QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Meqdad HUSSAIN**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	2011/942
DELIVERED ON:	27 May 2013
DELIVERED AT:	Brisbane
HEARING DATE(s):	25 October 2012; 27-29 November 2012; 11 February 2013.
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody, suicide, asylum seeker

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Family of the deceased:	Ms Kylie Hillard (instructed by Fisher Dore Lawyers)
Department of Immigration and Citizenship:	Mr Ralph Devlin SC (instructed by Clayton Utz)
SERCO:	Mr James Gibson (instructed by Corrs Chambers Westgarth)
IHMS:	Ms Jennifer Rosengren (instructed by Moray & Agnew Lawyers)

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The *Coroners Act 2003* provides in s. 47 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of Meqdad Hussain. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

Introduction

In March 2011 a section of the Scherger Air Force Base, located 30km inland from Weipa in north-western Queensland, was being used by the Commonwealth as an immigration detention centre (IDC). It was run by a private company, Serco, on behalf of the Department of Immigration and Citizenship (DIAC). At that time Scherger housed almost three hundred male predominantly Afghani asylum seekers, one of whom was 19 year old Meqdad Hussain.

He had travelled from Quetta, Pakistan arriving by boat at Christmas Island before being transferred to Scherger in January 2011. On the evening of 17 March 2011, Meqdad was found deceased; slumped on the floor of his room with a bed sheet tied tightly around his neck.

The investigation into his death revealed, amongst much else, that:

- Since arriving in Australia Meqdad had undergone psychological assessment during which a series of cuts on his forearm was noted;

- On the day of his death Meqdad had been marked on the 'nominal role' as having been sighted by a Serco officer though that officer later admitted he had lied about seeing Meqdad and that the role was incorrect; and

- A notebook found in Meqdad's room by investigating police after his death contained several pages of handwriting in which two people were nominated as 'killers' and as having 'killed Meqdad Hussain'.

These findings:

- confirm the identity of the deceased person, the time, place and medical cause of his death and determine how he died;

- consider whether any other person(s) contributed to his death;

- determine whether the authorities charged with providing for the deceased's mental and physical health care needs adequately discharged those responsibilities; and

- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

Jurisdiction

The *Coroners Act 2003* at section 10 defines '*custody'* to mean:

> *…detention, whether or not by a police officer, under –*
>
> *……*
>
> *(d) the authority of an Act of the Commonwealth.*

At the time of his death Mr Hussain was detained pursuant to the power conferred by s. 189(1) of the *Migration Act 1958 (Cth)*.

Because Mr Hussain died in custody, the *Coroners Act 2003* requires that an inquest be held into the circumstances of his death.

The investigation

Mr Hussain's death was investigated by Detective Sergeant Graham Camp. He prepared a detailed report on his investigations and conclusions which was tendered at the inquest.

DS Camp, then stationed at the Weipa Criminal Investigation Branch, was re-called to duty at 8:10pm on 17 March 2011. He was advised of the death at Scherger IDC and told that two uniformed officers were on their way to the scene. DS Camp contacted the Northern Coroner and then travelled to Scherger with another detective.

On arrival at 11:30pm, DS Camp was advised that Serco staff were guarding the locked door to the deceased's room but that a large number of detainees had surrounded the area. These detainees were expressing their wish to remove, wash and wrap the body in preparation for burial in accordance with Islamic practice. After some negotiation, DS Camp was allowed access to the room.

In the room he observed the deceased lying on the floor. He then took a series of photographs before leaving. The large crowd of detainees were clearly upset and it was made clear they would not allow the body to be removed by police at this stage. DS Camp locked the door to the room and left the scene so as to prevent any further aggravation. He then set about taking statements from relevant Serco staff through the early hours of the morning.

At 5:35am DS Camp was asked by the acting centre manager to address the detainees surrounding Meqdad's room. After he did this they appeared satisfied as to why the body could not be interfered with prior to the completion of the investigation. The body was then removed and taken to Weipa morgue.

QPS scientific and scenes of crime officers examined Meqdad's room and a series of further photographs were taken. A number of items from the room were seized as exhibits including a notebook containing handwritten notes.

DS Camp conducted another examination of the room and seized relevant documentation from Serco including a copy of the 'nominal roll'. A crime scene warrant was issued and the effect of this explained to the centre manager.

A large number of the detainees at Scherger were interviewed by investigating police. DS Camp travelled to Scherger on several occasions subsequent to the death to take further statements from staff including a statement analysing Meqdad's interaction with services at the centre such as the internet room and canteen. Serco IT officers confirmed that the detainees had no individual phone accounts, rather detainees use pre-purchased phone cards so no records could be linked to Meqdad.

Over the following weeks and months, DS Camp conducted extensive investigations into the process by which Meqdad came to be at Scherger. He obtained details of the procedures and policies applicable to DIAC and Serco staff. He also examined the interaction between Meqdad and the agency contracted to provide health care services for detainees, International Health and Medical Services (IHMS). A large amount of documentation was obtained relating to the relevant policies applicable to these agencies and to their dealings directly with Meqdad.

DS Camp, together with DIAC staff, oversaw communication with Meqdad's family in Pakistan. He spoke directly with Meqdad's step-mother and pursued a line of enquiry she raised in that discussion.

DS Camp and Queensland Police Service document experts examined the notebook found in Meqdad's room. Notes in that book gave rise to further investigations into the possible involvement of other detainees in the death.

These leads were pursued.

On the day prior to the commencement of the inquest, I and the lawyers representing those granted leave to appear, attended the facility at Scherger. We were shown around the relevant parts of the centre. Although by that time it had expanded from when Meqdad was accommodated there, his room remained in substantially the same condition and the process was useful in understanding some of the subsequent oral evidence and in framing these findings.

In addition to the autopsy report of Dr Paull Botterill to which I refer later, I was assisted by a further review of the autopsy examination by a forensic pathologist engaged by lawyers for the family of the deceased.

I am satisfied that all relevant exhibits and documentation were obtained and tendered at the inquest. I thank DS Camp for his assistance and commend him for what was a very detailed and comprehensive coronial report.

The Inquest

A pre-inquest conference was held on 25 October 2012. Mr Johns was appointed counsel assisting. Leave to appear was granted to the family of the deceased, DIAC, Serco and IHMS. A view of the immigration detention centre at RAAF Scherger was conducted on 26 November 2012 and the inquest commenced in Weipa on 27 November 2012. It continued the following day in Cairns and then on 29 November 2012 in Brisbane. A further hearing was held in Brisbane on 11 February 2013.

All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

The evidence

Personal circumstances

When he arrived at Christmas Island, Meqdad Hussain told DIAC officials he was from Afghanistan where he had been born in 1991. He was therefore, on his own account, 19 or 20 years of age, when he died on 17 March 2011 at an immigration detention centre on the Scherger RAAF Base, approximately 30km from Weipa in north Queensland.

Meqdad was brought up predominantly by his step-mother from the age of one. He had travelled with her from Afghanistan to Quetta, Pakistan where he had lived for the last 15 years. Meqdad's step-mother identified Meqdad in a photograph shown to her by an Australian Federal Police (AFP) officer. It is evident from notes discovered after his death that Meqdad had great respect for his father and placed great importance on his father's opinions although, in a notebook found after his death, he made reference to his father as having been 'missing' for ten years. He had also told a mental health nurse on Christmas Island that his father 'went missing' in Afghanistan 10 years ago.

On the brief account of his step-mother given to a DIAC officer, Meqdad had been sent overseas by his family in the hope he may be able to provide support to his brothers and sisters who it seems have little.

According to his own account, Meqdad likely left Pakistan in late September 2010 and travelled by plane via Dubai to Malaysia where he stayed for 15 days. He then travelled onto Indonesia where, after 25 days, he boarded a barely seaworthy boat with 41 other people and set off, likely in the hope of reaching a territory of Australia.

The accounts of Meqdad by other detainees about his time at Scherger consistently describe him as quiet, shy and polite. He was respectful to the older detainees. Although he became friends with a group of four or five other

detainees at Scherger and socialised with them, he apparently spoke little with them, if at all, about his own thoughts, feelings and background.

Clearly Meqdad's death has been a devastating blow to his family and he is very much missed. I offer them my sincere condolences.

Nature of detention

Section 189(3) of the Migration Act provides that if an officer knows or reasonably suspects that a person in an excised offshore place is an unlawful non-citizen, the officer may detain a person. Section 5 of the Migration Act defines an *excised offshore place* to include the Territory of Christmas Island.

On 11 November 2010, Australian Customs officers boarded a vessel approximately 12 nautical miles north of Ashmore Island. Due to the condition of the vessel the 42 people on board were transferred to the Customs ship. That ship took them to Christmas Island where they arrived on 16 November 2010. Each of those persons was then detained by DIAC officers under the power granted by section 189(3) of the Migration Act. Meqdad Hussain was one of those 42 people.

In mid January 2011, it was apparent that the immigration facility at Christmas Island was near capacity. On 16 January 2011, 87 male detainees were transferred to the immigration detention centre at RAAF Scherger. Mr Hussain was one of those transferred. On landing he was then in the *migration zone* for the purposes of the Migration Act. Section 189(1) of that Act requires that if an officer who reasonably suspects a person in the migration zone is an unlawful non-citizen, the officer must detain the person.

Mental and physical health - history and assessment

On arrival at Christmas Island on 16 November 2010, Meqdad underwent an *induction health assessment* which included an *induction mental state examination*. This records that he appeared *happ*y and denied any thoughts of suicide or of being a victim of torture or trauma. Also on 16 November 2010, a Serco employee filled out an *Individual Risk Assessment* form with respect to Meqdad. This recorded that he was *content* and had no thoughts of self harm.

IHMS policy required that detainees undergo an *Initial Mental State Examination* (MSE) within seven days of arrival. In Meqdad's case this did not occur until 23 days later, on 9 December 2010. The inquest heard this was due to the high numbers of arrivals at the Christmas Island IDC during late 2010.

The MSE was conducted by an experienced mental health nurse, Patricia Curtain. She gave evidence at the inquest and although she had no specific recollection of Meqdad she had examined his MSE records. She noted that it was possible another practitioner assisted her with the examination as that was sometimes the practice.

The typed notes of the interview (which Ms Curtain said could have been written up to a day or two after the interview) include the following:

> ***Appearance and Behaviour***
> *Young man, looks stated age, wearing casual attire, well groomed, good eye contact, polite and cooperative. He has numerous dark scars on his L inner forearm, states he accidentally put his hand through a door.*
>
> ***Mood and Affect***
> *Reports mood as happy since he got to CI, feels safe, affect appropriate.*
>
> ***Content of Thought***
> *Worries about his younger siblings.*
> *Denies thoughts of harm to self or others*
> *…*
> ***Trauma/Torture***
> *Trauma associated with bomb blast, denies torture.*
>
> ***Risk Assessment***
> *Low for self or others*

A series of pro-forma questions were asked of Meqdad with a view to discerning, amongst other things, his state of mind and risk of self harm. None of his answers raised any concern.

Ms Curtain stressed in her statement and again in her evidence at the inquest that the notes of her interview with Meqdad were far from comprehensive. They do not, for instance, record the usual discussion she said she had with all clients about the mental health services available to them and *…common signs and symptoms of mental health difficulties to look out for including changes in behaviour, difficulty sleeping and losing interest in activities, prayer or food*.

Ms Curtain did not have an independent recollection of the scars on Meqdad's left forearm. On viewing post-mortem photographs she took the view that there could be a number of different explanations for them but acknowledged they would be consistent with self-inflicted wounds. She said that if the scars were present to the same extent on 9 December 2010 she would have:

> *Asked a number of questions including when and/or where and/or how the door incident occurred. I would also have asked him further questions, the nature of which would have depended on his responses to the above-mentioned questions. I would not necessarily have taken his responses at face value as I would have been aware he was likely to have been ashamed of having engaged in any self harming behaviours and that it probably would have been against his cultural and religious beliefs.*

Ms Curtain was well aware, she said, of the link between self harming behaviour in the past and a vulnerability to engaging in similar behaviour in the future. She said she expects that in Meqdad's case, she weighed this against other factors including his ongoing contact with family in Pakistan; his denial of a personal or family history of mental illness or of current thoughts of self harm or suicide; the fact he was not taking medication; that his affect was appropriate; that his eye contact was good and his form of thought was clear and logical.[1]

Ms Curtain said that if she was concerned that Meqdad was vulnerable to engaging in self harm in the following six months she would have, as was her usual practice in such circumstances, implemented a plan that incorporated a review of him sooner than the standard, mandated six month review.

Ms Curtain also had no memory of Meqdad telling her of trauma associated with a bomb blast. She is sure that on being told this information she would have asked a number of follow-up questions seeking details about the incident even though these, or the answers, have not been recorded. She is also confident that she would have offered Meqdad referral to the torture and trauma counselling service. She said it was her practice to offer this counselling to all clients she saw for a formal MSE. Asked at the inquest whether the failure to note this on the MSE record meant she had not done so in Meqdad's case, Ms Curtain said that was not the case; it meant only that it had been offered but that Meqdad had not taken up the offer. If the offer had been accepted Ms Curtain says she would have noted it.

After arriving at Scherger, Meqdad had further contact with IHMS staff members in order to be screened for tuberculosis and to be treated for a dental problem.

Witnesses at the inquest from both IHMS and Serco satisfied me that Meqdad is likely to have been well aware of the process by which he could have sought counselling.

The responsibility on the three agencies responsible for the care of Meqdad extends, of course, beyond a reliance on detainees self-reporting of problems. I will discuss the adequacy of the practices and policies in place for prevention of self harm and suicide at Scherger later in these findings.

Operational structure and facilities at Scherger

The IDC at Scherger was and is run by Serco, a private company which is contracted by the DIAC. Another private company, IHMS was and is contracted to provide medical services at the facility, including mental health services. This was also the case, for both organisations, for the IDC at Christmas Island.

[1] This is a selective list. Ms Curtain outlined further reasons in her statement.

Scherger IDC opened in September 2010 and was designed as a low security facility intended to accommodate detainees with a *low risk* security classification. Prior to the commencement of the inquest, I had the opportunity to examine the facilities at Scherger IDC with the understanding that they have changed and expanded since the time Meqdad was accommodated there. The accommodation consists of a number of demountable buildings each with five rooms. Each of the rooms contains a bunk bed and can accommodate two detainees. The buildings are grouped into 'blocks' with a further demountable building providing laundry and bathroom facilities. Other facilities available to detainees as at early 2011 included internet access, international dialling telephones, sports facilities and an open area where cable television could be viewed. English lessons were offered and records show that Meqdad attended two such classes during his stay.

At the time of his death Meqdad was housed in room 2 of building 522 in Alpha block (one of only two blocks at the time). Earlier in his stay at Scherger Meqdad had shared this room with another, older detainee, Mohammed Ali Mirawkhoor. On 4 March the latter moved to another room apparently because he and Meqdad had different sleeping patterns and from that time Meqdad was the sole occupant of room 2/522.

In each block the meal room and internet room were overseen by a Serco employed client service officer (CSO). The CSO's were overseen by a client service manager (CSM) who in turn reported to the Centre Manager. At the time the Centre Manager was Alan Mills, although acting Centre Managers were in charge on the day of Meqdad's death.

DIAC and IHMS staff are located outside the centre, though nearby. In each case the staff members from these agencies were and are encouraged to interact with the detainees on a regular basis. CSO's are expected to spend their shifts interacting with the detainees rather than being stationed at a post. There were, though, offices in each of the two accommodation blocks where the CSO assigned to that block could perform paperwork and where room keys were kept.

The inquest also heard that requests could be made by detainees either directly to Serco, IHMS and DIAC staff, or, through a system of written requests which would then be addressed by the relevant agency. This is the method by which medical appointments (physical or psychological) could be sought by detainees in addition to appointments instigated by medical staff.

Regular meeting were and are held between staff from Serco, DIAC and IHMS to discuss, amongst other matters, the progress and welfare of particular detainees.

Application for visas and notification of decisions

After arrival at Christmas Island, Meqdad was interviewed by DIAC staff as was the usual process at the time. This entry interview occurred on 25 November 2010. Having expressed a fear of returning to his country of origin and thus engaging Australia's UN chartered protection obligations, Meqdad

was invited to request a Refugee Status Assessment (RSA).[2] This assessment involved an interview of the claimant by a DIAC officer. Under policy in place at the time, if the person is found to be owed protection pursuant to Australia's UN obligations the matter is referred to the Immigration Minister who, if satisfied it is in the public interest to do so, allows the person to make application for a visa. In most cases this will be a protection visa.

If DIAC decides the claimant is not owed protection, they are notified in writing. This decision can be reviewed within seven days of notification. The review is to be conducted by a number of independent reviewers who conduct a merits review of the RSA decision.

On 16 December 2010, Meqdad attended a group information session in relation to the immigration pathways and return options available.

As with all involved in the RSA process, Meqdad was provided with assistance by DIAC to prepare his application through the allocation of a registered migration agent. That agent was Mr Alec Alexandrou who gave evidence at the inquest. Meqdad was also assigned a case officer; a DIAC employee who was the detainee's point of contact with the Department as the process takes place. That person was Cameron Hope who first met with Meqdad in a group interview at Scherger on 18 January 2011.

He next spoke to Meqdad in another group meeting on 28 January 2011. On the second occasion the purpose of the meeting was to advise the group that dates had been set for their RSA interviews. Mr Hope, who was based at Scherger in an area adjacent to the detention centre while assigned as Meqdad's case officer, told the inquest that he was expected to be accessible to his clients. He did this by explaining at the outset that a meeting could be arranged by a detainee making a request through Serco officers. He would also regularly walk around the centre and make himself available to any of his clients who wished to approach him.

On 2 February 2011, Mr Alexandrou met with Meqdad in order to assist him with preparation for the RSA interview. Meqdad underwent his RSA interview by a DIAC officer, Darren Williams, on 7 February 2011. Also present were a junior DIAC officer and Mr Alexandrou.

Subsequent to this interview, Meqdad was interviewed by DIAC staff to collect information to be sent to the United Nations High Commissioner for Refugees (UNHCR). This process also involved notifying the detainee of his ability to make contact with UNHCR and the assistance that could be provided through that agency. DIAC have advised that no notes or recording of this interview were made.

The process by which the subsequent RSA decision was made by DIAC was the subject of extensive examination at the inquest. It was explained that the decision and reasons for the decision are distributed through a central area in

[2] The RSA process ceased and a new process was implemented on 31 March 2011.

Canberra to the relevant case manager who is on site at the detention centre. If the decision is negative there is a requirement that the case manager contact the detainee's migration agent at least 24 hours ahead of the planned notification to the detainee. A meeting is then held between DIAC, IHMS and Serco staff to make arrangements for the meeting with the detainee. The likely reaction is discussed. Notification of the decision is given in the absence of any other detainees and although Serco officers are on hand if needed, it is their practice to remain hidden so as not to aggravate the situation.

In Meqdad's case DIAC decided on 16 March 2011 as he was not a *refugee* under the *United Nations 1951 Convention* and issued written notification of the negative assessment. DIAC director of case management, Gavin Metcalfe, told the inquest he would normally be the first person to see this assessment. He would then notify the relevant case officer, in this case Mr Hope, and arrangements should then be made for Mr Alexandrou to be advised at least 24 hours before the notification to Mr Hussain.

Both Mr Metcalfe and Mr Hope told the inquest they were not aware the negative assessment had been made prior to Meqdad's death. Although the decision would potentially have been accessible on computer by other DIAC staff at Scherger prior to Meqdad's death, there is no evidence it was in fact accessed and no evidence that staff at Mr Alexandrou's office or any IHMS or Serco officer became aware of the negative assessment. There is certainly nothing to indicate that Meqdad himself had or could have become aware of the decision prior to his death.

Mr Hope told the inquest that in the days prior to Meqdad's death he had given notification of both a positive and negative RSA assessment to two other detainees who had arrived at Christmas Island on the same boat as Meqdad.

Observations of Meqdad on 7 February 2011

In his statement to police Mr Alexandrou included the following passage:

> *Throughout the process of assistance as duty of care, we are obliged to provide this* (the service provided to asylum seekers) *and more importantly report our observations and concerns for the individual client. I raised my concerns for the well-being of this client with the* (DIAC) *Case Officer at the time. I also highlighted this fact with the Serco officers and Detention facility management.*

Unlike the rest of his statement the above passage is part of a section written in italics and framed in general terms. I suspect it is part of a pro-forma paragraph also used in other statements. Mr Alexandrou made no notes of the particular concerns he held for Meqdad or of the conversations he had with DIAC and/or Serco staff. Extensive efforts during the inquest to examine this issue further did not progress particularly far. DIAC and Serco deny having any record of being spoken to by Mr Alexandrou in these terms about Meqdad. The DIAC officer who interviewed Meqdad for his RSA, Darren

Williams, recalls Mr Alexandrou speaking to him about the welfare of another client he interviewed for an RSA on 7 February 2011 who had also been assisted by Mr Alexandrou. Mr Williams recalls the other client was undoubtedly showing signs of mental health distress and that after the interview, steps were taken to advise the DIAC team leader. Mr Williams says that Meqdad did not show signs of distress during his RSA interview.

Pressed further at the inquest and when contacted by Mr Fisher, solicitor for the family, Mr Alexandrou said he based his concerns about Meqdad on a view that he was melancholy, very quiet, withdrawn and thoughtful. Mr Alexandrou recalls that the interview was conducted with empathy.

The inquest heard evidence from those other detainees who most closely associated with Meqdad. They too described him as being very quiet and shy.

I accept Mr Alexandrou's evidence in relation to his perceptions of Meqdad but I am inclined to accept the evidence of Mr Williams that no specific concerns were raised by Mr Alexandrou with DIAC in relation to Mr Meqdad's mental health.

Last sighting of Meqdad

Meqdad was one of a group of five detainees who socialised together. It seems that they predominantly slept through the day and socialised with each other at night by playing games and watching movies. The inquest heard from others in the group which, apart from Meqdad, included Irfan Hussaini, Ali Ewaz, Sadat Alli, Syed Hussaini and Syed Mehdi Zaidi. When interviewed by police each member of the group described Meqdad as shy or quiet. He was observed to listen to his MP3 player during the day when he was not sleeping. Although Meqdad always joined in activities with the group, he tended to say little. Although some questions were raised about the markings on his forearm, it seems Meqdad convincingly dismissed these as being due to a childhood accident.

Although some of that group said that Meqdad became ever more quiet and withdrawn in the days before his death, and seemed to miss perhaps a few more meals, none of them had been concerned for his welfare or mental state during any of the time they knew him.

In the early hours of 17 March 2011, the group watched a movie which finished at around 5:30am. It was normal for the group to keep such hours. Syed Hussaini and Syed Zaidi both noticed Meqdad to be laughing at times during the movie. No one considered Meqdad's behaviour to be unusual. At the end of the movie the group left the marquee where it had been screened and mostly returned to their rooms.

Mohammed Masumi says that around 8:10am he was having breakfast in the dining hall when he saw Meqdad sitting alone. He thought this unusual as he did not normally see Meqdad there at this time of day. When he asked Meqdad why he was there he says Meqdad claimed to always come to breakfast around that time and the matter was not taken further.

Ali Ewaz told investigators that he saw Meqdad at around 9:45am purchasing some items from the canteen although did not speak to him. Records from the canteen show that Meqdad did make a purchase of items on 17 March 2011. This purchase consisted of a pouch of tobacco, cigarette papers, crisps, a chocolate and a packet of Life Savers. Each of these items was evident in photographs taken of Meqdad's room after his death.

Mohammed Masumi, having returned to the room he shared with Syed Mehdi Zaidi after breakfast and fallen asleep, was woken at around 11.00am. This was caused by the door to his room being opened by Meqdad who was evidently looking for Syed. Apparently noticing that both occupants of the room were or had recently been sleeping, Masumi says that Meqdad made an apologetic gesture to him before closing the door. This is the last confirmed sighting of Meqdad alive; though it is not the last reported sighting.

Check by Serco staff

A document known as the 'nominal roll' is kept by Serco staff. It contains the details of each detainee currently residing at the centre. It is used to record the outcome of welfare checks which were performed three times a day. The checks required that each detainee was sighted by a member of staff. Confirmation that the detainee had been seen was required before the corresponding name could be ticked on the nominal roll.

This process was carried out at meal times when most detainees would be sighted in the meal room. After the meal, a staff member would be tasked to locate those detainees who had not attended the meal room. Once sighted, this would be noted on the nominal roll by recording a code for the location of the detainee. If sighted in their room for instance, the letter 'R' would be entered on the nominal roll.

When police seized the Scherger IDC nominal role for 17 March 2011, the letter 'R' was recorded next to Meqdad's name in the column corresponding to the lunch time welfare check. CSO Meshek Gray told investigating police he had made that entry and he had done so on the advice of another CSO, James Latailomoloma, who told him over the radio he had sighted Meqdad and a number of other detainees whom he had been tasked to locate.

When investigators initially spoke to Mr Latailomoloma he denied having been involved in the welfare check for Meqdad on that day. When re-interviewed by investigators challenging this aspect of his account, he acknowledged he had in fact been tasked to locate Meqdad amongst several other detainees. He admitted he had not in fact sighted Meqdad at the relevant time. He told investigators that because he had seen Meqdad walking around at some time prior to lunch, he told CSO Gray he had sighted Meqdad for the purpose of the welfare check in order to save time.

Meqdad is found deceased

Irfan Hussaini told the inquest it was the practice of their small group of friends to ensure each of the others was woken up so they could go to dinner

together as a group. At around 7:30pm, he woke Syed Mehdi Zaidi who in turn went to Meqdad's room to wake him. Finding the door locked Mr Zaidi approached a Serco officer, Robin Sigai. Mr Sigai says it was about 7:45pm when he was approached. In his experience, rooms were rarely locked and, thinking it was likely to have been locked by mistake, he used a key to open the door. On doing this he noted Irfan Hussaini and others make their way towards the room before, a moment later, turning around and telling him to call for help. He looked into the room briefly to see a man sitting on the floor with a bedsheet around his neck. Mr Sigai immediately called *Code Black Blue* on his radio to signal a medical emergency.

Serco officer, Michael Cerneka was the first to respond. He lifted Meqdad up by holding him under his arms in order to release the tension from the deceased's neck. At this time, security operations manager, Antony Ellis (who had been the acting centre manager throughout the day shift) arrived. Mr Ellis commenced CPR and a short time later an IHMS nurse, Matthew Armstrong, arrived. Although they noted the body was stiff and cold to touch and those in the room formed the opinion Meqdad had been deceased for some time, CPR attempts continued until the arrival of Queensland Ambulance Service paramedics.

Mr Cerneka went to the gate to escort the paramedics to Meqdad's room. They arrived at 7:48pm and it was immediately clear to paramedic Robert Devries that Meqdad had been deceased for an extended period and could not be revived. He declared Meqdad deceased at 7:50pm.

After the paramedics left and it was clear to the other detainees drawn to the scene that Meqdad was deceased, they requested to be allowed to remove the body and prepare it for burial. This led to the stand off described earlier. During this time, the door to the room was locked and guarded and not accessed again until the arrival of police.

Contents of notebook

One of the items found in Meqdad's room and seized for examination was a notebook with handwriting on a number of pages.

QPS document examiners compared the handwriting to writing Meqdad is known to have authored on DIAC documents. The limited writing available for comparison (signatures of the deceased) meant that only certain parts of the handwriting in the notebook could be positively identified as being that of Meqdad. Fingerprint analysis of the book identified Meqdad's fingerprints.

Early entries in the book refer to Meqdad's missing father and fears for his safety if he is returned to Afghanistan. A passage on page 5 reads:

> *Start in the name of god I am Ahmed Ali hazara and I am SHia Muslim. And my different name is Meqdad Hussain. So my real name is ahmed ali ahmed ali. I go to god. SO muslim public is not good. And I am keep the god god. Please I am respect the Australian Government and I am requested the Australian*

> *government my dead bodie is transfer to my country Pakistan. So please please my bodie transfer to Pakistan. I requested to govt of Australia so pls my (indis) to my home.*

Following this passage are telephone numbers and an address for his family in Quetta, Pakistan.

On page 7 of the notebook in large letters is the entry:

> *Mohammed Ali He is killer.*
> *Gulzari He is killer*

Similar entries are found over subsequent pages before a more specific statement on page 13:

Mohammed Ali Pakistani Hazara is Responsible for my death.

On the following page, in Urdu, is written:

> *I disappointed god*

On page 16, again in Urdu is the following entry:

> *O my cruel god there is a limit of cruelty. He broke me. I kicked you out of my heart. Now there is no one behind me. I thought you were compassionate. But you proved yourself worse than others. Come now give me death OR I will humiliate you in front of me more. Come now give me death or I will abduct you more from my heart*

DS Camp conducted extensive interviews in order to investigate any basis for the apparent accusations against those responsible for his, impending, death. In so far as either of the two people accused can be identified, one was another detainee at Scherger during the relevant time and Meqdad's former room mate, Mohammed Ali Mirawkhoor. Two other detainees could be the *Gulzari* referred to in the notebook. In each case the detainee denied any contact with Meqdad on the day of his death. Each denied having had any disagreement with Meqdad or any possible motive for being involved in his death.

Mohammed Mirawkhoor gave evidence at the inquest. He stated he and Meqdad were not particularly friendly with each other, there being a significant age difference between them, but there were no problems between them. He found Meqdad respectful but spoke little with him. When he left the room it was to find another with someone who shared his sleeping patterns. There was no bad blood between them at all and he had little if anything to do with Meqdad subsequent to moving to another room.

Autopsy examination

An external and partial internal autopsy examination was carried out on 18 March 2011. This was followed by a full internal autopsy examination on 24 March 2011. Both examinations took place at Cairns Mortuary and were undertaken by an experienced forensic pathologist, Dr Paull Botterill.

Prior to the commencement of the examination, the body was subjected to a full body computed tomographic radiographic examination. Blood and urine samples were taken and subjected to toxicology testing. Various swabs, hair and nail samples were reserved for investigating police. Several tissue samples were taken during the internal autopsy and microscopically examined.

Dr Botterill reported the following amongst the 'identifying features' of the body:

> *Multiple linear approximately parallel scars were noted in an approximately 90 x 70mm area over the ventral aspect of the mid and distal left forearm.*
>
> *Raised scarring, possibly in the shape of the letters "I" and "A", were noted over the ventral possible right forearm.*
>
> *Two raised linear scars up to approximately 20mm in length were noted over the lateral distal left arm.*

Dr Botterill considered that these scars would have been at least six weeks old and could have been present for a number of years. No features of the scars allowed him to be more precise than this.

Dr Botterill noted the following sign of *recent injury*:

> *A ligature compression-abrasion mark was situated around the neck, the upper margin passing the midline at a point approximately 75mm from the tip of the chin, the lower margin passing in the midline at a point approximately 40mm above the level of the supra sternal notch, and centred about 1.42 metres above the level of the left heel. The ligature mark passed over the right side of the neck at a point approximately 30mm below the inferior border of the right earlobe, and over the left side of the neck at a point approximately 20mm below the inferior border of the left earlobe.*
>
> *The ligature mark was up to approximately 75mm wide at its widest point but showed narrower linear red marks, and appeared to be consistent with the application of a broad ligature, such as bed sheeting, over the presence of the necklace seen on the neck.*

> *It was difficult to identify the site of location of* (sic) *a knot but the suspension point was most probably situated posteriorly.*

Dr Botterill also noted a 5mm abrasion adjacent to the base of the right index finger. The only other injuries noted were healing scars on the feet. After examining the extremities Dr Botterill found:

> *The hands, nails, feet and soles were otherwise unremarkable and showed no additional external evidence of injury*.

The internal examination also led to the discovery of conjunctival petechial haemorrhages.

In his autopsy report Dr Botterill concluded:

> *In plain terms, limited examination showed a pressure rubbing mark around the neck, consistent with the placement of a broad ligature (such as a bedsheet) as well as scars over the left forearm which would be consistent with past self harm…..No additional significant injuries or alternative potentially lethal natural disease processes were identified on subsequent complete internal examination, and the cause of death was believed to be hanging.*

Toxicology testing was negative for alcohol or any drugs apart from a very small amount (Detected < 0.01mg/kg) of Mirtazapine. At the inquest, Dr Botterill opined that this was a sub-therapeutic, and certainly a sub-toxic, level of this anti-depressant medication that would have played no part in the death.

Dr Botterill issued a certificate listing the cause of death as:

> *1(a) Hanging*

At the inquest counsel for the family, appropriately, framed some questions on a reference made shortly after the death by a non-medically trained person to apparent scarring on the deceased's back. Markings on Meqdad's back are clearly visible in photographs taken at the scene. Counsel assisting explored this issue with Dr Botterill when he gave evidence with the use of a photograph of the apparent markings:

> *CA:* *One last thing; did you observe any markings or scarring to the deceased person's back at all? Can I just - just while you're looking; can I ask the doctor to be shown this photograph? It's, your Honour, photograph 25 in Exhibit E1?*
>
> *Dr Botterill:* *Thank you. The answer to your question is, no, I've not indicated on my diagram or in my description any - any scarring that I can see. The markings that appear to be*

present on the back are a combination of creases related to clothing or other contact surfaces, and the accentuation that appears to be present, the - sort of, the reddish edge that appears to be there, is just an accentuation of lividity. I don't believe that that represents either a scar or a more recent injury. We did reflect the skin at the back looking for evidence for underlying bruising even though there was nothing seen on the surface, and no such area of bruising was identified.

CA: *Thank you for that. I asked the question because it has been identified by a non-medically trained person as scarring, but you're confident, are you, that it represents the effects of lividity and the contact surface?*

Dr Botterill: *Yes. In my opinion, yes, that's what it is.*

The family of the deceased provided several exhibits, including the autopsy report and a transcript of Dr Botterill's evidence at the inquest, to another forensic pathologist, Dr Johan Duflou. Dr Duflou subsequently issued a report which was tendered as an exhibit.

Dr Duflou offered the following opinions:

> *I conclude that the cause of death, hanging, as given by Dr Botterill is entirely reasonable. In my opinion there is no plausible other cause of death in this case.*
>
> *I note concerns were expressed about the possibility of suffocation. Although it is possible that there may have been a degree of external airway obstruction during the process of hanging in this case, in my opinion there is no evidence of, for example, the deceased having been suffocated then placed in a hanging position in this case.*

Dr Duflou considered the scars on the deceased's forearms to be consistent with them all being at least three to six months old but acknowledged he could not exclude the possibility that they were a number of years old. He agreed with Dr Botterill that no toxicity would be expected from Mirtazapine at the levels encountered and that *markings on the deceased's back are predominantly in the form of post mortem lividity*.

Although I am mindful of his area of expertise and the setting in which he made his observations it is appropriate to note the following opinion of Dr Duflou:

> *I note that on 9 December 2010, the deceased was observed to have* 'numerous dark scars on his L inner forearm, stares(sic) he accidentally put his hand through a door'. *It appears likely to*

me that these are the same scars been described as those seen at autopsy and depicted in the autopsy photographs. I do not believe that it would be reasonable to accept that the most likely mechanism of having sustained those injuries would be the result of putting a hand through a door. The scars are typical of self infliction, and it would be difficult to imagine any other reasonable mechanism with the possible exception of another person having inflicted those injuries while holding down the deceased arm.

Identification

The deceased had his DIAC identification card in the name of Meqdad Hussain when his body was found. Investigating officers obtained a statement from another asylum seeker who identified the body as that of Meqdad Hussain, whom he had met in January 2011.

On 23 February 2011, a DIAC fingerprint expert took fingerprint samples from Meqdad Hussain. This was a standard procedure carried out on all detainees. That expert, Peter Gerritsen, has compared those fingerprint samples with the fingerprints taken by a police officer from the body at the morgue. Mr Gerritsen has confirmed the two sets of fingerprints were taken from the same person. He has also identified a photograph of the deceased as being the person, Meqdad Hussain, from whom he took the sample prints on 23 February 2011.

The notebook found in the deceased's room after his death contained a handwritten address which led an AFP officer in Pakistan to a person identifying herself as the step-mother of the deceased. That person, Setaro Gulamdam, was shown a photograph of the deceased and, according to the AFP officer, identified him as Meqdad Hussain whom she had known since he was aged one.

Investigation findings

Observations and photographs of Meqdad's cell did not reveal any obvious signs of struggle. At the inquest it was established that a rubbish bin which was depicted on its side in one photograph had been tipped over after the body was discovered.

Tape lifts and swabs from the neck and fingernails of the body revealed a single DNA profile which matched that of Meqdad (a reference profile obtained from a blood sample taken at autopsy). Samples taken from the blue sheet wrapped around his neck and from a spot of blood seen on his shorts revealed mixed DNA profiles. In the case of the sample taken from the spot of blood, one of the profiles identified matched that of Meqdad.

Analysis of a number of samples taken from cigarette butts found in Meqdad's room revealed a number of mixed profiles and two specific profiles belonging to two different males, neither being Meqdad. This was consistent with evidence tendered at the inquest indicating that Meqdad's friends would

sometimes congregate around each other's rooms to smoke, chat and play games.

At the request of counsel assisting, Mr Mirawkhoor agreed to provide a sample of DNA. This was later compared against the two specific profiles obtained from the cigarette butts and was found not to match.

Apart from the fingerprints linked to Meqdad on the notebook found in his room, fingerprint examinations did not return any useful evidence.

In all of the interviews conducted with other detainees there was no mention, and indeed specific denials, of any fights or arguments involving Meqdad. No one knew of anyone who had a problem with him or who might have a motive to harm him. Each of the four or five detainees who spent the most time with Meqdad were adamant he had never spoken of difficulties or a bad relationship with Mohammed Mirawkhoor or *Gulzari*; or indeed anyone.

During a telephone call Meqdad's stepmother told DS Camp that approximately four days prior to his death Meqdad had called her to advise that three other detainees had said to Meqdad *we will kill you*. She gave three names to DS Camp. None of these could be linked with any of the detainees at Scherger IDC. No other information was available to take this line of enquiry further. No other staff member or detainee was aware of any such event. Nothing found in Meqdad's room could be linked to this information.

It was confirmed with centre management that the door to Meqdad's room could only be locked from inside using a latch or externally by utilising a key which is kept in the CSO control room.

Although the toxicological analysis of blood taken at autopsy showed the presence of Mirtazapine, it was established that this drug had not been prescribed to Meqdad. It is a drug that was and is dispensed by IHMS staff but only to those detainees to whom it is prescribed.

The admissions by Mr Latailomoloma that he had falsified information which found its way onto the nominal roll led to Serco disciplining him. He was ordered to return to Serco's main office in Melbourne to undertake further training for a minimum of three months and was given a first and final written warning.

Conclusions

I conclude Meqdad Hussain died as a result of his own actions; that he intended to end his life and that no other person contributed to his death.

Mr Latailomoloma's false report of having sighted Meqdad after lunch on the day of his death, is most unlikely to have affected the outcome. I am satisfied Serco responded appropriately to ameliorate his under performance.

I am also satisfied that Mr Latailomoloma's unsatisfactory performance on the day in question was not indicative of a systemic problem. DS Camp went to

impressive lengths to test the knowledge of many Serco employees with regard to the tasks expected of them and whether these were in fact carried out. All had a clear understanding of the requirements with respect to the marking of the nominal roll and all denied seeing or hearing of practices similar to that which Mr Latailomoloma adopted on 17 March 2011. Evidence from detainees was less definitive but it could be that on any given day they might be appropriately monitored without being aware of it.

I am satisfied Meqdad was made aware of the counselling services available to him and that the IHMS employee who undertook the initial MSE, Ms Curtain, alerted him to symptoms which might indicate he should seek it.

Due to a surge in the number of maritime arrivals, that initial MSE did not occur within seven days of Meqdad's arrival on Christmas Island, as required by the relevant policy. There is no evidence that delay had any adverse consequences in this case.

I have given anxious consideration to whether Ms Curtain adequately responded to the scars she observed on Meqdad's arm. I accept the evidence that in all likelihood they were the result of self harming. Ms Curtain acknowledged the link between past and possible future self harm. I accept the cogency of the factors she *expects* she considered when concluding he was nonetheless at low risk of self harming in detention. It would have been better had she included in her assessment a record of her reasoning that allowed her to reach that conclusion despite the evidence of previous self harming. However, there is insufficient evidence for me to conclude she made an error of judgement in assessing Meqdad to be of low risk of self harming – the scars were only one of many issues she needed to consider. In those circumstances, she should not be criticised for not foreshortening the period for Meqdad's next MSE to earlier than the mandatory six monthly interval.

Ms Curtain said she believes she would have advised Meqdad of the availability of torture and trauma counselling when he disclosed having been injured by a bomb blast. I do not accept the submission that she should have referred him for further assessment under those protocols, if, as she claimed, he declined it.

I do not accept the submission that other IHMS, Serco or DIAC officers should have questioned Meqdad about the scars, or that they should have been prompted by observing them to cause him to undergo further mental health reviews. I do however accept that Serco and DIAC should have been made aware of the likelihood that he had a history of self harming and had suffered from trauma. It is impossible to ascertain whether this didn't happen because Ms Curtain failed to accurately identify the scars as evidence of self harming or because there was insufficient data sharing between the agencies.

In assessing the need for mental health interventions, far more important than the scars evidencing historical self harming, were his demeanour and actions during his detention and there is no evidence those characteristics should have prompted concern.

After the death, it was learnt that Meqdad had conversations with his mother and had written things in a notebook that reflect a disturbed mental state. However, none of that was known to the staff or detainees at Scherger prior to his death.

His friends said that in hindsight he had become a little more withdrawn and quiet in the days before his death, but it seems he was always reserved and private and all of his associates who were interviewed expressed surprise and shock when they discovered he had taken his own life. Certainly, none of Meqdad's friends considered his demeanour or behaviour warranted their seeking assistance for him. Further, I am of the view that there were no observable symptoms that should have alerted DIAC, Serco or IHMS staff members that Meqdad was of such risk of self harming as to warrant intervention. His death at his own hand was a surprise to everyone there and was not reasonably foreseeable.

It has not been ascertained how the drug Mirtazapine came to be in Meqdad's system. Although it was the practice of nursing staff to watch detainees take their medicine when it was given, it seems that this practice may not have been enforced as strictly as it might be in, for example, a prison. I do not suggest that this should be the case.

Findings required by s. 45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he died. As a result of considering all of the material contained in the exhibits and the oral evidence, I am able to make the following findings:

Identity of the deceased – The deceased person was Meqdad Hussain

How he died - Mr Hussain intentionally took his own life by hanging himself with a sheet tied to the upper rail of the bunk bed in his room at the Scherger Immigration Detention Centre where he was being detained pursuant to the Commonwealth Migration Act.

Place of death – He died at Weipa in Queensland.

Date of death – He died on 17 March 2011.

Cause of death – Mr Hussain died from hanging.

Comments and recommendations

Section 46 provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

In my investigation of this death I have been mindful of the distress and the propensity for harm to mental health that result from being detained in a setting such as the Scherger IDC - detainees are a vulnerable population; detention centres are high risk environments; protracted and apparently *ad hoc* immigration processing exacerbates these risks. This is appropriately recognised in the policy documents of DIAC, IHMS and Serco. Meqdad's death does not extend my jurisdiction to a wider analysis of the policy of detention itself. In considering whether there is anything that can be done to prevent such deaths in future, I have considered whether to recommend changes to the policies and practices of the agencies charged with providing care for those in detention.

DIAC mental health assessments, counselling and interventions

DIAC acknowledges its duty of care for the welfare of detainees and its obligation, therefore, to monitor the agencies it has contracted to provide, among other services, mental health care.

DIAC has three linked mental health policies that those contracted to deliver services on behalf of DIAC are obliged to comply with.

- Mental Health Screening Policy
- Psychological Support Program for the Prevention of Self Harm for people in Immigration Detention policy; and
- Survivors of Torture and Trauma policy

In July 2011, the then Commonwealth and Immigration Ombudsman announced an own motion investigation to examine the incidence and nature of suicide and self-harm in Australia's immigration detention network that reviewed and critiqued the content and application of those policies and other matters.
[1]
The Terms of Reference of that investigation were to:

1) Examine the incidence and nature of suicide and self-harm in the immigration detention network.

2) Identify the factors contributing to suicide and self-harm including:
- *demographic information including gender, age, country of origin, urban/rural background, language, and length of time in detention of people who participate in suicidal or self-harming behaviours*
- *potential determinants of this behaviour, including pre-existence of mental illnesses*
- *catalysts for suicidal ideation and self-harming behaviours, for example denial of visa applications, detention overcrowding, uncertainty about the future*
- *contagion issues and the impact of attempted or completed suicides and incidents of self-harm on other detainees.*

3) *Evaluate the practices, policies and procedures of the Department of Immigration and Citizenship (the department) and its contracted service providers in relation to:*
    - *prevention, intervention and postvention initiatives including access to counselling and other health services*
    - *adequacy of detention facility guidelines and protocols*
    - *the availability of appropriately qualified and professionally trained staff*
    - *the nature and different types of immigration detention facilities, access to means to self-harm or suicide, physical environments, risk assessments and mitigation strategies/measures.*

In undertaking the investigation, the Ombudsman's team reviewed all relevant data and policies from DIAC, Serco and IHMS; interviewed key staff members from those organisations; attended a number of IDCs, received submissions from key stakeholders, considered previous inquest findings into similar deaths, and consulted relevant eminent content experts and advocacy groups.

The Ombudsman published its report earlier this month. It identified a number of gaps in the policies comprising the Detention Health Framework, including the absence of an overarching suicide prevention strategy that explicitly relates to the National Suicide Prevention Strategy. It also agreed with the department's own internal review that aspects of the Framework had not been effectively implemented because of overwhelming operational pressures due to a surge in maritime arrivals.

The report contained numerous detailed recommendations to which the department has been asked to respond. The department has done so indicating that it accepts all of the recommendations and it has already set out in brief form its plans to actively respond to those within its scope of operation.

Obviously the Ombudsman's investigation had a far wider scope and a more comprehensive evidence base than that available to me when reviewing the circumstances of this one death. I consider it would be at best duplicative, at worst presumptuous of me to make further recommendations about the same matters. I will therefore refrain from doing so.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
27 May 2013