IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2014 / 0867

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the death of Dalvir Singh

Delivered On:	26 March 2015
Delivered At:	Coroners Court of Victoria
Hearing Dates:	28 October 2014; and 19–28 November 2014
Findings of:	Coroner Jacqui Hawkins
Representation:	Mr G Barnes appeared on behalf of Ms Bala Ms C Harris appeared on behalf International Health and Medical Services Mr P Lawrie appeared on behalf of the Chief Commissioner of Police Mr P Rozen appeared on behalf of Serco Australia Pty Ltd Mr T Wraight appeared on behalf of the Department of Immigration and Border Protection
Counsel Assisting the Coroner	Mr S McGregor of counsel Ms S McIntyre, solicitor of the Coroners Court of Victoria

I, Jacqui Hawkins, Coroner having investigated the death of Dalvir Singh

AND having held an inquest in relation to this death on 28 October 2014 and 19–28 November 2014

at MELBOURNE

find that the identity of the deceased was Dalvir Singh

born on 15 October 1986

and the death occurred on 13 February 2014

at the Maribyrnong Immigration Detention Centre, 53 Hampstead Road, Maribyrnong, Victoria, 3032

from:

1 (a) HANGING

in the following circumstances:

BACKGROUND

1. Dalvir Singh was a 27 year old Indian Citizen who was in custody at the Maribyrnong Immigration Detention Centre (MIDC) at the time of his death. At approximately 6.35pm on 13 February 2014, he was located deceased in his bedroom at the MIDC where he had taken his own life by hanging.

2. On 1 October 2007, Mr Singh came to Australia on a 'Higher Education Sector' Student Visa which was extended for two years. Mr Singh initially resided with his older brother Harpal Singh and he had intended to study hospitality, however this did not eventuate and he gained employment driving taxis, trucks and working on farms.

3. On 22 October 2009, Mr Singh's student visa was cancelled and the following day he was classified as an unlawful non-citizen. On 12 November 2009, Mr Singh was granted a bridging visa to regularise his immigration status pending departure from Australia. This bridging visa was valid until 19 November 2009, however Mr Singh did not make any further visa arrangements and he was once again classified an unlawful non-citizen.

4. Mr Singh met Ms Bala in 2012 and shortly afterwards they commenced an intimate relationship and had a son together in March 2013. Mr Singh and Ms Bala married in June 2013.

5. Mr Singh had a history of excessive alcohol consumption and had been a heroin user. He had been prescribed Suboxone[1] by Dr John Sherman since September 2012 however neither his wife nor his brother were aware of this information.

Contact with Victoria Police

6. On 26 December 2013, Victoria Police spoke with Mr Singh in relation to a report of family violence and issued him with a family violence safety notice. At this time, Ms Bala mentioned to police that Mr Singh may have overstayed his visa.[2]

7. The following day Ms Bala made a further report of family violence and Mr Singh was taken into custody by Victoria Police and held in a cell at the Pakenham Police Station. He was recorded as having a blood alcohol reading of 0.137%. In custody overnight, Mr Singh attempted suicide by hanging and was taken to Casey Hospital[3] and discharged the following morning. The details of this incident were entered into the Law Enforcement Assistance Program (LEAP) and Mr Singh was allocated a self harm warning flag.

8. On 31 December 2013, an Interim Intervention Order was made. After this time Mr Singh continued to contact Ms Bala and was notified of allegations that he was in breach. On 10 January 2014, Mr Singh voluntarily attended the Pakenham Police Station where he was arrested and interviewed.

Involvement with the Department of Immigration and Border Protection

9. While Mr Singh was in custody at the Pakenham Police Station on 10 January 2014, Victoria Police made enquiries with the Department of Immigration and Border Protection (DIBP) who advised that according to their records Mr Singh was an unlawful non-citizen.

10. Mr Luke Cooper, Compliance Officer for DIBP emailed Victoria Police and requested that they detain Mr Singh pursuant to section 189 of the *Migration Act* 1958 (Cth) (Migration Act) and attached two forms for completion.[4]

11. Constable Sheree Osborne completed the DIBP Form 1275 which required Mr Singh's personal particulars as well as other relevant information, including any health issues. Once completed, Sergeant Richard Dawson returned the form to Mr Cooper by email.

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1 "Suboxone contains buprenorphine hydrochloride and naloxone hydrochloride. Buprenorphine acts as a substitute for opiate drugs like heroin, morphine or oxycodone and it helps withdrawal from opiate drugs over a period of time. When taken sublingually (under the tongue) as prescribed, naloxone has no effect, as it is very poorly absorbed. However, if SUBOXONE SUBLINGUAL FILM is injected, naloxone will act to block the effects of other opiates like heroin, morphine and oxycodone, leading to bad withdrawal symptoms." Suboxone Consumer Medicine Information Sheet.

2 Exhibit 90 – Balance of Inquest Brief, Statement of Ms Bala dated 28 March 2014, Inquest Brief at p44

3 Part of Monash Health

4 Exhibit 2 – Request for Officer to Hold in Immigration Detention form, Inquest Brief at p1324; Exhibit 3 – Form 1275 – Police Record of Immigration Detention, Inquest Brief at p1325

12. Mr Cooper then conducted a Compliance Client Interview (CCI) with Mr Singh by telephone[5] and determined that he posed a risk to the migration process and should be detained.

13. Mr Cooper then issued a Transfer of Custody form[6] which authorised Victoria Police to transfer custody of Mr Singh to Serco Australia Pty Limited (Serco). He also sent a Request for Service (RFS) to Serco and Serco Client Services Officers (CSOs) Mr Barnsley and Mr Harris were tasked with transferring Mr Singh from the Pakenham Police Station to the MIDC.[7]

14. There is conflicting evidence as to whether Victoria Police members notified either of the Serco officers that Mr Singh had previously attempted suicide whilst in custody.

Immigration Detention

15. At the time of Mr Singh's death there were approximately 95 detainees at the MIDC which has an operating capacity of 99 detainees.[8]

16. When Mr Singh arrived at the MIDC on 10 January 2014, CSO Ms Mateta Zyntek, conducted his induction including a Self Harm Assessment Interview.[9] The following day a Mental Health Assessment was conducted by Ms Amy Hubbard, Registered Nurse who was employed by International Health and Medical Services (IHMS). Mr Singh did not disclose any mental health issues during either interview nor did he disclose any previous self harm or suicide attempts.

17. On 11 January 2014, Mr Singh was further assessed by Nurse Hubbard in relation to his opiate withdrawal and Suboxone prescription. Nurse Hubbard made concerted efforts to ensure that Mr Singh could access his Suboxone medication which he thereafter took daily whilst detained at the MIDC.

18. On 12 January 2014, Serco created a Individual Management Plan (IMP) which documented amongst other things information about his previous drug use.

19. On 13 January 2014, DIBP Security Liaison Officer Daniel Schmidts emailed Victoria Police seeking information that might assist management of Mr Singh while in detention, including a request for details of any pending criminal charges.

20. On 14 January 2014, Julie Gambrell from DIBP was assigned as Mr Singh's Case Manager. She engaged in a general discussion with Mr Singh about his background information.

21. The Australian Federal Police (AFP) assisted the MIDC with checking Mr Singh's identity via the National Automated Fingerprint Identification System (NAFIS).

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5 Exhibit 4 – Client Compliance Interview by Luke Cooper dated 10 January 2014, Inquest Brief at p1327.

6 Exhibit 5 – Transfer of Custody Form dated 10 January 2014, Inquest Brief at p1327

7 Exhibit 16 – Statement of Peter Barnsley dated 10 October 2014, Inquest Brief at p1934

8 Exhibit 81 – Statement of Johnathon Holmes dated 15 July 2014, Inquest Brief at p246

9 Exhibit 32 – Serco Self Harm Assessment Interview Inquest Brief at pp537-538

22. On 21 January 2014 AFP notified DIBP by email of warnings in relation to Mr Singh's criminal history of "family violence/assault" and "suicide/self-harm" in the Victorian jurisdiction. No action was taken in response to this email.

23. On 24 January 2014, a comprehensive Mental State Examination was conducted by Registered Psychiatric Nurse Ian Garlick which included completion of the Depression, Anxiety and Stress Scale (DASS21) and a General Health Questionnaire (GHQ30).[10] No concern for Mr Singh's mental health arose from this.

24. By 13 February 2014, DIBP had tentatively set a date in late February for Mr Singh's removal however Mr Singh is not believed to have been informed of this.[11]

25. Between 6.15pm and 6.26pm on this day, closed circuit television (CCTV) footage shows Mr Singh entering and exiting his room a number of times. At 6.26pm, Mr Singh opened the door to his room, looked into the corridor and then closed the door again.

26. Serco CSO Mark Mayne conducted a routine welfare check at approximately 7.05pm. When he did not receive a response to a knock on Mr Singh's door he entered the room and found Mr Singh tied by his neck to the railing on his bed. Mr Mayne called for urgent assistance.

27. Additional Serco officers arrived and assisted Mr Mayne with cardiopulmonary resuscitation (CPR). Medical staff from IHMS arrived and assisted until the paramedics were present who then assumed responsibility for the CPR. Resuscitation attempts were ultimately unsuccessful and Mr Singh was pronounced deceased at 7.21pm.

28. Mr Singh spent a total of 34 days in detention at the MIDC. According to Mr Daniel Florent, Director of Detention Operations at DIBP, Mr Singh

> interacted well with other detainees, participated in programmes and activities and presented with little or no indication of stress or anxiety. Further, his time in detention was free of incidents and consequently he was not placed on an increased level of the Psychological Support Program or a Behaviour Management Plan.[12]

JURISDICTION

29. The Coroners Court of Victoria is an inquisitorial jurisdiction.[13] The role of the coroner in this State includes the independent investigations of deaths to contribute to a reduction in the number of preventable deaths, the promotion of public health and safety, and the administration of justice. It is not the role of the coroner to lay or apportion blame, but to establish facts.[14]

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10 Exhibit 52 – Mental State Examination Assessment dated 24 January 2014, Inquest Brief at p1592; Exhibit 49 – Statement of Ian Garlick dated 13 October 2014, Inquest Brief, p1540

11 Exhibit 79 – Statement of Daniel Florent dated 14 July 2014, Inquest Brief, at p1048

12 Exhibit 79 – Statement of Daniel Florent dated 14 July 2014, Inquest Brief, at p1050

13 Section 89(4) of the Coroners Act

14 *Keown v Kahn* (1999) 1 VR 69.

30. A coroner may comment on any matter connected with the death, may report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with the death, including recommendations relating to public health and safety and the administration of justice.[15]

31. As Mr Singh's death occurred while in the custody of the DIBP an inquest into his death was mandatory.[16]

32. In writing this finding I have considered the *Charter of Human Rights and Responsibilities Act* 2006 (Vic), particularly in the context of how it relates to investigations into the conduct of public authorities, especially when people die while in the care of public authorities, for example, deaths in custody.[17]

CORONIAL INVESTIGATION AND INQUEST

33. Mr Singh's death was subject to a thorough coronial investigation in which extensive further material was requested from and provided by the following Interested Parties:
    - Ms Bala
    - Chief Commissioner of Police
    - Serco
    - IHMS
    - DIBP
    - Monash Health.[18]

34. Two directions hearings were held on 16 July 2014 and 23 September 2014 to assist in defining the direction and scope of my investigation.

35. An inquest into the death of Mr Singh commenced on 28 October 2014 and resumed between 19 and 28 November 2014. To assist with my understanding of the circumstances of Mr Singh's death, a viewing of the MIDC facility was conducted on 19 November 2014.

Witnesses

36. The following witnesses gave *viva voce* evidence at the Inquest:
    - Mr Luke Cooper, Compliance Officer, DIBP
    - Mr Peter Barnsley, Client Services Officer, Serco
    - Mr Moomooga Harris, Client Services Officer, Serco
    - First Constable Sheree Osborne, Victoria Police
    - Sergeant Richard Dawson, Victoria Police
    - Ms Mateta Zyntek, Client Services Officer, Serco

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15 Section 72(1) and (2) of the Coroners Act

16 See sections 4 and 52(2)(b) of the Coroners Act 2008 and Regulation 7 of the *Coroners Regulations 2009*.

17 Section 9 and 22 of the *Charter of Human Rights and Responsibilities Act* 2006 (Vic)

18 I note that Monash Health were excused at the second directions hearing held on 23 September 2014 from participating further in the Inquest process, as an assessment of the appropriateness of their involvement with Mr Singh was considered outside scope.

- Ms Anne Chiang, Client Services Officer, Serco
- Ms Amy Hubbard, Registered Nurse, IHMS
- Dr Emily Shaw, General Practitioner, IHMS
- Mr Ian Garlick, Registered Nurse, IHMS
- Dr Mark Parrish, Regional Medical Director, IHMS
- Superintendent Andrew Humberstone, Victoria Police
- Mr Daniel Schmidts, Security Liaison Officer, DIBP
- Ms Julie Gambrell, Senior Case Manager, DIBP
- Mr Michael Kingma, Centre Manager, MIDC, DIBP
- Mr Daniel Florent, Director, Detention Operations, DIBP
- Mr Johnathon Holmes, National Operations Manager, Serco
- Dr John Sherman, General Practitioner, Open Family Footscray.

37. At the conclusion of the evidence, I considered whether an independent expert would assist my understanding of the self-harm and suicide risk screening processes and the mental health monitoring and management of Mr Singh. Based upon all of the evidence, I concluded that this was unnecessary.

38. Written submissions and submissions in reply were provided by each Interested Party in February 2015.

Issues investigated

39. Section 67 of the Coroners Act requires me to find if possible the identity of the deceased, the cause of death and the circumstances in which death occurred.

IDENTITY OF THE DECEASED

40. I find that the identity of Dalvir Singh was without dispute and required no additional investigation.[19]

CAUSE OF DEATH

41. On 14 February 2014, Dr Jacqueline Lee, Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted an autopsy on the body of Mr Singh and attributed his medical cause of death as 1a) HANGING.[20]

42. No drugs or alcohol were detected in his blood as part of the toxicological analysis.

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[19] A statement of identity was completed by Anne Chiang dated 13 February 2014.

[20] Exhibit 13 – Autopsy and Toxicology Report, signed by Dr Jacqueline Lee, Forensic Pathologist dated 6 June 2014.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

Intention to suicide

43. The weight of the evidence available to me prior to the commencement of the Inquest established that Mr Singh's death was a suicide. Suicide has been defined as:

> voluntarily doing an act for the purposes of destroying one's life while one is conscious of what one is doing. In order to arrive at a verdict of suicide there must be evidence that the deceased intended the consequence of his act.[21]

44. Evidence in support of this finding included Mr Singh's previous suicide attempt in custody, the CCTV footage which excluded the possibility of another person's involvement and the explicit and implicit expressions of suicidal intention contained in notes located at the scene.[22]

45. It is not possible to nominate with any degree of certainty the contribution of any one reason for a person's decision to take their own life. Nevertheless, it is evident that a number of stressors were operant at the time of Mr Singh's death that placed him in a particularly vulnerable position including:

- The loss of his liberty;
- The breakdown in his relationships with his wife and son;
- Potential civil and criminal consequences of his family violence behaviour;
- The possibility of deportation;
- Withdrawal from opiates;
- Separation from family, friends and other community supports; and
- General uncertainty about his future.

46. I accept that Mr Singh was not showing any significant overt signs that he was particularly distressed or experiencing suicidal ideation in the days leading up to his death. Further, I agree that, as opined by Nurse Garlick, this would indicate his action on the day of his death "may have been impulsive".[23]

47. However, although Mr Singh's intent was not in issue at Inquest, given the known vulnerability created by the accumulation of the above stressors, his decision to take his life raises questions about whether the agencies involved in the management of his immigration detention appropriately identified, treated and monitored his mental state.

Issues investigated as part of the Inquest

48. A number of complex and interrelated issues pertaining to the circumstances of Mr Singh's death were identified throughout the course of my investigation, however the following are canvassed at length in this Finding:

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[21] *R v Cardiff City Coroner, Ex parte Thomas* [1970] 1 WLR 1475.

[22] Exhibit 90 – Balance of Inquest Brief, Inquest Brief at pp 58-60

[23] Transcript of evidence, p483

- Inter-agency communication about Mr Singh's previous suicide attempt;
- The appropriateness of care and management with respect to self-harm and suicide risk screening, assessment and management at the MIDC.

49. These issues are explored in relation to each of the following in turn:
    - Victoria Police;
    - Serco;
    - IHMS; and
    - DIBP.

50. I do not propose to recount or summarise all of the evidence but rather refer to the parts that are necessary, touching upon the relevant circumstances investigated as part of the inquest.

VICTORIA POLICE

51. The appropriateness of the response by Victoria Police and Casey Hospital to Mr Singh's previous suicide attempt did not fall within the scope of the Inquest. In contrast, who did or did not have knowledge of the circumstances was germane to my investigation because of the question's relevance to subsequent assessments and management. This information about Mr Singh's previous suicide attempt was important and should have been exchanged between the agencies was not disputed by any of the Interested Parties at Inquest.

52. When Mr Singh attended Pakenham Police Station on 10 January 2014, Constable Osborne was aware of the LEAP warning flag regarding Mr Singh and his previous suicide attempt.[24] Sergeant Dawson stated that Constable Osborne informed him of this information[25] and he instructed her to ensure that Constable Raven maintained observations on Mr Singh while further enquiries with DIBP were made.[26] It is clear that key members of Victoria Police were aware of his history and the implications of this for his ongoing management.

53. While Victoria Police members are regularly involved in transferring people between police stations and custody centres, the transfer of Commonwealth immigration detainees is far less common. Indeed, prior to their involvement with Mr Singh, neither Constable Osborne nor Sergeant Dawson had ever experienced a transfer of custody to DIBP or Serco.[27]

54. It is problematic that Victoria Police did not have any documented procedures in the Victoria Police Manual (VPM) or provide any training to guide Sergeant Dawson and Constable Osborne on the requirements and best practice for the transfer of Mr Singh's custody. Consequently, the police members were reliant upon DIBP's instructions and otherwise applying the general transfer of custody principles to this novel exercise.

55. A number of issues arose with respect to sharing pertinent information including:
    - Transfer of information to DIBP

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24 Exhibit 22 – Statement of Constable Sheree Osborne dated 29 April 2014, Inquest Brief at p937
25 Exhibit 29 – First statement of Sergeant Richard Dawson dated 31 July 2014, Inquest Brief at p940
26 Exhibit 22 – Statement of Constable Sheree Osborne dated 29 April 2014, Inquest Brief at p938
27 Transcript of evidence, p267

- Transfer of information to Serco
- Ability to share information on internal databases.

56. In addition I address in short compass the issue raised by counsel for Ms Bala in relation to Victoria Police's response to allegations that Mr Singh continued to breach the FVIO.

Transfer of information from Victoria Police to DIBP

57. When Mr Cooper requested Victoria Police to detain Mr Singh he required them to complete a Form 1275, which was done by Constable Osborne. Although asked at Question 11 of this form the:

> Reason/circumstances for detention and any relevant information including travel documents, health issues, injuries, etc.

58. Constable Osborne did not make reference to Mr Singh's previous suicide attempt anywhere on the Form 1275 and noted "Nil health issues disclosed".[28]

59. Constable Osborne gave evidence that she did not record information about Mr Singh's previous suicide attempt because the question asked her to comment about *health* as opposed to *mental health* issues. She considered health issues were "medical such as heart conditions or diabetes" and Mr Singh had not indicated any such health problems to her. When asked specifically whether a suicide attempt was a health issue Constable Osborne said no[29] because in her mind medical conditions and mental health are quite separate things.[30]

60. Constable Osborne stated that at the time she did not appreciate that Question 11 was asking for information contained in Mr Singh's LEAP record,[31] and she believed that the form related mainly to custody issues not health issues. Constable Osborne indicated that if Question 11 included an information request about health, welfare and behavioural issues, she would have included the suicide risk.[32]

61. The evidence is that Sergeant Dawson had an opportunity to review the completed Form 1275 before returning it to Mr Cooper however he could not remember whether he had.[33] With the knowledge he has now, he accepts that the warning regarding the suicide risk should have been included in answer to Question 11 because he recognised its relevance.[34]

62. Mr Cooper's evidence was that DIBP provide police with an opportunity to make known any concerns on the Form 1275 and during conversations when they ask how the person was

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28 Exhibit 3 – Form 1275 – Police Record of Immigration Detention, p1325
29 Transcript of evidence, p206
30 Transcript of evidence, p209
31 Transcript of evidence, p206
32 Transcript of evidence, p207
33 Transcript of evidence, p265
34 Transcript of evidence, p258

located and then referred to them. Although conceding that he ought to have raised Mr Singh's previous suicide attempt with Mr Cooper on the phone,[35] Sergeant Dawson could not recall whether he did so.[36]

63. Mr Singh's previous suicide attempt was never communicated to Mr Cooper, either by telephone or in writing on the Form 1275. The underlying reason for this seems to have been a misunderstanding on the part of Constable Osborne and Sergeant Dawson about the purpose and use of Form 1275. Specifically, they construed the purpose of the document more narrowly than it was intended.

64. Counsel for DIBP informed the Inquest that their client had since revised Form 1275 and the email to which it is attached to rectify any obscurity in relation to the information required. The Revised Form 1275 came into operation in November 2014.[37] It contains an additional question which specifically asks: "Is there a record of any health/mental health or behavioural issues recorded on police systems or other relevant data sources". Constable Osborne indicated that she would see this new question as an appropriate place to mention self-harm risks.[38] Sergeant Dawson agreed that the Revised Form 1275 was a significant improvement[39] and in his opinion would elicit appropriate checks of Victoria Police LEAP records and prompts the communication of information such as the risk of suicide or self-harm.[40]

65. In addition, submissions on behalf of the Chief Commissioner of Police confirmed that the role and importance of the Revised Form 1275 will be supported by new instructions in the Victoria Police Manual.[41]

Transfer of information from Victoria Police to Serco

66. There is conflicting evidence as to whether Serco officers Mr Barnsley and Mr Harris were advised by Victoria Police of Mr Singh's previous suicide attempt while at the Pakenham Police Station.

67. The evidence of Sergeant Dawson was that, as Mr Singh was being transferred to the vehicle in the collection bay, he informed the older of the two Serco officers.[42] At Inquest, Sergeant Dawson testified that although he could not remember the exact conversation, he was of the belief it occurred because "it was in the interests of Mr Singh and also the people looking

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35 Transcript of evidence, p269
36 Transcript of evidence, p262
37 Exhibit 15 – Revised Form 1275 in effect as of 18 November 2014
38 Transcript of evidence, p208
39 Transcript of evidence, p259
40 Transcript of evidence, p258
41 Submissions on behalf of the Chief Commissioner of Police, p9
42 At Inquest it was established that this was most likely to have been Mr Barnsley.

after him that they should have that information".[43] Sergeant Dawson was unable to provide any evidence to corroborate his version of events.[44] He confirmed in evidence that he did not make a note in his daybook and that in hindsight he probably should have.[45]

68. In contrast, neither of the Serco officers had any recollection of this information being provided by Sergeant Dawson or any other member of Victoria Police. Mr Barnsley denied that Sergeant Dawson advised him of any previous suicide attempt.[46] Had he been provided with this information, he would have asked Mr Harris to note it on the Transport and Escort Operational Order,[47] advised the MIDC operations manager and included the information on the Initial Security Risk Assessment Form.[48] Mr Barnsley informed the court that his philosophy is "if it isn't in writing it never happened".[49]

69. Mr Harris supported Mr Barnsley's version of events. He believes that he was within earshot of Mr Barnsley at all times while at the station and at no time did he hear Sergeant Dawson or any other police officer inform Mr Barnsley of a previous suicide attempt[50] and if he had, he would have noted it down.

70. All three witnesses presented as credible and honest however as Counsel for the Chief Commissioner of Police succinctly articulated: "all three witnesses had imperfect memories".[51] Given this and the lack of any objective and contemporaneous evidence, I am ultimately unable to determine on the balance of probabilities whether Sergeant Dawson did convey this information verbally to either of the Serco officers.

71. What is evident, however, is that it was not formally documented and as a result could not inform subsequent care and management decisions. Sergeant Dawson conceded at Inquest that there had been a degree of informality about the way in which he communicated a matter of gravity to another custody provider.[52]

72. Although the importance of recording information in writing is not a novel concept to members of Victoria Police, the ultimate breakdown in communication may be understood in light of the fact that the transfer of custody to Serco was an experience out of the ordinary for members of Victoria Police.

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43 Transcript of evidence, p263

44 Transcript of evidence, p263

45 Transcript of evidence, p266

46 Transcript of evidence, p167

47 Transcript of evidence, p136

48 Exhibit 16 – Statement of Peter Barnsley dated 10 October 2014, Inquest Brief at p1934; Transcript of evidence, p118

49 Transcript of evidence, p137

50 Exhibit 21, Statement of Moomooga Harris dated 8 October 2014, Inquest brief at p1931

51 Submissions on behalf of the Chief Commissioner of Victoria Police, p7

52 Transcript of evidence, p268

73. Accordingly, the ability to manage Mr Singh while in immigration detention would have been strengthened by better systems being in place in the early stages of his custody to ensure that essential information was clearly documented and therefore readily conveyed to other agencies.

Ability of Victoria Police to share internal records with other agencies

74. The Inquest considered whether Victoria Police could have provided Serco or DIBP with information from internal databases, such as LEAP records. Members of Victoria Police were unsure of whether this was permitted. In fact, Constable Osborne did not believe she was authorised to release LEAP information to another party.[53]

75. At the time a Memorandum of Understanding[54] (MOU) existed between DIBP[55], AFP and Victoria Police to facilitate the provision of police services to Immigration Detention Facilities in Victoria. Section 9 specifically dealt with Information Exchange and Data Security. Paragraph 9.1 stated:

> The Participants may exchange information pursuant to this MOU in accordance with relevant Commonwealth, state and territory laws.[56]

76. Although the MOU clearly provided for the exchange of information with DIBP, Sergeant Dawson and Constable Osborne appear not to have been aware of its existence.[57] Sergeant Dawson indicated that he could have provided the Serco officers with a copy of the LEAP printout that evening but was unable to provide a reason for why he had not. [58]

77. I consider that the provision of the LEAP printout would have facilitated the easy exchange of information about Mr Singh's previous suicide attempt between DIBP, Serco and subsequently, IHMS. Although the MOU allows for the exchange of information, it would appear that this did not occur, in part because there were not suitable procedures in place to promote it.

Breach of the Family Violence Intervention Order (FVIO)

78. Counsel for Ms Bala raised concerns about the excessive number of phone calls made to her by Mr Singh whilst in detention. Phone records obtained as part of this investigation provide evidence in support of the allegations that the FVIO had been breached.

79. I affirm the importance of providing a response to family violence that promotes the safety of victims and the accountability of perpetrators, however I did not consider that Victoria

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53 Transcript of evidence, p233

54 Exhibit 90 - Balance of Inquest Brief, Memorandum of Understanding, at p1005

55 At the time of the execution of the Memorandum of Understanding the DIBP was known as the Department of Immigration and Citizenship (DIAC)

56 Exhibit 90 – Balance of Inquest Brief, Memorandum of Understanding, at p1011

57 Transcript of evidence, p215

58 Transcript of evidence, p266

Police's response fell within the ambit of my investigation of Mr Singh's death and I did not call the police officer in charge of investigating them to give evidence. I therefore do not consider it appropriate to comment on this issue.

Changes made by Victoria Police following the death of Mr Singh

80. In April 2014, Sergeant Pietrosanto reviewed the circumstances of this incident and identified that the VPM gave no guidance concerning the transfer of custody to external agencies. He recommended that a policy position or amendment was required.[59]

81. At the commencement of the Inquest, Superintendent Andrew Humberstone presented an amended VPM Guideline on Safe Management of Persons in Police Care or Custody, highlighting in particular section 9.4 Transfer to External Agency.[60]

82. Superintendent Humberstone was cross-examined on the efficacy of the document and the potential to create confusion by adding another document into the process. He agreed that it would be preferable for all relevant agencies to develop and implement a single document.[61]

83. At inquest, I affirmed the importance of a coordinated response to the issue and suggested that DIBP, Serco and Victoria Police meet with this purpose in mind. Victoria Police subsequently communicated to the Court through Counsel that further development or promulgation of the amended guidelines would be suspended pending consultation with DIBP and Serco.[62]

SERCO

84. Serco has responsibility for the management and control of Australian immigration detention centres including the MIDC. Whilst DIBP owns the MIDC, it grants Serco a licence to occupy and use the premises and contracts Serco to provide "a range of services to promote the wellbeing of people in detention and create an environment that supports security and safety".[63]

85. The process for physical detention of Mr Singh on behalf of the DIBP occurred pursuant to the RFS sent by Luke Cooper on 10 January 2014 to Serco.

86. Although Serco does not receive a copy of the Form 1275 completed by Victoria Police, the RFS is required to contain all relevant personal information provided on that form. Mr Holmes stated that a detainee's history of self-harm or suicide attempts is relevant to Serco and should be included in the RFS.[64] In relation to Mr Singh, the RFS specifically noted that there were "no known behavioural/violence concerns. Detainee is taking daily

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59 Exhibit 90 - Balance of Inquest Brief at p968

60 Exhibit 64 - VPM Guideline on Safe Management of Persons in Police Care or Custody

61 Transcript of evidence, p580

62 Submissions on behalf of Chief Commissioner of Police, p8

63 Exhibit 90 – Balance of inquest brief, Detention Services Contract, Inquest brief at p2836

64 Exhibit 81 - Statement of Johnathon Holmes dated 15 July 2014, Inquest Brief at p247

medication for Suboxone for previous drug addiction".[65] Mr Singh's level of risk was recorded as 'low'.

87. The risk level indicated in the RFS determines the number of officers required to conduct the task of transfer and as Mr Singh's risk level was low two officers were assigned, being Mr Barnsley and Mr Harris.

88. Mr Barnsley had approximately 15 years experience working as a CSO[66] and Mr Harris four years.[67] As the more senior and experienced CSO, Mr Barnsley was the 'officer in charge' of the transfer.

89. Before leaving the MIDC, Mr Barnsley and Mr Harris were provided equipment, a briefing and a Transport and Escort Operational Order form which provides details of the pick up location, detainees risk rating and other relevant information. Mr Barnsley said his usual practice was to review this form prior to departing.[68] Detainees were usually transported to the MIDC from the airport, but other than the location, Mr Singh's was just a routine transfer.[69]

90. Although Serco and IHMS work collaboratively to manage the physical and mental wellbeing of detainees,[70] it is to the following aspects of management by Serco employees that I now turn my mind:

- Initial security risk assessment;
- Self-harm assessment interview;
- Individual Management Plan and Personal Officers; and
- Alleged breach of the FVIO.

Initial Security Risk Assessment

91. In accordance with Serco policy, Mr Harris observed Mr Singh en route to the MIDC and completed an MIDC Initial Security Risk Assessment[71] form on arrival, which he subsequently provided to Serco's client services department. In evidence, Mr Barnsley explained that this risk assessment relates more to security risk than detainee safety; for example the risk of escape or violence during transportation.[72]

92. Although Mr Singh was noted to be calm and compliant throughout the trip, Mr Barnsley indicated that Mr Singh's previous suicide attempt, if known, would have required him to have been rated as 'high' on the Initial Security Risk Assessment Form. However, on the

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65 Exhibit 17 – Request for Service document signed 10 January 2014, Inquest brief at p528
66 Exhibit 16 – Statement of Peter Barnsley dated 10 October 2014, Inquest brief at p1933
67 Exhibit 21 – Statement of Moomooga Harris dated 8 October 2014, Inquest brief at p1929
68 Exhibit 16 – Statement of Peter Barnsley dated 10 October 2014, Inquest brief, p1933
69 Transcript of evidence, p128
70 Exhibit 81 - Statement of Johnathon Holmes dated 15 July 2014, Inquest Brief at p246
71 Exhibit 19 – MIDC Initial Security Risk Assessment form dated 10 January 2014, p2027
72 Transcript of evidence, p121

basis that they had no information to the contrary, a consensus was reached to rate Mr Singh as low.[73]

93. It is therefore clear that the flow-on effect of the breakdown in communication from Victoria Police to Serco and DIBP was that subsequent risk assessments were based on an incomplete picture. I therefore reiterate in this context the importance of interagency communication and collaboration.

Self Harm Assessment Interview

94. On arrival at MIDC, detainees undergo an administrative induction process including photographing, fingerprinting and the recording of information such as personal characteristics and property in their possession. The detainee is shown an induction video, provided with fresh clothes and information about their rights and responsibilities. They are also given the opportunity to make a phone call.

95. As part of this process they also complete a Self Harm Assessment Interview which comprises scripted questions as outlined in the DIBP Detention Services Manual (DSM).[74] When Mr Singh arrived at the MIDC, CSO Mateta Zyntek inducted Mr Singh and conducted his Self Harm Assessment Interview.[75]

Conduct of the interview

96. Mr Singh's response to Question 5 of the interview ("Tell me how you're felling now?"), was recorded as "Feeling not well".[76] Ms Zyntek testified that she did not pursue an explanation from him because he started to cry and indicated that he wanted to talk to his wife.[77] She noted that this response was not unusual and many people who come to the detention centre are not happy to be there, a lot of people cry, are stressed, depressed and scared.[78] Ms Zyntek further testified that she did not consider that Mr Singh was particularly upset nor was he displaying any concerning behaviour.[79]

97. Mr Singh responded affirmatively in response to Question 6 ("Do you feel in control of your emotions now?). The consequence of this was that Ms Zyntek was directed by the form to skip the follow-up question which related to whether Mr Singh was having any thoughts of hurting or harming himself.[80]

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73 Exhibit 16 - Statement of Peter Barnsley dated 10 October 2014, Inquest Brief at pp1931 and 1933A

74 Submissions on behalf of Serco, p10

75 Exhibit 32 – Serco Self Harm Assessment Interview, Inquest Brief at p1923

76 Exhibit 32 – Serco Self Harm Assessment Interview, Inquest Brief at p1925

77 Transcript of evidence, p293

78 Transcript of evidence, p361

79 Exhibit 31 – Statement of Mateta Zyntek dated 18 September 2014, Inquest Brief at p1916; Transcript of evidence, p361

80 Exhibit 31 – Statement of Mateta Zyntek dated 18 September 2014, Inquest Brief at p1916

98. The submissions on behalf Ms Bala indicated that the Self Harm Assessment Interview form should be amended and enhanced.[81] Ms Zyntek indicated at Inquest that since the death of Mr Singh she always asks detainees if they have thoughts about hurting or harming themselves even if they feel in control or their emotions.[82] I consider that asking this, as a separate and independent question, is an appropriate adjustment to the interview process.

Recording of information on the Self Harm Assessment Interview form

99. The level of information recorded on the Self Harm Assessment and Interview Form was inadequate. Many questions contained answers of only a few words and Ms Zyntek's exchange with Mr Singh raised a number of aspects of his mental state and wellbeing that could have been the subject of further exploration and record.

100. I acknowledge the purpose of the interview as a screening process, yet I note that Ms Zyntek is not medically trained[83] however I am of the view that this increases the need to thoroughly document all information provided and observations made. This provides important context to subsequent mental health assessments.

101. Ms Zyntek herself acknowledged that she could and should have put more information in the document so the next person would be better informed about Mr Singh.[84] Serco also accepted that as much detail as possible should be included in the records of Self Harm Assessment Interviews.[85]

Action taken by Ms Zyntek on the basis of the Self Harm Assessment Interview form

102. On the basis of the Self Harm Assessment Interview and the information provided on the RFS, Ms Zyntek rated Mr Singh as a low risk of self harm and referred him for an initial medical assessment by IHMS the following morning.

103. KeepSAFE and PSP set out the clinically recommended approach for the identification and support of detainees who have psychological vulnerabilities or are at risk of self-harm and/or suicide. According to Mr Holmes, KeepSAFE and PSP are based upon nine principles of prevention and management of self-harm and includes a detailed SAFE (Support, Action, Follow up and Evaluation) process, and monitoring and engagement processes.[86]

104. The KeepSAFE process is triggered when a risk or concern is identified by either Serco or IHMS and/or when information is received from DIBP regarding historical psychological health concerns. If DIBP receives information regarding a history of self harm or suicide

[81] Submissions on behalf of Ms Bala, p33

[82] Transcript of evidence, p362

[83] Exhibit 31 – Statement of Mateta Zyntek dated 18 September 2014, Inquest Brief at p1917

[84] Transcript of evidence, p294

[85] Submissions on behalf of Serco, p11

[86] Exhibit 81 - Statement of Johnathon Holmes dated 15 July 2014, Inquest Brief at p249

attempts, the detainee is assessed as high risk upon induction until the detainee is medically assessed by IHMS and a revised risk rating is assigned.[87]

105. In accordance with KeepSAFE, a Serco staff member will either stay with the detainee if high risk until he/she can be assessed by IHMS or check on the detainee periodically if moderate or ongoing.[88]

106. It was Ms Zyntek's opinion that there were no factors in relation to Mr Singh that warranted consideration of the KeepSAFE process.[89] The evidence of Ms Zyntek was that, like other CSOs, she relies heavily on the self-disclosure of the detainee. Mr Singh did not disclose any previous self-harming behaviour or suicide attempt. Based on this, she did not consider him to warrant any immediate assistance.

107. However, submissions for Ms Bala referred to Chapter 6 of the Detention Services Manual[90] which states that "staff conducting [Self Harm Risk Assessment Interviews] should carefully observe the person's level of distress"[91] and that if a person is showing signs of distress then they should be referred to a health professional. On this basis, Mr Singh's presentation during his interview meant that he ought to have been referred to IHMS for assessment on the evening of his arrival to the MIDC.[92]

108. It is difficult to determine in retrospect whether Mr Singh's level of distress was such as to warrant an immediate mental health review or monitoring by way of the KeepSAFE program. However, I consider that Ms Zyntek's understanding of Mr Singh's mental state may have been different had she been fully appraised of his history of suicide attempts in custody. Indeed, Ms Zyntek stated that had she known about the previous suicide attempt, she would have placed Mr Singh on KeepSAFE overnight, contacted IHMS on call and reported it to her supervisor.[93]

Appropriateness of Serco employees conducting the Self Harm Assessment Interview

109. The submissions on behalf of Ms Bala suggested that Serco employees should not conduct the Self Harm Assessment Interviews because they are not mental health professionals.[94]

110. However, it is clear to me that this preliminary assessment is not intended to be all encompassing. Rather, it serves as a screening mechanism to identify any emergent issues so

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87 Exhibit 81 - Statement of Johnathon Holmes dated 15 July 2014, Inquest Brief at p249

88 Exhibit 81 - Statement of Johnathon Holmes dated 15 July 2014, Inquest Brief at p249

89 Exhibit 31 – Statement of Mateta Zyntek dated 18 September 2014, Inquest Brief at p1917

90 Exhibit 66 – Chapter 6 of the Detention Services Manual – Psychological Support Program, Inquest Brief at pp1064-1119

91 Submissions on behalf of Ms Bala, p33

92 Submissions on behalf of Ms Bala, p18

93 Transcript of evidence, p362

94 Submissions on behalf of KB, p33

that detainees receive necessary interim assistance prior to a comprehensive assessment by the medical and mental health professionals employed by IHMS.

111. Accordingly, I do not consider it necessary that this assessment be carried out by mental health clinicians. Nevertheless, I do consider that CSOs conducting these assessments require a minimum level of training in mental health first aid and in eliciting information from a detainee, actively observing the detainee for signs of distress and ensuring this information is appropriately documented.

Individual Management Plan and Personal Officers

112. According to the DSM and the associated operating procedures, an Individual Management Plan (IMP) is to be completed within 1-2 days of the detainee being brought into custody. The purpose of an IMP is to obtain background information about the detainee to identify and monitor any underlying issues that might need to be addressed.[95]

113. On 12 January 2014, CSO Anne Chiang met with Mr Singh to complete his IMP. Ms Chiang stated that before these meetings she usually obtains and reviews the detainee's dossier, which contains information provided to/obtained by Serco including the original RFS and the Self Harm Risk Assessment.

114. According to the Serco Incident Review, Mr Singh participated in the development of his IMP and advised Ms Chiang of his drug addiction for which he had medical support. Further, the Incident Review noted that Mr Singh had stated he had never tried to self harm.[96]

115. Ms Chiang did not remember Mr Singh being upset or displaying any concerning behaviour during the interview.[97] She stated that had this been the case she would have reported it to her manager. Ms Chiang testified that if she had known Mr Singh had made a previous suicide attempt, she would have recorded it on the IMP.[98]

116. At the time of developing Mr Singh's IMP there had not been any notification to Serco by IHMS that he required any particular mental health monitoring as a result of an assessment of his risk of self-harm. I note that Serco staff do not receive a copy of the IHMS medical assessment of new detainees and are only informed of the level of risk allocated and whether the PSP has been activated.[99]

117. The risk recorded on the IMP was marked "medium" which does not appear to accord with any assessments conducted by Serco or IHMS staff. Ms Chiang's evidence was that this

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95 Transcript of evidence, p385

96 Exhibit 81 - Statement of Jonathon Holmes dated 15 July 2014, Inquest Brief at 251; Exhibit 43 - IMP File, p1034

97 Exhibit 42, Statement of Anne Chiang dated 4 September 2014, Inquest Brief at – Inquest Brief at p1032

98 Transcript of evidence, p387

99 Exhibit 42, Statement of Anne Chiang dated 4 September 2014, Inquest Brief at – Inquest Brief at p 1030

rating had already been filled in when she accessed the form.[100] No other witness could shed any light on this although Mr Holmes confirmed that there was no default to a medium risk rating.[101]

118. Ultimately, Mr Singh was assigned two personal officers and his IMP was updated on an ongoing basis throughout his detention at the MIDC. The case notes of these personal officers recorded that Mr Singh was presentable and pleasant although reluctant to speak.[102] Serco records also reveal that Mr Singh participated in the daily life of the facility including engaging in sports, attending the gym, interacting with a number of other detainees and had friends from the community visit him.[103]

119. Ms Chiang noted that there have been no changes to the way the IMP is filled in since Mr Singh's death.[104]

Management of breach of FVIO

120. A number of witnesses were asked whether they were aware of Mr Singh's numerous calls to Ms Bala in breach of the FVIO and what implications that might have had for Mr Singh's ongoing management. The evidence is that no Serco employee was aware of these calls.

121. However, I note that because MIDC is administrative detention, not a term of imprisonment, detainees are allowed to have access and use of phones both landline and mobiles, as long as they do not have the capacity to record or video. Therefore, I consider it reasonable that Serco staff were not aware that the calls were being made and thus did not have the opportunity to consider the implications of these breaches for his ongoing mental health management.

IHMS

122. IHMS are contracted by DIBP[105] to provide health care services to people in immigration detention. The overarching philosophy of IHMS is to ensure that:

> people in detention have access to clinically recommended care at a standard generally commensurate with health care available to the Australian community, taking into account the diverse and potentially complex health needs of people in detention.[106]

123. IHMS are further required to have a Policy and Procedures Manual (PPM) that is developed having regard to recommendations made by the Detention Health Advisory Group

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100 Transcript of evidence, p386

101 Transcript of evidence, p789

102 Exhibit 80 - Serco Post Incident Review – 17 February 2014, Inquest Brief at p202

103 Exhibit 80 - Serco Post Incident Review – 17 February 2014, Inquest Brief at p203 and Exhibit 81 - Statement of Johnathon Holmes dated 15 July 2014, Inquest Brief at p250

104 Transcript of evidence, p390

105 Exhibit 90 – Balance of Inquest Brief, Health Services Contract, Inquest Brief at p2082

106 Exhibit 54 – Statement of Dr Mark Parrish dated 4 September 2014, Inquest Brief at p1501

(DeHAG) in relation to community-based health care.[107] The standard of care expected of IHMS is described in the Standards for Health Services in Australian Immigration Detention Centres.[108] Immigration detention centres are accredited to these standards by an independent body.[109]

124. I now turn my mind to the two key mental health assessments conducted by IHMS during the time of Mr Singh's detention, being:

- the Mental State Examination (MSE) Screening[110] undertaken by Nurse Amy Hubbard on 11 January 2014;
- the more comprehensive Mental State Examination Assessment conducted by Psychiatric Nurse Ian Garlick conducted on 24 January 2014;

125. I then consider the following aspects in relation to IHMS' management of Mr Singh:

- Management by general practitioner Dr Shaw;
- Management of opiate withdrawal;
- Knowledge of Mr Singh's previous suicide attempt;
- Obtaining collateral information from external agencies; and
- Internal reviews; and
- Changes to IHMS systems and processes.

MSE Screening undertaken by Nurse Hubbard

126. Nurse Hubbard, who is employed by IHMS and presented as a reliable witness at Inquest, advised the Court that the medical induction includes a basic medical and mental health screening assessment. The purpose of the induction is to record a baseline of mental health[111] and involves questions about past history, whether there has ever been any self harm or previous suicide attempts, any thoughts of suicide, and physical observations.[112]

127. Nurse Hubbard conducted an MSE on 11 January 2014, the day after Mr Singh arrival.[113] He did not present with any evident symptoms of depression. Nurse Hubbard recalled that Mr Singh made "very good eye contact, he was happy to discuss other things about his medication"[114] and he was factual, coherent and cooperative throughout the consultation.

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107 In 2007-2008 the Mental Health Sub-Group (MHSG) of the Detention Health Advisory Group (DeHAG) reviewed mental health screening arrangements and found that with the exception of the MSE, the tools used were not the most appropriate for the immigration detention environment. "The process described in the instruction reflects the revised approach recommended by the MHSG and endorsed by the DeHAG on 28 February 2008". *Detention Services Manual Chapt 6 - Mental Health Screening,* Inquest Brief p888

108 Exhibit 36 - (RACGP) Standards for Health Services in Australian Immigration Detention Centres

109 Exhibit 54 – Statement of Dr Mark Parrish dated 4 September 2014, Inquest Brief at p1502

110 Exhibit 47 – MSE Screening dated 11 January 2014

111 Exhibit 90 – Balance of Inquest Brief, Detention Services Manual Chapter 6 - Mental Health Screening, Inquest Brief at p889

112 Transcript of evidence, p411

113 Exhibit 46 – Statement of Amy Hubbard dated 19 August 2014, Inquest Brief at p1470

114 Transcript of evidence, p428

However, she admitted that he did show some annoyance when he answered questions about his wife.[115]

128. Nurse Hubbard's notes were reliant on what Mr Singh reported to her. She acknowledged that her MSE was brief and could have provided more information. She attested to the fact that she had never been formally trained or supervised in how to complete an MSE record however she did say that she has conducted hundreds if not thousands of them.[116]

129. According to Nurse Hubbard, if Mr Singh had presented with any mental health issues such as past experiences of depression or other mental health problems or if she was made aware by him or by any other means of previous suicide attempts she would have immediately referred him to the IHMS Mental Health Team for review.

130. At the conclusion of her assessment, based on what he had told her, Nurse Hubbard did not consider Mr Singh was at risk of self harm of suicide.[117]

Mental State Examination Assessment undertaken by Nurse Garlick

131. Psychiatric Nurse, Ian Garlick is a very experienced mental health nurse with over 30 years experience and was an impressive witness whose evidence was both reflective and thoughtful.

132. On 24 January 2014, he conducted the detailed Mental State Examination Assessment[118] which DIBP requires IHMS to undertake. Nurse Garlick made notes of this consultation on the IHMS electronic management system, Chiron including that Mr Singh:

- did not present with any biological features of depression;
- had no significant problems with sleep or appetite;
- was well-groomed and able to care for himself;
- had no thoughts of harming himself or others;
- denied any mood problems or history of depression; and
- did not report any previous suicide attempts.

133. Nurse Garlick used the DASS21 to assess Mr Singh's symptoms of depression, anxiety and stress[119] and the GHQ30[120] to assist with the detection and diagnosis of formal psychiatric disorders.[121]

134. Nurse Garlick indicated that Mr Singh's mental health risk factors included his past history of heroin use, disrupted family background, the intervention order, potential criminal

115 Exhibit 46 – Statement of Amy Hubbard dated 19 August 2014, Inquest Brief at p1470

116 Transcript of evidence, p409

117 Exhibit 46 – Statement of Amy Hubbard dated 19 August 2014, Inquest Brief at p1471

118 Exhibit 51 – IHMS Mental Health Assessment dated 24 January 2014; Exhibit 52 – Mental State Examination Assessment dated 24 January 2014

119 Exhibit 52 – Mental State Examination Assessment dated 24 January 2014, Inquest Brief at p1592

120 Exhibit 52 – Mental State Examination Assessment dated 24 January 2014, Inquest Brief at p1592

121 Exhibit 49 – Statement of Ian Garlick dated 13 October 2014, Inquest Brief at p1540

charges, deportation and a wife and young baby.[122] He acknowledged that almost "universally everybody who comes into detention is [..] downcast"[123] but that was not always an indication of depression.

135. According to Nurse Garlick, "Mr Singh did not exhibit any signs of depression or any other psychiatric illness" and the results of the DASS21 and GHQ30 were "clinically unremarkable".[124] Importantly, he did not consider Mr Singh to be at any significant risk of self harm or suicide.

136. Nurse Garlick commented that IHMS personnel are highly dependent on Serco staff to provide observations of the detainees, and immigration detention is a strange environment in that:

> the mental health team is quite isolated from the detainees as opposed to if you were working in a psychiatric hospital you'd obviously be mingling with clients all day, you'd be observing things, noticing things, that's not something that's encouraged in fact its discouraged, so you're waiting on information to present to you rather than sort of observing anything yourself.[125]

Management by general practitioner Dr Shaw

137. IHMS provide general medical practitioners on site at the MIDC three days a week. Dr Emily Shaw first conducted a health assessment of Mr Singh on 15 January 2014. Dr Shaw indicated that his physical examination and history indicated that he was an essentially well gentleman who had been referred to her for his Suboxone prescription.[126]

138. Dr Shaw took a history of his drug use and found that he had been using heroin for a period of two weeks and that he had not used any other illicit substances.[127] Dr Shaw prepared a management plan to reduce his Suboxone medication from 8 milligrams to 4 milligrams and to review him at a later date; Mr Singh agreed with this plan.[128] Dr Shaw commented that in her experience people who are on opiate replacement medication are very focussed on knowing their medication dosage.[129]

139. Dr Shaw said Mr Singh was not agitated or distressed when she saw him[130] and that had he been she would have spoken to the mental health team and request them to assess him.[131]

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122 Transcript of evidence, p457
123 Transcript of evidence, p473
124 Exhibit 49 – Statement of Ian Garlick dated 13 October 2014, Inquest Brief at p1540
125 Transcript of evidence, p470
126 Transcript of evidence, p315
127 Transcript of evidence, p304
128 Transcript of evidence, p305
129 Transcript of evidence, p327
130 Transcript of evidence, p337
131 Transcript of evidence, p338

She said it was not her practice to conduct a formal mental or mini-mental state examination.[132]

Management of opiate withdrawal

140. Dr Souvannavong completed a formal review of the incident by way of a Root Cause Analysis (RCA)[133] on behalf of IHMS. The review found that the *root causes* of Mr Singh's death could be identified in relation to the treatment and services provided by IHMS. However the RCA did identify that the management of opiate withdrawal was nevertheless a "contributory factor", which was strongly disputed by Dr Shaw and Dr Parrish.[134] Dr Shaw's evidence was that the withdrawal symptoms were identified by Nurse Hubbard and she had implemented a management plan for Mr Singh's planned withdrawal.[135]

141. Nurse Hubbard was aware of Mr Singh's Suboxone treatment and was worried he would experience withdrawal symptoms if he did not obtain his medication. She contacted Dr Shaw who in turn instructed her to contact the pharmacy to confirm they had a prescription.[136] Dr Shaw suggested obtaining 3 days worth of Suboxone from the pharmacy to ensure Mr Singh had adequate supplies until she could review him.[137] Dr Shaw believed that if he did not receive his regular dose of Suboxone "he would likely go into rapid withdrawal, symptoms of which include diarrhoea, intense abdominal pains and sweating".[138]

142. Dr Parrish commented that from his review of the medical records and discussion with individuals involved in Mr Singh's care he did not see any evidence of a failure to detect symptoms of withdrawal.[139] Rather he considered that the actions of Nurse Hubbard to obtain the Suboxone from the pharmacy were impressive considering how difficult that can be.[140] I agree with Dr Parrish that the RCA was not accurate in relation to this issue.

IHMS knowledge of Mr Singh's previous suicide attempt

143. The evidence is clear that IHMS, as an organisation, had no knowledge of Mr Singh's previous suicide attempt. Mr Singh specifically denied having any history of mental health issues or previous instances of self harm and there was nothing in his presentation to Nurse Hubbard, Nurse Garlick or Dr Shaw that raised concern for his welfare.

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132 Transcript of evidence, p317

133 Exhibit 56 – Root Cause Analysis (Updated with completion of action plans)

134 The evidence also was that Dr Shaw and Nurse Hubbard were not interviewed as part of the RCA

135 Transcript of evidence, p348

136 Exhibit 46 – Statement of Amy Hubbard dated 19 August 2014, Inquest Brief at p1471

137 Exhibit 46 – Statement of Amy Hubbard dated 19 August 2014, Inquest Brief at p1471

138 Exhibit 34 – Statement of Dr Emily Shaw dated 19 August 2014, Inquest Brief at p1491

139 Transcript of evidence, p550

140 Transcript of evidence, p551

144. Nurse Hubbard stated that had she known he had previously attempted suicide she would have been more extensive with her consultation.[141] She acknowledged Mr Singh's death has taught her to put more detail in her answers when making notes about the consultation.[142]

145. Nurse Garlick also gave evidence that he had no information or indication that Mr Singh had previously self harmed and he commented that he did not have in his possession any collateral information to that effect.[143]

146. Nurse Garlick said it is useful to have as much information as possible:

> in my experience it's not only useful it's critical. ...one of the things I learned early on was that information is everything in dealing with ... assessments, that related to mental health and ...people .. have patterns of behaviour that they tend to repeat so if you can look at someone's history it's an indication of what's going to happen in the ... present and in the future.[144]

147. Nurse Garlick said that if Mr Singh had informed him that he had previously attempted suicide he would have taken it very seriously and questioned him further, conducted a comprehensive risk assessment and formulated a care plan for him which would include the allocation of a case manager.[145]

148. Dr Parrish, Regional Director of IHMS, commented that information about Mr Singh's previous suicide attempt would have resulted in an alternative course of action being taken. He further stated:

> If we had known that Mr Singh had attempted suicide two or so weeks previously, that would have raised an immediate flag with us and rather than waiting for the routine mental health assessment in seven to 10 days or so time we would, in fact, have done an assessment immediately and have contacted our mental health person and we would [...] also have elevated the level of [...] awareness of risk for this gentlemen and we would have communicated that with Serco and DIBP. We would have spoken about this at the PSP, [...] and we would have put him on a level of supportive management and engagement.[146]

149. There is no doubt that information of Mr Singh's previous suicide attempt was critical information and without that knowledge IHMS had an incomplete set of information as context to contemporaneously present clinical indicators and on which to base any decisions about medical and mental health management.

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141 Transcript of evidence, p416

142 Transcript of evidence, p424

143 Transcript of evidence, p464

144 Transcript of evidence, p455

145 Exhibit 49 – Statement of Ian Garlick dated 13 October 2014, Inquest Brief atp1540

146 Transcript of evidence, p514

Obtaining collateral information from external agencies

150. The second contributory factor identified by the IHMS RCA was that collateral information should have been obtained from previous health care providers. The DIBP review similarly commented that:

> mental health assessments undertaken with Mr Singh relied solely on his presentation during assessment and his response to questions. There is no evidence that any third party information was sought or used during these assessments.[147]

151. [...]

> Medical practitioners who treated Mr Singh previously may not have been aware of any mental health issues, however information about his medical history would have been relatively straightforward to obtain given his drug dependency.[148]

152. I note, however, that the DIBP Review acknowledges that medical records are not routinely obtained.

153. Dr Shaw indicated at Inquest that she had not contacted Mr Singh's treating GP in the community and Mr Singh had not wanted to provide any details of his treating GP to her. She said she thought it better for her to develop some rapport with him so that they could have an ongoing constructive doctor/patient relationship.[149] However, Dr Shaw did agree that on occasion and when appropriate she would request contact with other health providers, but it would more usually be done by others within the organisation.[150]

154. The actual evidence of Mr Singh's treating GP, Dr John Sherman, was that he could not really remember Mr Singh personally but his experience was that young Indian men are very coy about talking about their life's journey; they usually obtained their script and left.[151] As a result, the information that could have been obtained from Dr Sherman was limited and would not have assisted in identifying any previous mental health issues or suicide risk. Therefore, I did not consider the fact that the records of Mr Singh's General Practitioner, were not accessed, as identified in the RCA, was a contributing factor.

IHMS access to RAPID Database

155. In contrast, Mr Singh's previous suicide attempt and subsequent presentation at Casey Hospital on 27 December 2013 was likely to have been recorded in the Victorian Government 'Redevelopment of Acute & Psychiatric Information Directions' (RAPID) and this possibility was discussed at Inquest and addressed in submissions.

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147 Exhibit 77 – DIBP Internal Review Death in Detention of Dalvir Singh, Inquest Brief at p367

148 Exhibit 77 – DIBP Internal Review Death in Detention of Dalvir Singh, Inquest Brief at p380

149 Transcript of evidence, p348

150 Transcript of evidence, p309

151 Transcript of evidence, p813

156. RAPID is available to mental health specialists in the public hospital system and is used in hospital emergency departments to assist with identifying patients that may have a history of mental health treatment in Victoria. The evidence is that IHMS do not have access to this system at immigration detention facilities.

157. Nurse Garlick described RAPID as "an essential piece of software".[152] Dr Parrish supported this stating that "this flow of communication is just so important in healthcare and I think I would strongly support having access to that database".[153] Dr Parrish indicated that IHMS had unsuccessfully tried to obtain access to RAPID in the past.[154]

158. Enquiries were made by the legal representatives for IHMS as to whether their client had prospects of gaining access to the RAPID database in the future. The response they received indicated that this would not be possible, principally because there are privacy reasons why IHMS, as a private organisation, should not have access to information of the confidential nature stored on the database.[155]

159. I note that with respect to Mr Singh, the inability to access RAPID did not necessarily prevent IHMS practitioners from acquiring relevant historical mental health information, had his previous contact been known. In these circumstances, information is readily available from the service directly.

160. Furthermore, as I understand it, information contained in RAPID is limited to contact with public hospitals and therefore, in any event, does not provide a complete picture of mental health history. Thus, although I recognise that access to RAPID may be of some benefit to IHMS practitioners operating in the detention setting, I do not consider that these benefits outweigh the very real concerns for the protection of the privacy and confidentiality of the information contained on the database.

161. On this basis, I did not consider it appropriate to call the Department of Human Services to give evidence.

General comments with respect to the internal reviews

162. The DIBP Review of IHMS concluded that the mental health assessments, which indicated no concerns or issues about his mental state, appeared cursory and lacked any detail to justify that conclusion.[156] On balance of evidence, and particularly in light of Nurse Garlick's significant experience as a psychiatric nurse, I do not support this conclusion.

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152 Transcript of evidence, p469
153 Transcript of evidence, p516
154 Transcript of evidence, p516
155 Exhibit 84 – Letter from Moray & Agnew dated 28 November 2014
156 Exhibit 77 – DIBP Internal Review Death in Detention of Dalvir Singh, Inquest Brief at p1287

163. I further disagree with the comment that:

> It would appear that on this basis, noting that Mr Singh saw IHMS on at least a daily basis, that a more rigorous mental health screen and health assessment may have been warranted.[157]

164. In relation to the RCA, I note that it is unfortunate more of the clinicians involved in Mr Singh's care were not interviewed and consulted as part of that process. I consider that doing so would have been more consistent with best practice.

IHMS Changes to systems and processes

Chiron to Apollo

165. Dr Parrish told the inquest that IHMS have been providing health care in the immigration detention setting for approximately 10 years. He explained that CHIRON was an electronic health record system that had been in place for approximately eight years and at the time of its introduction was fit for purpose. In the years since its establishment, IHMS's role has expanded and the immigration process changed, such that CHIRON was unable to cope with what was now required.

166. At the time of Mr Singh's death, IHMS were in the process of moving towards a newer system called Apollo, which is an off-the-shelf database available to many health services within Australia.[158]

167. The CHIRON system was user driven. It relied upon users to exercise discretion in obtaining relevant information to input. In contrast, Apollo prompts the provision of more detailed information and has more trigger questions. Further, Apollo includes a more structured and detailed mental health assessment template and requires clinicians to complete all key elements of the assessment, including a standard risk screen, with prompts for further steps as required.[159]

168. According to Nurse Hubbard:

> The new Apollo system is a lot clearer, it's everything that you do from asking questions and what you observed but it's actually a tick format, you mark off the question and you can not actually go onto the next thing.[160]

169. Nurse Garlick explained that it is a far more extensive process now. There are more detailed questions and the clinician cannot move from one section to another until the previous section is complete.[161]

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[157] Exhibit 77 – DIBP Internal Review Death in Detention of Dalvir Singh, Inquest Brief at p1287

[158] Transcript of evidence, p503

[159] Exhibit 77 – DIBP Internal Review Death in Detention of Dalvir Singh, Inquest Brief at 1289

[160] Transcript of evidence, p422

[161] Transcript of evidence, p466

170. I consider that the change to Apollo should assist practitioners with conducting and recording a more comprehensive medical and mental health review and will strengthen the integrity of this process.

Change to Mental Health Diagnostic tools

171. At the same time as IHMS was changing databases, they implemented new mental health screening tools.

172. In January 2014, IHMS reviewed and updated its policy regarding the use of diagnostic tools and the organisation now uses the Kessler 10 (K-10) scale and the Health of a Nation Outcome Scale (HoNOS),[162] which are preferred in the Australian community setting.[163]

173. The K-10 is a simple, widely used self-report instrument. It is designed to measure psychological distress in the general population. The K-10 has been shown to be a good screening tool for detecting levels of distress that are associated with an independently determined diagnosis of an anxiety disorder and/or depressive disorder.

174. The HoNOS is a key clinician rating measure of problem severity that is used as a standard instrument by all Australian mental health services. The HoNOS is designed to capture a broad spectrum of information in a number of domains, not just symptoms. It has shown to be a reliable and valid instrument which is sensitive to change.[164]

175. I consider that these changes mean the diagnostic tools are now in line with the Australian community approach and will help improve the mental health assessment process by IHMS in detention centres.

DIBP

176. I considered the following aspects of DIBPs involvement in Mr Singh's care and management:

- Compliance Client Interview;
- Communication between Daniel Schmidts and Victoria Police;
- Communication of information received from the AFP;
- Case Management; and
- Changes to DIBP policies and procedures.

Compliance Client Interview

177. Mr Singh's Compliance Client Interview (CCI) was conducted by Mr Cooper over the telephone for the purpose of establishing his identity, gathering information regarding his personal circumstances and making an assessment of those circumstances to determine his

162 Transcript of evidence, p467

163 Exhibit 90 - Inquest Brief at p4231

164 Exhibit 90 - Inquest Brief at p4231

immigration status. The aim of the interview was to make a preliminary assessment of whether to continue Mr Singh's current detention or to grant a bridging visa.[165]

178. As part of the CCI, Mr Cooper completed a Preliminary Client Placement Recommendation (PCPR)[166] and outlined Mr Singh's reported health concerns, namely that he was on Suboxone to manage his heroin addiction and this was recorded.

179. Following his interview with Mr Singh, Mr Cooper spoke with a member of Victoria Police (although he is unable to remember whom) and asked whether there were any violence or behavioural concerns.[167] He believed that the answer he received was 'no'.[168] At no point after this time was Mr Cooper advised about Mr Singh's previous suicide/self harm attempt by Victoria Police.

180. Mr Cooper determined that Mr Singh was an "unacceptable risk to the community in terms of an integrity risk to the migration process".[169] However Mr Cooper assessed Mr Singh's transportation risk as low because he was cooperative and no concerns had been raised.[170]

181. Mr Cooper further stated that if he had been told about a previous suicide attempt:

> there would have been a lot more boxes checked, there'd be the self harm risk, health issues, the harm risk to or from others, suspected mental illness.[171]

182. I found Luke Cooper to be an honest and credible witness who had considered the manner in which Mr Singh had been managed and offered the Court possibilities for improvements.

Subsequent changes to this process

183. In addition to the amendments to the Form 1275 discussed at paragraph 64 above, DIBP has modified the template email communication sent to police which now requests them to conduct appropriate checks on their systems and confirm in writing that those checks have been conducted.[172] Specifically, the email now states:

> Please pay particular attention to Q.11 and ensure that any health / welfare / behavioural issues are clearly outlined. Please ensure that appropriate Police systems (and other relevant data) checks are conducted and please advise us of any concerns immediately as the above-named person is now being held in immigration detention.[173]

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165 Transcript of evidence, p23

166 Exhibit 9 - Preliminary Client Recommendation Report, Inquest Brief at p1354

167 Transcript of evidence, p26

168 Transcript of evidence, pp62 and 66

169 Transcript of evidence, p47

170 Transcript of evidence, p24

171 Transcript of evidence, p24

172 Transcript of evidence, p32

173 Exhibit 24 – New template email utilised by the ISS section (DIBP) when contacting Police to complete Form 1275, Inquest Brief at p4216

184. Mr Cooper explained that on the new template email the above notice is in bold, red, and underlined and DIBP staff are told to:

> specifically remind police that once we've sent that email out to pay particular attention to the instructions in the email and to record any of that information on the form.[174]

185. Sergeant Dawson agreed that this new process would be an improvement.[175]

Communication between Daniel Schmidts and Victoria Police

186. Mr Schmidts' role was to work as a conduit between DIBP, Serco and law enforcement agencies in relation to security and intelligence matters within the MIDC.[176]

187. Mr Schmidts was in contact with Victoria Police on a number of occasions between January and mid-February but no information regarding Mr Singh's previous suicide/self harm attempt was conveyed to him at any time.

188. As part of his role as SLO, Mr Schmidts reviews the completed CCI form for detainees to identify whether there were any outstanding police matters. On 13 January 2014, Mr Schmidts sent an email to Constable Osborne as a follow-up to his review of Mr Singh's CCI which indicated that Mr Singh had breached an intervention order and that there may be outstanding police matters in relation to this.[177] According to Mr Schmidts, the purpose of the email was to:

- advise Constable Osborne that Mr Singh was accommodated at the MIDC;
- obtain relevant information from Victoria Police about their dealings with Mr Singh; and
- ascertain whether there were any pending criminal charges, behavioural issues or health concerns so that they could ensure he was managed appropriately.[178]

189. On 15 January 2014, Constable Osborne provided a response to DIBP which noted that Mr Singh was the subject of an intervention order, pending criminal charges for multiple breaches of the intervention order and the associated court dates.[179] However, Constable Osborne's email was silent as to whether there were any behavioural issues and it did not mention his previous suicide/self harm attempt.

Contact with respect to the ongoing breaches of the FVIO

190. On 5 February 2014, Mr Schmidts had a conversation with Constable Marshall who advised him that Mr Singh had been repeatedly contacting Ms Bala in breach of the FVIO while in custody at the MIDC. Constable Marshall sought information from Mr Schmidts concerning to the possibility of Mr Singh being deported and whether DIBP were in a position to

174 Transcript of evidence, p38
175 Transcript of evidence, p260
176 Exhibit 65 – Statement of Daniel Schmidts dated 14 October 2014, Inquest Brief at p2029
177 Exhibit 65 – Statement of Daniel Schmidts dated 14 October 2014, Inquest Brief at p2030
178 Exhibit 65 – Statement of Daniel Schmidts dated 14 October 2014, Inquest Brief at p2030
179 Exhibit 65 – Statement of Daniel Schmidts dated 14 October 2014, Inquest Brief at p2030

restrict his phone access. Mr Schmidts advised Constable Marshall that they would be unable to restrict or monitor access to his telephone in immigration detention. Mr Schmidts then relayed this information via an email to Mr Singh's case manager, Julie Gambrell.[180] I do not consider this to have been an unreasonable response in the circumstances.

Communication of information received from the Australian Federal Police (AFP)

191. As part of the MIDC induction process, facial and fingerprint biometrics are acquired from all detainees. The biometrics are compared to departmental identity records as well as law enforcement databases including the NAFIS. When a positive biometric match occurs, a request is made to the AFP for relevant information pertaining to that individual.[181]

192. On 21 January 2014, after conducting a fingerprint check, the AFP sent an email to DIBP attaching a fingerprint and criminal history check in relation to Mr Singh. The covering email did not specifically draw attention to any risk of suicide and self-harm nor did it contain specific information relating to the suicide attempt made by Mr Singh while in police custody however it did include a line in red text that stated:

> PLEASE NOTE: Detainee has as serious criminal history recorded in VIC, please also note the warnings recorded.[182]

193. However, a warning for suicide/self harm *was* included in an attachment to the email.

194. DIBP did not make any further request to the AFP or Victoria Police for any additional information in relation to this note nor did they forward this information to Serco or IHMS.

195. The evidence is that whilst the AFP email was sent to generic mailboxes, a number of individual DIBP personnel did receive the email, including Mr Kingma, Mr Schmidts and Ms Gambrell. Importantly, this was the first time DIBP had been provided with information about Mr Singh's previous suicide/self-harm attempt.

196. The evidence is that, as Mr Singh's police history was known to DIBP staff and he had already been in detention for 10 days, displaying no indications of self-harm or suicide, the information was only noted and not referred to either IHMS or Serco.[183] Mr Kingma did not read the email at all. [184]

197. Mr Schmidts did not read the email[185] and did not take any action in relation to it because he had already made contact with and received information from Victoria Police.[186] Mr

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[180] Exhibit 65 – Statement of Daniel Schmidts dated 14 October 2014, Inquest Brief at p2030

[181] Exhibit 77 – DIBP Internal Review Death in Detention of Dalvir Singh, Inquest Brief at p1287

[182] Exhibit 67 – Email from Identity Resolution Centre to DIBP on 21 January 2014, re fingerprint criminal history, inquest brief, p2043

[183] Exhibit 77 – DIBP Internal Review Death in Detention of Dalvir Singh, Inquest Brief at p379

[184] A full audit of AFP fingerprint/criminal history checks was conducted as a result of this incident and confirmed that the information provided in all other AFP emails had been provided to DIBP, Serco and IHMS, Exhibit 75, – Statement of Michael Kingma, dated 21 August 2014, Inquest Brief at p1284

[185] Transcript of evidence, p597

Schmidts also noted that there was no procedure in place for how this type of information should be managed internally within DIBP.[187] In evidence, he acknowledged he should have read it and verbally notified IHMS.[188]

198. Ms Gambrell remembers receiving the email and reading the alerts.[189] She realised the information was new, however did not communicate it to IHMS. She noted that it was common practice for the case manager to review the form for any alerts, raise any issues with IHMS and record information on the detainees file however she believed no further action was required[190] because Mr Singh was already engaged with IHMS and she mistakenly assumed this information would be known by them. She commented that:

> if Mr Singh had not already engaged with IHMS, [she] would have immediately raised these warnings with the IHMS medical and mental health team. However, as Mr Singh had already been engaging with IHMS, and he was already aware of the support services ...available...., I was not required to action any referral to IHMS in relation to the warnings recorded.[191]

199. Ms Gambrell acknowledged in hindsight that not actioning this email created an information gap.[192]

Changes made to the process of communicating information from the AFP

200. The issue of the transfer of information received from the AFP was identified during the DIBP Review and was acknowledged in submissions made on behalf of DIBP. At the time of Mr Singh's death there was no documented procedure for handling this information and therefore depended on the judgement and discretion of the officers who received it. One of the central issues identified was that there was no single point of accountability.[193]

201. Mr Florent gave evidence that this is no longer the case. A procedure was implemented to ensure that this type of information provided through the DIBP identity resolution process is considered and actioned by relevant staff in detention facilities and passed on to service providers, as appropriate.[194]

202. Ms Gambrell confirmed that the new process requires the Case Manager to review the document and look for any new information, particularly whether there are any alerts and/or

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186 Exhibit 65 – Statement of Daniel Schmidts dated 14 October 2014, Inquest Brief at p2030

187 Transcript of evidence, p597

188 Transcript of evidence, p613

189 Transcript of evidence, p644.

190 Exhibit 69 – Statement of Julie Gambrell dated 18 August 2014, Inquest Brief at p1249

191 Exhibit 69 – Statement of Julie Gambrell dated 18 August 2014, Inquest Brief at p1250

192 Transcript of evidence, p646

193 Exhibit 77 – DIBP Internal Review Death in Detention of Dalvir Singh, Inquest Brief at p366

194 Exhibit 79 – Statement of Daniel Florent dated 14 July 2014, Inquest Brief at p1056

warnings. Where a warning is noted, the case manager will communicate with stakeholders including IHMS and Serco to confirm their awareness of the alert or warning.[195]

Case management

203. Ms Gambrell's role as Mr Singh's case manager was to assist him to resolve his immigration status in a fully informed manner consistent with legislation and government policy. Further, it was to monitor the health and welfare of Mr Singh in association with the MIDC stakeholders and DIBP.[196]

204. Ms Gambrell first met Mr Singh on 14 January 2014 and they discussed various subjects including the fact that he was separated from his wife and had a son. Apart from the intervention order, Mr Singh claimed to have no criminal or domestic violence history. He confirmed that he was engaged with IHMS for his drug dependence issues and for mental health support. However, Ms Gambrell did not have access to information held by IHMS in relation to Mr Singh and, in particular, did not have a copy of the relevant mental health assessments.[197]

205. During this initial meeting Ms Gambrell also discussed Mr Singh's immigration pathway and noted that at that time his intentions were unclear. Mr Singh did not want to return to India and Ms Gambrell said that he wanted to seek legal advice so she provided him contact numbers for this purpose. The evidence is that between 14 and 21 January, Ms Gambrell saw Mr Singh more than any other detainee.[198]

Changes to DIBP policies and processes

206. DIBP provided the court with a copy of their internal review which resulted in a number of changes to DIBP policies and procedures since Mr Singh's death including:

- The Revised Form 1275.
- The amended template email sent by DIBP to Victoria Police when sending Form 1275.
- Changes to the ISS officer's CCI template.
- New procedure regarding receipt of emails from the DIBP Identity Resolution Centre; and
- The development of a new strategy: Building PSP Capacity 2014-2015 Policy: A Plan to build staff capacity to apply the Psychological Support Program and mental health policies.

207. In addition, submissions on behalf of DIBP outlined the following changes currently being considered:

- Information sharing between DIBP, AFP and Victoria Police generally, and specifically a review of the MOU, was to occur in February 2015.

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195 Exhibit 69 – Statement of Julie Gambrell dated 18 August 2014, Inquest Brief at p1254

196 Inquest Brief at p1246

197 Transcript of evidence, p639

198 Transcript of evidence, p 685

- Inquiries made regarding access to the RAPID database, however DIPB have been advised that direct access cannot be permitted due to privacy concerns associated with the sensitive nature of the records; and
- Finalisation of the Continuity of Care Policy regarding general health issues which does not cover mental health issues.

INTER-AGENCY MANAGEMENT OF MR SINGH'S DETENTION AT MIDC

Psychological Support Program Meeting

208. PSP meetings are held every day at the MIDC with employees of DIBP, Serco and IHMS in attendance. The requirements for the operation of the PSP is set out in Chapter 6 of the DSM including that the meetings are led by a senior clinician from IHMS.[199] Ms Gambrell attested that "we will discuss and raise anyone of concern or anyone with changed behaviour that we wanted to alert each other of for the day".[200]

209. Mr Singh was discussed at the PSP meeting on 29 January 2014. Ms Gambrell raised with those present that Mr Singh's wife had attended MIDC for a pre-arranged visit, Mr Singh had not been permitted to talk with his wife during the visit and this had seemed to aggravate him. She requested that stakeholders be aware of this and monitor him.[201]

210. Ms Gambrell said "that was the only sort of out of character behaviour that I witnessed the whole time with Mr Singh...That was the only time I ever saw a variance of his behaviour".[202]

211. DIBP and Serco staff were interviewed as part of the DIBP Review process which indicated that a consensus was reached between participants at the meeting that whilst Mr Singh seemed annoyed at times during the visit with Ms Bala, he had coped well with no ongoing concerns.[203] No further action was taken except to update Mr Singh's IMP.[204]

Preventative Health Meetings

212. Another forum for discussion and review of detainees is the Preventative Health Meetings (PHM), which are held every fortnight with employees from DIBP, Serco and IHMS in attendance.[205] On 7 February 2014, Ms Gambrell raised Mr Singh for discussion as a result of his upcoming voluntary removal and alleged breach of the FVIO.[206]

213. The decision concerning whether Mr Singh should be placed on ongoing monitoring alert after this meeting was made by IHMS, who determined that this was not necessary.[207]

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199 Exhibit 66 – Chapter 6 of the Detention Services Manual – Psychological Support Program, Inquest Brief at p1073; Transcript of evidence, p652
200 Transcript of evidence, p651
201 Exhibit 69 – Statement of Julie Gambrell dated 18 August 2014, Inquest Brief at p1253
202 Transcript of evidence, p668
203 Chapter 6 of the Detention Services Manual – Psychological Support Program, Inquest Brief at p1080
204 Exhibit 81 - Statement of Johnathon Holmes dated 15 July 2014, Inquest Brief at p252
205 Exhibit 70 – Supplementary statement of Julie Gambrell dated 22 November 2014, paragraph 5
206 Exhibit 70 – Supplementary statement of Julie Gambrell dated 22 November 2014, paragraphs 3 and 6
207 Submissions on behalf of DIBP, p13

FINDINGS

214. I find that Dalvir Singh died on 13 February 2014 from 1a) HANGING.

215. I further find that Mr Singh intentionally tied a bed sheet around his neck and secured it to the bunk in his room from which he suspended himself with the intention of causing his own death.

216. No one single factor accounts for Mr Singh's decision to take his own life. Rather it can be understood in the context of a combination of personal stressors, including a previous suicide attempt in custody, the breakdown of his relationship and separation from his son, the consequences of his alleged perpetration of family violence, his withdrawal from opiate dependence and immigration detention.

217. Although a number of deficiencies have been identified, particularly in relation to communication of critical information between agencies, I do not consider any to have contributed in a significant way to his death. However, the circumstances of Mr Singh's death provide a good opportunity to reflect on current practices and procedures of those agencies involved in providing services to people in immigration detention.

Findings in relation to Victoria Police

218. I find that Victoria Police did not communicate knowledge of Mr Singh's previous suicide verbally or in writing to Mr Cooper on 10 January 2014.

219. I am unable to determine on the balance of probabilities whether Sergeant Dawson conveyed information about Mr Singh's previous suicide attempt to either Serco officer at any time during the transfer process. However, it is evident that the information was not formally documented at the time and therefore valuable insight into the way Mr Singh's immigration detention should and could have been managed was lost.

220. I find that Victoria Police had no documented process, procedure or system in place to guide its members on how to adequately transfer critical information about Mr Singh to Serco and DIBP.

Findings in relation to Serco

221. I find that Serco employees who engaged with Mr Singh were unaware of his previous suicide attempt whilst in police custody.

222. I find that no Serco employee who observed or interacted with Mr Singh were concerned about his mental health or wellbeing or that he was at risk of self harm during his time in detention. In fact the evidence demonstrates that he participated in programmes and activities and he was interacting well with other detainees.

223. Documentation completed by Serco employees, particularly the Self Harm Risk Assessment Interview, lacked adequate detail. However, I find that Mr Singh was subsequently reviewed on a number of occasions by mental health professionals and I therefore find that there is no

direct relationship between the manner in which the Self Harm Assessment Interview was conducted and Mr Singh's death.

224. On the balance of probabilities and on the evidence before me, I find that Serco's general care and management of Mr Singh whilst in detention at the MIDC was appropriate in the circumstances.

Findings in relation to IHMS

225. I find that IHMS did not receive any information in relation to Mr Singh's previous suicide attempt either from Mr Singh himself or from other agencies in possession of that information. When interviewed by the health nurse, general practitioner and psychiatric nurse, Mr Singh did not present as depressed or otherwise unwell and when prompted specifically denied any thought or intention of self harm or suicide. On this basis, I find it reasonable that none of the IHMS clinicians identified the potential that he was suffering from an undiagnosed mental illness or that there was an acute risk that he might engage in self harm or suicidal behaviour.

226. I accept the evidence that had the information about his previous suicide attempt been known, the overall strategic management by IHMS would have been different.

227. I acknowledge that the IHMS Root Cause Analysis identified the management of Mr Singh's opiate withdrawal and not having sought collateral information from previous health care providers as problematic. With respect, I do not agree. Indeed I find that Mr Singh's opiate withdrawal was quickly identified and managed in a proactive way, in particular by Nurse Hubbard. Further, in relation to obtaining collateral information from the GP, I find that although good practice, it would not have disclosed any information in relation to Mr Singh's mental health.

228. I further acknowledge that IHMS have implemented changes to their computer system and mental health assessment tools in line with those used in the community. I commend IHMS for their commitment to continuous improvement in their systems and processes.

229. Based upon all of the evidence, I find that the medical and mental health care and management provided to Mr Singh by IHMS was reasonable and appropriate in all of the circumstances.

Findings in relation to DIBP

230. The attachment to the AFP email to DIBP on 21 January 2014 contained a warning about Mr Singh's history of self harm. I find that the email was not actioned by any employee of the DIBP. I further find that there was a lack of appropriate systems or processes in place to guide the management, action and communication of new and critical information about a detainee. In particular, at the time of Mr Singh's death there was no single point of accountability for reading and actioning this information. This is unfortunate because it was

the first time this information had been provided to DIBP and it was another missed opportunity for this information to inform his management whilst in detention.

231. Although I am unable to find that, had this information been actioned, Mr Singh's death would have been prevented, the evidence is that it would have triggered a different response and management plan. However, I am satisfied that DIBP have taken appropriate measures to remedy this process breakdown to ensure that this situation does not occur again.

232. It is clear that DIBP have taken a proactive approach to the death of Mr Singh and implemented a number of changes to their policies and procedures. They are to be commended for their approach to the inquest in terms of providing documents, information, policies and procedures and what appeared to me to be full and frank disclosure to my investigation.

COMMENTS

233. Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

> Recognition of the multiple vulnerabilities experienced by immigration detainees is an essential first step in the provision of appropriate care and management. Many of these paths of vulnerability are common to all detainees including estrangement from family, friends and community, uncertainty about the future, and loss of liberty and control over their personal circumstances.
>
> The importance of applying an understanding of these vulnerabilities when working with detainees cannot be understated and foreshadows the need to take positive action towards ensuring that this translates into effective policies and procedures for the promotion of health and well being.
>
> In light of this, effective communication between and within agencies involved in the immigration detention process is imperative because without a complete picture, assessment and management of the risk of suicide or self harm at any one point in time becomes more difficult.
>
> Although a coronial investigation is a stressful process, it was made considerably easier by the open and transparent manner in which it was approached from the early stages by the Interested Parties and witnesses alike. In particular, it was encouraging to see that some of the Interested Parties were pro-active in identifying and modifying areas that required improvement.

RECOMMENDATIONS

234. This inquest focussed on Mr Singh's care and management and in general highlighted the importance of effective interagency communication and adopting a coordinated approach to the immigration detention process.

235. To promote public health and safety and contribute to a reduction in preventable deaths and pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death:

Department of Immigration and Border Protection, Serco and Victoria Police

Recommendation 1

To promote the safety and wellbeing of immigration detainees, I recommend that appropriate representatives of the Department of Immigration and Border Protection, Serco and Victoria Police meet to discuss and develop a coordinated transfer of custody process which ensures that all relevant information held by one agency is conveyed contemporaneously with the detainee when transferred.

Recommendation 2

To ensure the efficacy of any interagency coordinated transfer process, I recommend that the Department of Immigration and Border Protection, Serco and Victoria Police each independently ensure that any necessary internal policies and procedures are effectively developed and implemented.

Recommendation 3

To ensure the efficacy of any interagency coordinated transfer process that is developed, I recommend that Department of Immigration and Border Protection, Serco and Victoria Police each ensure that their employees are aware and appropriately trained in the aspects of the process pertaining to them.

Serco and the Department of Immigration and Border Protection

Recommendation 4

I recommend that Serco and the Department of Immigration and Border Protection collaborate to amend the Self Harm Assessment Interview to require all detainees to be specifically questioned about their mental health and suicide and self-harm history, to ensure that any relevant information is elicited and recorded at the earliest available opportunity and appropriately actioned.

International Health and Medical Service

Recommendation 5

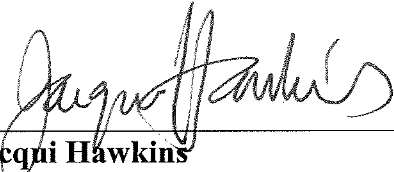
To increase the safety of detainees, I recommend that the Department of Immigration and Border Protection, Serco and the International Health and Medical Service meet to consider the feasibility of, and options around, developing a system whereby qualified mental health practitioners are able to observe and interact with detainees within the common areas of the Maribyrnong Immigration Detention Centre, particularly during periods of higher suicide and self harm risk such as when first detained or when informed about deportation or when identified as someone who is at risk.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that finding be published on the internet.

I direct that a copy of this finding be provided to the following:

- Senior Next of Kin, Ms Bala;
- The Chief Commissioner of Police;
- Serco Australia Pty Ltd;
- The International Health and Medical Service; and
- The Department of Immigration and Border Protection.

Signature:



Jacqui Hawkins
Coroner
Date: 26 March 2014