mr Al Jhelie was upset because he had moved so far from his family.[257] At the time the three men went to the room, none of them had any suspicion of what they were about to find.

197. At 5.51 pm DSO Ali unlocked the door to the room at Mr D's request. Immediately, the men could see Mr Al Jhelie hanging from the top of the bed frame with a ligature around his neck that was made from a bedsheet. DSO Ali called a Code Blue medical emergency over the radio while Mr D and Mr Z went inside the room and tried, with some difficulty, to hold Mr Al Jhelie up. DSO Ali then used his Hoffman knife to cut the ligature and they then lowered Mr Al Jhelie onto his back on the ground. Mr Z said he pulled Mr Al Jhelie's tongue out to keep his airway open and Mr Z and Mr D began to perform CPR but then they stopped as Mr Z believed Mr Al Jhelie had a pulse.[258] Three other detainee services officers, including DSO Walker, had very quickly arrived at the scene and Mr Z indicated to them that he believed Mr Al Jhelie had a pulse. DSO Walker put his face near Mr Al Jhelie's face and believed he could hear faint breathing, so Mr Al Jhelie was moved into the recovery position and his breathing was monitored. Mr Z and Mr D had left the room around this time and DSO Ali went with Mr Z as he was still tasked with supervising him.[259]

198. Shortly afterwards, DSO Hicks, arrived with a defibrillator. Around this time, DSO Walker was having difficulty detecting Mr Al Jhelie's breathing, so he got DSO Hicks to check. DSO Hicks could not detect any breathing, so he commenced CPR. This was the first time DSO Hicks had performed CPR, but he felt he had sufficient training to do so.[260] He commenced chest compressions and attempted to do breaths with a face mask.[261] DSO Hicks recalled Mr Al Jhelie's jaw was quite rigid and hard to open, and he had to use a fair amount of force to open it. He then noticed the inside of Mr Al Jhelie's lips and tongue was quite discoloured, appearing to be a blue-grey colour.[262] The defibrillator was also applied, which advised 'no shock'. The DSO's then took turns performing CPR and monitoring the defibrillator, which continued to advise not to shock Mr Al Jhelie after each reading.[263]

199. The Serco Emergency Response Team officers arrived on scene to assist with CPR. FOM Howell, as part of the relieving night duty team, also arrived on scene and made a '000' call to request St John Ambulance attendance at 5.58 pm. FOM Howell then tasked some officers to clear a pathway from the room to the compound gate in

[255] T 300 – 301.
[256] Exhibit 1, Tab 15.
[257] Exhibit 5.
[258] T 98; Exhibit 5.
[259] T 219, 324.
[260] T 121 – 122.
[261] T 118.
[262] T 117 – 118.
[263] T 119; Exhibit 1, Tab 15.

preparation for the arrival of the ambulance. The ambulance arrived at 6.05 pm and parked at the compound gate. Mr Al Jhelie was placed onto the emergency stretcher and taken to the gate where the SJA paramedics were waiting. The Serco officers continued CPR until the handover to SJA officers. They advised that Mr Al Jhelie had been receiving continuous CPR for approximately 10 minutes with no response. Prior to Mr Al Jhelie being placed in the ambulance, another status check was conducted, and the defibrillator still indicated not to administer a shock.[264]

200. Mr Al Jhelie was then placed on a stretcher and carried to where the ambulance was parked, in a secure area of the compound. The compressions were ceased while he was transported on the stretcher as the Serco officers found it too difficult to continue the compressions while he was being moved downstairs and across a gravel road, and it was felt that it was preferable to move him quickly to the paramedics, who could provide advanced care and give Mr Al Jhelie the best chance of recovery.[265]

201. Once Mr Al Jhelie had been transferred to the ambulance, paramedics provided him with immediate medical treatment at the scene for 18 minutes. They left the detention centre at 6.23 pm and continued CPR *en route* to Northam Hospital. Mr Al Jhelie's remained asystole, with no electricity or movement in the heart, throughout this time.

202. I note at this stage that there were some comments made by Mr Z and Mr D to the effect that there were long delays in Serco officers providing CPR and their efforts were ineffective, and that there were also delays in the ambulance attending. I have no doubt it felt to them like a long time elapsed before help arrived and the chaos of the scene would have been disturbing, but I am satisfied from the objective evidence of the CCTV footage that there were no inappropriate delays and that all efforts were made to provide Mr Al Jhelie with prompt and effective first aid and resuscitation from the moment he was discovered hanging.

TRANSFER TO HOSPITAL

203. Mr Al Jhelie arrived in the ambulance at Northam Hospital Emergency Department at 6.27 pm. He was seen immediately and was found to still be in cardiac arrest. He was given adrenaline and one shock, after which spontaneous circulation was restored. However, he remained unresponsive, with fixed and dilated pupils and no respiratory effort. Blood gases showed severe acidosis. Mr Al Jhelie was intubated and given medications to maintain his blood pressure. CT scans showed no cervical spine fracture but signs of damage to the brain were noted. A provisional diagnosis of hypoxic brain injury was made.[266]

204. Royal Perth Hospital Intensive Care Unit agreed to accept transfer. The Royal Flying Doctor Service were unavailable until midnight, so a decision was made to transport Mr Al Jhelie to RPH by road with a doctor escort.[267]

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[264] Exhibit 1, Tab 15.
[265] T 120, 144.
[266] Exhibit 1, Tab 15.
[267] Exhibit 1, Tab 15.

205. After being transferred to Royal Perth Hospital (RPH), Mr Al Jhelie was handed over to RPH medical staff at 11.12 pm. He was admitted to the RPH Intensive Care Unit. At that time he had a Glasgow Coma Scale of three. Despite intensive medical efforts, Mr Al Jhelie's condition did not improve, and his prognosis was poor. His sister Rawiya was contacted by the hospital on 3 September 2018 and his family were informed that he was seriously ill and might not survive. Mr Al Jhelie's brother Fadee immediately booked a flight and arrived in Perth that evening. He spoke to Mr Al Jhelie's doctors, who explained that they would need to do further testing, but they believed if Mr Al Jhelie was to survive, he would be severely disabled.[268]

206. Mr Al Jhelie's father and a sister arrived in Perth on 4 September 2018. A family conference was held at RPH with the assistance of an interpreter. It was explained to Mr Al Jhelie's family that he had suffered a non-survivable brain injury. The test results did not meet the strict criteria for brain death but were not compatible with life. With Mr Al Jhelie's family's permission, life support was withdrawn, and his death was confirmed at 4.34 pm on 5 September 2019.[269]

CAUSE AND MANNER OF DEATH

207. On 12 September 2018, Forensic Pathologist Dr Daniel Moss conducted a post-mortem examination on the body of Mr Al Jhelie with three police officers in attendance. Dr Moss noted there was a ligature mark, which was consistent with the ligature comprised of two pieces of green sheet that accompanied Mr Al Jhelie's body. The only other evidence of injury to the skin surface were multiple recent superficial scratch-like abrasions and incised wounds to the left wrist, which were all transversely oriented and barely broke the skin. There was also evidence of extensive medical intervention. Of note, given the various issues he had been experiencing, the bowel examination was reported to be normal with no evidence of ulceration to suggest inflammatory bowel disease.[270]

208. Microscopic examination of the brain showed findings in keeping with hypoxic ischaemic injury as well as non-specific peri-vascular lymphocytic cuffing.[271]

209. Toxicology analysis of post-mortem blood samples found no common basic illicit drugs or alcohol. The medications present were consistent with Mr Al Jhelie's medical care, noting Mr Al Jhelie had been treated in hospital for a few days before his death. During the coronial investigation, the police requested Mr Al Jhelie's pre-admission blood samples from Northam Hospital. Unfortunately, the samples had been discarded by hospital staff, so no toxicology testing could be undertaken of Mr Al Jhelie's blood samples immediately after his hanging, to determine whether he had taken any drugs that day. A tablet found in Mr Al Jhelie's possessions was later tested and found to be a vitamin tablet.[272]

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[268] Exhibit 1, Tab 18.
[269] Exhibit 1, Tabs 15 and 18.
[270] Exhibit 1, Tab 8A -8B.
[271] Exhibit 1, Tabs 8A – 8B and Tab 9.
[272] Exhibit 1, Tab 10 and Tab 15, p. 34.

210. At the conclusion of all investigations Dr Moss formed the opinion that the cause of death was complications of ligature compression of the neck (hanging).[273] I note the complications were explained as a lack of blood and oxygen supply to the organs, which in this case caused primarily brain damage, secondary to lack of oxygen and blood to the brain due to strangulation from the ligature.[274] I accept and adopt Dr Moss' opinion as to the cause of death.

211. In the course of his evidence at the inquest, Dr Moss explained that Mr Al Jhelie would have become unconscious within approximately 10 to 15 seconds due to the ligature compression around his neck, and he would have developed irreversibly brain damage within an unspecified period of time, but "probably minutes at most."[275] The fact that Mr Al Jhelie was able to be resuscitated and then survived, at least with cardiovascular function for a few days in hospital, suggested a relatively short timeframe between the hanging occurring and the resuscitation commencing. However, Dr Moss explained that the brain is much more sensitive to lack of oxygen and blood supply and glucose supply, etc, than the heart. Resuscitation is about restarting the heart, which then has the effect of getting blood circulating and distributing oxygen to the other organs, which will hopefully then prevent further injury to the brain. However, if the length of downtime has already been too long, then the damage to the brain may already be irreversible, and then nothing can be done to save the person even though the heart was able to be restarted.[276]

212. So, it would seem in Mr Al Jhelie's case that he was discovered not long after he had hanged himself, and appropriate steps were then taken to remove the ligature and promptly commence resuscitation so that his heart was able to be restarted, but sadly too much time (in the order of at least a few minutes) had already elapsed with his brain not receiving oxygen, so the damage to his brain was already irreversible.

POLICE INVESTIGATION

213. Mr Al Jhelie's death triggered a riot at Yongah Hill. FOM Howell indicated in his statement that immediately after Mr Al Jhelie was taken away by ambulance detainees started to become aggressive towards officers and multiple fires were started, causing the Serco officers to have to withdraw from the Falcon compound.[277] There were later media reports indicating detainees were concerned about overcrowding and a 'pressure cooker environment', as well as concerns about Mr Al Jhelie's treatment.[278]

214. When the WA Police were informed of the death at 6.00 pm, police officers immediately attended Yongah Hill and were met by FOM Howell at reception. FOM Howell informed the police that due to the riot, a Code Black had been declared and it was not safe for police to enter the Falcon Compound and view Mr Al Jhelie's room. The attending police were handed the Hoffman knife used by DSO Ali

[273] T 294; Exhibit 1, Tab 8A - 8B.
[274] T 294.
[275] T 295.
[276] T 295, 298.
[277] Exhibit 1, Tab 44.
[278] Yongah Hill detention centre riot breaks out after alleged suicide attempt by detainee - ABC News

to cut Mr Al Jhelie down and the sheet ligature that had been removed, and the police officers requested the body worn camera footage from the Serco ERT officers and any relevant CCTV footage, as well as incident reports from all Serco officers who were involved in the incident.[279]

215. Police officers reattended later that evening and had an opportunity to take photographs of Mr Al Jhelie's room and the bunk bed, despite the riotous behaviour continuing.[280]

216. A full police forensic examination of the scene was conducted on 3 September 2020, after the riot had been quelled, and it was noted there were no signs of a struggle in the room and no blood was sighted. A partial torn green sheet, matching the ligature, was located and seized.[281]

217. On 3 September 2020, officers from the WA Police Coronial Investigation Squad attended Yongah Hill. They reviewed and seized the CCTV footage, which confirmed Mr Al Jhelie's movements prior to entering his room, and showed Mr D leaving the room at 5.29 pm and returning at 5.51 pm, with no other person approaching the room in the intervening period.[282]

218. Mr D was spoken to by the police. He advised that Mr Al Jhelie had told him that he felt down due to the break-up with his girlfriend and the fact that his mobile phones had been locked by her, meant that he could not communicate with his girlfriend directly to mend the relationship.[283] Mr D showed the police the text messages that were then sent to Mr Al Jhelie's girlfriend from Mr D's mobile phone. There was no response from his girlfriend to the messages.[284]

219. It is apparent from other evidence that Mr Al Jhelie's girlfriend must have seen the messages, as her mother became aware of them soon after. Her mother, who was in detention in Villawood, informed Villawood staff and also sent texts to Mr Al Jhelie's brother, Fadee, asking about Mr Al Jhelie's welfare and indicating that he needed help as Mr Al Jhelie's girlfriend had broken up with him. Fadee said that the girlfriend's mother stated Mr Al Jhelie "Was a very depressed kid."[285] Mr Al Jhelie had also apparently told his girlfriend that he was dying of cancer, although this was not true.[286]

220. The investigating police attempted to contact Mr Al Jhelie's girlfriend to obtain further information from her, but their attempts were unsuccessful. The investigating officer, Detective Sergeant Tidey, also tried to download Mr Al Jhelie's phone, to obtain any additional messages that were sent between them, but she had limited success, as noted below.[287]

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[279] Exhibit 1, Tab 15 and Tab 44.
[280] Exhibit 1, Tab 15.
[281] Exhibit 1, Tab 15.
[282] Exhibit 1, Tab 15.
[283] Exhibit 1, Tab 15.
[284] Exhibit 1, Tab 15.
[285] Exhibit 1, Tab 15, p. 29.
[286] Exhibit 1, Tab 15.
[287] T 37; Exhibit 1, Tab 15.

221. Another detainee, Mr A, occupied a room near Mr D and Mr Al Jhelie's room. He corroborated Mr D's observations of Mr Al Jhelie's demeanour that day and indicated that he had noticed a change in Mr Al Jhelie's behaviour in the three days prior to his death. Mr A provided information that he believed Mr Al Jhelie associated with the wrong people and was involved in drugs. He heard that Mr Al Jhelie had separated from his girlfriend and hence had no credit and no money for his phone.[288]

222. Mr Al Jhelie's brother, Fadee, provided a statement to police in September 2018. The statement outlined various information about Mr Al Jhelie. Fadee was aware that Mr Al Jhelie needed a psychiatric assessment for the visa review process. Fadee understood there was a long waiting list for the assessment, which is consistent with the long period of time that had elapsed without any assessment occurring, and he was told that Mr Al Jhelie had been advised to get a private assessment. Mr Al Jhelie's sister, Rawiya, apparently transferred money to Mr Al Jhelie for that purpose, although it does not appear that this private assessment took place. It is mentioned above that when Rawiya asked Mr Al Jhelie about requests from a specialist for money, he became angry with her.[289]

223. Fadee provided police with a photograph of Mr Al Jhelie sitting on a hospital bed after his second overdose in late July 2018. Mr Al Jhelie sent the photograph with a text message in Arabic saying, "I did it again." Fadee understood from his conversations with Mr Al Jhelie, that Mr Al Jhelie had attempted suicide on both occasions.[290]

224. Fadee had some text conversations with Mr Al Jhelie's girlfriend's mother, after Mr Al Jhelie's death, which provided him with some additional information about Mr Al Jhelie's state of mind at Yongah Hill, which he provided to police.[291]

225. Fadee also provided information he had received in text messages from Mr Z, in relation to what he saw when Mr Al Jhelie was found hanging in his room. Mr Z also confirmed that from what he witnessed, Mr D and Mr Al Jhelie had a good relationship and Mr Al Jhelie had been able to confide in Mr D.[292]

226. Mr Al Jhelie's three mobile phones were seized by police from his room. Two had been restored to their factory settings and had no relevant data on them. The third mobile phone had incoming and outgoing calls, but no times or dates displayed and no text messages.[293]

227. In his diary, Mr Al Jhelie had written about having thoughts of taking his life. It is unclear when the notes were written.[294] Also found in his room after his hanging was a handwritten version of the typed letter he had provided for his visa review, in

[288] Exhibit 1, Tab 15.
[289] Exhibit 1, Tab 18 and Tab 19.
[290] Exhibit 1, Tab 15, p. 29.
[291] Exhibit 1, Tab 18.
[292] Exhibit 1, Tab 15, p. 29.
[293] Exhibit 1, Tab 15, p. 29.
[294] Exhibit 1, Tab 15, p. 31.

which Mr Al Jhelie admitted to relapsing back into drug use and talked about having family support to change himself and begin the rehabilitation process.[295] In the handwritten version of the letter, Mr Al Jhelie wrote that sending him to somewhere he had never seen, with no family, was "worse than giving [him] the death penalty"[296] and words to the effect he would rather die here than live anywhere else. [297] The written materials collectively highlight the struggles Mr Al Jhelie faced with his ongoing drug habit, breakdown in his relationships and inability to see his children and his fear about being deported from Australia.[298]

228. Detective Sergeant Tidey considered the materials she had managed to obtain during in her investigation, noting not everything requested had been provided by relevant stakeholders, and provided a report to the Coroner dated 31 August 2019 setting out her analysis and conclusions to assist the Coroner in determining the cause of death and manner of death.[299]

229. Having at the forefront of her mind Mr Al Jhelie's family's concerns that another person may have been involved in his death, Det Tidey first ruled out that possibility.[300] Detective Sergeant Tidey referred to Mr Al Jhelie's physical health issues, which indirectly isolated him as he couldn't participate in most group activities, and his mental health issues and self-harm tendencies, that had resulted in multiple suicide and self-harm attempts. She noted that, by his own admission, Mr Al Jhelie used drugs to self-medicate, rather than taking prescribed medication, and he was at high risk of overdosing.[301]

230. Detective Sergeant Tidey obtained evidence that Mr Al Jhelie's was unhappy about his transfer to Yongah Hill, on the other side of the country from his family, and he did not want to have to share a room with a stranger. Detective Sergeant Tidey concluded from her review of the materials that at the time of his death, Mr Al Jhelie felt isolated due to the physical separation from his family, his ongoing drug issues and the fact his communications with his girlfriend had terminated. In that frame of mind, he did not want to suffer anymore and took his life.[302] Detective Sergeant Tidey's conclusions were not challenged when she gave evidence at the inquest.[303]

231. There is no real dispute that Mr Al Jhelie died by way of suicide. The only dispute is what were the factors and circumstances that led to Mr Al Jhelie making that fateful decision on 2 September 2018 to hang himself.

DETENTION ASSURANCE REVIEW

232. On 14 September 2018, the Commander of Detention Operations referred the death of Mr Al Jhelie to the Detention Assurance Team for independent review. It was

[295] Exhibit 1, Tab 15, p. 29.
[296] Exhibit 4, Tab 2.3.
[297] Exhibit 4, Tab 2.3.
[298] Exhibit 1, Tab 15, p. 29.
[299] R 35.
[300] T 38.
[301] T 37 – 38.
[302] T 38.
[303] T 39.

noted that Mr Al Jhelie died on 5 September 2018 after a fatal self-harm incident, approximately seven months after entering immigration detention and after Mr Al Jhelie "was involved in three other self-harm incidents."[304] The fieldwork for the review was conducted between December 2018 and June 2019 and the report was completed and signed in early August 2019.[305]

233. I note the review did not seek to determine the cause of death or form conclusions about the factors that contributed to Mr Al Jhelie's death, as this was acknowledged as a task for the WA Police and the Coroner. The focus was, rather, on the Department's conduct in relation to the AAT ordered psychiatric report and to what extent the Department and IHMS implemented mental health support for Mr Al Jhelie in accordance with the Department's established policies and procedures (in particular given he had an incident of self-harm three hours before he hanged himself), as well as considering his risk of self-harm when decided to transfer him to Yongah Hill.[306]

234. The review found that there were positive aspects in the management of Mr Al Jhelie's case, such as periodic consultations with psychologist and psychiatrists, specialist treatment for recurring abdominal pain and regular drug and alcohol counselling.

235. However, the review found that there were several aspects of the Department's management of Mr Al Jhelie's case that could have been improved. In particular:[307]

- The Department adopted an unnecessarily complicated approach to obtaining the AAT ordered psychiatric report, due in part to a lack of clear procedures for obtaining court ordered medical reports, which led to a delay of around six months in securing an appointment for Mr Al Jhelie with a forensic psychiatrist. This delay prevented the Department from undertaking a re-assessment of Mr Al Jhelie's revocation request. I note the review doesn't mention the fact that the Department's lack of clear procedures in relation to the medical report also resulted in Mr Al Jhelie being repeatedly told for many months that the delay was, in effect, his fault as he was incorrectly told that it was his responsibility;
- Policies and procedures for mental health support and self-harm in immigration detention were not followed. Specifically, the Department, through its service provider (IHMS) failed to offer further trauma screening or trauma counselling to Mr Al Jhelie after he disclosed a history of trauma and they did not place Mr Al Jhelie on Supportive Monitoring and Engagement (SME) following his multiple attempts at self-harm, including on 2 September 2018 after he self-harmed in his room, three hours before he was found hanging;
- The review found no records to indicate that a comprehensive assessment of Mr Al Jhelie's risks of self-harm was undertaken before he was transferred from Villawood to Yongah Hill to disrupt his supply of drugs. It noted the health summary that was provided by IHMS for his transfer disclosed no

[304] Exhibit 6, Tab 2, p. 17.
[305] Exhibit 6, Tab 2.
[306] Exhibit 6, Tab 2, p. 24.
[307] Exhibit 6, Tab 2, pp. 18, 25.

mental health issues, despite his clinical notes indicting that he was at risk of self-harm, and it contained an incomplete summary of his health issues and care needs;

- There was no mental health screening undertaken with Mr Al Jhelie following his transfer to Yongah Hill despite Departmental policies indicating that Health Induction Assessments should be undertaken both at entry to immigration detention and on transfer between facilities; and
- Information that was relevant to decisions about Mr Al Jhelie's transfer, care and status resolution was not always adequately shared between the multiple business areas that were managing Mr Al Jhelie during his time in immigration detention. This made it possible for decisions to be made about one aspect of his case (for example his transfer to Yongah Hill) without consideration of the impact on other aspects of his case (such as his request for revocation of the decision to cancel his visa or his risk of self-harm). The Detention Assurance Review could not identify a single area that had a complete picture of his health and welfare needs and the progress of his immigration status during his time in immigration detention.

236. I agree generally with the conclusions of the Detention Assurance Review and note it shows the Department was at least taking a proactive approach to this matter internally. It is just a shame that the Department did not provide it to the Court at an earlier stage, as it was a very useful document for this inquest and reflected well on the Department, but there was limited opportunity to raise it with witnesses prior to their evidence.

237. I note that there was some clarification at the inquest with Dr Lienert about the finding as to the failure to refer Mr Al Jhelie to trauma therapy. He said that his notes suggest to him that he considered the referral, and it was declined by Mr Al Jhelie, as indicated in the reference to Mr Al Jhelie not wishing to engage in psychological therapy, which is the first line of treatment for PTSD.[308]

238. The Detention Assurance Review made four recommendations aimed at strengthening the procedures for obtaining legally required medical reports, strengthening stakeholder and medical input to transfer decisions for detainees at risk of self-harm and implementing a clinical assurance model within the health services contract that will enhance the Department's ability to satisfy itself that its health services provider is delivering a standard of care that is consistent with the Department's detention policies.[309]

239. In response to the recommendations, a Management Action Plan was completed by the stakeholders on 17 July 2019, setting out the actions they would take to address the report's recommendations, all of which were expected to be completed by December 2019, assuming negotiations with IHMS were favourable. Information was provided that the recommendations had been actioned.[310]

[308] T 409.
[309] Exhibit 6, Tab 2, p. 18.
[310] Exhibit 6, Tab 2, pp. 18 – 19, Tabs 3 - 11.

240. The current Medical Director for IHMS, Dr Sue Page, also was asked to respond to the recommendations of the review in her evidence at the inquest. Dr Page was not in this role at the time of Mr Al Jhelie's death. She commenced her position at the start of 2021. However, Dr Page did conduct a review of Mr Al Jhelie's case and was able to speak to her expectation of how matters would proceed at the current time at IHMS in similar circumstances.[311]

241. With reference to the torture and trauma counselling, Dr Page noted that individuals who identify a torture and trauma background are referred by IHMS staff to the TNT specialist service who have expertise in the area. Dr Page noted that in Mr Al Jhelie's case, he declined offers of medication and psychological therapy at the time he disclosed these issues, so it may have been that he could have declined referral to the TNT service, but this was not properly documented by the clinician. However, Dr Page also conceded that a disclosure of a history of trauma would usually trigger an incident reporting process, as IHMS maintain a separate database of people with torture and trauma in their background, and she could not find such a report for Mr Al Jhelie. Certainly, he was not referred to the TNT service, although it is difficult now to tell if he was offered a referral and declined, or not offered the referral.[312]

242. Dr Page agreed that the incident on 2 September 2018 should have triggered an SME process, and I canvas that more fully below.

243. Dr Page also agreed that the Fitness to Travel form should have included the forensic psychiatric appointment that was being scheduled for his AAT review, which I also address below. In essence, the information had not been entered into Apollo as it was immigration related rather than generally health related, so it was not available to the IHMS staff who were completing the Fitness to Travel form.[313] Dr Page did not consider Mr Al Jhelie's other mental health and drug and alcohol counselling needs as an impediment to his transfer, as those services could be provided at Yongah Hill.[314]

COMMENTS ON MATTERS CONNECTED WITH THE DEATH

244. As noted at the start of this finding, while I am not required under the Act to comment on the quality of the supervision, treatment and care of Mr Al Jhelie while in detention, I intend to make such comments about his care and supervision as I consider it appropriate under my general power to comment on any matter connected with the death. I do so, as I consider that the way in which the failure to progress expeditiously his psychiatric review necessary for his application for review of the decision not to re-instate his visa (following the AAT decision). [315]

245. Western Australia Police officers met with Mr Al Jhelie's family at the hospital, after his death, and Fadee also provided a statement. Mr Al Jhelie's family raised various

311311 Exhibit 8.
312 T 538, 550.
313 T 543 - 544.
314 T 542.
315 Section 25(2) of the *Coroners Act 1996* (WA).

concerns, including why he was transferred to Yongah Hill, so far from his family and other supports, and also about the standard of mental health care and support he received after the transfer. Mr Al Jhelie's family told police they believed he was pushed mentally to the brink by the transfer to Yongah Hill and the conditions he lived in, including having to share a room there, which led to him committing suicide. They queried why he was not sent to hospital after harming himself that day. They also questioned whether proper first aid was provided to Mr Al Jhelie by staff after he was found hanging. Mr Al Jhelie's family expressed a wish to ensure that lessons are learnt from his death and that another preventable death does not occur in similar circumstances.[316]

246. As I indicated earlier, there are a number of stakeholders involved in providing care to people in immigration detention, with the ultimate responsibility resting with the Department of Home Affairs. However, in terms of day-to-day dealings, the ongoing management and maintenance of the detention facility is subcontracted to Serco, who employ and manage their own staff, and the medical treatment is subcontracted to IHMS, who also employ and manage their own staff.[317]

247. The Department has specific procedures in place for responding to, and managing, incidents of self-harm by a detainee in an immigration detention facility. All staff who work with people in detention are required to be trained to recognise and respond to the warning signs and risk factors for self-harm and suicidal thoughts. In addition, all staff receive critical skills training and are required to be compliant in areas such as security, first aid and CPR.[318]

248. There is a specific programme, known as the Psychological Support Programme (PSP), that is designed to identify and manage the mental health welfare of all detainees. It is a clinically led intervention to assist in the management of the risk of self-harm and suicide. Its day-to-day management is provided by IHMS staff, led by a senior clinician, and is supported by facilities representatives and Serco staff.[319]

249. If an IHMS doctor or nurse is not available, and cannot assess a detainee properly to implement PSP, Serco staff can implement the equivalent, known as 'Keep SAFE' measures, in order to keep detainees safe out of hours until IHMS staff can assess them.[320]

250. Mr Al Jhelie's self-harming attempt on 2 September 2018 appears to have been in reaction to the break-up with his girlfriend and her actions in subsequently blocking his phone access. It seems unlikely this behaviour was a focussed suicide attempt, given the superficial nature of the cuts and the fact he disclosed his actions to his roommate. The cutting was more likely done out of anger or frustration and with the intention of eliciting a reaction from his girlfriend, given he asked his roommate to take a photograph of his wounds and send it to her. However, his mood clearly worsened in the afternoon, likely triggered by his break-up and thoughts of being far

316 Exhibit 1, Tabs 18 - 19.
317 Exhibit 1, Tab 15.
318 Exhibit 1, Tab 15.
319 Exhibit 1, Tab 15.
320 Exhibit 1, Tab 15.

away from his family, particularly given it was Father's Day the day before, and concerns regarding the uncertain status of his visa.

Dr Brett's Report

251. Dr Adam Brett is a highly qualified and respected consultant psychiatrist who has worked in mental health for over 27 years in a wide range of settings. Dr Brett was requested by this Court to provide an expert opinion on the mental health care provided to Mr Al Jhelie while he was held in detention.

252. Dr Brett currently holds a clinical position at the WA Magistrates Court's 'Start Court', which specialises in dealing with offenders with mental health issues, and he is also the Deputy Psychiatrist on the Mentally Impaired Accused Review Board. Dr Brett has worked across a wide range of forensic mental health settings, including prison mental health, and regularly gives evidence in criminal proceedings and coronial proceedings in Western Australia. Dr Brett has also been to immigration detention centres to prepare reports and discussed care with colleagues who work in detention facilities, but he acknowledged in his report and in his evidence that he has not worked in an immigration detention facility and is unaware of services in New South Wales.[321]

253. When Dr Brett was called to give evidence on the first day of the inquest, Senior Counsel appearing for the Department suggested to Dr Brett that another expert, more familiar with working at an immigration detention facility, would be in a better position to provide an expert report in this case. Dr Brett acknowledged that there would be better qualified people, but noted it is "a very niche area"[322] and he wasn't certain how many such experts, if any, would be willing to provide a report in the circumstances.[323]

254. I note that Dr Brett's expert report was provided to the Department as part of the brief of evidence provided on 15 April 2021. No issue was raised by the Department with this report either by correspondence or at the case management hearing held on 29 September 2021 and the Department did not seek to tender an expert opinion from another psychiatrist at the inquest hearing. At the conclusion of the day's evidence, I queried with Senior Counsel whether the Department was seeking, at that late stage, to contest Dr Brett's expertise. The response was that instructions would need to be sought.[324] The Court subsequently received a request for the names of some of the inquests in which Dr Brett had previously given evidence as an expert, and the names of a number of inquests were provided, along with a copy of Dr Brett's full curriculum vitae although it was not requested.

255. In the written submissions filed on behalf of the Commonwealth, a number of objections were raised to Dr Brett's evidence, and it was suggested that matters "falling outside his expertise, could have been briefed to him by way of assumptions

[321] T 63; Exhibit 1, Tab 52, p. 9 [63].
[322] T 63.
[323] T 54, 62 - 63.
[324] T 148.

for him to take into account."[325] I note that the Department had considerable time to suggest this be done long before the inquest hearing, if it was perceived this was a deficit in Dr Brett's expertise or the briefing provided to him, yet it did not. Other objections were raised to Dr Brett's opinion being framed in terms of an opinion as to Mr Al Jhelie's overall care, treatment and supervision whilst he was in detention and that his opinion was based on assumptions not supported by the evidence and he failed to make appropriate concessions.

256. I do not accept the criticisms made by the Department of Dr Brett's evidence. In my view Dr Brett provided a measured and useful opinion to the Court. There was an issue in relation to Dr Brett's assumption that the full prison health record was available to IHMS staff, but that was not an error on the part of Dr Brett. IHMS only provided information to the Court on the Friday afternoon, two days prior to the inquest hearing commencing, advising that only limited medical records had been provided by NSW Corrective Services in response to IHMS's request following his first prison sentence, and there is no evidence IHMS requested his prison health records during his second period of immigration detention. Given the large volumes of material that came in from all parties on the Friday afternoon (as well as on the Saturday and Sunday preceding the inquest commencing on the Monday morning), the Court was unaware of this new information and Dr Brett only became aware of it during questioning from counsel for IHMS during Dr Brett's evidence. Obviously, that was not the fault of Dr Brett and I have taken this new information into account in considering his report and evidence. I do, however, note that IHMS had an opportunity to seek that relevant information when the first set of health records came in and were clearly incomplete, as well as when Mr Al Jhelie went back into immigration detention for the second time, and there is no explanation as to why that did not occur.[326]

257. Dr Brett acknowledged in his report that "mental health issues and management are complex in detention centres. There is a higher prevalence of mental health and trauma related issues"[327] in that setting. Dr Brett also acknowledged that trauma is something which is often poorly managed in the public mental health system as well.[328]

258. In relation to Mr Al Jhelie, Dr Brett indicated that it was very difficult for him to get an understanding of Mr Al Jhelie's strengths and weaknesses and a sense of him as a person from the medical records. However, he expressed the opinion that from all the information available to Dr Brett, it seemed that Mr Al Jhelie had a trauma spectrum disorder and he used substances to try and manage the symptoms that he was experiencing. Dr Brett also expressed the opinion that the manner in which Mr Al Jhelie was managed in the last few months of his life "would have exacerbated his mental health issues,"[329] particularly given he was separated from his support system and he had been sent to the other side of the country, which probably would have increased his expectation that he would be deported.[330]

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[325] Written Closing Submission of the Commonwealth of Australia filed 26 November 2021, [126].
[326] T 67.
[327] Exhibit 1, Tab 52, p. 9 [1].
[328] T 44.
[329] Exhibit 1, Tab 52, p. 9 [64], [3].
[330] T 46; Exhibit 1, Tab 52, p. 9, [4].

259. Dr Brett considered the decision to move Mr Al Jhelie at short notice was "a bad decision from a clinical perspective."[331] Dr Brett was complimentary of the work being done by the clinicians in Villawood shortly prior to Mr Al Jhelie's transfer,[332] and he considered that moving Mr Al Jhelie away from the team who were engaging with him would not have helped. Dr Brett expressed the opinion that if a comprehensive psychiatric review had been performed with Mr Al Jhelie immediately prior to that move, including input from psychology and drug and alcohol services, as well as Mr Al Jhelie and his nominated family and friends, it is likely the clinicians would have advocated against his transfer to Perth.[333] However, Dr Brett acknowledged he was not privy to the rationale for the decision to move him.

260. While Dr Brett did not have all the necessary information available to him, particularly given some of it was not available even to the Court until the inquest, it is clear that even with all of the available evidence, that opinion is well-founded. Mr Al Jhelie was engaging with a psychologist and drug and alcohol services in Villawood and appeared to be forming a therapeutic alliance (which Dr Brett indicated was important and takes time to develop), so it was unfortunate that he was removed from those supports and sent to Yongah Hill. Importantly, Ms Tinsley, who was the most vocal proponent of the transfer, acknowledged in her evidence that if she had been aware of these supports being provided to Mr Al Jhelie by IHMS staff, she may well have not sought the transfer.

261. Dr Brett also gave evidence at the inquest that if, as was suggested, the primary reason to transfer Mr Al Jhelie was to disrupt his drug supply, then that increased his risk, as his ability to take the drugs and self-medicate for his trauma was taken away, causing him to resort to other methods to deal with his trauma on his own. Dr Brett noted that without access to drugs Mr Al Jhelie was more likely to cut himself as it has a similar effect to drugs when dealing with trauma symptoms. Dr Brett commented that this removal of him from one environment to another to limit his access to drugs, while not providing any other supports, was demonstrative of the unsophisticated manner in which Mr Al Jhelie was managed.[334]

262. While acknowledging that the clinicians at detention facilities work in very difficult situations with very difficult clients, Dr Brett expressed the opinion that Mr Al Jhelie was not getting the clinical management that he required at the time of his death, following his move to Perth. Ideally, Mr Al Jhelie should have been offered regular psychological counselling, with possible adjunctive medication.[335] That does not appear to be disputed by IHMS, in the sense that it was acknowledged by their own medical director, Dr Page, that Mr Al Jhelie should have had follow up with regular mental health supervision and drug and alcohol counselling after his transfer.[336] Dr Brett gave evidence that in his opinion the transfer increased Mr Al Jhelie's risk

[331] Exhibit 1, Tab 52, p. 10, [7.]
[332] T 45 – 46.
[333] Exhibit 1, Tab 52, p. 11 [14].
[334] T 47,
[335] T 84; Exhibit 1, Tab 52, p. 10 – 11 [11].
[336] T 545 - 546.

to himself,[337] so it was particularly important that there was thorough mental health follow-up, but in fact none whatsoever was provided.

263. As to the events on 2 September 2018, Dr Brett expressed the opinion that, "in retrospect, a more detailed mental health assessment and a formal risk assessment should have been performed."[338] In particular, a period of close supervision might have been beneficial. Dr Brett expressed this opinion with knowledge of the Mr Al Jhelie's history and the particular presentation on the day, with cutting a quite common behaviour in people with a trauma history to try and ease the pain they are experiencing and it has an association with an increased risk of suicide.[339] However, Dr Brett acknowledged that at the time, there was scant information available to the clinicians (the two nurses) who were on duty and they were possibly unaware of the triggering events of his breakup with his girlfriend and the limiting of access to his phone.[340] Therefore, the nurses "were put in a very difficult situation."[341] Dr Brett also suggested that the environment that Mr Al Jhelie was taken, namely a public dispensing area, was inappropriate for any kind of mental health consultation and not likely to elicit the important information about the break-up and locking of his phone that escalated Mr Jhelie's risk to himself.[342]

264. I make the comment at this stage, that having viewed all the evidence and having heard from Nurse Paterson at the inquest, I am satisfied that she was doing her best to offer support and empathy to a young man who appeared troubled. She had very limited information available to her at the time she spoke to Mr Al Jhelie, and also very limited time in which to try and offer him some support. Nevertheless, she did the best she could in the circumstances to engage with him and offer to speak to him privately. When Mr Al Jhelie declined, she took steps to ensure he would be followed up the next day and offered a full mental health assessment. I consider Nurse Paterson's conduct was reasonable, caring and appropriate in the circumstances, with the limited information and resources available to her at the time and noting that she had been put in a difficult position as the usual procedure of calling the HAS line had not been followed. As Dr Brett has noted, if a proper mental health assessment had been conducted, and a plan formulated, when Mr Al Jhelie had first come to Yongah Hill, then a clinician like Nurse Paterson would have been placed in a better position to deal with Mr Al Jhelie in an emergency.

265. Dr Brett also agreed that, in all likelihood, if Mr Al Jhelie had been in the community and presented to a hospital emergency department in similar circumstances, he would in all likelihood have been reviewed by a psychiatric liaison nurse and then sent home with instructions for follow up with his GP.[343] While even in the community, Mr Al Jhelie would obviously have had the option of declining mental health follow up, Dr Brett expressed his opinion on the basis of Mr Al Jhelie's tendency to minimise his mental health issues arising from his trauma and refugee status, which made it even more important for the same staff to spend time with him and to engage

[337] T 82 - 83.
[338] Exhibit 1, Tab 52, p. 10 [9].
[339] T 43.
[340] T 83 – 84.
[341] T 51.
[342] T 40 – 41, 84 - 85.
[343] T 71.

with him in order to develop a therapeutic alliance and formulate a plan for any emergencies. There had been no efforts to do so in Yongah Hill prior to the incident on 2 September 2018. There was no plan in place for the nurses to follow, and the circumstances on the day were not designed to gain Mr Al Jhelie's confidence in such a short time.[344]

266. Dr Brett was also asked by me at the inquest about the effect his ongoing abdominal pain and ulcerative colitis would have had on Mr Al Jhelie. Dr Brett gave evidence that undiagnosed health conditions can make a person's mental health worsen, as they can catastrophise and assume the condition is something more serious, which may have explained Mr Al Jhelie telling people he had cancer.[345] Dr Brett also noted that Mr Al Jhelie may well have been using illicit drugs to manage his pain for this issue, as well as for his trauma. Therefore, the lack of early follow-up with a doctor for Mr Al Jhelie's bowel issues, would not have assisted his mental health during the time he was at Yongah Hill. I note Mr Al Jhelie was eventually reviewed by a GP three weeks after his arrival at Yongah Hill, and he raised his 16 month history of rectal bleeding and failed colonoscopy, prompting the doctor to order more tests. However, two days later Mr Al Jhelie was taken to hospital for the same kind of issues, returning to the detention centre the day before his hanging attempt. Mr Al Jhelie still had no diagnosis for his symptoms at that time, which possibly preyed upon his mental state even further.

267. It was very clear from Mr D's evidence that Mr Al Jhelie was suffering from significant pain in his stomach that was causing him ongoing distress in the time leading up to Mr Al Jhelie hanging himself. Mr D believed this played a significant role in his decision to commit that act, separate to what was happening with Mr Al Jhelie's girlfriend.[346] Dr Lienert also agreed in his evidence that the fact that Mr Al Jhelie had a chronic health problem that was possibly Crohn's disease, and had more than one hospital attendance due to gastrointestinal pain, would indicate that Mr Al Jhelie was finding it distressing.[347]

268. Ultimately, Dr Brett expressed the opinion that the standard of mental health care provided to Mr Al Jhelie in the month or so of his life, when he was transferred to Yongah Hill away from his support and then given no structured mental health or drug and alcohol follow-up, was below the standard that would be expected in the community.[348] Dr Brett expressed the opinion that the, "transfer was the critical thing"[349] as Mr Al Jhelie lost hope, as the transfer, "was a line in the sand that things weren't going to get better"[350] This was also in the context of the long delay in the psychiatric assessment for the visa revocation review, although Dr Brett was unaware of this additional layer to Mr Al Jhelie's mental state.

269. Dr Lienert was asked his opinion on whether the standard of mental health care was below community standards. Dr Lienert indicated that the fact Mr Al Jhelie was not

[344] Exhibit 1, Tab 52, p. 11, [10] – [17].
[345] T 50.
[346] T 99; Exhibit 1, Tab 28, Statement signed 18.10.2021, [27].
[347] T 401.
[348] T 47; Exhibit 1, Tab 52, p. 11 [17].
[349] T 48.
[350] T 48.

seen or assessed for a month was possibly not best practice, but considering the reality of mental health services in NSW, he did not think it was outside the timeframe that might occur in the community given how stretched community mental health services are at the moment. However, Dr Lienert did acknowledge that, given what had been documented by the GP in Villawood, shortly before Mr Al Jhelie was transferred, he would have hoped that Mr Al Jhelie would have been followed up when he arrived at Yongah Hill. Nevertheless, as would happen in the community, Dr Lienert noted that if a detainee became acutely distressed, they could present to the medical clinic voluntarily or be transferred to hospital on request.[351]

The AAT ordered Psychiatric Report

270. As I noted earlier, it was the Department's responsibility to obtain the psychiatric report directed by the AAT and I note the conclusion of the Detention Assurance Review that the Department took an unnecessarily complicated approach to obtaining the report. In addition, Mr Al Jhelie was repeatedly incorrectly told that he would need to arrange for the report to be prepared himself.[352] The email exchange indicates his case officer was still telling Mr Al Jhelie it was his responsibility to obtain the psychiatric report on 17 May 2018, despite the fact that a Senior Legal Officer from the Department had made it very clear on 10 February 2018 that it was the responsibility of the Department to obtain the report as soon as reasonably practicable once Mr Al Jhelie returned to detention.[353]

271. The Case Officer's file note of her conversation with Mr Al Jhelie on 17 May 2018 indicates that Mr Al Jhelie told her he was trying to arrange an appointment with a psychiatrist at Villawood and when she confirmed he did not have a pending psychiatric appointment, he asked his case manager if she knew another way to obtain the report. She suggested he would need to "arrange for a private psychologist to attend the centre and it would most probably be at his own expense,"[354] which was clearly wrong. The case manager then told Mr Al Jhelie that it was difficult to progress his case at that stage and he indicated he understood and knew he needed to obtain the report. It must have been extremely frustrating and upsetting for Mr Al Jhelie to be told it was his responsibility to arrange the report, without any sensible advice as to how to go about it, and to be left feeling like it was his fault that he could not progressing his matter being determined.

272. Thankfully, on 18 May 2018 the Senior Legal Officer who had previously explained the need for the Department to obtain the report became involved in the discussions and it was agreed that a psychiatrist assessment and report would need to be arranged by the Department, and IHMS should be requested to arrange it.[355] I note that Mr Al Jhelie had been in detention since 1 March 2018, and the Department had known of its responsibility to arrange the psychiatric report when he returned to detention,

[351] T 413 - 414.
[352] Exhibit 17, Tab 2 to Tab 4.
[353] Exhibit 17, Tab 2, p. 5 and Tab 4, p. 17 and Tab 6 and Tab 9, p. 41.
[354] Exhibit 17, Tab 6, p.24.
[355] Exhibit 17, Tab 7.

from at least 10 February 2018, and yet nothing had been done other than to try and shift the responsibility on to Mr Al Jhelie.[356]

273. IHMS were not formally requested to obtain the psychiatric report until 21 May 2018. The Department asked IHMS to provide the report by 29 May 2018, which was obviously unrealistic. It was indicated that arranging a forensic psychiatry review was outside the usual role and scope of work provided by IHMS, but efforts were made to facilitate the request. After seeking some clarification from the Department, IHMS were advised of the particular requirements of the report and they indicated it would require referral to an external forensic psychiatric specialist.[357]

274. Further advice was sought by the Department from counsel who represented the Department at the AAT proceedings. As part of those discussions, it was noted that the timeframe would be about six weeks to arrange the report, unless it was deemed urgent. It was suggested that, since almost two months had passed since Mr Al Jhelie had transferred to immigration detention, it was advisable for the Department to arrange the assessment as soon as practicable, but six weeks was not unreasonable.[358] IHMS were, therefore, asked on 22 May 2018 to try to arrange the report within six weeks. IHMS responded they would provide an indicative time frame, once an appropriate provider had been engaged.[359]

275. I acknowledge that efforts were then made by a number of people in the Department, including the Senior Legal Officer previously mentioned and the Acting Manager of the Revocations Team to progress the matter, with the Acting Manager noting on 15 June 2018 that he did not want Mr Al Jhelie "needlessly waiting in detention."[360] Unfortunately, the matter continued to drag on.

276. It appears Mr Al Jhelie was still under the mistaken impression that his psychiatric appointment with Dr Lienert on 13 June 2018 may have been the appointment he needed, despite Dr Lienert explaining to him otherwise. There is a record that Mr Al Jhelie called his SRO, Ms Ishak, on 27 June 2018 and advised "he had an appointment with the psychiatrist a few weeks ago."[361] She told him to pass the psychiatrist's information on to the NCCC. Ms Ishak also emailed the NCCC, who confirmed that Mr Al Jhelie had contacted them the day before to advise that he had seen a psychiatrist and thought the appointment went well. Staff from the Department then attempted to obtain the psychiatric report from IHMS. They were advised by IHMS on 28 June 2018 that this appointment was not the forensic psychiatrist review and that IHMS were still in the final stages of engaging a provider to do the review and prepare the report.[362]

277. Mr Al Jhelie's SRO at the time, Ms Ishak, gave evidence at the inquest that she was aware that the psychiatric report was needed to be actioned in order for his case to progress and that she was aware other people in the Department were involved in

[356] Exhibit 17, Tab 2, p. 5.
[357] Exhibit 7, pp. 112 - 113; Exhibit 17, Tab 10.
[358] Exhibit 17, Tab 9.
[359] Exhibit 7, pp. 112 – 113.
[360] Exhibit 17, Tab 10, p. 47.
[361] Exhibit 17, Tab 16, p. 73.
[362] Exhibit 17, Tab 17, pp. 75 – 76.

arranging it.[363] Other than sending an email to someone at the NCCC on 27 June 2018, and encouraging Mr Al Jhelie to also contact the NCCC, Ms Ishak did not take any further action herself in this regard, stating that "organising that wasn't really in the scope of my role."[364]

278. IHMS then advised the Department on 6 July 2018 that the forensic psychiatrist appointment for Mr Al Jhelie would not be scheduled for a few more weeks as the psychiatrist was still undergoing security processing prior to being able to undertake the review.[365]

279. Some Department staff rightly expressed their concern at this news, noting that "this has taken months and still no appointment. The AAT Direction was set on 24 January 2018 and Mr Al Jhelie is held in detention."[366] Concerns were also raised about his recent first drug overdose, and whether this required an additional report on his physical health as well as his mental health.[367]

280. On 20 July 2018 IHMS confirmed that a Sydney based forensic psychiatrist had been subcontracted to attend Villawood to assess Mr Al Jhelie and complete a report to meet the AAT's order. However, it was indicated that the AFP security check was still underway and was likely to take several weeks. IHMS asked the Department whether it would consider dispensing with the police check requirements. Some attempts were made to try to expedite the AFP check so that an appointment could be booked in as soon as possible.[368] On 1 August 2018, the forensic psychiatrist submitted and Australia Federal Police Check with 'National Crime Check'. IHMS were unable to expedite the check.[369]

281. IHMS' Centralised Service Team were also instructed by Detention Operations on 1 August 2018 that Mr Al Jhelie was being transferred to Yongah Hill in the week commencing 6 August 2018.[370]

282. As previously noted, IHMS completed a 'Fitness to Travel' for Mr Al Jhelie to travel to Yongah Hill on 2 August 2018. The Fitness to Travel did not refer to Mr Al Jhelie's pending upcoming forensic psychiatry review. It is apparent that the Department's Detention Operations staff, who were arranging the transfer, were unaware of this pending appointment when making the transfer arrangements and felt the information should have been included by IHMS in the Fitness to Travel.[371]

283. Dr Page gave evidence on behalf of IHMS that she would have expected a pending forensic psychiatry appointment would be noted on the Fitness to Travel.[372] However, because the appointment had not yet been scheduled, there was no

[363] T 473; Exhibit 6, Tab 13, ST - 3.
[364] T 473.
[365] Exhibit 17, Tab 20, p. 93.
[366] Exhibit 17, Tab 21, p. 103.
[367] Exhibit 17, Tab 21, p. 101 – 103.
[368] Exhibit 17, Tab 22, p. 111 and Tab 23.
[369] Exhibit 7, Tab 17, p. 105.
[370] Exhibit 10.
[371] Exhibit 7, Tab 12, p. 87.
[372] T 543 – 544.

reference to it in the Apollo records and that was most likely why this information was not included in the Fitness to Travel documentation.[373]

284. The day after Mr Al Jhelie was transferred to Yongah Hill, the information about Mr Al Jhelie's pending appointment with a forensic psychiatrist was raised with National Detention Placements (ABF), with a request that he be returned to Villawood to facilitate the mental health assessment. I note that although IHMS had not included this information in the Fitness to Travel, some of the Department's staff (which in theory includes ABF who are part of the Department of Home Affairs) were well aware that this was being arranged and was urgent. The problem is, the Department is so enormous, with so many different components who apparently don't speak to each other, that one part of the Department is unaware of what the other is doing. This is apparent from the email of the Senior Legal Officer who had been attempting to facilitate the report's preparation. He expressed his surprise to hear that Mr Al Jhelie had been moved to Yongah Hill, without any prior advice, and the need to return him to Villawood so the psychiatric assessment could be completed. At that stage, IHMS were advising that the security check was expected to be finalised around 11 to 13 August 2018.[374]

285. There was some obvious resistance from the Detention Placements staff to the concept of returning Mr Al Jhelie to Villawood, given he had only just been transferred and the transfer was undertaken on the basis it was necessary for his safety as he was at risk of a further overdose if he remained at Villawood. It was queried whether the assessment could be done in Western Australia instead. On 15 August 2018, it appears that suggestion succeeded, and it was agreed that the psychiatric assessment would take place at Yongah Hill. However, this inevitably led to further delay in the psychiatric assessment taking place.[375]

286. In the end, an appointment was scheduled for 3 September 2018 with a new external provider in Western Australia. There is nothing to indicate that Mr Al Jhelie was advised of this upcoming appointment. As noted above, his new SRO was unaware that a psychiatric review was even required, and she did not have any contact with him, so he did not have an opportunity to raise it with her. Mr Al Jhelie hanged himself the day before the psychiatric appointment was scheduled and was in hospital, critically unwell, on 3 September 2018. After all of that, the appointment had to be cancelled.

287. IHMS submitted at the conclusion of the inquest that the evidence before me indicated that there was a lack of clarity and communication amongst the various stakeholders about the need for, and arrangement of, the forensic psychiatry review and report. I agree with this submission. It was also submitted that IHMS did not appear to have contributed to any delay in respect of the arrangements for the report.[376] I'm not as convinced by this submission, as there does appear to have been some pushback from IHMS in the early stages of being requested to obtain the report and there also seems to have been a general lack of urgency to get the report done

[373] T 600 – 601.
[374] Exhibit 7, Tab 17, pp. 103 - 104.
[375] Exhibit 7, Tab 5 and Tab 12, pp. 81 – 87.
[376] IHMS Submissions filed 26 November 2021.

quickly. However, I do agree that the primary responsibility for the delay rests with the Department, as it took the Department a considerable period of time to appreciate that they were required to make the arrangements and to make the request of IHMS, and the Department also contributed to the delay again by transferring Mr Al Jhelie even though there were staff within the Department who were aware of the impending appointment but were not consulted.

288. I have set this chronology out in detail, as it shows how miscommunication and misunderstanding led to unnecessary delay in obtaining the report, as acknowledged in the Detention Assurance Review. It also demonstrates that Mr Al Jhelie was aware that the psychiatric assessment and report was required for his matter to be reconsidered and he was told for months by the Department that it was his problem to fix, even though it was made very clear at an early stage that this was not the case. Mr Al Jhelie did his best, while held in detention and wholly unfamiliar with the processes, to try and arrange this. He appears to have thought he had achieved his aim when he saw Dr Lienert, although Dr Lienert tried to explain to him otherwise. Then he heard nothing.

289. Mr Al Jhelie does not appear to have been kept informed of what was happening with the obtaining of the psychiatric report after that. He contacted his SRO, Ms Ishak, on 19 July 2019 to express his frustration with the time taken for the psychiatric review process to be completed, and she simply told him that she had no new information and suggested he contact the NCCC.[377] Ms Ishak had explained her role as an SRO was to assist in ensuring that any barriers to status resolution were identified and addressed to ensure that resolution was progressed in a timely manner.[378] Ms Ishak agreed in questioning that the psychiatric report was a barrier to his status resolution, and she was asked then what steps she had taken to ensure that the report was actually being prepared. Ms Ishak gave evidence that she did recall having conversations with the case officer at NCCC and asked about the psychiatric assessment, but she agreed she had not made any records of those discussions, so there is no contemporaneous proof they occurred.[379] It also seems clear that Ms Ishak did not tell Mr Al Jhelie about those interactions and would refer him to the NCCC rather than trying to proactively find out information to report back to him.

290. I certainly accept the submission that Ms Ishak could have done more to assist Mr Al Jhelie and advocate for the barriers to his status resolution to be resolved, noting she understood it was her role "to ensure that things were progressing"[380] and they psychiatric assessment was an unusual request.[381] Given she was the primary 'face to face' Department contact for Mr Al Jhelie, it is apparent Mr Al Jhelie turned to her to express his frustrations about the delays and look for help, but the assistance and information he received in response was very limited. Ms Ishak indicated she considered this was the role of the case officer and she directed Mr Al Jhelie to them, but I note that Ms Parise, who I mention below, indicated that she would sometimes seek updates from the case officers on the detainee's behalf.[382]

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[377] T 483; Exhibit 6, Tab 13, [35] and ST-3.
[378] Exhibit 6, Tab 13, [16].
[379] T 485.
[380] T 472.
[381] T 484.
[382] T 497 – 498.

291. After Mr Al Jhelie was transferred to Yongah Hill he was allocated a new SRO and there appears to have been no handover between Ms Ishak and the new SRO, Ms Parise. Ms Parise was, therefore, unaware that the psychiatric report was required to progress his matter, despite the importance of this issue to Mr Al Jhelie's status resolution.

292. The Department submits that, whilst receipt of the psychiatric report was necessary for the decision to be made as whether or not to revoke the cancellation of Mr Al Jhelie's visa (and thereby end his indefinite period of detention and give him an answer as to whether he would be able to go back to living with his family in New South Wales or potentially be deported), there is no evidentiary basis for me to conclude that the failure to arrange this report in a timely manner was connected with Mr Al Jhelie's death. I disagree.

293. I note in another inquest relating to the death of a detainee held in an offshore immigration detention facility, psychiatric evidence was led in relation to the increased risk of suicidality in the refugee population, noting the "population have established mental health problems because of being indefinitely detained and their predicament being very uncertain, and the circumstances of the environment of immigration detention, which is disempowering and dehumanising."[383] Whilst the population in the relevant facility have some difference in their circumstances, in my view those comments still ring true for Mr Al Jhelie.

294. Similarly, in her findings into the deaths of three men being held at Villawood in 2010, the NSW State Coroner heard expert evidence about "the frustration, resentment and feelings of powerlessness and helplessness at being in immigration detention. These feelings have a potent capacity to exacerbate depressive disorders which in turn will exacerbate these feelings."[384] Her Honour observed that it "is surely stating the obvious that persons detained in Immigration Detention Centres must, by the nature of their various situations, be at much greater risk of suicide than the general community. Loss of families, freedom, status, work and length of time must all play their part. The corollary of that is that those responsible for detainees owe a greater than normal duty of care to those persons regarding their health and well being."[385]

295. With respect, the Department's submission that the evidence indicates only that "the matters which were weighing on Mr Al Jhelie's mind in the period immediately prior to his death related to the break-up of his relationship with his girlfriend, the fact that she had blocked his mobile phone, and the fact that it was Father's Day," takes a very naïve approach to the complexity of Mr Al Jhelie's situation. This was a young man with a known substance abuse problem and history of depression and trauma, who was far from his family and any other supports in an unfamiliar environment where he had no control over what was happening to him and no idea when he might

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[383] *Inquest into the death of Omid Masoumali,* 2015/1752, delivered 1 November 2021 (Qld State Coroner Ryan), [245].
[384] *Inquests into the deaths of Josefa Rauluni, Ahmed Obeid al-Akabi and David Saunders* delivered 19 December 2011 (NSW State Coroner Magistrate M Jerram), p. 10.
[385] Ibid.

be released, and to where. Mr Al Jhelie had no timeframe for how long he was to be held in detention, no official indication of whether his matter was progressing well or badly other than being moved to Yongah Hill and being given a procedural fairness letter that would very likely have given him the impression that his application was not going well. Before he was transferred, he had been having ongoing bowel issues without a diagnosis, had told someone he thought he might have cancer and was noted to have lost a lot of weight, which might well have fed into his fears and catastrophising when he continued to suffer significant abdominal pain at Yongah Hill. While I accept that the events with his girlfriend on 2 September 2018 were triggering events, they can't be considered out of the context of the overall hopelessness of his situation. Dr Brett gave expert evidence to that effect, but it is also really just common sense for anyone with any understanding of human nature.

296. Suicide is well known to be a complex phenomenon, with many factors usually contributing and the risks fluctuating at any given time. For the Department to suggest that only the events on the day are relevant to Mr Al Jhelie's fateful decision is frankly wrong and contrary to the weight of the evidence. Given the Department has ultimate responsibility for a population of detainees who are statistically, at greater risk than the general community of mental health issues and suicidal risk, it is very concerning that the Department would consider it appropriate to make such a simplistic submission.

297. I am satisfied that the failure of the Department (and to a lesser extent IHMS) to obtain the psychiatric report in a timely manner, as ordered by the AAT, was a circumstance connected to the death of Mr Al Jhelie. I note that if the report had been obtained earlier, it would have created the opportunity for the decision as to whether Mr Al Jhelie's visa should be reinstated to be considered at an earlier stage. While I accept that it is speculative as to whether Mr Al Jhelie would, as a result, have then been released from detention, it cannot be ignored that the opportunity was denied to him by the delay. Even, perhaps, if someone from the Department or IHMS had made the effort to inform Mr Al Jhelie that he was to see a psychiatrist the next day, that may have been enough to give him some hope that his circumstances might change. Unfortunately, that did not occur.

298. I understand that the recommendations of the Detention Assurance Review will hopefully ensure that if a similar order is made in the future, there will be greater clarity as to where the responsibility lies and the necessary procedures to be followed, so that a similar delay is unlikely to occur.

299. I also note that there appeared to have been a lack of information sharing between the Department's SRO and the Case Officers at the NCCC, before and after Mr Al Jhelie's transfer, in relation to the pending psychiatric report that was relevant to the resolution of his immigration status. I accept it was an unusual situation, but that suggests to me that the staff involved should then have done more to ensure that the people involved in Mr Al Jhelie's case were kept informed. They were able to pass on the need to provide the procedural fairness letter fairly quickly, so it's unclear why other relevant information couldn't also be communicated. I understand from the Department's submissions that the Department is a very large bureaucracy with different information silos, but in my view, it is entirely unhelpful for an SRO to

have no idea about what impediments there are to a particular detainee's status resolution. I make no criticism of Ms Parise, who did not have an opportunity to personally see Mr Al Jhelie and had no idea the psychiatric review was even required. In relation to Ms Ishak, I understand that she was working on the basis of what she considered to be her role, so my criticism is in relation to how the Department structures the role rather than her personal conduct. An SRO, who is seeing a detainee face to face, should be equipped with information that helps them to inform the detainee of the progress of their matter in a meaningful way, rather than having to divert them off to other people within the Department.

300. I accept the submission made on behalf of Mr Al Jhelie's family that the manner in which Mr Al Jhelie's visa status was managed would have left him in an extreme state of uncertainty and exacerbated his mental health issues.

Decision to Transfer to Yongah Hill

301. The Department also submits that there is an absence of evidence to show that the decision to transfer Mr Al Jhelie was connected to his death. Again, I do not accept that submission. As set out above in the recitation of the factual evidence, there was evidence before me that after arrival at Yongah Hill, Mr Al Jhelie was seen on 7 August 2018 as part of his admission and indicated he was unhappy about the transfer to Yongah Hill and away from his family in NSW.[386] He told his brother he was scared, and other detainees were aware during the time he was there that Mr Al Jhelie was unhappy about being away from his family.[387]

302. The decision to transfer Mr Al Jhelie to Yongah Hill also had the unfortunate result of delaying his psychiatric review, which I have indicated above, I consider connected to his death and took him away from the health practitioners with whom he was engaging following his second overdose. As noted above, continuity is an important part of the therapeutic relationship in drug and alcohol counselling and mental health treatment.

303. I accept that the Department's staff, in particular Ms Tinsley, pressed for the transfer as they were unaware that there were health services being provided to Mr Al Jhelie that were designed to reduce his risk of a third overdose. It is very unfortunate that this kind of information sharing did not occur. While I accept there are privacy elements involved, I can see no reason in that context why IHMS could not simply have informed Ms Tinsley that IHMS staff were treating the overdoses seriously and providing follow-up care to Mr Al Jhelie. Ms Tinsley gave evidence she sought this kind of reassurance from IHMS staff, both at the meeting she attended and through Detention Health services but did not receive it. If she had known what was already being provided to Mr Al Jhelie, this might well have influenced her decision-making and led to a different approach being taken by ABF. Ms Tinsley gave evidence that when she found out about Mr Al Jhelie's death, she was not surprised as she had been very concerned he was at high risk of sudden death, but she was also "very

[386] Exhibit 2, Tab 1, Self Harm Assessment Interview 7.8.2018.
[387] Exhibit 5.

disappointed."[388] It was very clear that Ms Tinsley had been trying her best to keep Mr Al Jhelie safe, and believed that she had been left with no other option but to transfer him in order to try to do so, but her efforts were in vain.

304. There is also the issue that there was no information sharing amongst relevant staff in IHMS and the Department about the pending psychiatric review, which meant that the decision to transfer Mr Al Jhelie was made without any appreciation that it would further delay his psychiatric review. I'm told the information about the pending psychiatric appointment, which still did not have a set date, could have been included in the special considerations section, but it wasn't as it hadn't been entered into the Apollo records system, so it seems it was overlooked by the person who prepared the form.[389]

305. It was noted in the Detention Assurance Review that Mr Al Jhelie's SRO and the NCCC staff were for some reason not included in the discussions about transferring Mr Al Jhelie. Indeed his SRO only became aware of it when they went to Villawood to deliver a procedural fairness letter to Mr Al Jhelie on 7 August 2018 and were told that he had been transferred to Yongah Hill that morning.[390] This also meant that he received that letter, which was likely to have had a negative effect on his mindset, after he had been moved to Yongah Hill, away from family and other supports and possibly thinking the transfer itself was a negative indicator of how his immigration status resolution was progressing.

Medical Care at Yongah Hill

306. Before his transfer from Villawood to Yongah Hill, Mr Al Jhelie was scheduled to receive regular mental health and drug and alcohol reviews, on the background of his two recent drug overdoses. Submissions filed on behalf of Mr Al Jhelie's family acknowledge that the approach of IHMS to Mr Al Jhelie's mental health care while he was in Villawood was very good,[391] and certainly in relation to that last period of time before his transfer in particular, I agree. As noted in the submissions filed on behalf of the family, regrettably, the same cannot be said for the way in which Mr Al Jhelie's mental health was managed at Yongah Hill. It is also noted that IHMS does not largely dispute this conclusion, although it is characterised in submissions as a "missed opportunity" only, which I think was a term adopted from comments I made during the inquest hearing.[392]

307. When he arrived in Yongah Hill, Mr Al Jhelie did not receive a health induction assessment. It was suggested by IHMS in submission that this was because he was a transferee rather than a new detainee, although this appears to be inconsistent with the Department's view of the required policy, as noted in the Detention Assurance Review. In any event, the Health Services Manager at Yongah Hill would have been made aware of his arrival, which should have prompted a review of his Apollo record. Even without that occurring, the Health Transfer Summary could also have

[388] T 449.
[389] T 542; IHMS Submissions filed 26 November 2021.
[390] Exhibit 6, Tab 2, p. 35.
[391] Closing Submissions on behalf of the family of the late Mr Al Jhelie, filed 30 November 2021, [29].
[392] Closing Submissions on behalf of the family of the late Mr Al Jhelie, filed 30 November 2021, [30].

provided the key relevant information, as I note it included a summary of the GP review on 31 July 2018 that recommended regular mental health counselling and close observation from the drug and alcohol team.[393] In addition, Dr Page gave evidence that a verbal clinical handover should have taken place between the Villawood Health Services Manager and the Yongah Hill Health Services Manager.[394]

308. All or any of these processes should have identified that Mr Al Jhelie needed follow-up for a colonoscopy referral as well as ongoing regular mental health supervision and drug and alcohol counselling. Dr Page gave evidence appointments for these services should have been made within the first week of his transfer and she was unable to find an explanation for why they were not on this occasion.[395]

309. Dr Lienert, the Consultant Psychiatrist who had seen Mr Al Jhelie on one occasion in June 2018, also agreed that once a care plan had been put in place in Villawood, he would have expected the plan to continue at Yongah Hill. Dr Lienert commented that "continuity of care is a very important principle when managing mental health conditions and, so much as practicable, you want to maintain, "ongoing care utilising the same kind of treatment modalities and as much as possible with the same staff obviously."[396] Clearly, once transferred to Yongah Hill, the staff would have to change, but Dr Lienert said he "would hope that the same kind of care plan … I continued."[397] Dr Lienert said his expectation would be that on arrival at Yongah Hill, Mr Al Jhelie would have had a health transfer assessment where somebody spoke to Mr Al Jhelie, reviewed the notes to see the treatment previously provided at Villawood and then talked to him about that previous treatment and put a plan in place for his new setting.[398]

310. Dr Lienert gave evidence that it is "part of our professional obligation to develop a treatment plan" and that plan should always be developed at the end of an assessment of the person. The plan might not involve active treatment or monitoring and may only be about giving the person information about how to re-access the services. However, there is still a plan. In Mr Al Jhelie's case, once he was transferred to Yongah Hill, that plan was sadly non-existent.

311. In terms of Mr Al Jhelie's behaviour around this time, Dr Lienert commented that anybody who had attempted self-harm, including taking a minor overdose, is in a higher risk group of completing suicide. A person who cuts themselves also falls into a higher risk group, although the vast majority of them are not going to complete suicide.[399] Dr Lienert also gave evidence that a previous history of depression is a strong predictive factor for a later successful suicide.[400]

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[393] Exhibit 10, Health Transfer Summary; IHMS Submissions filed 26 November 2021.
[394] T 544 – 545.
[395] T 545 - 546.
[396] T 381.
[397] T 381.
[398] T 405.
[399] T 381.
[400] T 406.

312. Dr Page also accepted, in relation to the two overdoses immediately prior to the transfer that, "even if you assume that an overdose is accidental, if you don't use it as an opportunity to look at the mental health of somebody, then I think that's a missed opportunity because by and large people use illicit medications as a form of self-treatment for psychological distress."[401]

313. Therefore, by the time of the incident on 2 September 2018, there were a number of factors that put Mr Al Jhelie into a higher risk group for a completed suicide, although that information had not been connected by IHMS staff and was not easily available to Nurse Paterson on the day when she sourced the Apollo records.

314. Nurse Paterson only saw him briefly on the afternoon of 2 September 2018 and she did attempt to develop a plan to see him the following day for mental health follow-up, based on her risk assessment that there was no high level of concern for him at that time. Dr Lienert expressed the opinion this was appropriate.[402] However, the difficulty for Nurse Paterson was that she was formulating that plan without the benefit of much of the information that ought to have been available through Apollo, and without anyone seeking to do a fulsome mental health assessment of Mr Al Jhelie before he was in crisis.

315. It was suggested that the Apollo record must have been reviewed (at least in part) as an appointment was scheduled with a general practitioner for 'asthma management plan review,' although in the end the appointment focussed more on the recurrence of Mr Al Jhelie's bowel symptoms. However, it is not disputed that no appointments were scheduled with mental health and drug and alcohol services, despite the plan that was in place in Villawood for regular monitoring. IHMS concedes that there was a missed opportunity for staff at Yongah Hill to re-engage with Mr Al Jhelie within the first few weeks of his arrival.[403] However, IHMS submits, in effect, that there is evidence to suggest that Mr Al Jhelie's mental state during his time in Yongah Hill was generally stable in those weeks, despite the lack of monitoring or support by health staff.

316. Given the known events of his death, I find it difficult to accept a submission that Mr Al Jhelie did not require any mental health follow-up. At the very least, a more concerted effort to provide Mr Al Jhelie with the regular mental health reviews recommended by IHMS staff may have picked up a deterioration in his mood or some red flags, or alternatively, helped equip him with greater resilience to disappointment and distress.

317. I note that Dr Page in her evidence agreed that given his appointments on the east coast, Mr Al Jhelie should have been reviewed within a week of his transfer to Yongah Hill and all of his appointments rescheduled, whereas only his dental appointment was rescheduled. Dr Page could find no reason as to why the rescheduling of the other appointments did not occur.[404]

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401 T 533.
402 T 383.
403 IHMS Submissions filed 26 November 2021.
404 T 554.

318. Dr Page agreed that the breakdown of his relationship was a "time-critical trigger"[405] that was obviously significant and would have increased his level of risk, but that information was not necessarily communicated to IHMS staff when they spoke to him. Unless Mr Al Jhelie was willing to disclose that information, he was unlikely to have been put on one-to-one observation.

319. Dr Page noted that IHMS has a very clearly defined root cause analysis process, and she could not see that one was done in Mr Al Jhelie's case. Obviously an IHMS root cause analysis would have had a different perspective to the Department's internal review, so Dr Page did not think the Detention Assurance Review was an appropriate substitute for IHMS doing its own internal review.[406] Dr Page gave evidence she is actively involved in ensuring that IHMS now does those reviews, as per the policy.

320. The Detention Assurance Review noted that the monthly case reviews by Mr Al Jhelie's SRO during the seven months that he was in immigration detention consistently note an absence of mental health issues, despite the information contained in his medical record. His final monthly case review conducted on 24 August 2018 (21 days after his arrival at Yongah Hill) only includes information on his asthma diagnosis. There were no mental health issues noted and no mention of the previous incidents of self-harm, his drug use or his disclosure of past trauma.[407]

321. Dr Page expressed the opinion that Mr Al Jhelie's possible inflammatory bowel disease was managed appropriately, and that there is a long waiting list for colonoscopies for public patients, which would have contributed to the delay in his treatment. However, from her review of the records she believed he was offered all the appropriate treatments and, in the fulness of time, he would have seen a specialist and been able to access further treatment.[408] However, I do note that there appears to have been little done to progress this once he moved to Western Australia, although I acknowledge Dr Page's comment that he would have been required to commence on a new waiting list once he changed States.[409] This was, perhaps, another reason why his transfer to a different detention facility ought to have been reconsidered from a medical perspective, but this information was obviously not provided to the Department.

322. Dr Gideon De Gouws is the Department's Chief Medical Officer who leads the Chief Medical Officer Branch, which sits within the Department's Health Services Division.[410] A key part of Dr De Gouw's role is to conduct assurance activities in respect of the work done by IHMS within the Department's immigration detention network. The Department's Chief Medical Officer Branch conducted a preliminary internal review into Mr Al Jhelie's case following his death in 2018. The raised concerns, amongst other things, in relation to:[411]

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[405] T 554.
[406] T 556.
[407] Exhibit 6, Tab 2, p. 35.
[408] T 548 – 549.
[409] T 549.
[410] Exhibit 6, Tab 17.
[411] Exhibit 6, Tab 17, p. 226.

- the basis for IHMS' assessment of Mr Al Jhelie's instances of overdoses as 'accidental';
- the irregular occurrence of mental health referrals;
- IHMS' management of detainees who missed mental health appointments; and
- whether IHMS sought the views of the psychologist and physician during the transfer process, and what continuity of care was implemented at Yongah Hill upon Mr Al Jhelie's arrival.

323. It does not seem that these issues were explored further, as there was no process for doing so at the time, although a new process has been implemented since that time. I note many of these issues were, however, addressed in the Detention Assurance Review in any event.[412]

324. On 14 April 2021, the Chief Medical Officer Branch finalised a 'Report on Mental Health in Immigration Detention' that related to Yongah Hill and the Perth Immigration Centre. The review is essentially a desktop audit of the Apollo records on a sample of detainees and is referenced against the RACGP Standards of Detention. A total of 12 recommendations were made to support the improvement of the health service delivery for detainees in those facilities and Dr De Gouws advised in a statement provided at the inquest that six recommendations had been closed and six were still progressing. Some of the recommendations related to areas such as offering referral to torture and trauma services and documenting any refusal, which is obviously relevant to Mr Al Jhelie's case. The recommendations are largely in relation to documentation.

325. In its written submissions filed after the inquest concluded, IHMS confirmed that there have been a number of changes implemented, including ensuring that root cause analyses are now conducted in similar cases, conducting weekly reviews with each of its medical directors to discuss key clinical cases, completing site-based incident reports and reviews and completing national reviews of the incident database.

326. I would suggest that in addition to these changes, IHMS needs to reflect upon the events that occurred with Mr Al Jhelie's transfer, both in terms of a lack of communication with the other relevant stakeholders (including what was happening with planned forensic psychiatric report and the wraparound care that was being provided to Mr Al Jhelie following his second overdose) and the lack of any kind of handover of Mr Al Jhelie's health care plan to the staff at Yongah Hill. These were two key aspects that arose in this inquest, and it is incumbent on IHMS to consider how it can improve this information transfer so that another detainee does not fall into the gaps like Mr Al Jhelie.

327. In conclusion, I find that there was an inexplicable failure on the part of IHMS staff to make any attempt to initiate steps to continue the treatment plan for Mr Al Jhelie following his transfer to Yongah Hill. I am satisfied the lack of mental health and drug and alcohol counselling follow up for Mr Al Jhelie was a likely contributor to his deteriorating mental health in the final weeks leading up to his death, particularly

[412] Exhibit 6, Tab 17, p. 226.

given the destabilising effect of the sudden transfer. I do not make any recommendations arising from those finding, given my comments above.

Supervision

328. A significant issue that arose during the inquest was the question of why Mr Al Jhelie was not put on closer monitoring and observation via the SME process, given the known self-harm incident that afternoon. Dr Page explained at the inquest that anyone can trigger the SME process, including Serco and IHMS staff, so it could have been done by the Serco officers or the two nurses that afternoon. That would have triggered a higher level of monitoring and observation by Serco staff until Mr Al Jhelie could be formally assessed by somebody with mental health training.[413]

329. Dr Page gave evidence that, although the scratches were described as superficial and not requiring a dressing, any form of self-harm would usually be a trigger for somebody to enter an SME process until they have been formally assessed with a full mental health assessment, as there is an increased risk. This would generate an incident report that would go to many people, including the health services manager at the facility. The person to do the incident report would usually be the person who first identifies the issue, so in this case it would most likely have been done by a Serco officer.[414]

330. The Serco officers involved with Mr Al Jhelie on the day suggested that it was unnecessary for Mr Al Jhelie to have been put on formal Keep SAFE, as they had unofficially had him on Keep SAFE until Mr Al Jhelie had been seen by someone with mental health training, and Nurse Paterson, and had given the 'all clear'. Accordingly, they did not generate an incident report or take the matter further formally, as they believed the necessary mental health assessment had already been completed at the dispensary. There was evidence that one of the Serco officers also took it upon himself to check in on Mr Al Jhelie during the afternoon, just as an extra level of monitoring, but not as part of any formal SME monitoring process.

331. The evidence of the Serco officers was that at the time Mr Al Jhelie had returned to his room, they had no further concern about his mental health. He did not say or do anything that suggested to them that he was feeling depressed or suicidal, otherwise they would have reinitiated Keep SAFE and had Mr Al Jhelie assessed again. DSO Hicks gave evidence that when he later was called to the medical emergency involving Mr Al Jhelie, he was very surprised.[415] DSO Walker, who had also escorted Mr Al Jhelie to and from the dispensary and checked on him an additional time at around 4.30 pm, also gave evidence he was surprised when he found out Mr Al Jhelie had hanged himself. Looking back in hindsight, DSO Walker could not point to any signs he missed that suggested Mr Al Jhelie was stressed or agitated or contemplating further self-harm at that time.[416]

[413] T 524 – 525.
[414] T 526 - 527.
[415] T 145 - 146.
[416] T 223, 231.

332. Nurse Paterson, who is an experienced mental health nurse, also gave evidence that when she found out the next day that Mr Al Jehlie had hanged himself that afternoon, she was "very shocked and very saddened."[417] Nurse Paterson confirmed that even in hindsight, there was nothing in her experience to indicate that he was at imminent risk at the time she had seen him, even acknowledging that she only spoke to him very briefly and did not have the opportunity to do a full mental health assessment.[418]

333. In this case, Dr Page gave evidence she would have expected Nurse Paterson to have generated an incident report in Apollo after her interaction with Mr Al Jhelie, if no incident report already existed. However, Dr Page noted that both Nurse Paterson and Nurse Cheema were new to the site and would not have been familiar with all of the policies. Although Nurse Paterson did have experience at other facilities, they were off-shore. Dr Page indicated that if the nurses had directed the Serco officers to call the HAS line instead, this would also have generated an IHMS incident report.[419]

334. Dr Page described what occurred on the day with Nurse Page as what is sometimes referred to as a 'corridor consultation' and not a proper consultation as the person hasn't fully committed to either consulting or not consulting.[420] Whereas the Serco officers regarded it as a mental health consultation, and as a result it was not documented properly by either party and the SME process was not triggered as it should have been. Dr Page commented that it is "a classic reason as to why policies are written and why policies should be followed,[421] as they are, "designed to keep you safe."[422]

335. However, Dr Page expressed the opinion that the nature of the incident was unlikely to have triggered the 'high imminent' SME category, so he would not have had continuous eyes on him if the process had been initiated. The next highest category is 30 minute observations, which meant that Mr Al Jhelie would have had someone checking on him every half an hour.[423] That would obviously have left Mr Al Jhelie with opportunity to commit the act that he did, so even if the SME had been activated, it would not necessarily have prevented his death.

336. Mr Geoffrey Pitout, the current General Manager of Operations at Yongah Hill, gave evidence he agreed with the approach of the Serco officers on the day. Once a concern had been identified, they immediately went to Mr Al Jhelie and remained in his company (effectively putting him on Keep SAFE constant observation for that period) until they had taken him to see the IHMS nurses. Once the nurses had cleared him, Mr Pitout believed there was no further requirement for a form to be completed as the assessment had already been done and Mr Pitout did not believe there were any further triggers to initiate the Keep SAFE process in the afternoon.[424]

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[417] T 246.
[418] T 246 - 247.
[419] T 528, 535 - 536.
[420] T 562.
[421] T 536.
[422] T 537.
[423] T 537.
[424] T 570.

337. Mr Pitout gave evidence that even now, something similar to what occurred in this case has occurred on other occasions in the past, including relatively recently, detainees will be taken to the nursing staff if the nursing staff have the time. Mr Pitout said Serco officers will pick up the phone and ask if they can bring a detainee down to the dispensary, if they have a headache or something similar, and it will depend on the nurses' availability as to whether they agree. He noted that Serco staff will build relationships with the IHMS staff that perhaps makes that sort of formal interaction possible, depending on the individual nurses' discretion.[425] DSO Walker also gave evidence that in his previous experience, when the Serco officers had called HAS on the weekend in the daytime, the HAS call receiver would ask them to go and see the onsite nurses in any event. He would then call the nurses at the dispensary, who might agree to see the detainee or at other times they would tell him to call HAS again. DSO Walker said that circular direction from HAS to nurse and back to HAS "happened constantly."[426] FOM Howell gave evidence that the official procedures were definitely "inconsistently applied, [427] and he had also experienced being told by HAS staff to go and see the nurses at the dispensary on occasion.[428] FOM Howell said he had experienced open fighting between the HAS nurses and the duty nurses over who was going to actually assess detainees.[429]

338. FOM Howell also gave evidence that the previous 24/7 health coverage with onsite staff at Yongah Hill had been preferable for Serco staff, and they were still transitioning to the more limited coverage at the time.[430]

339. It was submitted on behalf of Nurse Paterson that Mr Al Jhelie fell into a gap, which was created when Serco staff failed to follow policy. That policy is based on a contractual arrangement between the Department and IHMS that on weekends the only health services is a telephone advice service and the nurses on site cannot provide any health care other than medication dispensing and emergency care. Nurse Paterson could have insisted the officers follow policy and go and make a HAS call, but she was used to working in a facility where medical help was provided 24/7 and she is clearly a kind and caring nurse, so she did her best to help.

340. In my view, the real problem arises because of the changed contractual arrangement between the Department and IHMS, which means that the previous 24/7 health care available at Yongah Hill (and other onshore immigration detention facilities) is now only a weekday, business hours on site service, other than medication dispensing. It seems to me that a phone advice service after hours is a poor replacement, given the known high prevalence of mental health issues in detention facilities, as observed in other inquest hearings. I was not informed as to the reason for the decision to change the service. I can only assume cost was a factor, although it may also be due to lack of staff or other factors.

341. In terms of whether Mr Al Jhelie's death could have been prevented if the Serco officers and IHMS staff had followed policy and made a HAS call instead, the

[425] T 572 – 573, 578 - 579.
[426] T 225.
[427] T 348.
[428] T 349.
[429] T 367.
[430] T 365 - 367.

evidence does not support that conclusion. Dr Page suggested that the information available at that time made it unlikely that Mr Al Jhelie would have been put on 'high imminent' SME, requiring constant observation. I accept her opinion, noting that Dr Lienert and Dr Brett gave similar evidence in the sense that his indication that he was feeling better and did not want immediate treatment would probably have been taken at face value and he would have been marked down for general follow-up, even if he had been seen by a psychiatrist or taken to an emergency department and seen by a psychiatric liaison nurse. Mr Al Jhelie was likely to have been subject, at most, to intermittent checks by Serco officers. That is, in effect, what happened anyway as DSO Walker took it upon himself to check in on Mr Al Jhelie prior to ending his shift. Mr D was with Mr Al Jhelie until not long before he hanged himself, and he had not shown any sign of being suicidal. Sadly, as is well known, many acts of suicide are impulsive, and it seems that is the case for Mr Al Jhelie. His death is tragic, and there were certainly steps that could have been taken in the lead-up to 2 September 2018 that might have reduced the risk that he would take his own life, but on the day in question I am satisfied that even if procedures had been followed, the outcome was unlikely to have been any different.

CONCLUSION

342. Counsel for Mr Al Jhelie's family rightly pointed out at the end of the inquest that it is important not to overlook the humanity of this case. We must not treat Mr Al Jhelie simply as a case but remember that he was a young man who came with his family to this country with hopes for a better life that ultimately ended in tragedy.

343. Due to the trauma, he had experienced as a young child, and personal issues he experienced in Australia, Mr Al Jhelie had struggled to settle into life here and had made mistakes that meant he had put his right to continue to live in Australia in jeopardy. However, he was the father of three children who are Australian citizens and had other family members who continue to live in Australia, and as a young man who had no other life to go to outside Australia, it must have been extremely difficult for him to contemplate the future if he was to be deported. That much is clear from the letters he wrote in support of his application for a decision to be made to reinstate his visa. Although it is not my role to comment on broader government policy, it is very hard to understand the process that might lead to a 21 year old man being sent back to a country he has not lived in since he was three years old, and where none of his immediate family reside, and from his perspective, it must have been a very frightening prospect.

344. Given how fearful Mr Al Jhelie must have been about the prospect of being removed from Australia against his will, it is very concerning that there was no real attempt on the part of the Department's staff to keep Mr Al Jhelie informed of what was happening in his case in relation to the resolution of his visa status.

345. There is no doubt that Mr Al Jhelie became upset on 2 September 2018 following an argument with his girlfriend and her decision to stop his access to his phone, but on a wider background of all the other things that had led him to that place. He self-harmed by cutting himself, which he had reportedly done in the past. The cuts

themselves were not serious, but there is evidence they were a red flag as to what else might be happening for Mr Al Jhelie from a mental health perspective.

346. The Serco officers on the day took the matter seriously and escorted Mr Al Jhelie to the medical dispensary in the hope the IHMS nurses would agree to see him, as they sometimes did even though it was not in accordance with their policy. Both nurses took some steps to treat Mr Al Jhelie, Nurse Cheema in relation to his cuts and Nurse Paterson in relation to his mental state. I make no criticism of them doing so contrary to policy, as they did so in order to try to help Mr Al Jhelie in a caring and supportive way. However, it is clear that the circumstances in which they saw Mr Al Jhelie were not designed to elicit any information about him as to how he was really feeling, and he indicated he did not want to engage with them. Nurse Paterson appropriately noted him down for follow-up the next day, but sadly by then it was too late.

347. Not long after Mr Al Jhelie returned to his room and soon after he was left alone, Mr Al Jhelie hanged himself with the materials that were to hand. It was not a sophisticated method of suicide, but sadly it is a very quick and effective method, and Mr Al Jhelie would have been unconscious within less than a minute and irrecoverable after only a few minutes. As soon as he was discovered, Mr Al Jhelie was resuscitated and taken to hospital, but sadly by then it was too late. He died on 5 September 2018 after it became clear he would not respond to medical treatment.

348. Mr Al Jhelie's family questioned the care that he received in detention and were particularly concerned about why he was moved to Yongah Hill, so far from his family and emotional supports. The question was also raised as to why the supportive health care Mr Al Jhelie was receiving at Villawood was not continued at Yongah Hill. Ultimately, the answers to these questions appear to be that there were failures in communication between the various stakeholders, and a lack of good handover. These same issues arise in many inquests, and the lessons that need to be learned from them are particularly important in the context of a person being held in immigration detention, who the Department owes a duty of care to ensure that they are getting timely and appropriate support and information, both medically and otherwise, to ensure that they are well cared for and do not lose hope, despite their situation.

349. I extend my sincere condolences to Mr Al Jhelie's family. His family fled Iraq due to persecution and later made their way to Australia in the hope that they would have a better life. Sadly, those hopes were never realised for Mr Al Jhelie. His family, including his young children, are left to wonder why that is so and whether more could have been done to save him?

350. I would like to think that this country, which has so much to give to others less fortunate, can do more for young people like Mr Al Jhelie who lose their way while trying to make a life here. To simply detain them indefinitely when they flounder in their new home, until they lose all hope and decide that suicide is the only way out, in my view does not reflect the values of 'mutual respect, tolerance and compassion

for those in need' that are set out in the Department's own Australian Values Statement.[431]

S H Linton
Deputy State Coroner
14 July 2022

[431] Australian values (homeaffairs.gov.au): https://immi.homeaffairs.gov.au/help-support/meeting-our-requirements/australian-values.

I certify that the preceding paragraph(s) comprise the reasons for decision of the Coroner's Court of Western Australia.

DEPUTY STATE CORONER S Linton

15 JULY 2022