CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Moses Kellie
Hearing date:	20- 24 November 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 – were mental health care services adequate – was monitoring by detention staff adequate - is there a need for improved system for information sharing – are measures to reduce the risk of hanging adequate – did the person receive adequate mental health care in hospital.
File number:	2019/00028070

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 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 Coughlin, ? Lau and M Flores: Neale Dawson i/b Nurses and Midwives Association. The family of Moses Kellie: Deng Adut, Solicitor, AC Law Group.
Findings:	**Identity** The person who died is Moses Kellie **Date of death**: Moses Kellie died on 25 January 2019. **Place of death**: Moses Kellie died at Villawood Immigration Detention Centre, Villawood NSW **Cause of death:** Moses Kellie died as a result of hanging. **Manner of death:** Moses Kellie's death was an intentional self inflicted death, while he 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 amend the 2023 Procedural Instruction to require non-mental health clinicians employed by the DHSP and employees of FDSP to have access to advice provided by a mental health clinician 24 hours per day and 7 days per week*. 4. *The Commonwealth make a decision on the ASR submitted by IHMS requesting funding for a mental health nurse to be available on the HAS line 24 hours per day (assuming that this has not already occurred).* 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.*

	6. *That the Commonwealth consider commissioning an independent study to identify the reasons why detainees in VIDC do not routinely take their mental health medication.* 7. *That as a matter of priority, the Commonwealth*: *i. 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* *ii. commit to taking reasonable steps to remove ligature points identified in the 'ligature review'* To Serco Australia Pty Ltd, or the detention services provider which replaces Serco Australia Pty Ltd; *8. 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.* *9. 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.*

	10. *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.* 11. *That the training referred to in Recommendations 9 and 10 be provided by an external consultant* To International Health and Medical Services Pty Ltd or the health services provider which replaces it: 12. *DHSP staff be trained as to best clinical 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: 13. *That the Commonwealth and the DHSP expedite the development of a memorandum of understanding with South Western Sydney Local Health District regarding:*

	a) *the process for admitting and discharging a detainee from hospital; and* b) *the mental health care services that are to be provided to a detainee at VIDC.*

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 Moses Kellie.

Introduction

3. Moses Kellie was aged 33 years when he died at Villawood Immigration Detention Centre on 25 January 2019.

4. Mr Kellie had been in immigration detention since January 2015, when his visa to stay in Australia was cancelled. At the time of his death therefore he was in lawful detention, and an inquest into the circumstances of his 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.

Mr Kellie's life

7. Mr Kellie was born on 5 April 1985 in Sierra Leone. In 2006 he was granted a special humanitarian visa, and he and his three sisters arrived in Australia on 7 April that year.

8. Mr Kellie was subsequently convicted of criminal offences and he served sentences of imprisonment. This led to the cancellation of his special humanitarian visa in December 2014, pursuant to section 501(3A) of the *Migration Act 1958.* Mr Kellie became an unlawful non citizen, and he was transferred to Villawood Immigration Detention Centre [VIDC] on 7 September 2016 upon his release from criminal custody.

9. Mr Kellie immediately applied for a review of the decision to cancel his visa. When he died four years later, the outcome of this review was still outstanding.

10. A number of factors contributed to the delay in resolving Mr Kellie's application for review. In 2016 Mr Kellie requested to be removed from Australia and be returned to Sierra Leone. However he withdrew this request on 19 April 2017, in part because he did not have any documents of identity issued by Sierra Leonean authorities.

11. Additionally, there were legal proceedings and investigations into Mr Kellie's suspected involvement in the murder of a Mr Anthony Cawsey. On 7 September 2016 a murder charge which had been laid against Mr Kellie was withdrawn, and he was released from corrective custody and transferred into immigration detention.

12. Mr Cawsey's death was then examined in a coronial inquest in December 2017, following which Deputy State Coroner Russell referred the case to the Director of Public Prosecutions for reconsideration of criminal charges against Mr Kellie. Almost a year later the Director of Public Prosecutions determined that there would not be a prosecution of Mr Kellie in relation to the death of Mr Cawsey.

13. These events complicated and inevitably delayed the process of determining Mr Kellie's application for review of the decision to cancel his visa.

14. During his time at VIDC, Mr Kellie was known to be a quiet man, who attended both the Catholic and Hillsong Churches. A fellow detainee described him as a calm and mild person, and he was described by IHMS staff as *'kind and polite'*. He was also a very good artist.

15. Mr Kellie leaves behind a sister Elizabeth Josiah and her son Daniel Josiah, as well as nieces Esther and Hannah. Mr Kellie's family describe him as a kind, empathetic and gentle person. He was a much loved son, uncle, cousin and brother.

The issues examined at the inquest

16. As will be seen, Mr Kellie suffered from mental health issues for which he received treatment at VIDC. His tragic death was the result of hanging. For these reasons the inquest examined the following issues:

    1) Did Mr Kellie receive adequate monitoring, treatment and support for his mental health at VIDC?
    2) Did VIDC have adequate measures in place to ensure that detainees with significant mental health issues complied with medication and attended medical appointments?
    3) Does VIDC have in place adequate measures for information sharing between health staff and detention staff when a detainee has significant mental health issues?
    4) Does VIDC have in place adequate measures to remove or reduce the risk of detainees hanging themselves?
    5) Did Mr Kellie receive adequate mental health care at Liverpool Hospital in January 2019, including the decision to discharge him back to VIDC?
    6) Were the processes and policies in relation to Mr Kellie's discharge back to VIDC appropriate?

17. The following three issues were also highlighted for examination, but they were resolved in light of evidence heard at the inquest:

1) Should Mr Kellie have been housed with other detainees while he was living at VIDC? The evidence at inquest was clear that while room-sharing may have had protective benefits for Mr Kellie as a suicide prevention measure, Mr Kellie preferred to live alone and indeed may have created difficulties for a room mate were he forced to have one. There is no basis for criticism of the decision of VIDC authorities regarding this.
2) Should Liverpool Hospital have sought a Community Treatment Order for Mr Kellie when he was discharged back to VIDC on 18 January 2019? At the

inquest, the weight of expert psychiatric opinion was that the coercive step of a Community Treatment Order would not have improved Mr Kellie's mental health outcomes. I accept that this is the case.

3) Was the emergency response adequate when Mr Kellie was found in his room on 25 January 2019? It was noted that no health staff members attended when detention officers sent out the emergency call (known as a 'Code Blue'). Reportedly, this was because nurses understood that after 5.00pm their duties were limited to dispensing medicine. After Mr Kellie's death, the VIDC health service provider issued a notice to all its staff confirming that there is a requirement to attend 'Code Blue' calls even if made outside business hours. This response was appropriate, and there is no basis to examine this issue further.

Mr Kellie's mental health

18. For many years Mr Kellie had suffered mental health conditions. In 2010 while in corrective detention he was diagnosed with schizophrenia, post traumatic stress disorder, and substance dependence. His drugs of addiction were cannabis, alcohol, opiates and methamphetamine.

19. In corrective custody and subsequently in VIDC, Mr Kellie received treatment for these conditions. He was prescribed with anti psychotic medication, but there were periods of time when he declined to take it. This made him vulnerable to relapse of his psychotic illness. In addition he did not always attend his scheduled mental health appointments.

20. On 11 September 2016 Mr Kellie attempted to hang himself in his room at VIDC. He was taken to Liverpool Hospital where he remained for two days. When he was discharged back to VIDC, Mr Kellie was placed on what is known as a Keep SAFE plan and a Supportive Management and Engagement plan. These plans are described later in these findings.

21. By at least early January 2019, detention staff saw that Mr Kellie's mental health was deteriorating once again. On 7 January 2019 with the encouragement of a fellow detainee, Mr Kellie wrote a note seeking help, which was passed on to health staff. He was transferred to Liverpool Hospital on 10 January 2019, where he received treatment.

22. On his return to VIDC eight days later Mr Kellie had some scheduled medical appointments, but he did not attend these. As a result, he did not receive his prescribed anti-psychotic medication of Paliperidone. Detention officers again became concerned for his welfare.

23. On 25 January 2019 Mr Kellie spent the day sitting in his room in darkness. He received some welfare checks from two detention officers, after which health staff took him to his scheduled medication appointment.

24. At approximately 5.30pm, one of the detention officers visited Mr Kellie's room again. He found Mr Kellie unresponsive, hanging from a vent in the ceiling of his bathroom. Mr Kellie had used black nylon bag handles to fashion a ligature, which he had tied to electrical wiring behind the ceiling vent.

25. An ambulance was called, while on-site emergency services commenced chest compressions. Mr Kellie was not able to be revived, and he was pronounced deceased at 6.32pm.

The cause of Mr Kellie's death

26. Forensic pathologist Dr Rebecca Irvine performed an autopsy. She concluded that Mr Kellie had died as a result of hanging. Toxicological analysis of Mr Kellie's blood detected methylamphetamine and amphetamine.

27. At the inquest there was no dispute that Mr Kellie died as a result of hanging.

Overview of VIDC's administrative arrangements

28. 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.

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

30. 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].

31. 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.

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

33. Under its contract with the Department, Serco is responsible for providing garrison, facilities management, security, and transport services. Serco is 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 requires that Serco staff take an approach which emphasises communication and interaction with detainees.

34. Serco employs Detention Service Officers [detention officers] to perform many of these services. Detention officers at VIDC are responsible for maintaining security and stability and, although they are not medical officers, to attend to the welfare of detainees.

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

36. At the time of Mr Kellie'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 this 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.

37. 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 were to include education and prevention programs, as well as giving medication and referring detainees to specialists as needed. Periodic mental health screening, assessment and treatment were required.

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

39. 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.*'

The profile of detainees at VIDC

40. At the inquest, the Operations Director of Immigration for Serco, 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 had shared soccer fields and volleyball courts.

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

42. There is a medical clinic on the VIDC site, that was run 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.

43. 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.

44. At the time Mr Kellie was at VIDC, 5% of its detainee population had, like him, 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.*

45. 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.

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

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

Arrangements for mental health care at VIDC

48. The adequacy of the mental health monitoring and treatment provided to Mr Kellie at VIDC was a central issue at the inquest.

49. What follows is an overview of the procedures which were in place for the monitoring, treatment and support of detainees' mental health, at that time. As noted by Counsel Assisting, since Mr Kellie's death there have been changes to these procedures, which will be described later in these findings.

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

General procedures

51. At the time of Mr Kellie'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 10-30 days of their arrival, with follow up screenings at six months, twelve months, eighteen months and thereafter, at three monthly intervals.

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

[redacted]

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

Procedures for managing 'at risk' detainees

54. 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. Serco 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 Serco staff have medical training or clinical expertise.

55. 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

56. 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'.*

57. 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).

58. 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.

59. 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.

60. 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.

61. In the submission of Counsel Assisting, the PSP/SME policies contemplate that detention staff play *'a considerable role'* in implementing the PSP/SME process. Serco staff's 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.

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

63. 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 is to support IHMS in that process. Detention officers do 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.

64. 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

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

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

66. 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.

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

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

Routine 'welfare' checks

69. In addition to the above systems of monitoring, detention staff also conduct:

- two daily 'welfare' checks, one at lunch time when detention staff account for each detainee by using a headshot photograph of each. A second such check takes place at dinner
- two daily 'headcount' checks at the compound level.

Enhanced monitoring

70. 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.

71. 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.

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

ISSUES 1 AND 2

Did Mr Kellie receive adequate monitoring, treatment and support for his 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?

73. In closing submissions, Counsel Assisting submitted that there were significant deficiencies in the way in which Serco and IHMS staff managed Mr Kellie's mental health in the weeks leading up to his death.

74. Broadly it was submitted that during this period, while many of the involved detention officers were concerned for Mr Kellie and wanted to help him, there were deficiencies in the way they performed their duties under his PSP/SME plan.

75. In addition, Counsel Assisting submitted that IHMS did not have adequate measures in place to address Mr Kellie's frequent non attendances at scheduled clinical and medication appointments.

76. As a preliminary to addressing these two issues, I will provide a brief account of the evidence about Mr Kellie's state of mental health in the weeks leading up to his death.

Mr Kellie's mental health: October 2018 onwards

77. During the three months prior to Mr Kellie's death, his clinical notes indicate a decline in his mental health. This is outlined in the following records (it is accepted that these do not represent all of Mr Kellie's consultations over this period):

    - On 3 October 2018 Mr Kellie had a consultation with IHMS psychiatrist Dr David Lienert. According to Dr Leinart's notes, Mr Kellie said that his mood had dropped, that he had experienced suicidal ideation four days previously, and that he had not been complying with his opiate replacement therapy. Dr Lienert directed that Mr Kellie have daily follow ups with a mental health nurse, and he made an appointment for Mr Kellie to see himself on 10 October 2018.

    - On 4 October 2018, in accordance with Dr Lienert's direction Mr Kellie saw a mental health nurse. Despite Dr Lienert's direction, after this date it does not appear that Mr Kellie had any further reviews with a mental health nurse until 7 January 2019

    - On 10 October 2018 Mr Kellie did not attend his scheduled appointment with Dr Lienert. He had a replacement consultation with him the following day.

    - Dr Lienert asked detention officers to encourage Mr Kellie to attend his appointments. They replied that they would try, but that Mr Kellie slept most of the day, making morning appointments difficult. They suggested that Mr Kellie have afternoon appointments.

    - On 17 October 2018 Mr Kellie attended an appointment with Dr Lienert, in which he disclosed that he had been using the drug ice. He also described hearing voices which were '*distracting and distressing'*. Dr Lienert recorded that Mr Kellie had not been experiencing suicidal ideation, but that there were signs of '*distrust'* which fell short of

persecutory delusions. He recommended that Mr Kellie have a psychiatrist review every three to four weeks.

December 2018 to January 2019: further deterioration in Mr Kellie's mental health

78. In late December 2018 and early January 2019, fellow detainees and detention staff became alarmed by clear signs that Mr Kellie's mental health was deteriorating. Detention officer BA noticed that Mr Kellie had lost weight, cut off his dreadlocks, and did not appear to be eating or showering.

79. In response, detention officer RS and Serco Welfare Officer JR visited Mr Kellie in his room and noticed the same concerning features. They raised concerns at the IMPRC on 9 January 2019. .

80. A fellow detainee Mr Ozogow Aroub was also concerned. On 7 January 2019 he helped Mr Kellie to write a note requesting mental health help. Mr Aroub gave the note to BA. According to Mr Aroub, he told BA: '*this guy wants to kill himself, he's off his medication and needs some help. He has no family or friends that check on him or call him, he really needs some help'.*

81. BA took the note to his supervisor, Detainee Service Manager MB. MB was aware of Mr Kellie's previous suicide attempt in 2016. He too felt concerned and he went to visit Mr Kellie, after which he contacted IHMS staff.

82. This led to Mr Kellie having a consultation later that day with mental health nurse, Registered Nurse Mary Flores. Mr Kellie disclosed that he had not taken his medication for four weeks because he did not feel he needed it. RN Flores assessed that Mr Kellie's risk of self harm was high *'when unwell'.* As a result, the following day Mr Kellie was placed on a PSP with High Imminent rating.

83. Mr Kellie had a consultation with Dr Lienert on 9 January 2019. This took place in Mr Kellie's room within the residential compound, because Mr Kellie had not attended the clinic for this appointment and Dr Lienert therefore decided to go and see him. Mr Kellie told Dr Lienert that he had been having suicidal thoughts for a month. This caused Dr Lienert significant concern given his attempt in 2016.

84. Dr Lienert considered that Mr Kellie was suffering a relapse of schizophrenia with increasing auditory hallucinations, and that he had not been complying with his medication. He told Mr Kellie that unless he did so, he would have to go to hospital.

85. Mr Kellie did not attend for his medication, upon which Dr Lienert arranged for him to be transferred to Liverpool Hospital the next day.

Admission to Liverpool Hospital

86. On 10 January 2019 Mr Kellie was admitted to Liverpool Hospital and placed in its mental health unit. He told psychiatry registrar Dr Janet Berry that he had been hearing voices, was having suicidal thoughts, and had been using illicit drugs while in VIDC.

87. In hospital over the following eight days Mr Kellie received treatment and psychiatrist reviews, and was administered medication. His treating psychiatrist Dr Kai Kai Toh directed that Mr Kellie's anti psychotic medication be changed from Risperidone to paliperidone.

88. By 15 January 2019, Mr Kellie was reported to be more settled but still experiencing suicidal ideation.

89. Dr Toh discharged Mr Kellie from hospital on 18 January 2019. Dr Toh recorded that Mr Kellie denied current suicidal ideation and had no overt signs of psychosis.

90. On discharge Mr Kellie received a depot injection of paliperidone. His treatment plan directed that he receive monthly depot injections of this

medication commencing on 25 January 2019, and that for the following one to two weeks he receive daily oral doses of it.

91. I consider the adequacy of the treatment which Mr Kellie received at Liverpool Hospital later in these findings.

Mr Kellie's return to VIDC

92. When he returned to VIDC on the afternoon of 18 January 2019, Mr Kellie was reviewed by a primary health nurse, who booked him for a review by a GP on the following Monday.

93. I note that these steps appear to comply with IHMS policy. At the time this required that on return to VIDC after an acute psychiatric admission, a detainee receive a review by a primary health nurse on arrival, and a referral to a GP within 72 hours of their return.

94. However it appears that Mr Kellie did not attend his scheduled GP appointment, and he declined to attend a rebooked appointment for 23 January 2019.

95. For the period 21 to 24 January 2019 Mr Kellie did not present at the clinic to receive any of his medication. In addition, despite the recommendation in his treatment plan that he receive daily oral doses of paliperidone, from the time he returned to VIDC Mr Kellie did not receive any such doses.

96. Mr Kellie had a visit from Welfare Officer JB on 23 January 2019. When JB came to Mr Kellie's room he found it to be completely dark and he could not see Mr Kellie's face. Mr Kellie told JB he felt '*okay*', and he replied *'no'* when JB asked him if he needed anything for his welfare.

97. The following day, which was 24 January 2019, Mr Kellie received four physical checks from detention officers RS and EA, because of the level of their concern for him. After performing these checks, EA felt less concerned because he thought that isolating himself was normal behaviour for

Mr Kellie. However RS remained worried that Mr Kellie was not coping, and she spoke to JR of the Welfare Team. JR said they would visit Mr Kellie the following day.

98. RS also asked the Serco night shift to carry out extra checks on Mr Kellie.

The events of 25 January 2019

99. On 25 January 2019 Mr Kellie received a welfare check from EA at 6.15am. It was dark in Mr Kellie's room, and EA could not see his face.

100. There was a routine welfare check at midday, and then another at 1.30pm when detention officers realised that Mr Kellie had not come to the meal room for lunch. EA again went to Mr Kellie's room where Mr Kellie was sitting on his bed. He declined EA's offer to bring him some food.

101. Mr Kellie was booked to attend the clinic that day to receive his monthly depot injection of paliperidone, but he did not attend. This prompted detention officers RS and EA to again visit him, to remind him of the appointment. Mr Kellie was still sitting on the edge of his bed. He told RS that he would go to the appointment, but he did not move.

102. EA thought that Mr Kellie's mood was low. RS agreed, and she rang IHMS to request that a staff member speak with Mr Kellie. The staff member responded: '*We will just see if he makes his own way down'*.

103. RS followed this with an email at 2.09pm directed to JR . RS' email was as follows:

> *' …. If some one can come up and chat with Mr Moses Kellie that would be great. He is not doing well and is not going to medical and refusing his depo injection. He*

just sits in his room 24/7 and doesn't even come out for meals most of the time'.

104. JR replied that a welfare officer would try to visit Mr Kellie later, as they were busy with detainee assessments. Then at 2.30pm RS saw IHMS staff collecting medical request forms. She approached them and, as she says, '*pleaded'* with them to speak with Mr Kellie.

105. IHMS staff then came to Mr Kellie's room and took him to his scheduled appointment to have his depot injection. The two nurses who attended him there were mental health nurses Tawanda Mururi and Mary Flores.

106. RN Mururi performed a mental health examination of Mr Kellie, finding that he was '*flat in mood but settled in behaviour', 'appeared to be responding to [non apparent stimuli'*, and was reporting '*nil thoughts of harm to self or others'*. RN Flores also did not observe anything to suggest that Mr Kellie was at increased risk of suicide.

107. I have described at paragraphs 23 and 24 above the tragic events which took place later that afternoon, when Mr Kellie was found unresponsive in his room and soon afterwards was pronounced deceased.

The evidence in relation to Issue 1

108. I now turn to the question of whether Mr Kellie received adequate monitoring, treatment and support for his mental health at VIDC.

109. Counsel Assisting submitted that according to the evidence, the PSP/SME processes within VIDC were deficient, in that they failed to provide Mr Kellie with an appropriate level of support, and did not adequately address his risk of self harm.

110. Counsel Assisting particularised these alleged deficiencies as follows:

1) That there was a delay in placing Mr Kellie on an SME on 7 January 2019, despite evidence of a *'noticeable deterioration'* in his mental health during the second half of 2018

2) That the PSP/SME plan prepared for Mr Kellie on 7 January 2019 was '*pro forma'* in nature and provided detention officers with insufficient guidance

3) That after Mr Kellie returned to VIDC from hospital on 18 January 2019, there should have been consideration to placing him on a PSP/SME.

111. These assertions were not accepted by Serco and IHMS in their submissions.

112. I will deal with each of these in turn.

Was there delay on the part of detention staff in noticing Mr Kellie's deteriorating mental health?

113. According to Counsel Assisting*: 'The failure of Serco to notice or act on the evident signs of Mr Kellie's deterioration represents a failure in its processes.'*

114. In response, Serco contended that there was '*no reliable evidence'* of Mr Kellie's mental health noticeably deteriorating prior to early January 2019, at which point detention officers took prompt action to alert IHMS staff.

115. It is the case that most of the evidence of a deterioration in Mr Kellie's mental health prior to January 2019 (aside from his presentation in his consultations with IHMS staff) was given by fellow inmates Mr Makasa and Mr Aroub. At the inquest the court heard evidence from detention officers who had become familiar with Mr Kellie, that over the time they had known him they had generally found him to be quiet and reserved, and not very attentive to his personal hygiene. For this reason, they said, they had not held any particular concerns about his behaviour and presentation during the last few months of 2018.

116. Detention officer RS gave evidence in her statement that she attended the room of Mr Kellie in early January 2019 and spoke to her concerns at a meeting on 9 January 2019.

117. In my view the evidence does not enable a clear finding that Mr Kellie's declining mental health ought to have been noticeable to detention staff prior to early January 2019. I take into account the evidence that in their experience it was not unusual for Mr Kellie to keep to himself and not attend to his hygiene. I therefore do not find that there was unjustifiable delay on their part in bringing his health to the attention of IHMS staff.

118. As regards the situation with IHMS staff, it was submitted on their behalf that Mr Kellie had consultations with Dr Lienert on 3 October 2018 and 17 October 2018, and that there was no clinical evidence that Mr Kellie required SME monitoring at those times.

119. This submission is not quite in accordance with the evidence. As I have noted, the clinical notes from Mr Kellie's appointment on 3 October 2018 record that he had reported experiencing suicidal ideation for the previous four days.

120. However it appears that Dr Lienert's response to these disclosures was appropriate. He directed that Mr Kellie receive daily follow ups with a mental health nurse, and that Mr Kellie have an appointment with himself on 10 October 2018.

121. I have noted that Mr Kellie did not attend the 10 October 2018 appointment. And as for the daily reviews by a mental health nurse, these did not take place except for one on 4 October 2018.

122. I will return to the issue of Mr Kellie's missed appointments in the discussion of Issue 2.

123. I conclude that prior to early January 2019, there is no evidence of unreasonable delay by detention staff in noticing Mr Kellie's deteriorating mental health. Nor during this period is there evidence that Dr Lienert did not

appropriately respond to signs that Mr Kellie's mental health was deteriorating.

Did the PSP/SME plan prepared for Mr Kellie on 7 January 2019 provide Serco officers with sufficient guidance?

124. The inquest examined the appropriateness of the SME plan which was prepared for Mr Kellie on 7 January 2019.

125. The SME plan was prepared RN Maria Flores, and it instructed detention officers (among other things) to:

- maintain 24 hour constant line of sight observations and supportive monitoring and engagement
    - monitor Mr Kellie's mental state, interactions, food and water intake and sleep patterns
    - ensure he was able to access mental health and medical services
    - encourage the development of a daily routine: *'strategies for distractive/reintegration to be offered including TV, card games, music, reading etc'*
    - encourage client maintenance of '*contact with positive social supports via telephone calls/Skype or when appropriate, visits'*.

126. Counsel Assisting submitted that the above instructions:

> *' … provided little in the way of practical guidance to the Serco officers … as to what was needed to be done to address Mr Kellie's specific mental health concerns'.*

127. Counsel Assisting submitted further that to the extent that the SME obliged detention officers to '*monitor Mr Kellie's mental state*', it required them to make a judgement on clinical matters which they were not trained to

perform. For this reason it was not appropriate, stated Counsel Assisting, for non clinically trained staff to perform the kind of observations that were required in the SME plan.

128. These assertions were not accepted by Serco or by IHMS.

129. According to the Serco submissions:

> *'[Counsel Assisting's] submission ignores or misapprehends the role of Serco officers in making observations and supporting, monitoring and engaging with detainees. Serco's role in the PSP/SME is not to 'effectively address Mr Kellie's underlying mental health concerns', but to make and record observations through supportive monitoring and engagement for review by IHMS to make clinical judgements'.*

130. Serco therefore asserted that seen in its proper light, the role of detention officers in the PSP/SME process could appropriately be performed without medical training or clinical expertise.

131. In similar vein, it was submitted by IHMS that Counsel Assisting had:

> *' … conflated the role of IHMS and Serco in performing SME observations … Serco officers performing SME observations are not required to exercise clinical judgement (nor should they as they are not medically qualified) … mental health nurses use the observations recorded by Serco in the logs to inform the mental health examination that is undertaken by mental health nurses at each SME review'.*

132. In my view, the evidence is clear that the role of detention officers in the PSP/SME process was not to make clinical judgements (although in this context, the instruction to '*monitor Mr Kellie's mental state'* could have been better worded) but rather, to make and record objective observations which

would assist IHMS staff to make those judgements. I therefore accept that it is misconceived to perceive Serco's role, when monitoring Mr Kellie's behaviour, as involving a determination of '*what was needed to be done to address Mr Kellie's specific mental health concerns'.* This was the role of the reviewing IHMS clinicians.

133. I have examined Mr Kellie's SME plan within this context. In my view the SME plan was prescriptive enough to give sufficient guidance to detention officers about the behaviours that they needed to look out for *('interactions; food and water intake …; sleep patterns'*) and which, it appears, they were trained to understand as indicative of possible mental health decline. It was understood that these observations would then be reviewed by IHMS staff, for the purpose of determining an appropriate clinical response.

134. On this basis, I find that the role contemplated for Serco staff within the PSP/SME process did not require medical training or clinical expertise.

135. I further find that the PSP/SME plan prepared for Mr Kellie on 7 January 2019 provided detention officers with sufficient guidance for them to perform the role contemplated for them.

Should VIDC staff have placed Mr Kellie on a PSP/SME or Keep SAFE procedure after he returned from hospital?

136. As further evidence that the PSP/SME processes failed to provide Mr Kellie with an appropriate level of support, and did not adequately address his risk of self harm, Counsel Assisting submitted that after Mr Kellie returned from hospital on 18 January 2019, there ought to have been consideration of placing him on a PSP/SME.

137. Counsel Assisting acknowledged that over this period detention officers RS and EA took many steps to try to assist Mr Kellie, prompted by a genuine concern for his welfare. The efforts which they made to assist Mr Kellie on 24 and 25 January 2019 are outlined above at paragraph 23.

138. Even so, Counsel Assisting submitted that in hindsight, Mr Kellie's behaviour on 25 January 2019 (described above at paragraphs 23 and 24) might have indicated to EA and RS that there was a need for '*more urgent psychiatric attention'*. Counsel Assisting submitted that, again with the benefit of hindsight, it was '*unfortunate'* that they did not commence the process of placing him on the PSP/SME pathway.

139. I accept that when viewed in the light of hindsight, the appropriate course of action for the two detention officers on 24 and 25 January 2019 would have been to initiate the PSP/SME process for Mr Kellie.

140. Nevertheless RS in particular deserves credit for recognising that Mr Kellie was at risk, for feeling significant concern for him, for undertaking additional physical checks of him, for seeking the assistance of JR of the Welfare Team, and for taking steps to bring his condition to the attention of health staff. She also, together with EA, made significant efforts on 25 January 2019 to ensure that Mr Kellie attended the clinic for his depot medication.

141. In these circumstances, and also in view of the procedural reforms which have been introduced since Mr Kellie's death and which are outlined below, I do not consider it is appropriate to make adverse comment about the responses of officers EA and RS on 25 January 2019.

142. As for the response of IHMS staff when Mr Kellie returned to VIDC on 18 January 2019, this is addressed later in these findings at paragraphs 209 to 226.

Changes to mental health policy and procedures at VIDC

143. 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.

144. 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.

145. 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.

146. IHMS has lodged a request for additional funding to give effect to the above changes, and to add the following 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.

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

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

149. The court heard evidence that Serco is 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.

150. **The 2023 Procedural Instruction also introduced the Centralised IMP (CIMP) to create a single plan from which service providers can deliver services to detainees. The court head evidence that the new contracts with the new service providers will progress the CIMP.**

Conclusion regarding Issue 1:

151. Taking into account the above evidence, I conclude that the PSP/SME processes within VIDC provided Mr Kellie with an appropriate level of support and monitoring, and adequately addressed his risk of self harm.

152. Having said that, I believe there remains room for improvement, in particular 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.

153. This matter is further discussed below in the section on Recommendations.

154. One further matter was addressed in Counsel Assisting's submissions under this part.

155. This was the suggestion that Mr Kellie became aware on 25 January 2019 that a decision had been made in relation to his immigration status, and that it was adverse to him. It was submitted that were this to be the case, it would have been appropriate to provide him with additional support.

156. Both Serco and IHMS have responded that there is no reliable evidence to establish that an immigration decision adverse to Mr Kellie had been made, or that he had become aware of this. I accept this submission.

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?

157. By way of background, the court heard that IHMS staff administer 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 2019. There are after hours primary health care nurses available until 8pm, who are able to administer medication.

158. The evidence established that at VIDC, at the time of Mr Kellie'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.

159. Although there were periods when Mr Kellie followed his medical advice and was compliant with his anti psychotic and opiate substitution therapy, there were also periods when he was not compliant with either regime. He also had a history of missing appointments, both for his medication and for his clinical reviews. Some of these have been mentioned above. Other known instances were as follows:

- On 30 November 2016, psychiatrist Dr Absalam recorded that Mr Kellie was '*at high risk of relapse if his medication discontinues'.* After another appointment on 27 September 2017 which Mr Kellie did not attend, Dr Absalan recorded that he required monthly psychiatric reviews, and fortnightly counselling and review by mental health staff.

- In July 2018 Mr Kellie was referred for a Drug and Alcohol assessment, when he tested positive for opiates and disclosed that he had been using heroin and other substances for four months. He commenced

opiate replacement therapy. But on 3 October 2018 Mr Kellie told a Drug and Alcohol nurse that he had not attended on the previous six days for his opiate replacement medication. He was booked for a follow up appointment the next week.

160. Additionally on a number of occasions, mental health reviews which had been recommended for Mr Kellie did not take place. The fortnightly mental health reviews which Dr Absalan recommended on 27 September 2017 did not occur (Mr Kellie's next mental health review was not until 28 December 2017). He did not have daily follow ups with a mental health nurse as recommended by Dr Lienert on 3 October 2018 (there was only a single review on 4 October 2018). And Mr Kellie did not have any psychiatrist assessments between the period 17 October 2018 to 9 January 2019.

161. As to why these reviews did not take place, it is clear that on a number of occasions Mr Kellie did not attend clinical appointments which had been booked for him.

162. It is also the case that on other occasions, clinicians recommended that follow up appointments be booked for Mr Kellie, but this did not happen. One example of this occurred following Dr Lienert's instruction on 17 October 2018 that Mr Kellie see him again in 3-4 weeks' time. This appointment was not booked for Mr Kellie.

163. I have accepted that this failure was not due to inaction on Dr Lienert's part. According to the evidence, at that time psychiatrist appointments were booked by nursing staff. The court heard evidence from the then Mental Health Team Leader that there had been a system failure in relation to this particular appointment, and she was unable to explain how this had occurred.

164. In short, when Mr Kellie did not receive clinical appointments that had been recommended for him, it is not clear the extent to which this was due to his own non attendance, or to system failure in booking arrangements.

165. The above evidence also raised the question of what procedures were in place at VIDC to encourage medication compliance and attendance at scheduled appointments, and to follow up on missed appointments.

The processes in place at the time of Mr Kellie's detention

166. At the time Mr Kellie was in 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 obligation on 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 (and did so, in Mr Kellie's case) to transfer a detainee to hospital for consideration of involuntary treatment.

167. 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?

168. The above evidence prompted Counsel Assisting to submit that VIDC's processes for ensuring compliance with medication and attendance at clinical appointments are inadequate; and that a '*more proactive follow up model'* is required. 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.

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

170. 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.

171. 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.

172. However, she and Dr Sullivan agreed that any changes of this kind would require the input of a number of stakeholders. They agreed further (as did psychiatrist Dr Christopher Ryan) 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

173. In its 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 has introduced since Mr Kellie's tragic death. These are designed to strengthen their processes for following up on missed medications.

174. 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 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 senior IHMS staff

- A missed medication report is sent to a detainee identified through this process; and 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 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.

175. 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'.*

176. 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, should involve health staff going onto the compound to administer medication to detainees.

177. 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

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

179. 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.

180. The Commonwealth opposed the 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.

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

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

183. 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.

184. 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 made 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.

185. IHMS's submissions cited the evidence of Dr Heather Miller, Medical Director of Government Services within 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'.*

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

Conclusion regarding Issue 2

187. The evidence establishes that at the time of Mr Kellie's detention, VIDC had measures in place to address medication non compliance and missed appointments.

188. 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.

189. 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.

190. These factors must be taken into account when assessing the adequacy of IHMS's measures, at the time of Mr Kellie's detention, 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 procedures.

191. 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 paragraphs 43- 45 above about the changing profile of VIDC detainees and their consequent greater need for mental health and drug addiction services.

192. 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.

193. 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 medical appointments, there cannot be confidence that the proposed Recommendations will improve compliance levels.

194. 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.

195. 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 return to this suggestion later in the Recommendations section of these findings.

196. Before leaving this issue, the evidence established that when Mr Kellie returned from hospital, he did not receive the oral paliperidone with which he had been prescribed, and which the Liverpool Hospital treating team had directed he receive on a daily basis for one to two weeks. Counsel Assisting submitted that the evidence supports a finding that this medication had been provided by hospital staff to Serco officers, but that for unknown reasons IHMS staff did not receive it.

197. On the available evidence, it is not possible to conclude how it was that Mr Kellie's oral paliperidone medication was not available to him when he returned to VIDC. In any event, I note the unanimous opinion of the psychiatrist experts that this particular medication was probably not clinically necessary for Mr Kellie.

198. In these circumstances I do not intend to make further comment.

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

199. 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, Counsel Assisting submitted that the evidence disclosed the following shortcomings:

- 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.

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

201. 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'.*

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

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

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

204. 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.

205. 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 inevitably impacts the scope of authorities to design accommodation areas and furnishings, which will reduce their risk of providing detainees with opportunities for serious self harm.

206. 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.

207. I address this issue in the Recommendations section of these findings.

ISSUE 5: DID MR KELLIE RECEIVE ADEQUATE MENTAL HEALTH CARE AT LIVERPOOL HOSPITAL?

208. The court examined two specific aspects of Mr Kellie's treatment at Liverpool Hospital over the period 10 to 18 January 2019:

- Whether Mr Kellie's treating team prescribed appropriate medication for him
- Whether his discharge back to VIDC on 18 January 2019 was premature.

209. Those assisting the inquest sought an independent report from consultant psychiatrist Dr Richard Furst, who was asked his expert opinion on the treatment decisions made for Mr Kellie in Liverpool Hospital.

210. In his initial report Dr Furst was critical of some of the decisions made by Mr Kellie's treating team at Liverpool Hospital. In his opinion Mr Kellie was suffering from treatment resistant schizophrenia. This, he said, ought to have prompted a decision to extend his hospital admission in order to commence a supervised trial of the medication clozapine, an anti psychotic medication which is used when a person's illness does not respond to at least two other anti psychotic agents. Dr Furst was thus critical both of the choice not to

commence such a trial, and the decision to discharge Mr Kellie on 18 January 2019.

211. When he arrived at Liverpool Hospital Mr Kellie was reviewed by psychiatrist registrar Dr Jane Berry, and by consultant Dr Kai Kai Toh on 15 January 2019.

212. Dr Toh was aware that Mr Kellie had a history of not complying with the medication with which he had been prescribed for treatment of his schizophrenia. He was also aware that Mr Kellie habitually used methamphetamines. In Dr Toh's opinion both features would have had adverse effects on Mr Kellie's psychiatric health, and had probably significantly influenced his relapse into psychosis in the period leading up to 10 January 2019.

213. At the inquest Dr Toh strongly resisted Dr Furst's opinion that the appropriate treatment for Mr Kellie's schizophrenia was a trial of clozapine.

214. Dr Toh explained the reasons why he had approved Dr Berry's plan of commencing Mr Kellie on oral paliperidone, then moving to an injectable and long acting form of this medication provided that he had not experienced significant side effects from preliminary oral doses of it. The purpose of an injectable paliperidone regime was to minimise Mr Kellie's risk of relapse due to medication non compliance.

215. Additionally, it is well understood that while clozapine has clinical benefits (it has been shown to reduce the symptoms of schizophrenia, and to reduce the risks of suicide and hospitalisation), its use is associated with side effects which require long term monitoring by way of regular blood testing. Clozapine also increases the patient's risk of myocarditis (inflammation of the heart muscle), necessitating further blood and cardiac monitoring. For these reasons it needs to be trialled over a relatively lengthy period, with a relatively high degree of clinical monitoring.

216. For the above reasons, Dr Toh did not accept Dr Furst's opinion regarding a trial of clozapine for Mr Kellie. Neither did independent

psychiatrists Dr (first name?) Paton and Dr Christopher Ryan, who also gave evidence at the inquest.

217. Neither Dr Paton nor Dr Ryan were satisfied that Mr Kellie's schizophrenia was resistant to treatment, noting his significant history of medication non compliance. In their opinion, his historical lack of response to anti psychotic medication was more likely due to non compliance, together with use of illicit substances including methamphetamine. They considered that these two features were also the likely causes of his recent relapse into illness.

218. Dr Paton and Dr Ryan noted further that clozapine is only available in oral form, requiring a high level of patient co-operation which may not have been forthcoming in Mr Kellie's case. In his report Dr Ryan commented that injections of anti psychotic medications:

> *' … are known to be far more effective at preventing relapse into schizophrenia than anti psychotics administered orally'.*

219. For these reasons, Dr Paton and Dr Ryan considered that it was reasonable for Dr Toh to commence Mr Kellie on depot paliperidone rather than to commence a clozapine trial.

220. They were further of the view that it was a reasonable clinical decision to discharge Mr Kellie on 18 January 2019. Dr Toh had done so because in his opinion Mr Kellie's symptoms had diminished in response to treatment. He directed that Mr Kellie be discharged on 18 January 2019, after receiving another depot injection of paliperidone.

221. Dr Paton and Dr Ryan concurred that discharge of Mr Kellie on 18 January 2019 was reasonable. In their opinion the hospital records indicated that his symptoms were responding '*relatively well'* to paliperidone, and he had not made any attempts at self harm or expressed any intention to do so.

222. I note that in supplementary reports and in the conclave evidence, Dr Furst accepted evidence that in hospital Mr Kellie had responded well to paliperidone. He agreed that it was reasonable for Dr Toh to have concluded that his relapse had been due to medication non compliance.

223. On the basis of this evidence, the court accepts the opinion expressed by Dr Paton in his report (with which Dr Ryan concurred), that

> *' … the care provided [at Liverpool Hospital] was reasonable and would be considered appropriate by many peer psychiatrists and psychiatrists in training, under similar circumstances'.*

224. This also was the submission of Counsel Assisting.

225. I find that Mr Kellie received adequate mental health care and treatment during his admission at Liverpool Hospital in January 2019. I also find that there is no basis for adverse comment about Dr Toh's treatment decisions in relation to Mr Kellie, or his decision to discharge Mr Kellie back to VIDC on 18 January 2019.

ISSUE 6: WERE THE PROCESSES AND POLICIES IN RELATION TO MR KELLIE'S DISCHARGE BACK TO VIDC APPROPRIATE?

226. In his first report Dr Furst had opined that there were shortcomings in the communication between Liverpool Hospital and IHMS when Mr Kellie was discharged. In his opinion, a hand over telephone call from the Liverpool treating team would have been of assistance. In later reports however Dr Furst accepted that '*sufficient clinical information'* about Mr Kellie was provided by the Liverpool treating team.

227. Nevertheless Counsel Assisting submitted that, based on Dr Toh's evidence, it appeared that he had '*a degree of misplaced assumption'* about the types of follow up care which Mr Kellie would receive on his return to VIDC. In his evidence Dr Toh had expressed surprise that the model of

health care at VIDC was a primary-health based one, and said that he expected that Mr Kellie would have been reviewed on his return to VIDC.

228. As the evidence shows, Mr Kellie was in fact reviewed on the day of his return (a Friday), albeit by a primary health nurse. It does not appear however that the nurse referred Mr Kellie for any follow up reviews by mental health clinicians. She did however, book Mr Kellie in for an appointment with a GP for the following Monday.

229. I have noted above that in doing so, the reviewing nurse complied with existing IHMS procedures regarding the return to VIDC of detainees who have had an acute psychiatric admission.

230. The question arose whether these procedures were adequate.

231. In the course of their conclave evidence, Dr Furst, Dr Paton and Dr Ryan were asked about their timeframe expectations for a patient to receive a mental health review after discharge from a psychiatric admission.

232. According to Dr Furst, there ought to be review by a general nurse on arrival, and by a mental health nurse within a week, followed by a psychiatrist review within 2-4 weeks. Dr Paton and Dr Ryan agreed with this timeframe.

233. As can be seen therefore, the IHMS procedures which were in place in 2019 did not conform with the above expectations, in that a mental health assessment was not booked for Mr Kellie on his return. Hence, although there can be no criticism of the primary care nurse who performed Mr Kellie's review, there were shortcomings in the post-discharge systems in place at VIDC at that time.

234. However, positive procedural changes have since been made by IHMS in relation to detainees who return to VIDC after an admission for an acute psychotic episode. A detainee returning to VIDC after an acute psychotic admission is now to be assessed by a mental health nurse on their return; and if the return takes place after hours, the detainee will be placed on a Keep SAFE program until a mental health nurse becomes available.

235. These reforms bring VIDC's post-discharge procedures within the expectations for good mental health practice.

THE QUESTION OF RECOMMENDATIONS

236. In closing submissions regarding all three inquests, Counsel Assisting proposed 43 recommendations which, in their submission, were collectively supported by the evidence. In reply submissions, Counsel Assisting withdrew proposed Recommendations 8, 18, 20 and 23, after consideration of submissions on behalf of the interested parties. Counsel Assisting also made changes to some of the remaining Recommendations, taking into account matters raised in those submissions.

237. Counsel Assisting submitted that some of the proposed Recommendations were applicable to all three inquests, while others arose only from the circumstances of an individual inquest.

238. In my findings in relation to each of the three deceased persons, I have adopted the numbering used by Counsel Assisting in their closing submissions.

239. Some of the Recommendations proposed by Counsel Assisting require 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

240. 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.

241. 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.

242. 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.

243. The main such areas identified by Counsel Assisting were these:

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

244. At the inquest Mr Bahamondes advised that the first six 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.

245. Mr Bahamondes stated further that recommendations four to six have been addressed in the 2023 Procedural Instruction, which has been referred to above.

246. 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.

247. 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

248. 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.

249. 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):

> *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.*

250. 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 ….'*

251. 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'.

252. The Commonwealth also pointed to Mr Bahamondes' evidence, that the Jeyasingam/Sistenich review had informed the current procurement process, and that the procurement 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.

253. Counsel Assisting's Recommendation 1 was likewise not supported by 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 the Jeyasingam/Sistenich recommendations.

254. 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.

255. 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.

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

257. 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.

258. I make Recommendations 2 and 3.

Recommendation 4

259. 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'*.

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

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

Recommendations 5 and 6

262. 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.

263. 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.

264. I have addressed these proposed Recommendations at paragraphs 179 to 187 above. For the reasons set out therein, I do not propose to adopt these proposed Recommendations.

265. 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:

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

Recommendation 7

This proposes (in its amended form) that the health services provider update its critical medications list to include all anti psychotic and anti depressant medications; and that the incoming health services provider be required to adopt this approach, if necessary through any contract it enters with the Commonwealth.

This proposal is not supported by IHMS. Its submissions advised that IHMS's 'Critical and Missed Medications Policy' relates to medications which are prescribed for conditions which, if the medication was not taken, would *'have the potential to have catastrophic consequences'*. IHMS noted that, clozapine aside, mental health medications are generally not considered 'critical' in this sense.

The IHMS submissions noted further that IHMS policy was amended in 2022, to permit clinicians to exercise discretion if a mental health medication was considered '*critical*'.

For these reasons, IHMS submitted that the proposed Recommendation was neither appropriate nor necessary.

I accept this submission, and decline the Recommendation.

Recommendations 9 and 10

266. 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]'*.

267. The CIMP is described in the 2023 Procedural Instruction as a document which is to provide:

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

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

269. On the basis of the Commonwealth's submissions, the court understands that 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.

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

271. 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 a 'single behavioural plan'. It is not surprising that the inquest heard no evidence in relation to this decision.

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

273. In the circumstances I decline to make proposed Recommendations 9 or 10.

Recommendations 11 and 12

274. 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.

275. 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.

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

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

278. These limitations were also cited by the Commonwealth.

279. 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.

280. 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, Counsel Assisting submitted that these meetings did not afford the kind or degree of information exchange that was called for.

281. 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 behavioural 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.

282. 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*
>
> *subject to any applicable restrictions, the single mental health plan; and*
>
> b. *the single behavioural plan*.

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

284. 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].

285. In paragraph 274 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.

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

287. 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.'*

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

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

290. 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.

291. In my view, these uncertainties preclude me from making proposed Recommendations 11 or 12.

Recommendations 13 to 20.

292. This group of proposals recommends changes to the PSP/SME process.

293. Counsel Assisting's amended Recommendation 13 is that the 2023 Procedural Instruction be amended to require that non mental health clinicians, and Serco staff, have access to the advice of a mental health clinician on a basis of 24 hours a day, 7 days per week.

294. This proposal was prompted by the new and positive change to IHMS procedures, whereby a detainee returning to VIDC after an acute psychotic admission is to be assessed by a mental health nurse on their return; and that if the return takes place after hours, the detainee will be placed on a Keep SAFE program until a mental health nurse becomes available.

295. Counsel Assisting submitted that it would be a better solution than the potentially invasive Keep SAFE option, if *'after hours'* IHMS clinicians were able to have 24 hour access to the advice of a mental health nurse via the HAS (Health Advice Service) line. The HAS line provides telephone health advice in relation to detainees on a 24 hour, 7 days a week basis. This would enable the necessary mental health review to take place that same day.

296. The court heard evidence that although IHMS staff currently have 24 hour access to the HAS service, this service is not staffed by a mental health nurse. IHMS has made an application to the Commonwealth for funding for this availability, but it has not yet received a decision about this. Counsel Assisting therefore proposed Recommendation 14, that the Commonwealth make a timely decision on this funding application.

297. The Commonwealth did not oppose either of these proposed Recommendations.

298. There is clear merit in both proposed Recommendations, and I make them.

299. **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.

300. 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.

301. 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.

302. 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.

303. I decline to make this Recommendation.

304. **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'*.

305. 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.

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

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

308. 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.

309. This recommendation is declined.

310. 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.

311. Regarding the PSP/SME plan formulated for Mr Kellie, I have found that it was not deficient in the way it instructed Serco officers to achieve its broad goals. I found further that in Mr Kellie's case, the Serco officers did not lack an understanding of their obligations and responsibilities arising from Mr Kellie's SME.

312. This Recommendation was not supported by IHMS.

313. Nevertheless 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 detention and health staff 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 guidance and support to its staff.

314. I make this Recommendation.

315. **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'.*

316. 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.

317. 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'.*

318. In my view there is merit in this proposal, for the same reasons as appear in paragraph 313 above, regarding the increased incidence of mental health conditions within the VIDC cohort.

319. I make this Recommendation.

320. **Recommendation 21** (as amended in Counsel Assisting's reply submissions) proposes that those detention 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.

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

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

323. 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.

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

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

326. I make this Recommendation.

327. **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.'*

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

329. 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.

330. 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.

331. 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'.*

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

333. 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).

334. 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.

335. I decline to make proposed Recommendations 25 and 26. In their place, I make the following Recommendation:

> *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'.*

336. **Recommendation 27** was that a memorandum of understanding be developed, to provide for better processes when a detainee is admitted to and discharged from hospital.

337. IHMS opposed this Recommendation. IHMS pointed to the fact that an 'Information Sheet' has already been developed, which is sent with detainees when they are transferred to hospital, and which informs the hospital of communication pathways and the services which are available to the detainee on their discharge back to VIDC.

338. However this Recommendation was supported by the South Western Sydney Local Health District, which welcomed the opportunity to improve communications between VIDC and Liverpool Hospital. According to their submissions, '*work is underway'* to develop such a memorandum of understanding.

339. I make this Recommendation, in the amended form in which it appears in Counsel Assisting's reply submissions.

340. 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.

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

Conclusion

In closing, I convey to Mr Kellie's family my sincere sympathy for the loss of their brother and uncle.

I thank the Counsel Assisting team for their outstanding assistance in this sad and complex inquest.

Findings required by s81(1)

342. 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 Moses Kellie

Date of death:
Moses Kellie died on 25 January 2019.

Place of death:
Moses Kellie died at Villawood Immigration Detention Centre, Villawood NSW

Cause of death:
Moses Kellie died as a result of hanging.

Manner of death:
Moses Kellie's death was an intentional self inflicted death, while he was in lawful custody.

RECOMMENDATIONS

343. 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 Mr Kellie's death.

To the Department of Home Affairs:

14. *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.*

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

16. *That the Commonwealth amend the 2023 Procedural Instruction to require non-mental health clinicians employed by the DHSP and employees of FDSP to have access to advice provided by a mental health clinician 24 hours per day and 7 days per week*.

17. *The Commonwealth make a decision on the ASR submitted by IHMS requesting funding for a mental health nurse to be available on the HAS line 24 hours per day (assuming that this has not already occurred).*

18. *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.

19. *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 medical appointments.*

20. *That as a matter of priority, the Commonwealth*:

iii. 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

iv. commit to taking reasonable steps to remove ligature points identified in the 'ligature review'

To Serco Australia Pty Ltd, or the detention services provider which replaces Serco Australia Pty Ltd;

21. *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.

22. *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.*

23. *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.*

24. *That the training referred to in Recommendations 9 and 10 be provided by an external consultant*

To International Health and Medical Services Pty Ltd or the health services provider which replaces it:

25. *DHSP staff be trained as to best clinical 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 IHMS or the health services provider which replaces it:

26. *That the Commonwealth and the DHSP expedite the development of a memorandum of understanding with South Western Sydney Local Health District regarding:*

c) *the process for admitting and discharging a detainee from hospital; and*

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

I close this inquest.

Magistrate E Ryan
Deputy State Coroner
Lidcombe

6 March 2025