IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 004348

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

Inquest into the Death of Daniel Bryan Harvey

Deceased:	Daniel Bryan Harvey
Delivered on:	12 March 2025
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	12 March 2025
Findings of:	Coroner Leveasque Peterson
Counsel assisting the coroner:	Courtney Davies, Coroner's Solicitor
Key words:	Death in custody, unascertained, immigration detention, Melbourne Immigrations Transit Accommodation

INTRODUCTION

1. On the morning of 10 August 2020, Daniel Harvey was 48 years old when he was found unresponsive in his room at the Melbourne Immigrations Transit Accommodation, at 120-150 Camp Road, Broadmeadows.

2. Mr Harvey was born in New Zealand and was the youngest child of Pamela Harvey. He is survived by his mother, his stepfather and his two sisters. Ms Harvey described her son as a kind and loving man who liked cooking, and they enjoyed spending time together.

INVESTIGATION AND SOURCES OF EVIDENCE

3. This finding draws on the totality of the coronial investigation into the death of Mr Havey including evidence contained in the coronial brief as prepared by the Coronial Investigator, the inspection report from the Victorian Institute of Forensic Medicine, and advice received from the Coroner's Prevention Unit.

4. All of this material, together with the inquest transcript, will remain on the coronial file.[1] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

5. The purpose of a coronial investigation of a *'reportable death'*[2] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3]

6. Mr Harvey's death falls within the definition of reportable death, specifically section 4(2)(a) of the *Coroners Act 2008* (Vic) (**the Act**) which includes an unexpected or unnatural death and section 4(2)(c) which includes the death of a person who was placed in custody.

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[1] From the commencement of the *Coroners Act 2008*, that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

[2] The term is exhaustively defined in section 4 of the Act. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

[3] Section 67(1).

7. Section 3(1)(l) of the Act defines a person placed in *'custody or care'* to include a *'prescribed person'* or someone belonging to a *'prescribed class of person'*. According to Regulation 7(1)(a) of the *Coroners Regulations 2019* (**the Regulations**) this includes *'a person held in detention in Victoria by an authorised person under the law of the Commonwealth or another jurisdiction'*.

8. As discussed, Mr Harvey was detained by the Department of Home Affairs at the MITA pursuant to section 189 of the *Migration Act 1958* (**the Migration Act**) – a piece of Commonwealth legislation. Accordingly, Mr Harvey was, immediately before his death, a person placed in custody of the purposes of the Act and the Regulations. Section 52(2)(b) of the Act therefore required that an inquest be convened into his death.

9. The *'cause'* of death refers to the *'medical'* cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the *'circumstances'* in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[4]

10. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *'prevention'* role.[5]

11. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[6] These are effectively the vehicles by which the coroner's prevention role can be advanced.[7]

[4] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)
[5] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.
[6] See sections 72(1), 67(3) and 72(2) regarding reports, comments, and recommendations respectively.
[7] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

12. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[8]

BACKGROUND

13. Ms Pamela Harvey described Mr Harvey's difficult childhood; due to being born club-footed, he experienced rejection from his father. He was also profoundly dyslexic, and schooling presented significant challenges for him. Consequently, he left school early and held a variety of odd jobs however he never secured long term employment.

14. Mr Harvey arrived in Australia as a dependant however he was eventually granted an 'Absorbed Person' visa - granted to a person who is no longer considered an *'immigrant'* due to having been assimilated in the Australian community over a long period of time.

15. Mr Harvey's medical history included morbid obesity, Hepatitis C, diabetes mellitus type II, chronic back pain, asthma, poly substance use including methamphetamine and heroin and was on the methadone program. He also experienced mental ill health including anxiety, panic attacks, schizophrenia and had a history of self-harm. He also had extensive criminal history and cumulatively, spent more than 10 years of his life in custody.

16. Mr Harvey's final custodial sentence was an aggregate period of 20 months. During his time in custody, Mr Harvey was notified that he had failed to maintain the character requirements in section 501(6) of the Migration Act to continue holding an Australian visa. Mr Harvey sought a review of this decision on 10 August 2016 however, he was unsuccessful. Mr Harvey's visa was cancelled on 26 September 2016.

17. On 10 January 2017, Mr Harvey was detained under section 189 of the Migration Act and placed in immigration detention. He was housed in several different immigration facilities over the 42 months he was a detainee.

18. The Melbourne Immigrations Transit Accommodation (**MITA**) is operated by Serco Australia Pty Ltd (**Serco**). While Serco is responsible for the day-to-day management and operations of MITA, the Department of Home Affairs, through the Australian Border Force, is still ultimately responsible for making decisions about immigration detention.

[8] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

19. On 4 July 2019, Mr Harvey attended an appointment at the medical clinic operated by International Health and Medical Services (**IHMS**) for review of his asthma plan. IHMS is contracted to provide health services to people in immigration detention and is staffed by registered nurses and general practitioners.

20. During the appointment, Mr Harvey complained of chest pain when walking for exercise. An electrocardiogram (**ECG**) was performed however no ischaemic changes were seen.

21. Given Mr Harvey had several cardiac risk factors, the IHMS clinician referred him to Northern Health for a stress echocardiogram to exclude the possibility of cardiac chest pain. In the referral paperwork, the clinician recommended that that Mr Harvey be triaged as a *'Priority 1'* and be seen within 30 days. Mr Harvey's appointment was scheduled for 15 November 2019, but when he refused to attend, it was moved to April 2020 then again, to November 2020 due to COVID-19 restrictions.

22. During the 4 July 2019 medical appointment, Mr Harvey also reported a widespread respiratory wheeze associated with his asthma and dental pain which was an ongoing issue**.** Mr Harvey did not re-attend the IHMS clinician due to chest pain.

23. On 9 August 2020, at approximately 4:00pm, Mr Harvey was involved in a physical altercation with another detainee.[9] He did not sustain any injuries.

24. Later that day, Mr Harvey visited the pharmacy for his evening medication. One of the nurses noticed that he appeared *'drowsy and pale'*, they asked if he was alright and he responded that *'he was okay'*. The nurses spoke with the North Facility Operations Manager[10] about his appearance, who stated that he was recently in an altercation but also clarified *'it was not unusual for Mr Harvey to look drowsy and pale, and that he usually appeared unsteady'*. The nurses decided to check his vital signs, which were normal, and Mr Harvey *'denied feeling unwell'*.

[9] CCTV footage of this altercation has been received and reviewed.
[10] The North Facility Operations Manager is an employee of Serco.

25. The nurses asked that the North Facility Operations Manager *'keep an eye on'* Mr Harvey and advised they call the IHMS Health Advisory Service if there were any concerns.[11] The North Facility Operations Manager agreed to *'monitor'* Mr Harvey overnight.

26. Later that evening, closed circuit television (**CCTV**) footage captured at 11:43pm showed Mr Harvey left his room for the common area where he rummaged in a rubbish bin for around 40 seconds. He did not take anything from the bin. He spoke with a fellow detainee for a short time and then rummaged in a second bin for around one minute. He again, did not remove anything. Mr Harvey washed his hands and at 11:45pm, returned to his room. It is unknown what, if anything, Mr Harvey was looking for in the bins.

27. On the morning of 10 August 2020, at approximately 6:30am, Detainee Service Officers (**DSOs**) attended Mr Harvey's unit to perform a head count. One of the DSOs entered Mr Harvey's room and observed *'his feet and lower portion of his body lying on top of the blankets at the end of the bed'*. His torso and head were obscured by the ladder to the top bunk bed. The DSO did not check whether Mr Harvey was awake or asleep and did not know whether he was face up or face down but observed that *'everything in* [Mr Harvey]*'s room seemed normal'* and so they left the room.

28. At 8.30am, a nurse attended Mr Harvey's unit for the morning medication round. Their arrival was announced to the detainees, who are expected to line up for their medication. When Mr Harvey failed to line up, the nurse contacted the DSOs. A DSO attended Mr Harvey's room and notice he was lying face down on his bed and was unrousable. The DSO called for assistance and a team, including a trained emergency responder, arrived at Mr Harvey's room. He was placed on the floor, a Code Blue was called, and cardiopulmonary resuscitation (**CPR**) was commenced. Emergency services were contacted.

29. Upon their arrival, paramedics took over resuscitation efforts, however at 8.57am Mr Harvey was pronounced deceased.

IDENTITY OF THE DECEASED

30. On 10 August 2020, Mr Harvey Bryan Harvey, born 27 September 1973, was visually identified by Department of Home Affairs employee, Jennifer Green.

[11] The IHMS Health Advisory Service can be used after 5:00pm by Serco officers regarding medical concerns for a detainee. Nurses provide advice via the service including whether an ambulance should be called.

31. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

32. Forensic Pathologist Dr Paul Beford of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 14 August 2020 and provided a written report of his findings dated 8 December 2020.

33. The post-mortem examination revealed WHO Class III obesity, cirrhosis of the liver, a mildly enlarged heart with normal coronary arteries. There was no injury or internal pathology likely to have caused the death.

34. Toxicological analysis of post-mortem blood samples detected methylamphetamine, methadone and its metabolite, EDDP, pregabalin, 7-aminoclonazepam (the metabolite of clonazepam),[12] desmethylvenlafaxine, citalopram, quetiapine and paracetamol.

35. Post-mortem biochemistry showed a minimal raised C-reactive protein, a marker of inflammation and infection. Glucose was not elevated and there was no evidence of kidney failure. A urea concentration of 11 mmol/L raised the possibility of mild dehydration.

36. Dr Bedford commented on the toxicology results that several of the compounds (methylamphetamine, methadone, pregabalin, 7-aminoclonazepam, desmethylvenlafaxine, citalopram and paracetamol) are known to cause potential respiratory depression.

37. Dr Bedford hypothesised there were several possibilities arising from the post-mortem findings. He commented that obesity places stress on the heart and with a mildly enlarged heart there may be development of an abnormal and fatal heart rhythm. Cirrhosis of the liver can lead to biochemical abnormalities (not detectable on post-mortem samples) and it is noted there was no internal bleeding or injury likely to lead to death.

38. He commented the other possibility was that the drugs detected in his system upon post-mortem toxicology caused respiratory depression and death.

39. There was no infective process identified and nor was there a pulmonary embolus. A COVID-19 test returned a negative result.

40. Dr Bedford provided an opinion that the medical cause of death was 1(a) *unascertained*

[12] Clonazepam was not detected in post-mortem blood or urine samples.

41. I accept Dr Bedford's opinion as to cause of death.

INTERNAL REVIEWS

42. On 14 August 2020, Serco performed a Post Incident Review into Mr Harvey's death. It did not identify any shortcomings in the care provided which caused or contributed to his death. The organisation did not make any recommendations regarding systems improvements.

43. The Department of Home Affairs also reviewed the circumstances of Mr Harvey's death and arrived at a similar conclusion and determined that no further investigation was required.[13]

FAMILY CONCERNS

44. Following his death, members of Mr Harvey's family expressed their concerns that the DSOs ought to have done more during the morning headcount on 10 August 2020, given that Mr Harvey was seen at around 6:15am – approximately two hours prior to his death – but was not checked.

45. In a statement provided to the Court, Superintendent of Detention Operations Victoria, Australian Border Force, Ms Jennifer Green, advised that *'DSOs are instructed not to wake the detainees" and to be "as unobstructive as possible'* during head counts. Ms Green explained that head counts are conducted only to ensure all detainees are present in the facility and that welfare checks are conducted separately, and later throughout the day.

CORONERS PREVENTION UNIT

46. Based on the concerns of care raised by Mr Harvey's family, I sought the assistance of the Coroners Prevention Unit (**CPU**)[14] to better understand the healthcare provided to Mr Harvey by IHMS in the lead up to her death.

47. The CPU considered the nurse's assessment conducted during the evening of 9 August 2020, following evening medication rounds, when he appeared *'drowsy and pale'*. This assessment concluded that *'there was no medical reason to send Mr Harvey to the hospital or take any further steps because his vistal signs were normal, he was alert and responsive, he was*

[13] Such as a Health Related Critical Incident review, Internal Clinical Review or Stakeholder Consultation/Workshop on the Health Related Critical Incident.

[14] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

speaking in full sentences, and he did not report any medical issues'. The CPU concluded that the nurses' assessment was reasonable and appropriate in that it did not require clinical experience or escalation to note a change in his presentation.

48. The CPU also noted that DSOs could call the Health Advisory Service overnight and speak to a nurse if they were concerned about a detainee's health when an onsite clinician was unavailable.

49. I accept the findings of the CPU review and I have not identified any prevention opportunities.

DELAY IN RECEIPT OF HEALTHCARE FROM NORTHERN HEALTH

50. As part of my investigation the Court obtained statements from IHMS and Northern Health regarding the delay in follow up regarding Mr Harvey's chest pain, which he first complained of in July 2019.

51. On 4 July 2019, Mr Harvey visited an IHMS clinician for a review of his asthma management plan. He complained of exercise induced chest pain which the clinician considered was atypical – the pain did not radiate, and he did not have concomitant shortness of breath. An electrocardiogram (**ECG**) was performed during the consultant which returned a normal result with no ischaemic changes. Despite the unremarkable ECG, due to Mr Harvey's cardiac risk factors (obesity, smoking, elevated cholesterol and pre-diabetes), the clinician referred him for a stress echocardiogram to exclude the possibility of cardiac chest pain.

52. Deputy Director of Northern Health's Cardiology Department, Dr Larry Ponnuthurai, reported in a statement to the Court dated 3 March 2023, that although Mr Harvey's referral recommended that he be triaged as a *'Priority 1'*, the referral was reviewed by a Cardiology Fellow and re-triaged as a routine appointment based on clinical prioritisation and assessment of the referral.

53. Dr Ponnuthurai also provided an overview of Northern Health's procedure for referrals to its specialist clinics:

> *'A triaging clinician reviews a referral to determine the clinician prioritisation. If it has been triaged by the triaging clinician as an urgent referral, the patient is to receive an appointment within 30 days of receipt of the referral If it has been triaged by the triaging clinician as a routine referral, the patient is to receive an appointment within 365 days of receipt of the referral.'*

54. An appointment was made with Northern Health's cardiology service on 15 November 2019. Mr Harvey refused to attend this appointment and *'IHMS is unable to force a patient to undergo treatment or attend medical appointments'*.

55. IHMS contacted Northern Health to re-schedule Mr Harvey's appointment, and it was booked for 21 April 2020. Due to COVID-19 restrictions enforced in early 2020, this appointment was moved to November 2020, by which time Mr Harvey was deceased.

FINDINGS AND CONCLUSION

56. The applicable standard of proof for coronial findings is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[15]

57. Pursuant to section 67 of the Act, I make the following findings:

    a) the identity of the deceased was Daniel Bryan Harvey, born 27 September 1973;

    b) the death occurred on 10 August 2020 at 120 Camp Road, Broadmeadows, Victoria due to unascertained causes; and,

    c) the death occurred in the circumstances described above.

58. Despite a thorough post-mortem examination and ancillary testing, the cause of Mr Harvey's death remains unascertained.

59. The evidence before me regarding the head count performed on the morning of 10 August 2020 is not sufficiently cogent to support a conclusion that had DSOs roused or otherwise interacted with Mr Harvey at that time his death could have been prevented.

60. There is no evidence of want of care provided to Mr Harvey.

61. I convey my sincere condolences to Mr Harvey's family for their loss.

[15] *Briginshaw v Briginshaw* (1938) 60 C.L.R. 336 especially at 362-363: *'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.*

ORDERS AND DIRECTIONS

62. Pursuant to section 73(1) of the Act, this finding is to be published on the Coroners Court of Victoria website in accordance with the rules.

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

Pamela Harvey, senior next of kin
Serco Australia Pty Ltd
International Health and Medical Services
Northern Health
Department of Home Affairs
Senior Constable Adam Read, Victoria Police, Coroner's Investigator

Signature:

Coroner Leveasque Peterson

Date: 23 October 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.