CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Leah Jane Porter
Hearing date:	4 December to 7 December 2023 and 11 -14 December 2023
Date of findings:	6 March 2025
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of a person in immigration detention – intentional self-inflicted death – where deceased died by hanging whilst in lawful custody – appropriateness of care and treatment provided to persons in immigration detention by relevant service providers – non-compliance with medication in immigration detention – whether detention service providers are sufficiently trained in mental health treatment – whether sufficient measures are taken to reduce risk of detainees suiciding - changing nature of immigration detention population.
File number:	2022/00148393

Representation:	Counsel Assisting the inquest: A Casselden SC with M Dalla-Pozza and S Danne of Counsel, i/b NSW Crown Solicitor The Department of Home Affairs; Australian Border Force: C Magee of Counsel with L Hutchinson of Counsel, i/b Australian Government Solicitors Serco Australia Pty Ltd: J Fernon SC with P Barry of Counsel, i/b K&L Gates International Health and Medical Services: K Nomchong SC with M Shume of Counsel and K Holcombe of Counsel, i/b Moray & Agnew Dr D Lienert: S Barnes of Counsel i/b Avant Law Dr K Toh: J Sandford of Counsel i/b Barry Nilsson Law South Western Sydney Local Health District: P Rooney of Counsel i/b McCabes Registered Nurses M Coughlan, M Flores, C Zhang, L Fang, M Nadakuditi, H Acharya, D Mpofu, R Dilernia: Neale Dawson of Counsel i/b Nurses and Midwives Association.
Findings:	**Identity** The person who died is Leah Jane Porter. **Date of death**: Leah Jane Porter died on 22 May 2022. **Place of death**: Leah Jane Porter died at Villawood Immigration Detention Centre, Villawood NSW **Cause of death:** Leah Jane Porter died as a result of hanging. **Manner of death:** Leah Jane Porter's death was an intentional self inflicted death, while she was in lawful custody.

Recommendations:	To the Department of Home Affairs: 1. That the Commonwealth revisit its processes for considering reviews of the immigration detention process commissioned by, or available to, the Commonwealth, and for implementing any recommendations made in such reviews and consider whether any improvements to those processes are required. 2. That the Commonwealth implement a specified timeframe for responding to any recommendations made in any review referred to in the recommendation above. 3. That the Commonwealth consider commissioning an independent study to identify the reasons why detainees in VIDC do not routinely take their mental health medication 4. That an external auditor conducts an audit of VIDC with a view to ascertaining the existence of any hanging points or features in the physical design of the premises which could be used by detainees to self-harm. 5. That the Commonwealth ensure that, as far as is reasonably practicable, to the extent that any of the above recommendations are directed to Serco and/or IHMS, those measures are implemented by any organisation that may succeed Serco as FDSP and IHMS as DHSP. To Serco Australia Pty Ltd, or the detention services provide which replaces Serco Australia Pty Ltd: 6. That FDSP staff be trained: a) in their responsibilities pursuant to a PSP/SME Plan; and b) as to the recognition of signs and symptoms of mental health illness and/or deterioration.

	7. That FDSP staff whose role includes performing or supervising the performance of welfare checks undergo training as to best practice in performing welfare checks of persons in immigration detention. 8. That Serco Staff who undertake the role of a "Personal Officer" receive further training as to the requirements of fulfilling the role of a "Personal Officer" in the Personal Officer scheme referred to in Serco Policy and Procedure Manual 0001- Keep SAFE and PSP/SME, 30 April 2020. To International Health and Medical Services Pty Ltd or the health services provide which replaces it: 9. DHSP staff be trained as to best practice in preparing a PSP/SME Plan with such training covering, in particular, the following topics: a) the importance of tailoring an SME Plan to the specific circumstances of a detainee; and b) the importance of communicating clear instructions to FDSP Staff (and to other persons who have responsibilities for implementing the measures contained in a PSP/SME Plan). To the Department and IHMS or the health services provider which replaces it: 10. That the Commonwealth and the DHSP expedite the development of a memorandum of understanding regarding: a) the process for admitting and discharging a detainee from VIDC; and b) the mental health care services that are to be provided to a detainee at VIDC.

	11. The Commonwealth is to obtain clinical recommendations (made by appropriately qualified mental health clinicians) from IHMS and any organisation who might succeed IHMS in the role of DHSP for the improvement of the BMP such that it is a program that can be fully endorsed by the DHSP to achieve its intended operation in relation to detainees for whom clinical input is appropriate.

Non-publication orders

The Court has made orders for non-publication of certain evidence, pursuant to section 74 of the *Coroners Act 2009.*

Details of these orders can be found on the Registry file.

1. Section 81(1) of the Coroners Act 2009 (NSW) [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

2. These are the findings of an inquest into the death of Leah Jane Porter.

Introduction

3. Leah Jane Porter was aged 50 years when she died at Villawood Immigration Detention Centre on 22 May 2022.

4. Ms Porter had been in immigration detention since 2 December 2021, when her visa to stay in Australia was cancelled. At the time of her death therefore she was in lawful detention, and an inquest into the circumstances of her death is mandatory pursuant to sections 23 and 27 of the *Coroner's Act 2009*.

The role of the Coroner

5. The Coroner must make findings as to the date and place of a person's death, and the cause and manner of their death.

6. In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

Ms Porter's life

7. Leah Jane Porter was born in New Zealand on 27 June 1971. While still a baby she was adopted by Doreen and Ted Aitken, and she was named Susan Jane Aitken. Soon afterwards Mr and Ms Aitken adopted another daughter, Emma Aitken.

8. In the mid 1990s Ms Porter met and married David Porter and the couple had two sons, Cameron and Matthew. At around this time, she changed her name to Leah Porter.

9. In 2007 when she was 36 years old Ms Porter moved to Queensland, Australia with her two sons. Her husband followed soon afterwards. Ms Porter had a visa known as a Visa sub-class TY444.

10. She and her husband separated in 2011 but they remained living under the same roof for several years, with Mr Porter saying that he did not want her to become homeless.

11. Ms Porter suffered a number of mental health conditions which included hyperactivity disorder [ADHD] for which she was prescribed Ritalin, and

treatment resistant depression. There is no doubt that these mental health conditions adversely affected her emotional stability and her capacity to cope with life's stress. A court issued a Domestic Violence Protection Order against Ms Porter on 12 July 2012, for the protection of her husband and sons. She breached this Order on a number of occasions in 2013 and 2014. This led to her being convicted and sentenced to a nine-month term of imprisonment in 2015.

12. In 2016 Ms Porter made at least three attempts to take her own life, which led to hospital admissions. During a later admission in 2019, Ms Porter told clinical staff that her distress was due to relationship difficulties with one of her sons. She also told staff that she was determined to suicide in the future.

13. Ms Porter was convicted of further offences in 2021 and she served another sentence of imprisonment. Then on 2 December 2021 her visa was cancelled pursuant to section 501(3A) of the *Migration Act 1958*, due to her criminal convictions. When she completed her terms of imprisonment on 4 January 2022 she was transferred into the custody of the Australian Border Force.

14. Ms Porter made an application for review of her visa cancellation in March 2022. Her application remained outstanding at the time of her death.

15. Ms Porter's sister Emma Aitken lives in New Zealand, and she followed her sister's inquest using AVL. Ms Aitken provided a statement to the coronial investigation, in which she outlined her sister's often troubled childhood and adolescence.

Ms Porter's immigration detention

16. When Ms Porter went into immigration detention she was initially housed in a hotel for a period of COVID-19 quarantine. She had a psychiatrist assessment which was conducted via AVL. The psychiatrist, Dr Jillian Spencer, noted that Ms Porter had a history of suicide attempts and alcohol misuse. According to Dr Spencer's notes, Ms Porter said she would not attempt to take her life again.

17. Dr Spencer concluded that Ms Porter had a severe personality disorder and was narcissistic and anti social. However Dr Spencer considered that her risk for suicide was *'currently low'*. She wrote that detention staff '*may need to implement a behavioural management plan in future if [Ms Porter's] behaviour escalates'.*

18. On 9 March 2022 Ms Porter was transferred to Villawood Immigration Detention Centre [VIDC].

19. In opening submissions, Counsel Assisting gave a broad outline of Ms Porter's time in detention at VIDC, which I now summarise. Its contents were not in dispute. Later in these findings I will give a more detailed account of Ms Porter's mental health care.

- At times, Ms Porter had a '*fractious*' relationship with VIDC staff, with behaviour that was reported to be aggressive and disruptive. She also made many complaints against staff about their conduct towards her, and the conditions of her accommodation.

- VIDC health staff prescribed Ms Porter with Ritalin for ADHD, Sertraline for borderline personality disorder, various medications for heart disease, and painkillers for her chronic back pain. However Ms Porter did not always take her medication. She was usually willing to take her ADHD and pain medication, but generally refused her Sertraline and heart medication.

- Ms Porter's attendance rate at scheduled medical appointments in VIDC was sporadic, and worsened over her time there.

- From time to time Ms Porter received medical attention for self-inflicted injuries, including after episodes of banging her head against a wall.

- At different times Ms Porter was subject to Personal Support Plans and Behaviour Management Plans. The nature of these programs will be described later in these findings.

- At some point Ms Porter adopted a stray kitten and became very attached to it. She was extremely distressed when detention staff took the kitten from her, reportedly for health reasons. Ms Porter responded with agitated behaviour, complaints against staff, refusals to take her medication or to attend her medical appointments, and verbal expressions that she would harm herself.

The events of 22 May 2022

20. On the morning of 21 May 2022 detention staff became concerned for Ms Porter because they could not rouse her from her sleep. Nurses from the clinic observed that she was breathing but unresponsive. Ms Porter awoke during their examination, and ambulance paramedics were called. Ms Porter told the paramedics that she was tired from her new medication, Mirtazapine, and she declined to go to hospital.

21. The next day, which was 22 May 2022, Ms Porter was escorted to the clinic to receive her regular medication. Health staff noticed that she was carrying a bag to which she had attached a length of rope. They made a report, which noted that the rope was a potential risk to Ms Porter and to fellow detainees.

22. This prompted detention staff to carry out a search of Ms Porter's room. The search uncovered many contraband items, which included:

- numerous lengths of rope and straps
- scissors, needles and syringes
- metal wires
- six loose tablets and one capsule
- the head of a mop
- a bottle with tubing attached to a smaller bottle.

23. After the search a detention officer asked Ms Porter is she was alright, to which she replied *'Of course I'm not alright'*. The officer said she would return to check on her soon, but Ms Porter slammed her door shut, saying '*Don't bother'*.

24. About half an hour later the detention officer went back to Ms Porter's room but found the door locked from the inside. The officer unlocked the door. Inside she found Ms Porter hanging by a piece of rope which had been tied to the top railing of the bunk bed.

25. The officer called emergency services and CPR immediately began. But in spite of their efforts and those of ambulance officers, Ms Porter could not be revived. She was pronounced deceased at 11.39am.

The cause of Ms Porter's death

26. Forensic pathologist Dr Jennifer Pokorny carried out an autopsy. She found the cause of Ms Porter's death to be "hanging". No antecedent cause of death was identified.

The issues examined at the inquest

27. Given the cause of Ms Porter's tragic death, the care and treatment which she received at VIDC for her mental health was the primary focus of the inquest. The issues were:

    - Did Ms Porter receive adequate monitoring, treatment and support for her mental health at VIDC?

    - Did VIDC have adequate measures in place to ensure that detainees took their prescribed medication and attended their mental health appointments?

    - Did the health providers and detention officers have adequate systems to share information regarding a detainee who had mental health concerns?

    - Did VIDC have adequate measures to remove or reduce the risk that detainees would hang themselves?

- Was the search of Ms Porter's room on 22 May 2022 adequate, and should VIDC staff have taken more steps to check on her welfare after the search?

28. The inquest also examined the question whether Ms Porter should have been housed with other detainees while she was living at VIDC. However the evidence was clear that while room-sharing may have had protective benefits for Ms Porter as a suicide prevention measure, she preferred to live alone and indeed may have created difficulties for a roommate were she forced to have one. There is no basis for criticism of the decision of VIDC authorities regarding this.

The profile of detainees at VIDC

29. At the inquest, DT told the court that between 2019 and 2022 there were on average between 470 and 500 detainees at VIDC. They were accommodated in nine compounds. Each compound had its own kitchenette, common area, access to computers, and recreational space for activities. Some areas also have shared soccer fields and volleyball courts.

30. Detainees have access to a community centre which had a shop, café, hairdresser, basketball court, library, gym, computer room, music room, dining hall and sitting areas.

31. At the time of Ms Porter's death, Serco was contracted as the Facilities and Detention Service Provider and IHMS was contracted as the health service provider. At the date of these findings, IHMS was no longer contracted to provide services to VIDC and Serco's contract will end in 2025.

32. There was a medical clinic on the VIDC site operated by IHMS. It provided healthcare services in relation to primary healthcare, drug and alcohol and mental health. Services included administering regular medications to detainees and providing psychological support through the Psychological Support Program [PSP]. The clinic was staffed from 7:30am to 8:30pm daily.

33. DT also gave the following evidence about the changing demographic profile of VIDC detainees. In my view this evidence has very important implications for the future delivery of health and welfare services to VIDC detainees.

34. In 2019, 5% of VIDC's detainee population had, like Ms Porter, been sent there from a corrective services facility. They had been convicted of offences and had served a term of imprisonment of twelve months or more in correctional centres. Because of this, they had had their visas cancelled under the *Migration Act 1958.*

35. But at the inquest, DT advised that this cohort now comprised approximately 75% to 80% of the VIDC population. It was beyond dispute

that there is now widespread illicit drug use within the VIDC, as well as a significant level of mental illness. DT told the court that this has made for a more vulnerable cohort, with a greatly increased need for health and welfare services.

36. Notably, funding for any increased health services at VIDC must be approved by the Department of Home Affairs. This is achieved either through contractual variation or the making of an application for additional funding, known as an Additional Services Request.

37. The implications of DT's evidence are discussed later in these findings.

Overview of VIDC's administrative arrangements

38. Because of the nature of the issues examined at the inquest, the court heard a large amount of evidence about the arrangements in place at VIDC for the management and care of its detainees, and the mental health services that were available to them.

39. The general administrative arrangements which underpin the operation of VIDC were described in paragraphs 12 to 22 of Counsel Assisting's closing submissions. The interested parties did not dispute the content of these passages. I have therefore borrowed liberally from them in giving the following outline.

40. The Commonwealth of Australia has overall responsibility for managing Australia's Immigration Detention Network. The Commonwealth discharges this responsibility through the Australian Border Force, which operates independently within the Department of Home Affairs [the Department].

41. The nature of immigration detention is administrative and not punitive. Because of this, detainees have a higher degree of autonomy than persons who are in corrective detention. Nevertheless, a detainee is not free to leave detention and must comply with directions given by detention officers.

42. Pursuant to a contract with the Department, Serco Australia Pty Ltd [Serco] as the Facilities and Detainee Service Provider was responsible for managing and operating Australia's detention facilities, including VIDC. Serco commenced providing these services in 2009.

43. Under its contract with the Department, Serco was responsible for providing garrison, facilities management, security, and transport services. Serco was also obliged to provide a range of welfare services to VIDC detainees which address their individual needs, and to develop and provide services and activities which contribute to their welfare. The contract required that Serco staff take an approach which emphasises communication and interaction with detainees.

44. Serco employed detention officers to perform many of these services. Detention officers at VIDC were responsible for maintaining security and stability and, although they are not medical officers, to attend to the welfare of detainees.

45. Serco also employed Welfare Officers to provide detainees with services and activities designed to promote their welfare. Like detention officers, they are not medically trained.

46. At the time of Ms Porter's death, International Health and Medical Services Pty Ltd [IHMS] as the Detainee Health Service Provider was responsible under contract for providing medical services to immigration detainees. At the time of the inquest, IHMS had not sought a renewal of its contract to provide health services to VIDC. IHMS is no longer providing services within Australia's onshore immigration detention network. On 14 October 2024, the Department executed a contract with Healthcare Australian Pty Ltd for the provision of Health and Wellbeing services

47. IHMS's contract with the Department required it to provide detainees with quality health care in a cost effective manner, and in accordance with the Department's policies and procedures. IHMS's primary and mental health services included education and prevention programs, as well as giving medication to detainees and referring them to specialists as needed. Periodic mental health screening, assessment and treatment were required.

48. The closing submissions on behalf of IHMS rightly emphasised the legal framework within which clinicians provide detainees with health care. IHMS noted that in common with clinicians who care for patients in the community, VIDC health staff are legally required to respect the autonomy of their patients. Because of this, in general IHMS staff cannot compel detainees to attend medical appointments or to comply with their medication regimes.

49. I accept IHMS's submissions that:

> *' … the question of the adequacy of measures that are in place at VIDC for encouraging compliance (which is all IHMS can legally do unless a patient is under the Mental Health Act) must be viewed in that framework.'*

Arrangements for mental health care at VIDC

50. The adequacy of the monitoring and treatment provided to Ms Porter for her mental health at VIDC was a central issue at the inquest.

51. What follows is an overview of the procedures which were in place at that time for the monitoring, treatment and support of detainees' mental health. Since Ms Porter's tragic death there have been changes to these procedures, which will be described later in these findings.

52. This overview largely derives from the closing submissions of Counsel Assisting, and those on behalf of IHMS and Serco.

General procedures

53. At the time of Ms Porter's detention at VIDC, a person who went into immigration detention had a health induction assessment within 72 hours of their arrival. This was performed by IHMS staff. In addition, the detainee was to have a comprehensive mental health assessment within ten to thirty days of their arrival, with follow up screenings at six months, twelve months, eighteen months and thereafter, at three monthly intervals.

54. Serco was required to prepare and manage an Individual Management Plan [IMP] for each detainee. According to Serco's Detainee Management policy, a detainee's IMP was to:

55. The IMP was to be reviewed every fortnight, or sooner if there was a significant event. Under the IMP, each detainee was to be allocated a Serco staff member who met with them every fortnight to review and discuss their IMP.

Procedures for monitoring 'at risk' detainees

56. Although IHMS is responsible for providing mental health services to detainees, under its contract with the Department, Serco is obliged to support IHMS in that task. Detention officers do this by providing a degree of monitoring of detainees' welfare, seeking advice from IHMS staff if they suspect there is a risk of self harm. It is understood that performing this task does not require that detention staff have medical training or clinical expertise.

57. At VIDC there were and are three formal monitoring programs in place:

- The Psychological Support Program [PSP], which provides the framework for Supportive Monitoring and Engagement [SME]
- The Keep SAFE program; and
- The Enhanced Monitoring program.

The PSP/SME program

58. The PSP is a framework to assist in managing detainees' risk of self harm or suicide. According to IHMS policy documents, it is to apply '*to all detainees at all times'* and not to consist only of monitoring. Rather, it is '*a*

clinically led intervention to assist in the management of the risk of self harm or suicide'.

59. A detainee who has been assessed as being at risk of self harm is to be provided with Supportive Monitoring and Engagement [SME]. Depending on the assessed level of risk, such a detainee will be subject to SME at the following risk levels:

- High imminent (requiring constant line of sight physical observation, with Serco officers making written observations at thirty minute intervals).
- Moderate (requiring thirty-minute physical observations and written observations).
- Ongoing (general non intrusive monitoring, requiring eight hourly physical observations with written observations made three times throughout the day).

60. The applicable risk level is set out in an SME plan, which IHMS staff prepare after a clinical review of the detainee. The SME outlines a clinical plan which usually includes an instruction that detention staff undertake physical monitoring and written observations in relation to the detainee.

61. Notably, the relevant policy stipulates that in carrying out their monitoring duties, detention staff are to *'provide meaningful engagement with detainees ... in a supportive way'*. Their written observations are to be recorded in a Detainee History log, and are likewise to be '*meaningful'* in character.

62. The above three risk levels also dictate the frequency of clinical review that IHMS staff must undertake, as follows:

- High imminent: clinical reviews at 12 and 24 hours from initiation; after that at least every 24 hours. There must be a medical officer after 48 hours.

- Moderate: clinical reviews every 24 hours.

- Ongoing: a clinical review every 7 days.

63. In the submission of Counsel Assisting, the PSP/SME policies contemplate that detention staff play *'a considerable role'* in implementing the PSP/SME process. Their duties include:

- To follow the clinical advice set out by IHMS in the detainee's SME;

- To look out for early warning signs and if a risk of self harm is suspected, to seek immediate advice from IHMS;

- To provide 'at risk' detainees with *'meaningful engagement … in a supportive way'*;

- To record *'meaningful observations'* when monitoring a detainee;

- To provide effective handovers about 'at risk' detainees to incoming shifts.

64. In submissions on behalf of Serco, Mr Fernon SC agreed that detention staff had '*a particular and important role'* to play in implementing the PSP/SME program.

65. However a central tenet of Mr Fernon's submission was that the role of detention officers had to be understood within the parameters of Serco's relationship with IHMS, whereby the latter's role was to provide advice and manage the PSP process, while that of detention officers was to support IHMS in that process. Detention officers did this, Mr Fernon said, by following the clinical decisions made by IHMS in the detainee's SME plan – principally, by supporting, monitoring and engaging with the detainee and recording observations of the detainee's behaviour.

66. Mr Fernon SC emphasised that detention officers are not medically trained and are not expected to exercise clinical judgement when performing those duties. Nor, he submitted, did they require such training in order to competently perform these duties. On this basis, Mr Fernon SC demurred with the description of Serco's role as *'considerable'*, noting that each stakeholder set out in the PSP/SME policies had '*specific roles and responsibilities'*.

The Keep SAFE program

67. The purpose of this program was described in Serco's submissions as:

> *' … to manage the immediate needs of detainees identified by a [detention] officer as being at risk of self harm, until a detainee can be clinically assessed by IHMS.'*

68. Pursuant to this program, where a detainee is identified as at risk of self harm at a time when IHMS staff are not on site, detention staff must maintain *'line of sight'* observations of the detainee at a minimum of one hourly intervals, notify IHMS and follow their advice, and arrange an IHMS assessment as soon as possible.

69. In fact however, at VIDC the Serco practice with regard to Keep SAFE was and is to maintain <u>constant</u> *'line of sight'* monitoring, with observations recorded every thirty minutes, until an assessment by IHMS could be arranged.

70. As noted in Serco's submissions, Keep SAFE monitoring equates to the level of monitoring required when a detainee had been placed on PSP High Imminent.

Routine ‘welfare’ checks

71. In addition to the above systems of monitoring, detention staff also conducted:

- two daily ‘welfare’ checks, one at lunch time when staff accounted for each detainee by using a headshot photograph of each. A second such check took place at dinner.

- two daily ‘headcount’ checks at the compound level.

Enhanced monitoring

72. The purpose of this program is to provide increased monitoring of detainees where they do not meet guidelines for using the PSP/SME or Keep SAFE programs. For a detainee subject to enhanced monitoring, detention staff are to record observations every thirty or sixty minutes, depending on the assigned risk level.

73. In 2019, enhanced monitoring at VIDC could be used in a variety of circumstances, including when a detainee was non compliant or aggressive, or may be intending to escape. Policy changes introduced in November 2022 have increased the applicable circumstances, to include where a detainee has concerns for their own safety, and where a detainee is vulnerable.

Behavioural Management Plans

74. Behavioural Management Plans [BHPs] operate separately and sometimes in parallel with the PSP/SME process.

75. Serco is required to prepare a BMP in respect of detainees deemed to have behaved in an anti social manner, to have conducted illegal activities, or to have behaved in a way which undermined the good order of the facility. A BMP typically sets out obligations and expectations of the detainee, with a system of punishment and reward for inappropriate and appropriate behaviour.

76. IHMS and the Australian Border Force are required to provide input into each BMP. In the case of IHMS, their input is to determine if the behaviour was mental health-related.

Overview of Ms Porter’s mental health care at VIDC

77. As a preliminary to examining the issues, I will give a broad overview of the mental health care which Ms Porter received at VIDC. This description is not in dispute.

78. Ms Porter had a long history of mental health disturbance. She struggled with diagnosed conditions of ADHD and depression, which at times severely disrupted her behaviour and led to serious self harm attempts.

79. On 9 March 2022, which was the day after Ms Porter arrived at VIDC, IHMS psychiatrist Dr David Lienert carried out a medication review. He slightly reduced her ADHD medication to 60mg daily of the drug Ritalin.

80. Over the next few days Ms Porter refused a number of her medications, and lodged a complaint that some of her other medications were not available. IHMS had ordered these medications, but they had not yet arrived.

81. On 10 March, 5 March and 16 April 2022 Ms Porter told detention officers that she was having chest pains. On each occasion detention staff notified IHMS staff, who responded appropriately by calling an ambulance for her to be assessed.

82. On the 15 March occasion, just prior to being taken to hospital for review Ms Porter was searched by detention staff. They found on her a 7cm metal bar. At hospital Ms Porter was found to have an infected finger and she was prescribed antibiotics. Back at VIDC she refused to take these.

83. On 16 March 2022 Ms Porter was found highly distressed, banging her head against a wall. She was put on a Keep SAFE program with 24 hour monitoring.

84. The next day a mental health nurse reviewed Ms Porter. Since Ms Porter appeared to have slept and eaten well and was denying any thoughts of self harm, the nurse recommended that both the Keep SAFE and SME be discontinued.

85. The Keep SAFE was reinstated the next day when Ms Porter threatened self harm. On 18 March 2022, the same nurse again reviewed her. Again Ms Porter denied thoughts of suicide or self harm, and the nurse decided that she did not need an SME.

86. Later that same day Ms Porter was again seen hitting her head against the door in her room. She was given medical care for a small head laceration, and the Keep SAFE was reinstated. The same mental health nurse reviewed her again on 21 March 2022, which resulted in the Keep SAFE being lifted.

Ms Porter's psychiatrist consultation on 24 March 2022

87. On 24 March 2022 Ms Porter was assessed by psychiatrist Dr David Lienert. He endorsed Dr Spencer's diagnosis of a Cluster B Personality Disorder. He did not find Ms Porter to be experiencing psychosis or suicidal ideation, but considered that she had '*paranoid transference'*. He added in his clinical notes that she had a '*likely low threshold for coping with stress due to personality disorder'.*

88. In his evidence at the inquest Dr Lienert said he had found it difficult to establish rapport with Ms Porter. He wanted, he said, to first try to build trust with her, believing that until this was established she would not listen to his advice about ways to cope with the stress she was under. He also wanted over time to build her willingness to undertake appropriate psychological therapies such as Dialectical Behaviour Therapy.

89. However Ms Porter did not see Dr Lienert again, or any other psychiatrist, until 5 May 2022.

Events in April and May 2022

90. Ms Porter's room was again searched on 15 April 2022, after she was seen throwing a capped syringe to and from another detainee. The search uncovered two syringes, an improvised weapon, two broken mop heads, an improvised smoking implement, two pieces of wire and fourteen unknown pills.

91. At some point after arriving at VIDC Ms Porter had befriended a stray kitten, which she sometimes kept in her room. She was greatly distressed when on 16 April 2022, detention officers told her she could not do this. She told them that if they took the kitten away she would be *'gone in the morning'*. The kitten was removed and Ms Porter was placed on a Keep SAFE.

92. On two further occasions (17 April and 19 April 2022) Ms Porter was seen banging her head against a wall. She was placed on a Keep SAFE after the 17 April occasion. But after the 19 April episode she refused to allow IHMS staff to treat her. She self harmed her own infected finger, telling detention officer HA in a state of great frustration that no one was listening to her. She was taken to Fairfield Hospital for medical treatment of her finger.

93. When she returned to VIDC on 27 April 2022, Ms Porter was described as agitated and verbally abusive to staff. A mental health nurse assessed her, recording that she was unable to maintain a stable emotional state and was at risk of causing harm to herself as a result.

94. Ms Porter was placed on a PSP/SME at High/Imminent level. A mental health nurse assessed her the following day, when Ms Porter denied thoughts of self harm. The SME was reduced to Moderate, but was increased to High/Imminent the next day because of her extreme agitation.

95. Over the following days the SME at High/Imminent remained in place, with Ms Porter very agitated and telling Serco staff that she would kill herself if the kitten was not given back to her.

96. In addition, on 2 May 2022 Ms Porter was placed on a Behavioural Management Plan [BMP].

97. Dr Lienert assessed Ms Porter again on 5 May 2022. He thought that her risk of suicide had reduced, but that she would be at risk of inadvertently harming herself if she became more behaviourally disturbed. He reduced her SME level to Moderate.

98. Mental health nurses assessed Ms Porter on 6 May and 9 May 2022. They noted that she had been refusing most of her medications. However on 9 May she told the mental health nurse that if she had any suicidal thoughts she would tell friends or Serco officers. Her SME was reduced to 'Ongoing' level.

99. Between 14 and 21 May 2022 Ms Porter's SME levels fluctuated between High/Imminent and Ongoing, depending on her degree of emotional dysregulation. She was reviewed several times by IHMS mental health nurses, and by a GP on 16 May 2022 because of her infected finger. The GP prescribed her with Mirtazapine to assist with her sleeping difficulties.

100. The next day, 22 May 2022, Ms Porter went to the clinic with detention officer HA. Ms Porter would not respond either to HA or to IHMS staff.

101. At paragraphs 21 to 24 I have described what happened when clinic staff noticed the length of rope tied to Ms Porter's bag. The following search of her room, Ms Porter's state of distress, and the tragic outcome have also been described above.

102. I now turn to the issues examined at the inquest.

ISSUES 1 AND 2

Did Ms Porter receive adequate monitoring, treatment and support for her mental health at VIDC?

Did VIDC have adequate measures in place to ensure that detainees with significant mental health issues complied with medication and attended medical appointments?

103. The evidence strongly supports the submission on behalf of IHMS that Ms Porter had chronic mental health issues which ' … *had been difficult to treat in the community and remained difficult to treat during her time in detention'*.

104. Counsel Assisting likewise acknowledged *'the high level of difficulty involved in treating someone with [borderline personality disorder].'* Their submissions quoted the comments made by Dr Lienert at the inquest:

> *'I think one of the major challenges that we have is that a personality disorder is highly correlated with a trauma background, and we know, in terms of treating trauma disorders, that being in a setting of safety and security, and having some degree of certainty abut one's environment,*

is important, from a therapeutic perspective. And the very nature of immigration detention … it makes it very hard to work therapeutically with people in that kind of setting'.

105. The impact of Ms Porter's mental illness on her behaviour was very evident. Counsel Assisting noted that during her time in detention, Ms Porter was involved in approximately 55 behavioural incidents. Some of these were relatively minor, but others involved actual and threatened self harm, abusive/aggressive behaviour, and keeping contraband items.

106. It will be seen from the outline above at paragraphs 82 to 85 that Ms Porter spent many periods of time subject to PSP/SME programs. Counsel Assisting acknowledged that as a result, Ms Porter received numerous assessments by mental health nurses.

107. However in Counsel Assisting's submissions, these reviews were *'fairly cursory in nature … and were primarily utilised for conducting a risk assessment, as they did not allow the opportunity to get the 'whole picture' in terms of a clinical insight into the patient'.*

108. Relatedly, Counsel Assisting noted - that at VIDC, Ms Porter received only two psychiatrist assessments. It was submitted that this was insufficient, given Dr Lienert's assessment that she needed such appointments in order to build her trust and to encourage her to engage in the types of therapy that were most suitable for her severe borderline personality disorder. In his evidence Dr Lienert emphasised that to be effective, such therapies need the willingness of the patient. His strong impression was that Ms Porter had not reached this stage.

109. Counsel Assisting's submissions were not critical of Dr Lienert for the fact that Ms Porter received only two psychiatrist appointments. Their submissions acknowledged that VIDC was understaffed in terms of psychiatrists. Although the court heard that funding had been increased after Ms Porter's death but before the termination of IHMS' contract, to enable psychiatrist cover for four days of the week, IHMS had found it a significant challenge to recruit a second psychiatrist.

110. As regards the adequacy of Ms Porter's mental health treatment, the court had the benefit of an independent expert from consultant psychiatrist Dr Jeremy O'Dea. Dr O'Dea was asked to give his opinion of the monitoring and treatment for her mental health which had been provided to Ms Porter at VIDC.

111. Dr O'Dea provided a report and gave oral evidence at the inquest.

112. Dr O'Dea concurred with Dr Lienert's opinion that places of detention are not ideal environments within which to deliver mental health care; and further, that resources and staffing within detention centres are often constrained.

113. Within this context however, Dr O'Dea considered that Ms Porter's mental health care and psychiatric treatment was *'adequate and appropriate in the circumstances'*. He said this in his expert report:

> *'I note that Ms Porter's non compliance with medication and non attendance at medical appointments can present a challenge to practitioners providing adequate and appropriate mental health care. As enforced treatment would not usually be indicated in patients with [borderline personality disorder], movement between levels of SME, with supervision of medications at least at times, is an appropriate intervention to endeavour to enhance compliance in the longer term'.*

114. Dr O'Dea was of the view that it was appropriate for Ms Porter's SME to be *'downgraded and upgraded several times prior to her death'*, in response to her variable state of mental health and circumstances. He noted that *'a difficult balance is required to be struck'* between the need to manage suicide risk in the least restrictive environment, and improving long term risk of suicide.

115. Furthermore, in Dr O'Dea's opinion, Ms Porter received an appropriate response from clinical staff with each of her mental health assessments.

Conclusion regarding Issue 1

116. Dr O'Dea is an experienced consultant psychiatrist, with extensive experience providing psychiatric care to patients within custodial settings. His opinion regarding the adequacy of mental health care given to Ms Porter carries significant weight.

117. I have considered his evidence, as well as that of the clinicians who gave care and treatment to Ms Porter while she was detained in VIDC. In my view the evidence supports the conclusion that the monitoring, treatment and support which was given to Ms Porter was adequate.

118. I will however note a specific deficiency which Counsel Assisting submitted was evident within VIDC's PSP/SME process. This was that the SME plans for Ms Porter *'all appear to be in template format*', and did not contain instructions to detention staff which were particular to her own circumstances.

119. This prompted Counsel Assisting to propose Recommendation 17, which is designed to encourage staff to prepare SME plans which are more specific to the detainee in question.

120. I endorse the submission of Counsel Assisting, that there is scope for improvement in this area. This is particularly the case, in light of the evidence at the inquest of the changing profile of VIDC detainees and their increased need for mental health and welfare services.

121. This matter is further discussed n the section on Recommendations.

122. Before leaving this issue, I will outline changes that have taken place since Ms Porter's death to mental health procedures at VIDC.

Changes to mental health policy and procedures at VIDC

123. At the inquest the court heard evidence about a Mental Health Procedural Instruction which has been in development since 2019. Its aim is to reform aspects of mental health care in immigration centres.

124. In early 2023 a revised draft of the Procedural Instruction was made available for review. On the basis of evidence heard at the inquest, the court understands that certain changes will be implemented.

125. Some of these changes will be made to the PSP/SME program. In particular:

- there is to be an increase to five, of the existing three risk levels of PSP/SME According to the evidence of the Department, this reform was to be trialled in 2024.

- there is to be an increase in the degree of clinical oversight, when there is a plan to de-escalate a detainee from one PSP/SME risk level to a lower one. This reassessment must be made by two clinicians, one being a mental health clinician; and one of the clinicians must assess the detainee in person. Additionally, the mental health clinician involved in the reassessment must lead and discuss any proposed changes to the SME risk level.

126. As at the hearing of the inquest in 2023, IHMS had lodged a request for additional funding to give effect to the above changes, and to the following additional services:

- Another team leader to administer the PSP/SME program;

- Two mental health nurses to work on weekends and on weekdays after hours;

- Two psychologists;

- Two clinical liaison nurses and one mental health nurse to staff the HAS.

127. The additional mental health nurses would enable VIDC's health clinic to operate from 7.30am to 8.00pm, seven days a week.

128. IHMS had also sought and received funding for two additional psychiatrists, so that it could provide a psychiatrist service four days a week instead of the existing two day coverage.

129. The court heard evidence that Serco was committed to making the changes necessary to support the 2023 Procedural Instruction. These changes would include creating and delivering new training to detention staff, revising existing policies and procedures, and modifying existing technology.

Issue 2: Did VIDC have adequate measures in place to ensure that detainees with significant mental health issues complied with medication and attended medical appointments?

130. By way of background, the court heard evidence that IHMS staff administered medication to VIDC detainees in the medication room of their clinic. The IHMS clinic is in a separate building to the residential compounds, and is staffed from 9am to 5pm. This was also the case in 2022. Primary health care nurses are available until 8pm for the purpose of administering medication.

131. The evidence established that at VIDC, at the time of Ms Porter's detention and continuing, there is a high rate of non attendance at medical appointments (estimated to be approximately 39%). There is an even higher rate of detainees not complying with their mental health medication, estimated to be around 65%. It was acknowledged that high rates of non compliance with clinical appointments and medication are also common in community health care.

132. Ms Porter herself had a history of missing appointments, both for her medication and for her clinical reviews. This behaviour increased after her kitten was taken from her in April 2022. The records for her clinical appointments show increasing notations of *'cancelled'*, '*rescheduled'* and '*did not attend'*.

133. Counsel Assisting acknowledged that the reasons for these missed appointments were not clear. On some occasions it is apparent that Ms Porter declined to attend, but the evidence did not disclose if this was in all cases the reason.

134. This evidence raised the question of what procedures were in place at VIDC to encourage compliance with medication and scheduled appointments, and to follow up on missed appointments.

The processes in place at the time of Ms Porter's detention

135. At the time Ms Porter was at VIDC, there were processes in place to follow up missed medication and review appointments. These were as follows:

- IHMS staff rescheduled appointments when detainees did not attend them;
- IHMS staff sought the help of Serco officers in encouraging detainees to attend their appointments;
- On occasions IHMS staff performed *'outreach'* services, attending the residential compound to consult with detainees, although there was no requirement for them to do so;
- Detainees who were considered to be 'at risk' due to medication non compliance were booked for a GP review;
- IHMS clinicians were able to take action to transfer a detainee to hospital for consideration of involuntary treatment.

136. IHMS also had procedures for following up on detainees who had missed what were considered to be 'critical medications'. Counsel Assisting outlined these:

> *'First, IHMS would maintain a list recording certain medications as "critical medications" (the 'critical medications list');*
>
> *Secondly, IHMS would record detainees who had failed to take medications appearing on the critical medications list. This would be done using a spreadsheet which recorded each detainee who had a medication prescription and whether the medication was administered.'*

Should IHMS adopt a more assertive approach regarding medication compliance?

137. The above evidence prompted Counsel Assisting to submit that a '*more proactive follow up model'* is required to improve compliance with medication and attendance at clinical appointments. This, it was submitted, could involve:

- a greater presence by IHMS within the residential compound
- administering medication within the residential compound
- greater involvement by IHMS staff in the development of detainee management plans.

138. The inquest heard limited expert evidence on this issue from independent consultant psychiatrists Dr Kerri Eagle and Dr Danny Sullivan.

139. Both witnesses affirmed the principle that as in the community, mental health care is best provided to detainees on a voluntary basis. However in Dr Eagle's opinion, persons in immigration detention need '*a more assertive level of care'* than is generally afforded to those in the community. This, she said, was due to:

- the fact that detainees have a higher and different rate of vulnerabilities to community members;

- the opportunities which conditions of detention offer, whereby authorities have a greater degree of control over a person's access to health care.

140. But as to the way in which detention health care might be provided in a more assertive manner, Dr Eagle said that she did not consider herself to be in a position to be prescriptive about this.

141. However, she and Dr Sullivan agreed that any changes of this kind would require the input of a number of stakeholders. They agreed further that an important element in promoting better compliance is providing psychoeducation to detainees, to enhance their understanding and sense of control over their health care decisions.

Changes to IHMS procedures regarding medication non compliance

142. In submissions, IHMS acknowledged that treating detainees who have significant mental health issues is very challenging, and agreed that a primary challenge was that of addressing medication non compliance. IHMS pointed to changes which it had introduced since Ms Porter's tragic death, which were designed to strengthen their processes for following up on missed medications.

143. Counsel Assisting acknowledged these changes, summarising them as follows:

- *At the conclusion of each day, a report of missed medications is automatically generated by the electronic medical record system ("EMR") that is maintained for a detainee*
- *This missed medication report records detainees who have not taken their medication for 4 days*
- *Three reports are automatically generated:*
    - *one for detainees who have been prescribed anti-psychotic medication;*
    - *one for detainees who have been anti-depressants; and*
    - *a third for detainees who have been prescribed noncritical primary health medication*

- *The reports are reviewed by either the IHMS Health Services Manager or IHMS team leaders*
- *A missed medication report is sent to a detainee identified through this process*
- *A primary health review is scheduled for that detainee*
- *If the detainee does not attend the primary health review, a GP appointment is booked*
- *If the detainee does not attend the GP appointment, a further GP appointment is booked. If the missed medication is assessed as significant, "relevant stakeholders" are to be updated*
- *If that further GP appointment is not attended, a "non-attendance/medication changed/ceased" letter is sent to the detainee*
- *If the missed medication has been designated a "critical medication", IHMS is to notify the [detention services provider] and request that the detainee be brought to the clinic during clinic hours.*
- *If the detainee refuses, an IHMS clinician will visit the detainee in the compound to reinforce the importance of taking this medication. If the detainee continues to refuse to take the medication, a GP will assess his or her capacity to make that decision "at the next available opportunity". If this review determines that the detainee lacks capacity to make that decision, the detainee "should be considered for transfer to hospital for assessment". If the detainee is assessed as having capacity to make this decision, this is documented and an incident report prepared.*
- *If a detainee does not present for the relevant medication round, IHMS is to notify the [detention services provider] and request the detainee be brought to the IHMS Clinic during clinic hours. If the detainee refuses to come to the Clinic, IHMS will visit the detainee in their compound during clinic hours to discuss the reasons for the non-compliance and reinforce the importance of taking their medication.*

144. IHMS submitted that the above new policies and procedures:

' … *amount to an assertive model of care, which is appropriate and adapted to the detention environment and is in conformity with applicable legal, ethical and therapeutic obligations…'*

145. But in reply submissions Counsel Assisting disagreed, contending that although the above changes are positive, they are not adequate to address the issue. Health services needed to maintain '*a more assertive presence in the compound of immigration detention facilities such as VIDC'*. This, when necessary, would involve health staff going onto the compound to administer medication to detainees.

146. Counsel Assisting's (amended) proposed Recommendations 5 and 6 were as follows:

> *5 That the Commonwealth amend the 2023 Procedural Instruction to require mental health clinicians employed by the DHSP to attend the residential compound of VIDC, in order to attempt to meet with detainees in order to provide medical advice to detainees who are currently prescribed any critical medication (as prescribed in the DHSP critical medications list) and who have:*
>
> - *failed to take their critical medication (for the avoidance of doubt, including any other medication used to treat mental health or personality disorders); or*
> - *missed a scheduled medical appointment with a mental health nurse, psychologist or psychiatrist.*
>
> *6 That IMHS (or whichever organisation succeeds IHMS in the role of DHSP) give consideration to the feasibility of administering:*
>
> - *critical medication; and*
> - *any other medication used to treat mental health or personality disorders, excluding any medication to be administered by syringe.*

The response of Serco and IHMS to proposed Recommendations 5 and 6

147. The above proposals were not supported by Serco, IHMS or the Commonwealth.

148. Serco's submissions highlighted *'the significant security and safety risks'* that would arise if IHMS staff were required to attend the residential compound to meet with detainees. For such an *'outreach model'* to occur there would need to be a significant number of detention officers to escort IHMS staff. On current funding models this would mean diverting detention officers from other critical tasks within the facility.

149. The Commonwealth also opposed the two Recommendations, on the basis that such outreach programs would not be practical to implement. The Commonwealth noted the need for risk assessments to be undertaken by Serco, the need for increased detention and health staff, and the need for detainee consent to enter their living areas.

150. The Commonwealth also submitted, as did IHMS, that the proposals were contrary to the principle of patient self agency.

151. IHMS's submissions pointed to similar issues of staff security. In addition, IHMS pointed to adverse impacts on patient privacy and confidentiality.

152. IHMS also took issue with the underlying assumption that the proposed Recommendations would be effective in increasing detainee compliance with their medication. IHMS's (in my view, compelling) submission was that there was insufficient evidence that the proposed 'outreach model' would be successful in improving the rate of medication compliance.

153. IHMS described the reasons why many detainees did not engage with health services as 'wide and varied'. This is true. At the inquest, IHMS clinicians offered various conjectures to explain the high rate of medication non compliance. These included that detainees disliked the side effects of their medication, that they did not consider their medication to be effective, that some were combining medication with illicit drug use, that their sleep patterns did not favour morning appointments, and that they did not want fellow detainees to know that they were unwell.

154. IHMS's submissions cited the evidence of Dr Heather Miller, Medical Director Government Services, IHMS, that a study or survey should be undertaken in partnership with a third party, to identify the reasons why detainees did not routinely take their mental health medications. This study would guide an effective approach to improving compliance outcomes. IHMS submitted that:

> *'In the absence of that evidence-based approach, the Coroner could not be confident that any of the proposed recommendations would improve the mental health outcomes of detainees at VIDC'.*

155. I will return to this proposal in the Recommendations section of these findings.

Conclusion regarding Issue 2

156. The evidence establishes that VIDC had measures in place to address medication non compliance and missed appointments.

157. When considering the adequacy of these measures, it is of course necessary to accept the foundational principle of patient autonomy, with its corollary that VIDC detainees could not be compelled to take their medication or attend their health appointments.

158. Furthermore, it is clear that the principle of patient autonomy, as well as the lack of an evidence basis identifying why detainees routinely do not

comply with their medication or their clinical reviews, inevitably constrain IHMS's efforts to achieve a higher level of medication and appointment compliance.

159. These factors must be taken into account when assessing the adequacy of IHMS's measures to encourage detainees to comply with their medication and to attend their appointments. On the whole, I find these to have been adequate, with the evidence as a whole indicating that IHMS staff appear to have complied with existing measures.

160. Having said that, the high rate of medication non compliance and non attendance at appointments at VIDC is very concerning - particularly in light of the evidence referred to at paragraph 34 above about the changing profile of VIDC detainees and their consequent greater need for mental health and drug addiction services.

161. This evidence, when combined with the high rate of medication non compliance within VIDC, provides a strong basis for concluding that there needs to be an evidence-based approach to improving the rates of medication compliance at VIDC.

162. I accept the IHMS submission that because there is a lack of evidence as to why detainees do not routinely take their medication or attend their clinical appointments, there cannot be confidence that the Recommendations proposed by Counsel Assisting will improve compliance levels.

163. Given the existing challenges involved in 'outreach' procedures, I do not consider it would be appropriate to expand their scope without evidence that this would in fact enhance mental health care outcomes for detainees.

164. In my view there is merit in the suggestion of IHMS that the Commonwealth instead commission a study examining the causes for high rates of non compliance in the detainee population. I address this suggestion in the Recommendations section of these findings.

ISSUE 3: THE ADEQUACY OF INFORMATION-SHARING BETWEEN IHMS AND DETAINEE SERVICE OFFICERS

165. Counsel Assisting submitted that the evidence in all three inquests established inadequacy in the information-sharing between IHMS staff and Serco detention officers. According to Counsel Assisting, the evidence established that important information in relation to all three deceased persons was not shared between staff of Serco and IHMS, and that when information was exchanged, this occurred in 'an informal, unstructured and somewhat ad hoc way'. For detention officers implementing a detainee's

PSP/SME, the following shortcomings were alleged:

- they received only verbal briefings from IHMS staff and did not always see the PSP/SME which had been prepared
- they did not receive information about a detainee's previous suicide attempts in any formal way
- they did not receive information about a detainee's prescribed medication.

166. This prompted a Recommendation designed to address the need for a formalised information exchange process.

167. Counsel Assisting's submissions pointed to the 'different, but nevertheless intertwined, obligations' on each party to support and care for detainees. This was particularly so with regard to the PSP/SME processes. Thus, according to Counsel Assisting:

> *'The overlapping of roles necessitates an effective process for exchanging relevant information within Serco and IHMS and between Serco staff and IHMS clinicians'*.

168. The proposal for a formalised information exchange process was not supported by IHMS, Serco or the Commonwealth.

169. I address this proposal in the Recommendations section of these findings.

ISSUE 4: STEPS TAKEN TO REDUCE THE RISK OF DETAINEES HANGING THEMSELVES

170. The death of a detainee by hanging is a tragedy for the families whom they leave behind. It also brings distress to staff members who have been involved with the detainee during the time of their detention.

171. As acknowledged by Counsel Assisting, there is no realistic possibility of removing all hanging points from within VIDC, or of identifying and removing all things which may be used as a ligature. Aside from the inherent practical challenges, regard must also be had to the right of detainees to live in a residential environment which resembles, as far as security considerations allow, a life in the community. This constrains the

scope to design accommodation areas and furnishings in a manner which would reduce their capacity to offer opportunities for serious self harm.

172. Counsel Assisting has rightly pointed out that the question is one of risk mitigation. In my view there is an obligation on immigration authorities to minimise, so far as is reasonably possible, the risks for serious self harm that are presented in the design and furnishings of detainees' accommodation areas.

173. I address this issue in more detail in the Recommendations section of these findings.

ISSUE 5: WAS THE ROOM SEARCH ON 22 MAY 2022 ADEQUATE, AND WAS MS PORTER'S WELFARE SUFIICIENTLY CONSIDERED DURING AND AFTER THE SEARCH?

174. I have outlined above at paragraph 22 the search of Ms Porter's room which took place approximately an hour before she was found hanging in her room.

Was the search adequate?

175. The search was conducted by a number of Serco officers. Also in attendance was WH, Acting Detention Services Manager at Serco.

176. The search was complete by 10.17am. I have noted above the items which were found in the search.

177. Counsel Assisting has submitted that there was a '*manifest failing'* with the search, since Ms Porter was soon afterwards able to access the piece of rope which she used to take her own life.

178. I am not able to make this finding. The evidence did not disclose where Ms Porter got this piece of rope from. It is entirely possible that she did not have it in her room, but rather, in the period 10.17am and 10.42am, she accessed it from a place outside her room once the searching officers had left.

Was sufficient regard given to Ms Porter's welfare during and after the search?

179. During the search there were some exchanges of words between Ms Porter and WH. These were of a sarcastic nature, and did not

reflect well on WH given his role as Acting Detention Services Manager. This was acknowledged by WH in his evidence at the inquest.

180. This evidence prompted Counsel Assisting to propose a recommendation that detention staff who are or could be involved in detainee room searches undertake updated training concerning the appropriate treatment of detainees during and after a room search.

181. This proposal was not opposed by Serco or by the Commonwealth. It has merit and I intend to make this Recommendation.

182. Counsel Assisting further submitted that more consideration ought to have been given to Ms Porter's welfare once the search was over. It is true that detention officer HA was concerned for Ms Porter and returned to her room to check on her emotional state. But as pointed out by Counsel Assisting, this was on her own initiative and not pursuant to any policy or procedure requiring a welfare check after a room search.

183. Counsel Assisting therefore proposed some Recommendations, which I will consider in the Recommendations section of these findings.

THE QUESTION OF RECOMMENDATIONS

184. In closing submissions regarding all three inquests, Counsel Assisting proposed 43 recommendations which, in their submission, were collectively supported by the evidence. Counsel Assisting submitted that some of these Recommendations were applicable to all three inquests while others arose only from the circumstances of an individual inquest. In reply submissions, Counsel Assisting withdrew proposed Recommendations 8, 18, 20 and 23, after consideration of the submissions on behalf of other parties.

185. In considering the proposed Recommendations, I have adopted the numbering used by Counsel Assisting.

186. Proposed Recommendations 1-3 required a basic understanding of a review into aspects of immigration detention health services, which was undertaken in 2020. I now provide an outline of this review.

The Jeyasingam/Sistenich review

187. The court heard evidence from Mr Fernando Bahamondes, Chief Superintendent of the Detention Contracts Management Unit of the ABF,

of a review which was commissioned by the Commonwealth in 2020. This was known as the Jeyasingam/Sistenich review.

188. This review made eight far-reaching recommendations concerning the structure and delivery of mental health services in immigration detention centres, following the authors' identification of deficiencies in this area.

189. In Counsel Assisting's submission, there is significant overlap between the issues examined in this inquest, and the matters considered in the Jeyasingam/Sistenich review. On this basis, Counsel Assisting submitted that the court would be assisted with a consideration of the recommendations which were made in the Jeyasingam/Sistenich review. The main such areas identified by Counsel Assisting were these:

    1. Whether there is a need for a comprehensive system of information-sharing between Serco and the health services provider, currently IHMS

    2. Problems with overlapping areas of responsibility between Serco and IHMS, with respect to mental health care, prompting the review to recommend the development of a '*single mental health plan'*.

    3. The need to move from the current *'assertive'* model of mental health care towards an '*intensive*' approach.

190. At the inquest Mr Bahamondes advised that the first six of the eight recommendations within the Jeyasingam/Sistenich review are intended to be addressed through a procurement process being undertaken by the Commonwealth. The procurement is for services to be provided both by a detention services provider (currently Serco) and a health services provider. As noted, health services continue for the time being to be supplied by IHMS.

191. Mr Bahamondes stated further that recommendations four to six have been addressed in the 2023 Procedural Instruction. Recommendations four to six of the Jeyasingham/Sistenich review recommended IHMS, the Department and Serco introduce a single mental health plan, a single behavioural plan and that screening processes introduce evidence-based measures such as depression and trauma scales.

192. Mr Bahamondes also told the court that recommendation 7 of the Jeyasingam/Sistenich review is undergoing a trial, and that the eighth recommendation is not being progressed.

193. In short, according to Mr Bahamondes, it is intended that seven of the eight

recommendations will be substantially implemented 'where they are found to be reasonably practicable to implement, following the current procurement process'.

The Recommendations proposed by Counsel Assisting

Recommendations 1-3

194. Notwithstanding Mr Bahamondes' evidence that the recommendations contained within the Jeyasingam/Sistenich review will substantially be implemented, Counsel Assisting submitted that other evidence indicates that this may not be the case.

195. This led to Counsel Assisting's submission that the court could not be satisfied that the Jeyasingam/Sistenich recommendations will be acted upon. On the basis that these recommendations had significant merit, Counsel Assisting proposed the following Recommendation (which incorporates amendments put forward in Counsel Assisting's reply submissions):

196. That the Commonwealth implement recommendations 1, 2, 3, 6 and 7 in the Jeyasingam/Sistenich Review and ensure that these measures are implemented in the current ongoing procurement process.

197. This recommendation was not supported by the Commonwealth. The Commonwealth noted:

> '*The Jeyasingam/Sistenich recommendations, and whether these were practicable and appropriate recommendations, were not put to any witnesses* ….'

198. The Commonwealth accordingly submitted that:

> *'Recommendation 1 of Counsel Assisting … ought to be afforded little weight and ought not to be made by the Court'.*

199. The Commonwealth also pointed to Mr Bahamondes' evidence, that the Jeyasingam/Sistenich review had informed the current procurement process, and that this process would enable the Commonwealth to assess whether the Jeyasingam/Sistenich recommendations are able to be implemented by Serco and the chosen health services provider. This, the Commonwealth submitted, was a more appropriate approach.

200. Recommendation 1 was likewise not supported by Serco (to the extent that

it would impact Serco). As pointed out in the Serco submissions, the recommendation involves 'an inherent assumption' that the Jeyasingam/Sistenich recommendations are appropriate to be implemented. Yet no evidence had been called at the inquest regarding the appropriateness of these recommendations.

201. In similar vein, IHMS' submissions urged the court to be cautious in endorsing the Jeyasingam/Sistenich recommendations. IHMS noted that they had not been examined by any expert psychiatric evidence at the inquest.

202. I accept the submissions on behalf of the Commonwealth, Serco and IHMS that the court has no evidential basis to conclude that Jeyasingam/Sistenich recommendations 1, 2, 3, 6 and 7 are practicable or appropriate. These far-reaching recommendations were not examined in any detail at the inquest, nor were they the subject of any expert review.

203. For these reasons, it is in my view not appropriate to make proposed Recommendation 1.

204. Proposed Recommendations 2 and 3 are directed to the Commonwealth, which does not oppose them. The two Recommendations aim to reduce delays in the Commonwealth's consideration of reviews of the immigration process.

205. I make Recommendations 2 and 3.

Recommendation 4

206. This Recommendation proposes that prior to implementing new policies or procedures which impact Serco and the health services provider, the Commonwealth discuss the proposed changes with both parties, and ensure that consequential policy changes have been reviewed by 'all relevant stakeholders'.

207. Submissions on behalf of the Commonwealth and Serco were to the effect that arrangements for such consultation and review are already in place.

208. I accept these submissions, and decline to make this Recommendation.

Recommendations 5 and 6

209. Recommendation 5 (as amended in Counsel Assisting's reply

submissions) proposes that the Commonwealth amend the 2023 Procedural Instruction, to require that mental health clinicians attend the residential compound in order to attempt to meet and provide medical advice to a specific class of detainees, namely those who are currently prescribed critical medication, and who have failed to take it, or have missed a scheduled mental health appointment.

210. Recommendation 6 proposes that the health services provider consider the feasibility of administering, in the residential compound, critical medication and any other medication used to treat mental health or personality disorders.

211. I have addressed these proposed Recommendations at paragraphs 145 to 153 above. For the reasons set out therein, I do not propose to adopt these proposed Recommendations.

212. In my view there is merit in the suggestion of IHMS that the Commonwealth instead commission a study examining the causes for high rates of non compliance in the detainee population. Thus, I recommend:

> *That the Commonwealth consider commissioning an independent study to identify the reasons why detainees in VIDC do not routinely take their mental health medication, or routinely attend their scheduled medical appointments.*

Recommendations 9 and 10

213. These proposals seek a revision of the 2023 Procedural Instruction, to provide for a 'single mental health plan' and 'single behavioural plan'. In the reply submissions of Counsel Assisting, it was proposed that these plans would 'sit under and would inform the CIMP [Centralised Immigration Management Plan]'.

214. The CIMP is described in the 2023 Procedural Instruction as a document which provides:

> *' … a holistic understanding of the detainee's health, behavioural and welfare needs using a 'joined-up care' and evidence-based approach.'*

215. It is to be maintained by Serco '*by including all relevant information which would contribute to the comprehensive health and wellbeing of the detainee'.*

216. According to the Commonwealth's submissions, after the release of the

Jeyasingam/Sistenich Review, discussions took place between the Department and Dr Jeyasingam. The purpose was to consider implementation of the 'single mental health plan' and the 'single behavioural plan', which had been recommended in that review.

217. The Commonwealth's submissions advise that following these discussions, the Department settled instead on the CIMP process. This has now been incorporated into the Mental Health Procedural Instruction.

218. It was well beyond the scope of this inquest to consider the merit of the Commonwealth's decision to favour the CIMP process over that of a single mental health plan' and the 'single behavioural plan'. It is not surprising that the inquest heard no evidence in relation to these discussions.

219. In addition, it is wholly unclear from the evidence and submissions what relationship the recommended 'single mental health plan' or 'single behavioural plan' would bear to the proposed new CIMP process, or to existing plans such as IMPs, Behaviour Management Plans [BMPS], and SMEs.

220. In the circumstances I am unable to make proposed Recommendations 9 or 10.

Recommendations 11 and 12

221. These, as amended in reply submissions, propose that the Commonwealth develop a platform to enable Serco and the health services provider to access and share the CIMP, and the 'single mental health plan' and the 'single behavioural plan' referred to in proposed Recommendations 9 and 10.

222. Counsel Assisting's submissions pointed to the *'different, but nevertheless intertwined, obligations'* on each party to support and care for detainees. This was particularly so with regard to the PSP/SME processes. This, according to Counsel Assisting, provided the justification for a more effective process of sharing relevant information.

223. The proposal for a formalised information exchange process was not supported by IHMS, Serco or the Commonwealth.

224. According to IHMS, the proposal was *'at odds with the ethical and statutory obligations to keep medical information regarding detainees confidential.'*

225. These limitations were also cited by the Commonwealth.

226. Serco's submissions cited the *'significant costs'* associated with the proposal, and that there presently existed processes for Serco and IHMS to share important information about detainees.

227. Counsel Assisting acknowledged that privacy and professional confidentiality obligations applied, in particular to IHMS staff. Their submissions also acknowledged evidence that IHMS and Serco were able to (and in fact did) exchange information about individual detainees at a number of regularly held meetings. Some of these meetings were held on a daily basis, others on a weekly or monthly basis. Nevertheless, it was maintained that these meetings did not afford the kind or degree of information exchange that was called for.

228. In submissions, Counsel Assisting suggested there may be two ways in which an information sharing capacity could be developed:

- through development of a *single mental health plan* and a '*single behaviour plan'*, stored in a location accessible to Serco and IHMS staff. This, Counsel Assisting noted, might actually be contemplated within the 2023 Procedural Instruction. However there was no certainty that it was, and even if it was, that the 2023 Procedural Instruction would be implemented;

- through the development of an integrated platform through which Serco and IHMS staff would have access to relevant information.

229. The second mechanism was the basis for Counsel Assisting's proposed Recommendation 11. In its amended form, it proposed:

> *That the Commonwealth develop a platform permitting both the [detention service provider] and the [health service provider] to access and share:*
>
> *a. the CIMP*
> *b. subject to any applicable restrictions, the single mental health plan; and*
> *c. the single behavioural plan.*

230. Proposed Recommendation 12 was that mechanisms be developed to seek the necessary consent from detainees for the exchange of their information.

231. I have noted above that the Commonwealth appears to have declined the model of a 'single behavioural plan' (derived from recommendations 4 and

5 of the Jeyasingam/Sistenich review); and instead proposes to proceed with the model of a Centralised Individual Management Plan [CIMP].

232. In paragraphs 214 to 218 above, I declined to make the proposed Recommendation to revise the 2023 Procedural Instruction, so as to provide a 'single mental health plan' or a 'single behavioural plan'. For the same reasons I decline to recommend the development of a platform to enable access and sharing of the information contained in any such plans.

233. There remains the proposal for a platform to enable information from the CIMP process to be shared.

234. I accept the general principle expressed by Counsel Assisting that:

> *' … the way in which care is provided to a detainee at VIDC in a practical sense … means that both these agencies require sufficient information about the detainee's behaviour and mental health to enable each to perform their respective roles.'*

235. However, limitations on the scope of the evidence heard at the three inquests makes it impossible to formulate a practical and feasible way of achieving this purpose.

236. For example, it is possible that the Commonwealth intends the proposed CIMP process to involve an information sharing mechanism between Serco and the health service provider. But this is not presently known; and if this is the intention, the scope is unclear.

237. Adding to the lack of clarity, it appears that the Commonwealth has decided to defer any progress on the CIMP process until after completion of the tender process for a health provider. This is because the details of the CIMP program will need to be informed by information from the tenderers about their plans for mental health care delivery.

238. In my view, these uncertainties preclude me from making proposed Recommendations 11 or 12. I decline to make these Recommendations.

Recommendations 13 to 20

239. This group of proposals concerns recommended changes to the PSP/SME process.

240. Recommendation 15 is that the Commonwealth amend the 2023 Procedural Instruction, to provide that one of the two clinicians required to decide if there should be a downgrade in the level of a detainee's SME

must be a psychiatrist, unless reasonable attempts to obtain the input of a psychiatrist have not been successful.

241. This proposal was not supported by the Commonwealth or by IHMS. Both objected on the basis that psychiatrist resources are already scarce within the immigration detention system.

242. IHMS's further objection was that the proposal was '*wholly unnecessary and unsupported by the evidence',* given the expertise of mental health nurses in conducting such assessments.

243. I accept this submission, and endorse the comments made by IHMS that mental health nurses are sufficiently experienced in the conduct of mental health examinations.

244. Recommendation 16 proposed that IHMS reconsider whether it is appropriate to maintain the current advice to IHMS clinicians, that when setting a detainee's PSP/SME risk level, they should '*start with a lower PSP/SME risk level and increase observations rather than starting with a higher PSP/SME risk level and decreasing observations'.*

245. Counsel Assisting submitted that this policy carried the risk that IHMS staff would suggest a lower risk level of observations than they might otherwise think were required.

246. In response, the Commonwealth submitted that the suggested change was *'inconsistent with an approach to mental health management which is least invasive'*.

247. IHMS concurred, citing the potentially adverse effects for a detainee which are associated with invasive SME monitoring.

248. I accept these submissions. I note further that there was no evidence at the inquest that IHMS clinicians had placed Mr Kellie on an inappropriately low level of SME.

249. This recommendation is declined.

250. Counsel Assisting's proposed Recommendation 17 was that the staff of the health provider service receive training as to best clinical practice in preparing PSP/SME plans. The training would focus on the importance of tailoring the SME plan to the specific circumstances of the detainee; and of communicating clear instructions to Serco staff who are responsible for implementing the SME plan's measures.

251. In my view there is merit in this proposal, in view of the evidence of a

marked increase in the incidence of mental illness within the current VIDC cohort. I infer that managing this situation and providing sufficient mental health care will be challenging for the staff of IHMS and Serco alike. It is reasonable in my view, for IHMS (or the replacement health services provider) to review their existing training in the preparation of PSP/SME plans and consider whether it provides sufficient support to its staff.

252. I make this Recommendation.

253. Recommendation 19 proposed that Serco staff be trained *'in their responsibilities pursuant to a PSP/SME plan; and as to the recognition of signs and symptoms of mental health illness and/or deterioration'.*

254. Serco did not oppose this recommendation, but its submissions noted that its existing training program includes training as to staff responsibilities pursuant to a PSP/SME plan; and also as to the signs and symptoms of deteriorating mental health.

255. For its part the Commonwealth did not oppose the recommendation either, stating that it was '*agreeable to enhancements in training in the recognition of points at which concerns may be escalated to health staff'.*

256. In my view there is merit in this proposal, for the same reasons as appear in paragraph 250 above.

257. I make this Recommendation.

258. Recommendation 21 (as amended in Counsel Assisting's reply submissions) proposes that those Serco staff whose role includes performing or supervising the performance of welfare checks, undergo training as to best practice in performing welfare checks of persons in immigration detention.

259. In reply, Serco submitted that its existing training program includes such training. Nevertheless Serco did not oppose the recommendation.

260. While the Commonwealth stated opposition to the proposal, it did not oppose '*enhancements'* to such training.

261. In view of the evidence heard at inquest of a very significant increase in the incidence of mental illness within the VIDC cohort, and consequent increased welfare issues, I see merit in this Recommendation and will make it.

262. Recommendation 22 proposed further training for Serco staff who fulfill the role of 'Personal Officer'.

263. In relation to this proposal, Serco and the Commonwealth took the same approach which each had taken in relation to proposed Recommendation 21.

264. I make this Recommendation.

265. Recommendations 25 and 26 are measures proposed for the physical safety of detainees. Counsel Assisting submitted that the Commonwealth should be asked to commission an external auditor to conduct:

> *'… an audit of VIDC with a view to ascertaining the existence of hanging points or features in the physical design of the premises which could be used by detainees to self harm that are identified by the auditor.'*

266. Relatedly, Recommendation 26 is that the Commonwealth consider the ensuing audit report, and take reasonable steps to remove the above features.

267. It must be accepted (as does Counsel Assisting) that it is not possible to remove all ligature points from the physical environment of a detention centre. This is particularly the case with immigration detention centres, which appropriately offer a less restrictive environment than do most corrective centres.

268. Nevertheless as noted in Counsel Assisting's submissions, the question is one of risk mitigation. The Commonwealth would not deny owing a duty of care to detainees, to minimise so far as is reasonably possible opportunities within their residential areas to carry out acts of serious self harm.

269. The Commonwealth did not support either Recommendation. However its submissions referred to the Department having conducted a 'ligature review' of all high care accommodation rooms as part of an Administered Capital Works project. The Commonwealth stated that it is committed to extending this review to 'all mainland IDC detainee accommodation rooms and bathrooms'.

270. No details were provided as to the scope or the outcomes of the 'ligature review'.

271. I note with interest the Commonwealth's reference to the 'ligature review', and its stated intention to extend this review to the accommodation areas of all mainland detention centres. The court did not have the benefit of examining the 'ligature review' and has no details of it (this is not a criticism of the Commonwealth).

272. Nevertheless it appears that this review may provide the basis for an outcome similar to that sought to be achieved by Recommendations 25 and 26.

273. For this reason, I make the following Recommendation, in place of proposed Recommendations 25 and 26:

> *That as a matter of priority, the Commonwealth:*
>
> *(a) extend its 'ligature review' (referred to in its submissions in the inquest into the death of Mr Moses Kellie) to all accommodation and bathroom areas within the VIDC as part of an Administrative Capital Works project; and*
>
> *(b) commit to taking reasonable steps to remove ligature points identified in the 'ligature review'.*

274. Recommendations 29 to 32 proposed changes the Serco's Behavioural Management Program [BMP].

275. Counsel Assisting submitted that the evidence raised the question whether detainees with behavioural or personality disorders ought to be treated with a different and targeted care regime than those without such a disorder. Their submissions noted clinical evidence that such disorders could not appropriately be managed with the PSP/SME program.

276. Proposed Recommendation 29 (as amended) was that the health service provider give clinical recommendations to determine how best to manage detainees diagnosed with a behavioural and personality disorder, with endorsement of the health service provider. The proposal aims to assist detention and health staff with the difficulties which frequently arise in their interactions with persons who suffer such disorders.

277. In my view there is merit in this amended proposal. The evidence at inquest raised a concern that neither the PSP/SME nor the BMP programs are apt to manage the challenging behaviours that are associated with personality disorders. Amended Recommendation 29 is designed to encourage detention and health providers to consider whether a new program might better support detainees and staff alike, in the management of such behaviours.

278. I will make amended Recommendation 29.

279. I decline however to make Recommendation 30, which is concerned with the BMP program and proposed that that any punitive programs which involve withdrawal of privileges '*are separate and distinct from the BMP*'.

Serco opposed this Recommendation, submitting that it misconceived the purpose of a BMP, which is '*a tool to manage difficult behaviours'*. Furthermore, the points system was '*an essential part of a BMP'*.

280. Proposed *Recommendations 31 and 32 were that there be '*comprehensive follow up plans' in relation to each BMP, and input from IHMS as to the BMP's ongoing appropriateness.

281. IHMS and Serco opposed these Recommendations. IHMS submitted that it had no objection to being consulted as to a particular BMP, where the behaviour was thought to indicate a mental illness. But IHMS reiterated the inappropriateness of health staff becoming closely involved in punitive programs, because this would compromise the trust and rapport which clinicians seek to establish with their patient.

282. The court did not receive evidence in the kind of detail that would be required to assess the extent to which this ethical objection would arise if the Recommendation was made.

283. I decline to make Recommendations 31 and 32.

284. Recommendations 33 to 36 proposed that the Commonwealth should take a more active role in ensuring that detainees who suffer from borderline personality disorder received appropriate treatment. These proposals were in part based on the evidence of Dr Lienert that Dialectical Behavioural Therapy [DBT] was a form of therapy which, if Ms Porter had been willing to engage with, could have benefited her in managing her condition of severe borderline personality disorder.

285. These Recommendations were not supported by IHMS or the Commonwealth. Dr Lienert, IHMS submitted, had given evidence that a modified form of DBT may have been available for Ms Porter, if she had chosen to engage.

286. I accept that Dr Lienert's evidence indicates his awareness of appropriate programs for the treatment of borderline personality disorder. I decline to make Recommendations 33 and 34.

287. The amended proposal in Recommendation 35 was that all detainees diagnosed with personality disorders be referred to a review of the type contemplated by the Complex Case Review.

288. The previous version of this Recommendation was not favoured by the Commonwealth or by IHMS. It was submitted that there was little utility in it, since there would inevitably be individual variation in the severity of symptoms and the degree of impairment. I accept this submission, and do

not consider that the amended version overcomes this objection.

289. I decline to make amended Recommendation 35.

290. IHMS submitted that Recommendation 36 regarding continuity of care did not arise on the evidence of any of the three inquests, as none of the three detainees had been released into the community. I accept this submission, and decline to make proposed Recommendation 36.

291. Recommendations 37 to 39 proposed changes to Serco's program of Enhanced Monitoring.

292. On three occasions while she was in VIDC, Ms Porter was placed on an Enhanced Monitoring Program.

293. Counsel Assisting pointed to a lack of documented clarity as to the reason why Ms Porter was placed on this program, the period of time for which it was to be in place, and what the purpose of the increase in monitoring was. Counsel Assisting therefore proposed Recommendations 37 to 39, that the involved agencies give further thought to how the Enhanced Monitoring program should be applied.

294. In response, Serco submitted that these issues were not sufficiently explored at the inquest, given that Enhanced Monitoring is not specifically concerned with the mental health of detainees.

295. I accept that for this reason it would be inappropriate for the court to make these Recommendations.

296. I decline to make Recommendations 37, 38 and 39.

297. Recommendations 40 to 42 proposed changes to procedures following detainee room searches. The proposed changes were directed to the welfare of detainees during and after such searches.

298. In paragraph 179 above I adopted Recommendation 40, which proposed training for detention officers concerning the appropriate treatment of detainees during and after the room search.

299. In addition, Counsel Assisting proposed the following (as amended):

- that the health provider consider whether a routine mental health review is appropriate after a detainee room search
- that detention officers and health staff, in the aftermath of a room search, confer to consider if monitoring or a welfare check is appropriate.

300. These proposals were not supported by IHMS. Their submissions pointed out that at the time of the search, Ms Porter was already being monitored pursuant to an SME. There was furthermore, no evidence at the inquest about the impact on detainees of having room searches.

301. I accept this submission, and I decline to make Recommendations 41 and 42.

302. Counsel Assisting's proposed Recommendation 43 was that the Commonwealth take reasonable steps to ensure that Recommendations which have been accepted are implemented by any organisations which succeed Serco and IHMS.

303. The Commonwealth did not oppose this Recommendation, and I make it.

Conclusion

I convey to Ms Porter's family my sincere sympathy for the loss of their sister and their mother.

I thank the Counsel Assisting team and the NSW Solicitors Office for the outstanding assistance which they provided in the preparation and conduct of this inquest.

Findings required by s81(1)

304. As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity
The person who died is Leah Jane Porter.

Date of death:
Leah Jane Porter died on 22 May 2022.

Place of death:
Leah Jane Porter died at Villawood Immigration Detention Centre, Villawood NSW.

Cause of death:
Leah Jane Porter died as a result of hanging.

Manner of death:
Leah Jane Porter's death was an intentional self inflicted death, while she was in lawful custody.

RECOMMENDATIONS

305. Pursuant to section 82 of the Act, Coroners may make recommendations connected with a death. I am of the view that the evidence supports that the recommendations outlined below are appropriate and are necessary or desirable to be made in relation to Ms Porter's death.

To the Department of Home Affairs:

12. *That the Commonwealth revisit its processes for considering reviews of the immigration detention process commissioned by, or available to, the Commonwealth, and for implementing any recommendations made in such reviews and consider whether any improvements to those processes are required.*

13. *That the Commonwealth implement a specified timeframe for responding to any recommendations made in any review referred to in the recommendation above.*

14. *That the Commonwealth consider commissioning an independent study to identify the reasons why detainees in VIDC do not routinely take their mental health medication or routinely attend their scheduled medical appointments.*

15. *That an external auditor conducts an audit of VIDC with a view to ascertaining the existence of any hanging points or features in the physical design of the premises which could be used by detainees to self-harm.*

16. *That the Commonwealth ensure that, as far as is reasonably practicable, to the extent that any of the above recommendations are directed to Serco and/or IHMS, those measures are implemented by any organisation that may succeed Serco as FDSP and IHMS as DHSP.*

To Serco Australia Pty Ltd, or to the organisation which succeeds them in the role of delivering detention services:

17. *That FDSP staff be trained:*
    c) in their responsibilities pursuant to a PSP/SME Plan; and

    d) as to the recognition of signs and symptoms of mental health

illness and/or deterioration.

18. *That FDSP staff whose role includes performing or supervising the performance of welfare checks undergo training as to best practice in performing welfare checks of persons in immigration detention.*

19. *That Serco Staff who undertake the role of a "Personal Officer" receive further training as to the requirements of fulfilling the role of a "Personal Officer" in the Personal Officer scheme referred to in Serco Policy and Procedure Manual 0001- Keep SAFE and PSP/SME, 30 April 2020.*

To International Health and Medical Services Pty Ltd, or the organization which succeeds them in the role of delivering health services:

20. *DHSP staff be trained as to best practice in preparing a PSP/SME Plan with such training covering, in particular, the following topics:*
    c) the importance of tailoring an SME Plan to the specific circumstances of a detainee; and

    d) the importance of communicating clear instructions to FDSP Staff (and to other persons who have responsibilities for implementing the measures contained in a PSP/SME Plan).

To the Department and International Health and Medical Services Pty Ltd, or the organisation which succeeds them in the role of delivering health services:

21. *That the Commonwealth and the DHSP expedite the development of a memorandum of understanding regarding:*
    c) the process for admitting and discharging a detainee from VIDC; and

    d) the mental health care services that are to be provided to a detainee at VIDC.

22. *The Commonwealth is to obtain clinical recommendations (made by appropriately qualified mental health clinicians) from IHMS and any organisation who might succeed IHMS in the role of DHSP for the improvement of the BMP such that it is a program that can be fully endorsed by the DHSP to achieve its intended operation in relation to detainees for whom clinical input is appropriate.*

301. I close this inquest.

Magistrate E Ryan
Deputy State Coroner
Lidcombe

6 March 2025