Coronial Inquest
into suicides at Villawood Immigration Detention Centre

Prabha Nandagopal
Australian Human Rights Commission

New South Wales' State Coroner Mary Jerram has found that the Department of Immigration and Citizenship (DIAC), Serco Australia Pty Ltd (Serco) and International Health and Medical Services (IHMS) failed to fulfil their duty of care and identified a number of systemic failures in the care of three detainees at Villawood Immigration Detention Centre (VIDC) prior to their deaths.

The Coroner delivered her findings and recommendations on 19 December 2011 at the conclusion of a coronial inquest into the deaths of three detainees at the VIDC.

The inquest is the first to have been held into any of the seven deaths in Australian immigration detention centres that have occurred since August 2010 and as such, the Coroner's findings will set an important precedent for future coronial inquests into deaths in immigration detention. (Six of the seven deaths since 2010 appear to have been suicide.)

The Facts

In late 2010 Josefa Rauluni, David Saunders and Ahmed Al-Akabi committed suicide at VIDC within three months of each other. The coronial inquest into their deaths was conducted over three weeks and considered the following issues:

- Given the close proximity in time of each suicide, were there systemic issues which may have contributed to the deaths?
- Was the treatment of the three deceased by DIAC, IHMS and Serco staff appropriate and humane?
- Could their deaths have been prevented, or any risk of suicide have been detected?
- Have any necessary changes been made to protocols and procedures at the VIDC following these tragedies?

Josefa Rauluni

Mr Rauluni, a Fijian national, was detained at VIDC after overstaying his visa. Mr Rauluni unsuccessfully applied for a Protection visa on the grounds that he feared persecution in Fiji. After about one month in detention he was notified on Friday 17 September 2010 that he would be deported to Fiji on Monday September 20. On Sunday 19 September Mr Rauluni wrote to the Minister for Immigration and Citizenship stating that if he returned to Fiji it would be his 'dead body'. On the day of his removal Mr Rauluni refused to accompany staff to the airport.

After a tense and chaotic stand-off between DIAC and Serco staff Mr Rauluni dived off the balcony railing onto the concrete.

Ahmed Al-Akabi

Mr Al-Akabi, an Iraqi national, arrived by boat on Christmas Island. Mr Al-Akabi was detained for four months on Christmas Island then transferred to VIDC where he remained for a further eight months.

His application for a Protection visa was unsuccessful.

Mr Al-Akabi's physical and mental health deteriorated during his time in detention. While he was initially assessed by Serco as not being at any risk of suicide he ticked 'yes' to questions as to whether he felt that life was not worth living.

On 15 November 2010 Mr Al-Akabi was found hanging from a pipe in a bathroom at VIDC.

David Saunders

Mr Saunders, a national of the United Kingdom (UK), was detained at VIDC for 25 days after the Australian Federal Police were advised that he had breached his bail conditions in the UK.

DIAC and Serco were advised that Mr Saunders had threatened suicide in the past and had made recent threats to self-harm.

Mr Saunders was not placed on suicide watch but was placed on security watch, which required observations every 60 minutes.

On 8 December Mr Saunders was found hanging in a shower cubicle at VIDC.

CCTV footage revealed that the Serco officer did not maintain the required 60 minute observations of Mr Saunders.

Findings and recommendations

The Coroner found that Mr Rauluni, Mr Al-Akabi and Mr Saunders committed suicide.

The Coroner said that since people in immigration detention are at a higher risk of suicide than the general community, DIAC, Serco and IHMS have an elevated duty of care to detainees. The Coroner stated:

> "when government chooses to maintain a detention system, it carries a heavy responsibility. Similarly, a company which contracts to shoulder a large part of that responsibility it is under a major obligation to fulfil its contract, both to government and to those in its care.[1]

The Coroner found that DIAC, Serco and IHMS did not fulfil their duty of care to the deceased and criticised the absence of appropriate screenings or protocols, the constant changing of case managers and health professionals and the failure to record or share important information.

The Coroner stated that in all of the deaths 'some of the actions of some of the staff were careless, ignorant, or both, and communications were sadly lacking'[2].

It was found that Serco staff were 'unprepared and untrained'[3] to deal with Mr Rauluni's threats to jump from the balcony.

DIAC also failed to follow its own standards when it notified Mr Rauluni of his removal on a Friday when no mental health staff were available.

The Coroner found that Mr Al-Akabi was 'probably misdiagnosed and medicated'[4]. IHMS failed to identify the seriousness of his mental state and failed to communicate his true level of risk.

In relation to Mr Saunders the Coroner found the failure by IHMS, DIAC or Serco to place him on suicide watch and the failure of the Serco officer to adequately monitor him, to be 'deplorable'[5].

Of significance was the Coroner's rejection of DIAC's submission that the power to make recommendations under the *Coroners Act 2009* (NSW) does not extend to the Commonwealth Ministers.

The Coroner held that the Coroners Act binds the Crown in right of the Commonwealth in light of the purposes of the coronial jurisdiction. Accordingly, the power to make recommendations does extend to Commonwealth Ministers.

The Coroner proceeded to make recommendations focused on the development and implementation of policies and procedures to adequately monitor the mental health of detainees and the use of force in effecting removal.

While the Coroner's recommendations are not binding, given the damning systemic failures clearly identified, it is hoped that the agencies will give serious consideration to the implementation of all recommendations.

Endnotes

1. *Inquest into the Deaths of Josefa Rauluni, Ahmed Obeid Al-Akabi and David Saunders, NSW Coroners Court, 19 December 2011, p 12.*
2. Above n 1, p 11.
3. Ibid.
4. Ibid.
5. Ibid.