CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Robert Elan Peihopa
Hearing dates:	18-22 September 2017
Date of findings:	28 November 2017
Place of findings:	The State Coroner's Court, Glebe
Findings of:	**Deputy State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – Cause and manner of death Death in immigration detention
File number:	2016/102487
Representation:	**Ms Naomi Sharp SC, Counsel Assisting instructed by Ms Jessica Wardle and Jennifer Hoy on behalf of the Crown Solicitor** **Mr Stephen Rushton SC, for Serco Australia Pty Ltd** **Mr Rob Bhalla for the Department of Immigration and Border Protection** **Mr Duncan Fine and Ms Verity Smith for Mrs Hera Peihopa** **Mr Ian Denham for International Health and Medical Services (IHMS)**

Findings:	**Identity of deceased**: The deceased person was Mr Robert Elan Peihopa **Date of death**: 4 April 2016 **Place of death**: He died at Villawood Immigration Detention Centre at Villawood in Sydney **Cause of death:** Fatal cardiac arrhythmia **Manner of death:** Underlying chronic coronary artery disease and triggers of ingestion of methamphetamine in the hours before Mr Peihopa's death and the physical and emotional distress arising from his involvement in a fight immediately prior to his death.
Recommendations:	**1. The Department of Immigration and Multicultural Affairs ("Department") and Serco Australia Pty Ltd ("Serco") should each review the circumstances of this matter and give consideration to whether two Detention Service Officers in the Mitchell Compound is sufficient to provide an adequate level of supervision and security.** **2. The Department should liaise with International Health and Medical Services ("IHMS") about developing and making available at VIDC a rehabilitation program specifically targeted at ice users.** **3. The Department should investigate ways to facilitate drug and alcohol rehabilitation programs being provided to detainees who require them.** **4. Search and seizure powers available at immigration detention facilities should be enhanced to (a) prevent the entry of illegal drugs into immigration detention centres and (b) detect illegal drugs which have entered immigration detention centres.** **5. The Department and Serco should review their procedures to facilitate greater sharing of information about suspected drug and alcohol use by detainees with staff members who have supervision or welfare responsibilities towards those detainees.**

	6. Serco should review the way in which it manages intelligence holdings suggesting detainees are using illegal drugs or alcohol in order to ensure that adequate supervision arrangements are in place in relation to such detainees. **7. The Department should investigate with NSW Corrective Services and NSW Justice Health options for obtaining information from them about a detainee's custodial history including information regarding their behaviour whilst in custody, health and welfare and any history of drug and alcohol use, and options for making this information available to both Serco and IHMS.** **8. The Department and Serco should develop a protocol which:** **(a) clarifies their respective roles in enquiring into the background and circumstances giving rise to a Critical Incident;** **(b) clarifies the means by which they will keep abreast of developments of any police investigations.** **9. The Department and Serco should develop a protocol for notifying in a timely manner the next of kin of the death of a detainee, and a representative of both the Department and Serco should communicate with the next of kin to acknowledge with appropriate sensitivity the death of their loved one while in Serco and the Department's care and control.**

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The Coroners Act 2009 (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the reasons and findings of an inquest into the death of Robert Elan Peihopa.

Reasons

Introduction:

1. Robert Elan Peihopa died at Villawood Immigration Detention Centre ("VIDC") on 4 April 2016. His identity, and the date and the place of his death are not in dispute. Further, the evidence before this inquest establishes that the immediate physical cause of Mr Peihopa's death was cardiac failure. The key issue for this inquest was the manner of Mr Peihopa's death, that is, the circumstances leading up to Mr Peihopa's death.

The Inquest:

2. An Inquest concerning the death of a person is required to be held if it appears to the coroner that the manner and the cause of the persons death has not been sufficiently disclosed.

3. Section 81 of the *Coroners Act 2009* (NSW) requires a coroner presiding over an inquest to confirm that the death occurred and make findings as to:-

    - the identity of the deceased;
    - the date and place of the death; and
    - the manner and cause of the death.

Mr Peihopa:

4. Mr Peihopa was born on 22 November 1973 and was 42 years old at the time of his death. He was a citizen of New Zealand who had resided in Australian since he was around 15 years old.

5. Mr Peihopa is survived by his mother Mrs Hera Peihopa and sister Janette Peihopa. Mr Peihopa is also survived by his four children. Jay, Dion and Billy Peihopa reside in Australia with their mother and Mr Peihopa's former partner of 17 years, Anastasia Kalaboukis. Mr Peihopa's son with his former partner Jesse Hohiana, Jhavan Peihopa, resides in New Zealand.

6. The evidence established that Mr Peihopa had an extensive criminal record, largely comprised of driving offences such as driving whilst disqualified or under the influence of illegal drugs. There were also some offences involving violence.

7. The Department of Immigration and Multicultural Affairs ("Department")[1] first wrote to Mr Peihopa on around 15 January 2002 to warn that if he was convicted of a further offence the Minister would consider exercising the discretion under s.501 of the *Migration Act 1958* (Cth) ("Migration Act") to cancel his visa.[2]

8. In the years that followed, Mr Peihopa was convicted of a number of further offences and from time to time received further warnings from the Department relating to the cancellation of his visa.

9. In January 2014, following convictions for reckless driving, driving under the influence of drugs and certain other offences, Mr Peihopa was sentenced in Waverley Local Court to two years' imprisonment.[3]

10. While still in custody on 25 June 2015, Mr Peihopa was notified by the Department that his visa has been cancelled on character grounds.[4] He was invited to make submissions about why the visa cancellation should be revoked. At that time, Mr Peihopa became an "unlawful non-citizen" for the purpose of the Migration Act.

11. Mr Peihopa's term of imprisonment came to an end on 7 July 2015. That same day he was taken into immigration detention at VIDC.

12. Upon being detained at VIDC, Mr Peihopa was initially placed into the Mackenzie Compound. However, on about 19 February 2016, he was transferred to Hotham Compound, which a progress note records as being "a reward for his good behaviour".[5] He was accommodated in a single room in room 4 of Unit 2 at the Hotham Compound.

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[1] During the relevant period the Department has undergone a number of name changes and in the balance of these findings will be referred to as the Department.
[2] [Exhibit 1, vol.3, tab 52].
[3] [Exhibit 1, vol.3, tab 60].
[4] [Exhibit 1, vol.3, tab 62].
[5] Detainee Progress Note [Exhibit 1, vol.3, tab 79].

Framework for immigration detention and DIDC:

13. It is necessary to say something about the legal framework governing immigration detention. The starting point is s.189 of the Migration Act, which provides that if an officer knows or reasonably suspects that a person in the migration zone is an unlawful non-citizen, the officer must detain the person.

14. Section 196 of the Migration Act relevantly provides that an unlawful non-citizen must be detained in immigration detention until he or she is removed from Australia or granted a visa.

15. The Migration Act itself provides little guidance regarding the management of immigration detention centres. Section 273(1) provides, under the heading "Detention Centres", that the Minister may cause detention centres to be established and maintained. Section 273(2) provides that the regulations may make provision in relation to the operation and regulation of detention centres.

16. Section 252 of the Migration Act sets out how searches may be conducted in an immigration detention centre. There are limits on the search powers. For example, it is not permissible to remove a person's clothing and search them. However, s. 52A does provide for a limited power to strip search a detainee.

17. Section 252AA of the Migration Act sets out how screening procedures may be conducted in an immigration detention centre. Again, there are limits on the scope of these powers. Section 252G of the Migration Act sets out powers concerning the entry into a detention centre. For example, an officer might require a person seeking to enter a detention centre to walk through screening equipment and allow an officer to pass hand-held screening equipment over them.

18. The *Migration Regulations 1994* (Cth) ("Migration Regulations") make little reference to the administration of immigration detention centres. Apart from Regulation 5.32A, which deals with work which may be performed by unlawful non-citizens in detention centres, and Regulation 5.35, which gives power to provide medical treatment against the will of a person in an immigration detention centre, the only relevant Regulation is 5.35B, which concerns the exercise of power to restrain an individual.

19. Relevantly, the Department has outsourced the operation of VIDC to Serco Australia Pty Ltd ("Serco") by way of contract. The relevant contract commenced on 10 December 2014 ("Contract").[6] In Section 4 of Schedule 2 to the Contract detailed provision is made for the provision of security services by Serco at immigration detention centres. Relevantly, under clause 2.3, Serco must use its best endeavours to detect Excluded and Controlled Items, Illegal Items and any other items that may pose a risk to the security of the immigration detention centre.

[6] Extracts of the Contract appear at [Exhibit 1, vol.2, tab 50].

20. Sitting under the Serco contract is the Detention Services Manual. Chapter 8 of this manual sets out Serco's obligations in respect of searching and screening.

21. While the Department has contracted out certain of its responsibilities to Serco and International Health and Medical Services ("IHMS") respectively, it nevertheless owes a non-delegable duty of care to all immigration detainees. A non-delegable duty of care is essentially a duty to ensure that reasonable care is taken for a person whose care, supervision or control the duty-owing party has assumed. It has been held that the Commonwealth owes a non-delegable duty of care to immigration detainees in *S v Secretary, Department of Immigration and Multicultural and Indigenous Affairs* (2005) 143 FCR 217 at [205], [213]; *Shayan Badraie by his tutor Mohammad Saeed Badraie v Commonwealth of Australia and Ors* [2005] NSWSC 1195 at [28].

22. Accordingly, although the Commonwealth may contract out the services with respect to health, care and control of immigration detainees, it may be liable for the failure by such contractors to reasonably carry out those services.

23. A non-delegable duty of care is not a duty to preserve a person from all harm whatsoever. However, whether the non-delegable duty of care has been satisfied will require consideration of matters like whether the Department has instructed its contractors properly and trained and supervised them adequately. It invites consideration of whether the Department had appropriate systems and processes in place.

24. VIDC is located in Sydney. There are six accommodation compounds at VIDC, three of which are known as Mackenzie, Hotham and Mitchell respectively. Mackenzie and Hotham, both in April 2016 and at present, hold a mix of medium and high risk detainees. As at April 2016, detainees could walk freely between the Hotham and Mitchell Compounds.

25. Many witnesses gave evidence that in recent times there has been a change in the nature of the detainee cohort at VIDC, with a higher number of detainees with a criminal history and less detainees who are what are called "Illegal Maritime Arrivals". This has provided challenges to security at VIDC.

Unavailability of important witnesses:

26. A number of important witnesses were not available to give evidence. The evidence established that Tupou Leaaetoa and Aisea Tikoipau are no longer in Australia, having been removed from Australia by the Department. In addition, the following people who were detainees in the Mitchell Compound are no longer in Australia:[7]

    (a) Dave Callaghan;

[7] Supplementary statement of Dt Sgt Morrell dated 18/9/17 [Exhibit 2].

(b) Vinesh Chand;

(c) Kohi Rolleston;

(d) Markere Hutley; and

(e) Brent Tiddy.

27. Inquiries revealed that two other former detainees, Khaleb Collinson and Lee Mulligan, apparently still reside in Australia but cannot be located.[8]

28. However, NSW Police did speak to many of these witnesses during the period 4 to 6 April 2016 and the notes of those conversations are evidence. In addition, Aisea Tikoipau and Tupou Leaaetoa both participated in electronically recorded interviews on 6 April 2016 and the footage of those interviews was played during the hearing.

Manner and cause of death:

Immediate cause of death was sudden cardiac failure

29. It is not in dispute that the immediate physical cause of Mr Peihopa's death was cardiac failure. However, at the time of his death he was only 42 years old. Despite what is now known about Mr Peihopa's cardiac condition, Mr Peihopa maintained an active physical routine. For example, Mr Karetai said in his statement that Mr Peihopa was a *"big fit guy who did a lot of boxing*".[9] There is therefore a question about what caused Mr Peihopa's sudden cardiac failure. This raises a question about the manner of his death, which I now turn to.

Relevant sequence of events:

Jayde Karetai's account

30. Jayde Karetai is a New Zealand national who was in immigration detention at VIDC as at April 2016. He was friends with Mr Peihopa. He admits he did not give police a full account of relevant matters on the night. However, he later voluntarily approached police and gave them a full account. He later gave a further statement to the Counsel Assisting team. In oral evidence, Mr Karetai

[8] Supplementary statement of Dt Sgt Morrell dated 18/9/17 at [12]-[18] [Exhibit 2].
[9] J Karetai statement dated 1/8/17 at [13] [Exhibit 1, vol 1, tab 38A].

presented as a frank and truthful witness with no obvious motive to lie. I accept his evidence.

31. On the basis of Mr Karatai's evidence, I am able to find that he saw Mr Peihopa on Monday 4 April 2016 in the early evening and was told by Mr Peihopa he suspected that another detainee, Tupou Leaaetoa, had stolen money from him the previous evening.[10] Mr Peihopa was angry and agitated about this.[11]

32. Later that afternoon, Mr Karetai and Mr Peihopa bumped into another detainee, Aisea Tikoipau, who Mr Karetai identified as the leader of the Islanders at VIDC. Mr Peihopa told Aisea Tikoipau that he wanted to speak to him about Tupou Leaaetoa.

33. Early in the evening on 4 April 2016, Mr Karetai and Mr Peihopa were in Mr Peihopa's room (being room 4 of Unit 2 in the Hotham Compound) when Aisea Tikiopau and Tupou Leaaetoa entered. Mr Peihopa accused Tupou Leaaetoa of stealing his money and appeared *"wild"* and *"angry".*[12]

34. Mr Karetai sought to calm Mr Peihopa down by offering to go boxing with him. Mr Peihopa came to Mr Karetai's unit, which was Unit 3 at the Mitchell Compound. Mr Karetai said in oral evidence that Mr Peihopa had gathered together all the people in room 2 of Unit 3 who had been present in the room the previous evening when money had allegedly been stolen and identified them as Kohi, Markere, Kaleb, Tupou and a "*Fijian man".*

35. Mr Peihopa appeared angry and Mr Karetai said he would wait for him at Unit 1 of the Mitchell Compound and did not want any involvement in the dispute.

36. Mr Karatei gave oral evidence that while he was at Unit 1 he heard a loud thud noise come from Unit 3 of the Mitchell Compound. He looked and saw "*the young fellas"* running out of Unit 3, whom he identified as Kahleb, Markete and *"the Fijian fellow".* Mr Karatei also said in oral evidence that he saw the Fijian man run up to Ace (Aisea Tikoipau) and a Samoan (likely Laumua Lalogafau) and saw them walk up to and then inside Unit 3 and after a few minutes' walk back out again.

37. Mr Karetai's account is corroborated in many respects by CCTV footage which will be discussed in more detail below.

38. Mr Karetai said he then saw Mr Peihopa come outside of Unit 3 and sit on a chair. Mr Karetai returned inside Unit 1 but came out a short time later and saw Mr Peihopa lying on his back around the corner from Unit 3.[13] He ran over to Mr Peihopa and commenced CPR. Serco Detention Services Officers

[10] See also J Karetai statement dated 1/8/17 at [26] [vol 1, tab 38A].
[11] See also J Karetai statement dated 1/8/17 at [23] [vol 1, tab 38A].
[12] See also J Karetai statement dated 1/8/17 at [27] [vol 1, tab 38A].
[13] See also J Karetai statement dated 1/8/17 at [40] [Exhibit 1, vol 1, tab 38A].

("DSOs") Garry Kellett and Johnny (Serco) also assisted.[14] Sadly, Mr Peihopa could not be revived.

A fight occurred

39. The evidence establishes that a physical fight involving Mr Peihopa occurred shortly before his death in room 2 of Unit 3 in the Mitchell Compound. This was the room ordinarily occupied by two New Zealand detainees Khalib Collinson and Kohi Rolleston.[15]

40. Mr Karetai did not actually see any fight, but gave evidence consistent with one occurring. Relevantly, he gave evidence of tensions between Tupou Leaaetoa and Mr Peihopa; of hearing noises emanating from Unit 3 consistent with a fight; of seeing detainees running out of room 2 of Unit 3; of seeing Mr Peihopa breathless on a chair; and of seeing fresh injuries on Tupou Leaaetoa the following day.

41. There is no direct witness to the fight, but many witnesses gave evidence which supports the conclusion that a fight involving Mr Peihopa occurred:

    (a) First, detainee Gary Griffiths, who lived upstairs in room 4 of Unit 3 of the Mitchell Compound, said in oral evidence that during the evening of 4 April 2016 he was using the computer upstairs in the common room and heard a lot of banging at around "9-ish" for around half an hour coming from downstairs.[16] He thought the noise was coming from room 2, being the room of Khalib Collinson and Kohi Rolleston. He went downstairs and observed that room 2 was locked and was told by Kohi and Kaleb that *"Rob and the Tongan boy"* were inside. Later he saw another *"Tongan boy"* who was a *"big fellow"* bang on the door (this was most likely Aisea Tikoipau). Mr Peihopa and the first Tongan boy came out and the Tongan boy went into his room. Mr Griffiths observed that Mr Peihopa was breathing heavily and fast and gave him a glass of water.

    (b) Secondly, detainee Wayne Keen, who lived in room 6 of Unit 5 in the Mitchell Compound,[17] said in oral evidence that when he was standing outside of Unit 5, he saw Aisea Tikoipau and Laumua Lalogafau walk down to Unit 3 and knock on a door to which they could not gain access. One of them kicked on the door and they then walked away. Aisea Tikoipau yelled out *"I'll fucking take on you cunts".* However, Mr Keen says that they *"never touched"* Mr Peihopa. He said he later saw Mr Peihopa leaning on a rail outside of Unit 3 and told Aisea Tikoipau

[14] During the course of the inquest I made a non-publication order over the surnames of certain Serco employees and in these reasons I refer to them only by their first names.
[15] A Serco Welfare Check report establishes which detainees occupied which rooms in the Mitchell Compound as at 4 April 2016 [Exhibit 1, vol.3, tab 50RAD].
[16] See signed police notebook statement of W Keen dated 15/4/16 [Exhibit 1, vol.1 tab 41].See also unsigned police notebook at [Exhibit 1, vol.1, tab 15].
[17] See signed police notebook statement of W Keen dated 15/4/16 [Exhibit 1, vol.1 tab 41].

and Laumua Lalogafau that Mr Peihopa was *"not looking good".*[18] Mr Keen said they responded by saying *"Fuck him. Just leave him. Don't worry about him".*

(c) Thirdly, detainee Dave Callaghan (who is no longer in Australia) said to police on 5 April 2016 that he resided in room 5 of Unit 3 at the time and heard loud noises coming from room 2 below him, which sounded like chairs being thrown around and male voices shouting. At around 8.30pm he saw Mr Peihopa come out of room 2 and sit down at the dining table to try and catch his breath. He saw Mr Peihopa go outside and stumble.[19]

42. The CCTV footage is corroborative of the above accounts as follows:

(a) According to CCTV006, Aisea Tikoipau walked towards Unit 3 at 9.11.56pm, and Laumua Lalogafau did so at 9.14.20pm. They both walk back on camera from the direction of Unit 3 at 9.16:33. They both walk back towards Unit 3 at 9.17.30pm and have both returned to outside Unit 5 by 9.19.21pm. This suggests that they went to Unit 3 on two occasions but only for very short periods of time. The CCTV footage is consistent with the accounts of Mr Griffiths and Mr Keen;

(b) According to CCTV814, at 9.26.46pm, a person in a red or orange shirt and black shorts (which is what Mr Peihopa was wearing on the night according to police photos),[20] walks onto camera in the gap between Units 3 and 4 of the Mitchell Compound and collapses. This CCTV footage shows that subsequently, other unidentified people attempt to lift him up and place him on a chair;

(c) According to CCTV006, at 9:37:30pm, a man in black long pants and a black t-shirt with a white logo (most likely Tupou Leaaetoa) walks on camera from the direction of Unit 2/Unit 3. He speaks briefly with Laumua Lalogafau in front of Unit 5 and then sits on a chair in front of Unit 5. He appears to be breathing heavily;

(d) According to CCTV006, at 9.43:40pm a detainee in a grey long sleeve top and black shorts (most likely Lee Mulligan) approaches the guardhouse and Serco guards Garry Kellett and Johnny (Serco) run towards Unit 3 and Mr Peihopa's position.

43. Consistently with the CCTV footage, the Serco security log shows that a "code blue" was called by DSO Garry Kellett at 9.43pm on 4 April 2016. [21] It was at this time that the Serco response to the incident commenced.

[18] See also signed police notebook statement of W Keen dated 15/4/16 [Exhibit 1, vol.1 tab 41].
[19] Police notebook statement of Mr Callaghan's account taken by OIC [Exhibit 1, vol.1, tab 42].
[20] For example, see the photograph of Mr Peihopa in clothing at Exhibit 4 (taken by forensic investigator Snr Const. Catherine Allen).
[21] The Serco Security Manager's handwritten log is an attachment to the statement of Snr Const. Audibert dated 4/5/16 [Exhibit, vol.1, tab 10]. See also statement of Mr Kellett dated 15/4/16 at [5] [Exhibit 1, vol.1, tab 31].

44. The CCTV footage shows that at least two separate people sought to pick Mr Peihopa up once he had collapsed at around 9.26pm. It is unclear who these people are. However, it would appear that at one stage Nenad Rajkovic did try to pick him up. In this regard, Mr Rajkovic, who was a detainee at the relevant time, gave oral evidence that in the evening of 4 April 2016, while he was watching TV in his Unit 2 of the Mitchell Compound, he heard some noise. He went outside and saw Mr Peihopa lying outside on the grass between Units 3 and 4. He was groaning. Mr Rajkovic said he lifted Mr Peihopa up and helped him try to lean on the rail. He then put Mr Peihopa on a concrete path in the recovery position and went to get pillows. He saw detainee Lee Mulligan approach and call the Serco guards. Mr Rajkovic gave a consistent account in his initial conversation with NSW police on 5 April 2016.[22]

45. Lee Mulligan was also a detainee as at 4 April 2016. He provided his account to the police on 4 April 2016 but could not be located to give oral evidence.[23] He told the police that he saw Mr Peihopa lying on his back and "*two Islanders*" were around him trying to turn him over. They looked like they were trying to sit him up.

46. It is possible that the *"two Islanders*" were Kohi Rolleston and Khaleb Collinson. In this regard, according to NSW police notes, Mr Collinson told them that he and Mr Rolleston found Mr Peihopa.[24] However, the evidence does not permit a firm conclusion about who the "*two Islanders"* seen by Lee Mulligan may have been.

47. Laumua Lalogafau, who remains in detention at VIDC, was not completely candid during his oral evidence and he changed his position on a number of occasions. After viewing the CCTV footage, he eventually agreed that he had gone to Unit 3 twice on the evening on 4 April 2016. He would not agree that he was aware there was a fight although he said in oral evidence he was aware that *"something was happening".* I find that in all likelihood he was aware there was a fight.

48. After viewing the CCTV footage, Mr Lalogafau agreed that at about 9.14pm he had walked to Unit 3 with Aisea Tikiopau because he had heard *"something was happening there".* He said*, "everyone was running there".* He also said that on one of those occasions he saw Mr Peihopa sitting on a couch *"huffing and puffing"* and that he offered him a glass of water. He denied knocking on the door at Unit 3. Mr Lalogafau denied that either he or Aisea Tikoipau knocked or kicked on a door in Unit 3. He also denied striking Mr Peihopa.

[22] Police notebook of Snr. Const. Shakila Fawkner [Exhibit 1, vol.1, tab 13].
[23] Notes of Mr Mulligan's account are in exhibit to Det. Snr. Const. Rogerson's statement dated 1/6/16 [Exhibit 1, vol.1, tab 11] and police notes of an interview with Mulligan on 4/4/16 are an exhibit to Snr. Const. Jones' statement [Exhibit 1, vol.1, tab 14].
[24] Notes of Mr Mulligan's account are in exhibit to Det. Snr. Const. Rogerson's statement dated 1/6/16 [Exhibit 1, vol.1, tab 11] and police notes of an interview with Mulligan on 4/4/16 are an exhibit to Snr. Const. Jones' statement [Exhibit 1, vol.1, tab 14].

49. Aisea Tikoipau is now overseas and was not available to give evidence. However, in an electronically recorded interview with NSW police on 6 April 2016, he claimed he was folding washing on the evening of 4 April 2016.[25] This is contrary to the CCTV footage that shows him in front of Unit 5 of the Mitchell Compound and walking back and forth between Unit 5 and Unit 3 of the Mitchell Compound. Mr Tikoipau said he was not aware of any fight occurring involving Mr Peihopa.[26] Mr Tikoipau also claimed that he last saw Mr Peihopa on the Sunday,[27] which is directly contrary to Jayde Karetai's account. I do not accept Mr Tikoipau's version as being truthful.

50. As noted above, Tupou Leaaetoa is overseas and was not available to give evidence. A transcript and video footage of an interview in which he participated on 6 April 2016 is in evidence. In that interview, he maintained that he had not been involved in a fight with Mr Peihopa.[28] He claimed he was watching television in Aisea Tikoipau's room in Unit 5. [29]

51. Based on the CCTV footage seen in the light of witness testimony, it is most likely that the fight had finished by 9.26pm and that by that time Mr Peihopa had come outside to catch his breath. At 9.43pm, Serco guards responded to his collapse. Aisea Tikoipau and Laumua Lalogafau were twice in the vicinity of Unit 3 between 9.11pm and 9.19pm but it is doubtful that during those small periods they could have themselves have been involved in a fight. Further, nothing in their demeanour when they walked back onto camera suggested that they have been involved in a fight. There is insufficient evidence to find that either of them was directly involved in any fight.

52. Also corroborative of a fight having taken place is the evidence of numerous witnesses who said they observed injuries on Mr Peihopa's face at the time of his death:

    (a) Mr Karetai gave oral and written evidence that he observed a large fresh cut on the side of Mr Peihopa's face that he had not seen earlier in the evening; [30]

    (b) Serco DSO Cengiz (Serco) was not available to give oral evidence on medical grounds. However, his written statement indicates that he saw Mr Peihopa at about 8.45pm on 4 April 2016. When he later saw Mr Peihopa's body after he had been declared deceased he observed a scratch and bruising on his face that had not been there when he saw Mr Peihopa at 8.45pm; [31]

[25] Annexure to statement of Snr. Const. Rabih Semaan dated 10/4/16 [Exhibit 1, vol.1, tab 17].
[26] Transcript dated 6/4/16 at p.18 [Exhibit, vol.1, tab 37].
[27] Transcript dated 6/4/16 at p.9 [Exhibit, vol.1, tab 37].
[28] Transcript dated 6/4/16 at p.10 [Exhibit, vol.1, tab 40].
[29] See also J Karetai statement dated 1/8/17 at [42] [Exhibit 1, vol 1, tab 38A].
[30] See also J Karetai statement dated 1/8/17 at [42] [Exhibit 1, vol 1, tab 38A].
[31] Signed police notebook statement of C Khan dated 15/4/15 at [10] [Exhibit 1, vol 1, tab 25].

(c) The forensic pathologist who conducted Mr Peihopa's autopsy, Dr Szentmariay, also said in oral evidence that there was evidence of recent bruising to Mr Peihopa's face, consistent either with blunt force or falling down. He depicted these recent abrasions on a diagram of Mr Peihopa's body in black ink and depicted areas of deeper injury on that diagram in red ink.[32]

53. In addition, photographs taken by forensic investigator Senior Constable Allen of Mr Peihopa's face shortly after his death show apparent fresh grazes and bruising on his face.[33]

54. Chief Inspector David Small's evidence was that he did not observe fresh injuries upon Mr Peihopa's face. That is a question calling for a degree of judgment. However, his judgment is against the weight of the other evidence, including that set out above and also the evidence of attending ambulance officer, Matthew Vernon. Mr Vernon said in evidence that he told an unidentified police officer that the injuries were fresh.

55. The following witnesses also said that they observed injuries on Tupou Leaaetoa:

(a) Mr Karetai said in oral evidence that he observed Tupou Leaaetoa on 5 April 2016 to be "bruised up", have a bruise under his chin and a puffy eye;[34] and

(b) Mr Keen said in oral evidence that on the evening of 4 April 2016, he saw Tupou Leaaetoa come up to his unit (being Unit 5) with wraps on his hands and blood coming out of his mouth.[35]

56. In addition, during Tupou Leaaetoa's interview with NSW Police on 6 April 2016, he was observed to have a swollen lip and swollen right side of his cheek, although he claimed it was a football injury.[36]

57. Mr Lalogafau claimed in oral evidence that he did not observe any injuries on Tupou Leaaetoa. I do not accept that evidence as he was not always a truthful witness.

58. Further evidence corroborative of a fight having taken place is the oral and written evidence of Mr Karetai to the effect that he went into room 2 of Unit 3 on 5 April 2016 and observed *"a fair bit"* of blood on the floor, the walls and a doona.[37] Notably, NSW Police did not forensically test room 2. They only tested room 1, which was Tupou Leaaetoa's room.[38]

[32] [Exhibit 12].
[33] [Exhibit 6].
[34] J Karetai statement dated 1/8/17 at [53] [Exhibit 1, vol 1, tab 38A].
[35] See also signed police notebook statement of W Keen dated 15/4/16 [Exhibit 1, vol.1 tab 41].
[36] Transcript dated 6/5/16 at p.9 [Exhibit 1, vol.1, tab 40].
[37] J Karetai statement dated 1/8/17 at [52] [Exhibit 1, vol.1, tab 38A].
[38] See statement of Snr Const. Claire Power [Exhibit 1, vol.1, tab 24AA].

59. The weight of evidence before me supports the fact that Mr Peihopa was involved in a physical fight immediately before his death and that the fight at least involved Tupou Leaaetoa. It is not possible to say who the aggressor was, although there is evidence that Mr Peihopa had looked for Tupou Leaaetoa earlier that evening and had rounded people up into room 2 of Unit 3. From the injuries sustained to both Mr Peihopa and Mr Leaaetoa it appears that both may have landed blows on the other. However, from all accounts including those of ambulance officer Matthew Vernon (who found no "boggy mass" on Mr Peihopa's head) and NSW Police Forensic Investigator Senior Constable Catherine Allen (who found upon examination that there were no major injuries), as well as Forensic Pathologist Dr Szentmariay, the wounds were superficial and insufficient on their own to cause Mr Peihopa's death.

The SERCO and Ambulance response

60. As mentioned above, Serco called a "code blue" at 9.43pm on 4 April 2016. Records from the NSW Ambulance Service show that it was called at 9.45pm and that the first ambulance was assigned at 9.48pm and arrived at the gates of VIDC at 9.58pm.[39]

61. Matthew Vernon, one of the attending ambulance paramedics, gave evidence that he reached Mr Peihopa at 10.02pm at which time Mr Peihopa was asystole, that is, "flat lining". Mr Vernon continued to perform CPR and performed the asystole protocol until 10.17pm. Mr Peihopa was non-responsive and was declared deceased at 10.17pm.

Forensic evidence

62. The forensic pathologist who conducted the autopsy on Mr Peihopa, Dr Istvan Szentmariay, found that present in Mr Peihopa's blood was methamphetamine of 1.8 mg per litre and 0.08 mg per litre of amphetamine. [40] Expert toxicologist, Professor Alison Jones explained in oral evidence that as methamphetamine breaks down it metabolises into amphetamine, and that in her opinion Mr Peihopa had only ingested methamphetamine. Dr Szentmariay agreed. Professor Jones also said the best estimate was that Mr Peihopa had ingested it only a few hours before his death.

63. The autopsy also revealed that Mr Peihopa had a focally severe narrowing of the right coronary artery of up to 80 to 90% and that this in itself was known to cause sudden death. Dr Szentmariay said in his autopsy report that the direct cause of Mr Peihopa's death was methamphetamine toxicity complicating ischaemic heart disease.[41]

[39] [Exhibit 1, vol.2, tabs 47-49].
[40] Autopsy Report [Exhibit 1, vol.1, tab 3].
[41] Autopsy Report [Exhibit 1, vol.1, tab 3].

64. A question of causation arises as to whether ischaemic heart disease on its own caused Mr Peihopa's death or the ingestion of methamphetamine on its own caused death or whether it was a combination of the two, and whether the fight in which Mr Peihopa was involved was also a contributing factor.

65. Along with Professor Alison Jones, Professor Mark Adams, an interventional cardiologist, also gave evidence. Both experts agreed that:

    (a) it depends upon the particular individual as to what is a toxic (that is, lethal) dose of methamphetamine, but 1.8mg/l was well within the fatal range; and

    (b) methamphetamine has an effect on the heart, making the heart beat faster (tachycardia) and a risk of arrhythmia (an irregular rhythm).

66. Professor Jones also gave oral evidence that she would not expect to see a man *"of 40"* with the degree of narrowing of the arteries that Mr Peihopa had and explained that methamphetamine use can cause this.

67. There is no evidence that Mr Peihopa was aware that he had ischaemic heart disease. His mother, Mrs Hera Peihopa was not aware of such a history and neither was his ex-partner, Ms Anastasia Kalaboukis, or his partner at the time of his death. In a NSW Justice Health screening tool, Mr Peihopa indicated that he had no diagnosed heart disease.[42]

68. Dr Szentmariay said in oral evidence that the likely cause of death was methamphetamine toxicity complicating ischaemic disease. He explained that Mr Peihopa's heart disease alone could have caused his death but given that it was present in the weeks before his death, methamphetamine must also have played a role. Dr Szentmariay agreed that involvement in a fight could also possibly be a contributing cause, although evidence that Mr Peihopa was struggling for breath in the period before he died could equally be consistent with methamphetamine toxicity.

69. Professor Jones said in oral evidence that her view of the likely cause of death was cardiac arrhythmia due to methamphetamine exposure. She also agreed that the emotional or physical response to being involved in a fight could, in the circumstances of methamphetamine usage and narrowed arteries, have contributed to the arrhythmia.

70. Professor Adams said in oral evidence that the most likely cause of death was the trigger of a physical fight and ingestion of methamphetamine against a background of chronic coronary artery disease. He explained in his report that while the chronic coronary artery disease carried with it some risk of sudden death, it was stable and *"the immediate risk of death would not have been high".*[43] He said:[44]

[42] [Exhibit 1, vol.3, tab 56A].
[43] Report of Professor Adams dated 2/9/17 at p.2 [Exhibit 1, vol.3, tab 50RBA].
[44] Report of Professor Adams dated 2/9/17 at p.2 [Exhibit 1, vol.3, tab 50RBA].

"in the presence of other triggers such as physical exertion, emotion stress or prothrombotic stimuli such as dehydration and cigarette smoking the risk of sudden cardiac death and myocardial infarction would have been greatly increased compared to someone with normal coronary arteries."

71. Professor Adams also said in his report that *"increased physical activity and stress, as might be seen in a violent confrontation, has long been associated with an increased risk of sudden cardiac death".*[45] However, he said that while the physical fight in which Mr Peihopa was involved on 4 April 2016 may have been more demanding than previous sessions in the gym *"it seems less likely that this alone would have triggered a cardiac arrest".*[46] He thought it was *"almost certain that methamphetamine contributed to Mr Peihopa's cardiac arrest".* [47]

72. Professor Adams concluded that:[48]

"the combination of significant coronary artery disease, high levels of physical and emotional stress as well as toxic levels of methamphetamine are more likely to have resulted in death in combination rather than any one factor having been responsible."

73. In view of the agreement by Dr Szentmariay and Professor Jones that involvement in a physical fight may have been a trigger and Professor Adams' firm view that it was, I find that the fight, the methamphetamine and the underlying heart disease all contributed to Mr Peihopa's death.

Conclusions on manner and cause of death:

74. Section 81 of the *Coroners Act 2009* (NSW) requires me to make a finding as to the manner and cause of Mr Peihopa's death.

75. The evidence before this inquest supports the finding that the immediate cause of Mr Peihopa's death was a fatal cardiac arrhythmia. The circumstances that contributed to this were his underlying chronic coronary artery disease and the triggers of ingestion of methamphetamine in the hours before his death and the physical and emotional distress arising from his involvement in a fight immediately prior to his death.

Recommendations:

76. Under s.82(1) of the *Coroners Act 2009* (NSW), a coroner may make such recommendations as are considered necessary or desirable to make in relation to any matter connected with the death with which this inquest is

[45] Report of Professor Adams dated 2/9/17 at p.2 [Exhibit 1, vol.3, tab 50RBA].
[46] Report of Professor Adams dated 2/9/17 at p.2 [Exhibit 1, vol.3, tab 50RBA].
[47] Report of Professor Adams dated 2/9/17 at p.3 [Exhibit 1, vol.3, tab 50RBA].
[48] Report of Professor Adams dated 2/9/17 at p.3 [Exhibit 1, vol.3, tab 50RBA].

concerned. By and large, recommendations have a protective purpose, their aim being to prevent the occurrence of similar deaths in the future. I consider that it is desirable to make recommendations in this case.

77. The recommendations I make concern the Department and Serco. I have taken into account the submissions of all the interested parties and I am pleased to note that the submissions made on behalf of the Department indicate that the Department agrees with the proposed recommendations and welcomes them.

78. I have taken into account the submissions made on behalf of Serco in relation to the proposed recommendations and note that even where Serco submitted that the underlying facts and contentions were not supportive of proposed recommendations, Serco is willing to consider the recommendations in consultation with the Department. Serco has submitted that it *"supports reasonable and practicable steps which it might take or might be taken by the Department which will enhance the wellbeing of detainees and improve effective co-operation between stakeholders within the immigration detention system."*[49]

Was there an adequate level of supervision?

79. Based on witness accounts and the CCTV footage, it is most likely that the fight in which Mr Peihopa was involved took place over an extended period of time (on Mr Griffiths' account around half an hour) and was over by 9.26pm when Mr Peihopa was captured on CCTV footage stumbling outside. The CCTV footage then captures him collapsing on a number of occasions and at least two different people trying to pick Mr Peihopa up. Notwithstanding that two Serco DSOs were on duty in the Mitchell Compound, a "code blue" was not called until 9.43pm. Thus, a period of some 17 minutes elapsed between when Mr Peihopa first collapsed outside and when he was detected by Serco staff.

80. Some detainee witnesses, but not all, gave evidence of a commotion in the lead up to Mr Peihopa's death:

    (a) Mr Karetai gave oral evidence that he could hear loud noises from Unit 3 while he was in Unit 1 and he could not understand why Serco guards could not hear this; and

    (b) Mr Griffiths said in oral evidence that he observed around 9 or 10 detainees outside of Unit 3 and Unit 4 at the time that Mr Peihopa came out of room 2 and sat down.

81. However, Mr Rajkovic said in oral evidence that prior to hearing Mr Peihopa groaning, he did not hear any loud noises. Nor, while he was in Unit 2 did he observe people coming and going from Unit 3.

[49] SERCO closing submissions, 31 October 2017

82. Not only was Mr Peihopa's collapse undetected by Serco DSOs but so was:

(a) the fact that Mr Peihopa rounded up a large number of people and directed them into room 2 of Unit 3 (on Mr Karetai's account);

(b) the noise that some witnesses say was emanating from room 2; and

(c) Mr Tikoipau and Mr Lalogafau going down to room 2 and banging and kicking on the door and swearing.

83. The two Serco DSOs on duty in the Mitchell Compound on the evening of 4 April 2016 were Garry Kellett and Johnny (Serco). They each did a 12 hour shift. Mr Kellett has now passed away.

84. Johnny (Serco) gave oral evidence that he and Mr Kellett were responsible for supervising about 60 detainees. According to Amit (Serco), the Serco Detainee Service Manager at the relevant time, among other things, this involved doing two welfare checks each shift on all detainees in the Mitchell Compound. Johnny (Serco) also gave evidence that he performed functions such as making detainees drinks.

85. The view attended by all interested parties illustrated that the compound area in the Mitchell Compound was not large. The guardhouse was positioned so that each unit within the compound was visible to it. All units had glass sliding doors to facilitate a view inside.

86. The view showed that there were computer screens in the guardhouse displaying CCTV footage. When sitting at the desk in the guardhouse it would have been necessary for a Serco DSO to look up and away from the computer screens to see outside and across to Unit 3 and its surrounds.

87. Johnny (Serco) said he did not notice any disturbance on the evening on 4 April 2016. He says he did not hear any loud noises and did not see detainees congregating outside of Unit 3.

88. Mr Kellett signed a statement on 15 April 2016. He said he was checking his emails in the Serco guardhouse and then looked up and saw a male detainee on his back. He ran outside and was met by detainee Lee Mulligan who said there was something wrong with Mr Peihopa.[50] It follows from this evidence that Mr Kellett did have a clear view of the point where Mr Peihopa collapsed. It was not out of sight of the guardhouse. For this reason, I reject the submission from Serco that Mr Peihopa collapsed in a "*blind spot*".

89. Mr Kellett also said in his statement:

"Usually if there is a fight in the yard there is a lot of yelling and noise and I didn't hear any of that before seeing [Mr Peihopa] on the ground."

[50] Statement of Mr Kellett dated 15/4/16 at [3]-[4] [Exhibit 1, vol.1, tab 31].

90. Joe (Serco), the Serco Centre Manager at VIDC, said in oral evidence that in his view two DSOs were sufficient in the compound. The most plausible explanation for why Johnny (Serco) and Mr Kellett did not observe Mr Peihopa's collapses and attempts by detainees to pick him up between 9.26pm and 9.43pm is because they were "spread too thin" in discharging their responsibilities.

91. Mr Peihopa's family submitted that I should recommend that the day-to-day supervision of detainees at VIDC should follow a ratio of one DSO for every 20 detainees. However, there was insufficient evidence before me to form a view about what particular supervision ratio may be appropriate in the circumstances.

Recommendation 1

92. **The Department and Serco should each review the circumstances of this matter and give consideration to whether two DSOs in the Mitchell Compound is sufficient to provide an adequate level of supervision and security.**

The presence of ice and other drugs at VIDC

93. I am satisfied that at the time of Mr Peihopa's death there was a widespread presence of ice and other illegal drugs at VIDC for the following reasons.

94. Almost all detainees or former detainees who gave oral evidence said that whilst at VIDC they consumed ice or other illegal drugs. A number of Intelligence Reports are in evidence which show that drugs or drug paraphernalia are regularly detected during searches at VIDC and that a significant number of detainees are involved in drug supply.

95. Mr Karetai gave oral evidence that it was *"easy"* to get ice at VIDC and a person "*could get anything in there".* He said in his written statement that *"the drug ice is everywhere at VIDF"*.[51]

96. Mr Keen said in oral evidence that he was on ice and marijuana daily in VIDC and that *"everyone is fried in there".*

97. Mr Lalogafau said that on the evening of 4 April 2016 he was *"stoned"* on marijuana. He said he had used ice at VIDC and it was *"easy"* to obtain. He also said he was currently on the methadone program run by IHMS.

98. DSO Johnny (Serco) also said he was aware there was ice at VIDC. Ms Kerrie Pennell, the Inspector of Detention Operations with the Australian Border Force at VIDC, also agreed she was aware of drug use at VIDC.

[51] J Karetai statement dated 1/8/17 at [59] [Exhibit 1, vol 1, tab 38A].

99. Joe (Serco), the Serco Centre Manager of VIDC, said that drugs were present at VIDC but he did not consider it a *"significant problem".* He said the level of presence of drugs was consistent with other centres within the immigration detention network. Similarly, Ms Holben, the Commander of Detention Operations, said that drugs were a problem at VIDC but it was not a *"serious problem".*

100. An associate of Mr Peihopa's who gave oral evidence at the hearing and whose name has been suppressed said that she supplied ice to Mr Peihopa on six occasions whilst he was at VIDC.

101. A Serco Intelligence Report dated 2 September 2015 recorded that information had been received on 2 September 2015 that "*most of the detainees in Mackenzie company are using drugs, many of them intravenously*". It also referred to information from Stakeholder Information Sheet ("SIS") Staff that five detainees in the Mitchell company had been using and selling drugs. The report also noted that in four separate rooms drug paraphernalia was located, which was tested and revealed the presence of cannabis and methamphetamine. The report set out profiles for nine detainees believed to be involved in drug use.[52] This was assigned an admiralty rating of "*B2*", which means B ("*usually reliable*") and 2 ("*probably true*").[53] Notably, this is an Intelligence Report rather than a Security Information Report (**SIR**) and was therefore "assessed" rather than "raw" intelligence.[54]

102. The Serco Intelligence Report dated 2 September 2015 concluded:[55]

> *"SIS Intel assess as CERTAIN detainees are using and supply illicit substances at VIDC … SIS Intel assess as PROBALE illicit drugs and implements [REDACTED] to avoid detection and detainees being held personally accountable if located. SIS Intel assess as PROBABLE detainees using and supplying drugs are residing in close proximity to the cached items for easy access and distribution. SIS Intel assess as PROBABLE the illicit substances are trafficked [REDACTED] based on current intelligence holdings, by persons able to [REDACTED]. SIS Intel assess as LIKELY detainees will continue to seek alternate methods for drug secretion and trafficking in an attempt to avoid detection by SIS staff.*
>
> *SIS Intel assess as LIKELY given the location of multiple syringes, the potential for detainees to share intravenous needles could increase the spread of communicable disease. SIS Intel assess as LIKELY detainees partaking in illicit substance use are at risk of overdose which could have fatal*

[52] Intelligence Report [Exhibit 1, vol.3, tab 68].

[53] Intelligence Report at last page [Exhibit 1, vol.3, tab 68].

[54] As Serco submits at [37], SIRs "*document source (ie raw) intelligence which is then assessed by Serco's Intelligence team who produce Intelligence Reports*".

[55] [Exhibit 1, vol.3, tab 68].

consequences. Furthermore, SIS Intel assess as PROBABLE the incidents of adverse behaviours at VIDC will continue to increase with detainees using and distributing illicit substance, placing staff and other detainees at further risk." (emphasis added)

103. In addition to the above, an Intelligence Report dated 14 December 2015 profiled five separate detainees suspected of drug use at VIDC.[56] Further, an Intelligence Report dated 7 January 2016 referred to intelligence from SIS staff that five detainees in the Banksia compound were observed under the influence of an unknown substance. The report set out profiles for ten detainees (including Mr Peihopa) believed to be involved in drug use. The intelligence was assigned an admiralty rating of "C2" (fairly reliable/probably true).[57]

104. It goes without saying that drug and alcohol use at VIDC creates risks to the welfare and safety of detainees whilst in detention. Ms Pennell agreed in oral evidence that the Department had responsibility for addressing these identified risks.

105. The evidence established that IHMS runs a methadone program at VIDC. However, it is unlikely that a methadone program would provide any assistance to a detainee with an ice addiction. Given the apparent prevalence of ice at VIDC it may be of assistance to develop a rehabilitation program specifically targeted at ice. Ms Holben gave evidence that VIDC is on a trial program to provide drug treatment programs but did not provide any further evidence about this.

Recommendation 2

106. **The Department should liaise with IHMS about developing and making available at VIDC a rehabilitation program specifically targeted at ice users.**

107. It seems unlikely that detainees would self-report drug and alcohol problems to the Department and Serco, since they would naturally enough be concerned that it would affect their immigration pathway.

Recommendation 3

108. **The Department should investigate ways to facilitate drug and alcohol rehabilitation programs being provided to detainees who require them.**

Search and screening powers at VIDC

109. The presence of ice and other drugs at VIDC also raises a question about the adequacy of search and screening powers at VIDC. The present entry control

[56] Intelligence Report [Exhibit 1, vol.3, tab 70].

[57] Intelligence Report [**Exhibit 1, vol.3, tab 74**].

and search and screen obligations imposed upon Serco are set out in cl.2 of Section 4 of Schedule 2 to the Contract.[58] Relevantly, Serco must use its best endeavours to detect Illegal Items (which include illegal drugs) and must screen all persons and personal belongings entering an immigration detention facility. However, under cl.2.3(b), screens and searches may only include the use of metal and other material or substance detectors; the use of x-ray machines and visual inspections.

110. Joe (Serco), the Serco Centre Manager, and Grant (Serco), the Serco Security and Risk Manager, both gave evidence of the search and screening procedures utilised at VIDC and of the limitations on search and screening powers. They emphasised that VIDC was not a prison and the search and seizure powers were not the same as those available in correction centres.

111. The Department submitted that the *Migration Amendment (Prohibiting Items in Immigration Detention Facilities) Bill 2017*, will, if enacted, enhance search and seizure powers. However, the Bill has been referred to the Senate Standing Committee on Legal and Constitutional Affairs for further consideration. At this stage, there is no guarantee that it will be enacted in its current form.

112. The evidence of widespread drug use at VIDC highlights the need for increased search and seizure powers to prevent illegal drugs from finding their way to detainees where they create serious security and welfare risks.

Recommendation 4

113. **Search and seizure powers available at immigration detention facilities should be enhanced to (a) prevent the entry of illegal drugs into immigration detention centres and (b) detect illegal drugs which have entered immigration detention centres.**

Mr Peihopa's involvement with ice

114. The evidence supports the conclusion that Mr Peihopa had a long-standing addiction to ice:

(a) his mother and former partner, Ms Kalaboukis, gave oral evidence of his long usage of ice;

(b) a NSW Justice Health D&A form dated 5 May 2007 records that Mr Peihopa reported using ice on a daily basis, with his last use being on 4 February 2007;[59]

(c) during Mr Peihopa's 12 September 2007 sentencing hearing, his then counsel referred to his "amphetamine habit" and that he was using two

[58] [Exhibit 1, vol.2, tab 50].
[59] [Exhibit 1, vol.3, tab 52A].

hundred dollars per week on the drug.[60] His counsel submitted that after a period of four to five years of abstinence, he commenced re-using ice in August 2005;[61]

(d) a NSW Justice Health Screening tool dated 20 April 2012 indicated that Mr Peihopa thought he had a problem with ice and a detox program was planned; [62]

(e) a NSW Justice Health D&A Clinical Follow-Up form recorded that Mr Peihopa had had an "ice overdose" in April 2012, resulting in an admission to Canterbury Hospital. The sheet recorded that Mr Peihopa snorted 1 gram of ice daily ($600 worth);[63]

(f) a Probation and Parole report noted that on 24 June 2012 Mr Peihopa was charged with possession of crystal meth whilst in custody.[64]

115. In addition, it appears that IHMS was aware that Mr Peihopa had a history of ice usage, since in the immediate aftermath of Mr Peihopa's death, IHMS reported that it was aware that Mr Peihopa was an ex-intravenous ice user and had undertaken a detox program whilst in prison.[65]

116. Further, Serco had information available to it suggesting that Mr Peihopa possessed and used drugs whilst in detention:

(a) on 29 November 2015, a routine search of the room that Mr Peihopa shared with another detainee revealed $150 (money was banned at VIDC) and drug paraphernalia.[66] Given that the room was occupied by only two people, a reasonable inference is that the money and drug paraphernalia did belong to one of the two occupants;

(b) a Security Intelligence Report dated 6 January 2016 ("SIR") recorded that an informer had been told by detainees that Mr *Peihopa "has been accessing drugs thrown over the fence as well as from his visitor named [name suppressed]. [Name suppressed] is a recent visitor and has been seeing detainee Peihopa for approximately six weeks"*.[67]

117. However, it does not appear that this information informed the management of Mr Peihopa. Grant (Serco), who was the Security and Risk Manager at the time and who was made aware of the SIR at the time, could not say that any special supervisory arrangements had been made for Mr Peihopa on the basis of this intelligence. Grant (Serco) said that he did not issue any

[60] Transcript 2/13 and 2/23-25 [Exhibit 1, vol.3, tab 53].
[61] Transcript 3/1-3 [Exhibit 1, vol.3, tab 53].
[62] [Exhibit 1, vol.3, tab 56A].
[63] [Exhibit 1, vol.3, tab 56B].
[64] [Exhibit 1, vol.3, tab 58].
[65] [Exhibit 1, vol.4, tab 89].
[66] Security Information Report dated 29/11/15 [Exhibit 1, vol.3, tab 69]. See also Incident Detail Report [Exhibit 1, vol.4, tab 98].
[67] [Exhibit 1, vol.3, tabs 73 and 74].

instructions in relation to the supervision of Mr Peihopa on the basis of this information.

118. Mr Peihopa's Department Case Manager, Graham, said he was not aware of Mr Peihopa's history with drugs and was not aware of the information in the 6 January 2016 SIR. He said in oral evidence that Case Managers have a limited role with respect to detainee health and welfare and little liaison with Serco. He suggested that the first point of contact for a detainee welfare issue was a Serco Personnel Officer. However, in re-examination he said that it was the Departmental Case Officer who bore the ultimate responsibility for a detainee's welfare. Aside from the methadone program, he was unaware as to what other drug and alcohol programs may have operated for detainees at VIDC.

119. "Graham" had no recollection of his interactions with Mr Peihopa. He said that he was surprised that he had not been made aware of the SIR and that it "*would have been nice to know what was happening".*

120. Ms Kerrie Pennell, the Department's Inspector of Detention Services at VIDC, said it was unlikely that such information would be made known to a Case Manager although she agreed that the Case Manager did have *"some"* responsibility for the detainee's welfare. She suggested that the Serco Personnel Officer also had responsibility for a detainee's welfare.

121. Further, the history that Mr Peihopa was an ex-IV ice user and the January 2016 SIR were not disclosed in the monthly Individual Management Plans **("IMPs")** prepared in relation to Mr Peihopa by his various Serco Personnel Officers (and according to IMPs in Exhibit 1 he had at least five different Personnel Officers during his period at VIDC).[68] Joe (Serco) agreed in answer to a question from Serco's counsel that it would have been *"utterly stupid*" to disclose the information in the SIR in the IMP since Mr Peihopa signed the IMP. However, this begs the question of whether the Personnel Officer should be informed of this information, which on any view, goes to a core welfare and security concern relating to Mr Peihopa. Clearly, the information could have been framed in such a way in the IMPs so as not to disclose the source of the information. It is telling that cl.1.7(c) of Section 4 of Schedule 2 to the Contract expressly provides that Serco must:

"*consider the Detainee Security Risk Assessment and intelligence data holdings when developing Individual Management Places …"*

122. It appears that this did not happen in the present case. Ms Holben was of the view that the information should have been communicated to the Serco Personnel Officer.

123. Additionally, the Detention Services Manager who was rostered-on on 4 April 2016, being Amit (Serco), was not aware of the SIR. DSO Johnny (Serco)

[68] See for example the Individual Management Plan dated 21/1/16 being the first one after the 6/1/16 SIR [Exhibit 1, vol.3, tab 77].

also said in oral evidence that he was not aware of information that Mr Peihopa used drugs (however, it is to be noted that Mr Peihopa was accommodated at the Hotham Compound rather than the Mitchell Compound). DSO Johnny (Serco) agreed in oral evidence that it would be useful for him, as a DSO, to be made aware of information that particular detainees were using drugs as he would *"be more careful".*

124. No witness from Serco was able to positively confirm in oral evidence that the intelligence on Mr Peihopa did inform his management. No documents established this either, including Mr Peihopa's monthly Individual Management Plans.

125. I am satisfied that no-one who was involved in the management and supervision of Mr Peihopa on the ground was made aware of information which suggested that he continued to use drugs at VIDC. Had these people been made aware they may have been more vigilant towards the supervision of Mr Peihopa. Further, they may have been able to guide him towards suitable rehabilitation programs operated by or on behalf of IHMS.

126. When asked what procedures were in place for DSOs to be made aware of information in intelligence reports, Amit (Serco) said it was a matter that was discussed orally during shift handover. This appears to be an *ad hoc* way of transferring information, which leads to obvious gaps.

Recommendation 5

127. **The Department and Serco should review their procedures to facilitate greater sharing of information about suspected drug and alcohol use by detainees with staff members who have supervision or welfare responsibilities towards those detainees.**

Recommendation 6

128. **Serco should review the way in which it manages intelligence holdings suggesting detainees are using illegal drugs or alcohol in order to ensure that adequate supervision arrangements are in place in relation to such detainees.**

129. It seems clear that IHMS had obtained some information from NSW Corrective Services or Justice Health about Mr Peihopa's history of drug use.[69] Grant (Serco) agreed it would be useful in the management of detainees to have this information as a matter of course. However, he was not aware of any protocol between Serco and Corrective Services for sharing such information. He suggested that there were privacy problems in obtaining this information. In contrast, Ms Holben said that health treatment information from the correctional context can be passed on. Therefore, it appears there is

[69] [Exhibit 1, vol.4, tab 89].

some level of confusion amongst relevant agencies about what information can be obtained for the purpose of immigration detention.

130. There was also evidence that an increasing proportion of detainees at VIDC were people whose visas had been cancelled on character grounds and who therefore had a custodial history.

Recommendation 7

131. **The Department should investigate with NSW Corrective Services and NSW Justice Health options for obtaining information from them about a detainee's custodial history including information regarding their behaviour whilst in custody, health and welfare and any history of drug and alcohol use, and options for making this information available to both Serco and IHMS.**

Lack of investigation by SERCO and the Department

132. The evidence reveals that neither the Department nor Serco conducted their own investigations into the events leading to Mr Peihopa's death.

133. Extracts of the Contract are in evidence.[70] Clause 3 of the Contract requires Serco to provide *"Services"* to the Department. According to the Glossary to the Contract, these *"Services"* include the services set out in Schedule 2 to the Contract, entitled *"Statement of Work"*. In turn, Schedule 2 is divided into a series of sections. Of present relevance is Section 4, which is entitled *"Security Services".*

134. Clause 4 of Section 4 is entitled *"Incident Management".* Relevantly, cl.4.1(a) provides that the *"Service Provider"* (i.e. Serco) must manage all incidents. Clause 4.1(b) provides that Serco *"will manage all Incidents unless the Department exercises a Step-in Right"*. Ms Vanessa Holben, Commander Detention Operations, confirmed in oral evidence that the Department had not exercised a step-in right in this case. She also said that the Department was the handover point to the NSW police and the matter became a NSW police investigation *"with Serco in support".*

135. Clause 4.7 of Section 4 imposes various reporting requirements upon Serco in the event of a "Critical Incident" occurring. Mr Peihopa's death in detention was a "Critical Incident". Further, in relation to a Critical Incident, cl.4.8 imposes an obligation upon Serco to:

"conduct a post-Incident review to:

(A) determine the causes and contributing factors to the Incident (including relevant Security Intelligence);

[70] [Exhibit 1, vol.2, tab 50].

(B) analyse and evaluate the actions taken in response to the Incident, including the conduct of Service Provider Personnel;

(C) identify any gaps in processes, procedures and training requirements; and

(D) make appropriate recommendations and implement any necessary changes …"

136. Serco's post-incident review into Mr Peihopa's death, dated 12 April 2016, was in evidence.[71] Grant (Serco), who at the relevant time was the Serco Security and Risk Manager at VIDC, said in evidence that he drafted this document. I find that certain important information was not included in this document:

(a) first, no reference was made to Serco's intelligence holdings that Mr Peihopa had been supplied with ice and had previously been found with $150 (money was banned at VIDC) and drug paraphernalia (note that the report does say at p.6 that he had been found with "contraband", but the kind of contraband is not identified);

(b) secondly, no express reference was made in the report to the fact that security cameras captured Mr Peihopa collapse at 9.26pm but there was no Serco response until 9.43pm, leaving a gap of 17 minutes (although I note that p.4 of the report which shows stills from the thermal CCTV camera does bear time marks); and

(c) thirdly, the report stated that *"Whilst there has been speculation in the media that Detainee Peihopa's death may have been linked to a group of detainees he has previously had disputes with and who were allegedly sighted in the vicinity at the time of his death, at this stage there is no supporting evidence."*

137. As to the first point, Ms Holben said it was a *"serious omission"* for Serco not to include this information in the report.

138. As to the third point, evidence emerged that in fact Serco had not conducted any of its own enquiries and had not kept abreast of the police investigation. Accordingly, the basis for the assertion is questionable. Further, Ms Holben said it was important to get that information right since it could have affected the Department's ongoing response in terms of ensuring safety and security.

139. The report asserted that the matter was subject to an ongoing police investigation and coronial investigation. The report then asserted *"Accordingly, it is inappropriate to draw any conclusions in the context of contributing factors to his death".* It is unclear to me why it was inappropriate for Serco to draw any conclusions. In fact, the assertion appears to be

[71] Serco Post Incident Review [Exhibit 1, vol.4, tab 109].

inconsistent with Serco's contractual obligation under cl.4.7 of Section 4 of Schedule 2 to the Contract. Moreover, Ms Holben gave evidence that it would not be inappropriate.

140. In oral evidence it emerged that the Centre Manager, Joe (Serco), had no awareness that there was information suggesting that Mr Peihopa had been involved in a fight immediately prior to his death. He said that assuming that there had been a fight it was a concern to him that he had no knowledge of it and it had not been reported to him.

141. At the outset of oral evidence, Grant (Serco) agreed it would be "prudent" for Serco to keep abreast of police investigations. However, Joe (Serco) said that the only steps that Serco took to keep abreast of the police investigation was to obtain information from Ms Kerrie Pennell, the Departmental Inspector of Detention Operations at VIDC.

142. Joe (Serco) said he did not personally take any steps to investigate and did not require anyone else from Serco to do so. He did not accept that Serco had any responsibility for this and suggested that it was the responsibility of the Australian Border Force.

143. Chief Inspector Small said in oral evidence that he could see no reason why the Department or Serco could not continue with their own inquiries. However, he also said that he would be concerned if Serco had questioned witnesses before the NSW Police had access to them.

144. Similarly, Ms Holben said in oral evidence that it would not compromise a police investigation for Serco to conduct its own enquiries.

145. Grant (Serco) agreed in oral evidence that at no time did the NSW Police ask him that Serco not conduct its own investigation.

146. Grant (Serco) said in oral evidence that Serco was *"not allowed"* to have direct contact with the NSW police. He originally claimed that Superintendent Brent Totten had told him this but then resiled from this saying there was nothing in writing and he was not given any instruction to this effect. He said he was not aware that Serco officers had in fact contacted police in the days following the incident and asked them to attend at VIDC to view CCTV footage.

147. Ms Holben said that at no point had the Department given any instruction to Serco not to deal with the police or ask about the police investigation. Her expectation was that Serco would keep abreast of the police investigation. She also said that the Department relied upon Serco to provide an accurate account of events to it.

148. Ms Kerrie Pennell, the Departmental Inspector of Detention Operations at VIDC, attended at VIDC at 10.40pm. She agreed in oral evidence that there was *"conversation"* on the night of 4 April 2016 that Mr Peihopa had been involved in a fight although when detainees were questions *"we were met by*

silence". However, she said that the possibility that there had been a fight had not been excluded by 5 April 2016. Indeed, at 2.34pm on 5 April 2016, Ankica Romic (Assistant Director, NSW Case Management) emailed Ms Pennell stating:[72]

"Further to our brief discussion on this, below information/commentary received from CMs [presumably case managers] from detainees".

149. There was then a reference to a report from detainee Lee Mulligan that when he entered the room where Mr Peihopa was found there were two other detainees standing above Mr Peihopa and he suspected foul play.

150. Despite this, some time on 5 April 2016, the Department issued a media release stating in relation to Mr Peihopa:[73]

"*The man, who was in detention due to his visa being cancelled, is thought to have suffered a heart attack.*

The Department <u>can confirm</u> there were no disturbances at the centre last night. It is not aware of any suspicious circumstances surrounding the death." (emphasis added)

151. This media release was publicly available, including to Mr Peihopa's family.

152. It does not appear that at the time this media release was issued that there was any basis upon which the Department could have "confirmed" there were no disturbances. Ms Holben said in oral evidence that she had approved this media release. She said she had relied on information provide to her by Ms Pennell. She agreed that, in hindsight, the media release did not seem *"quite right".*

153. In summary, it appears that inaccurate or incomplete information was passed by Serco to the Department about the circumstances giving rise to the death, and that the Department itself placed information into the public domain which was not correct. At least some of this difficulty appears to have arisen because Serco and the Department did nothing to themselves inquire into the circumstances surrounding Mr Peihopa's death. Nor did they keep abreast of the police investigation. As Ms Holben said in oral evidence, this could have ongoing implications for security and welfare at VIDC.

Recommendation 8

154. **The Department and Serco should develop a protocol which:**

(a) clarifies their respective roles in enquiring into the background and circumstances giving rise to a Critical Incident;

[72] [Exhibit 1, vol.4, tab 104].
[73] Media release [Exhibit 1, vol.4, tab 104A].

(b) clarifies the means by which they will keep abreast of developments of any police investigations.

Informing Next of Kin

155. Mr Peihopa's mother, Mrs Hera Peihopa, gave evidence that she was first notified of her son's death via messages from other detainees. She repeatedly called VIDC that evening and into the early hours of the following morning. She was told that someone would call her back but no-one did. It can only be imagined how distressing this was for her. Eventually, the NSW police informed her of her son's death.

156. Ms Pennell said that on the night that Mr Peihopa died she could not get access to the visitor logs to find Mr Peihopa's next of kin. She also said in oral evidence that there was no written policy that it was the responsibility of the Department to notify the next of kin of a death in detention. In fact, this is not correct. The Department's "Death in Detention" procedure provides at cl.47 that "the department's centre manager is responsible for notifying the next of kin in the event of a death".[74] She agreed that there might be a role for the development of a departmental protocol for notifying next of kin in a timely manner.

157. Mrs Peihopa also gave evidence that after her son's death, no-one from the Department or Serco provided her with support or follow up regarding his death. This was notwithstanding that Mr Peihopa had died whilst under their care and control.

Recommendation 9

158. **The Department and Serco should develop a protocol for notifying in a timely manner the next of kin of the death of a detainee and a representative of both the Department and Serco should communicate with the next of kin to acknowledge with appropriate sensitivity the death of their loved one while in Serco and the Department's care and control.**

Summary of recommendations

1. The Department and Serco should each review the circumstances of this matter and give consideration to whether two DSOs in the Mitchell Compound is sufficient to provide an adequate level of supervision and security.

[74] "Death in Detention" procedure [Exhibit 1, vol.2, tab 50RA]

2. **The Department should liaise with IHMS about developing and making available at VIDC a rehabilitation program specifically targeted at ice users.**

3. **The Department should investigate ways to facilitate drug and alcohol rehabilitation programs being provided to detainees who require them.**

4. **Search and seizure powers available at immigration detention facilities should be enhanced to (a) prevent the entry of illegal drugs into immigration detention centres and (d) detect illegal drugs which have entered immigration detention centres.**

5. **The Department and Serco should review their procedures to facilitate greater sharing of information about suspected drug and alcohol use by detainees with staff members who have supervision or welfare responsibilities towards those detainees.**

6. **Serco should review the way in which it manages intelligence holdings suggesting detainees are using illegal drugs or alcohol in order to ensure that adequate supervision arrangements are in place in relation to such detainees.**

7. **The Department should investigate with NSW Corrective Services and NSW Justice Health options for obtaining information from them about a detainee's custodial history including information regarding their behaviour whilst in custody, health and welfare and any history of drug and alcohol use, and options for making this information available to both Serco and IHMS.**

8. **The Department and Serco should develop a protocol which:**

   (a) clarifies their respective roles in enquiring into the background and circumstances giving rise to a Critical Incident;

   (b) clarifies the means by which they will keep abreast of developments any police investigations.

9. **The Department and Serco should develop a protocol for notifying in a timely manner the next of kin of the death of a detainee, and a representative of both the Department and Serco should communicate with the next of kin to acknowledge with appropriate sensitivity the death of their loved one while in Serco and the Department's care and control.**

I would like to thank the Officer in Charge, Detective Sergeant Dale Morrell.

I would like to thank my Counsel Assisting, Ms Naomi Sharp SC for her excellent assistance in this matter and for her extremely thorough written submissions. I also

thank her instructing solicitors, Jessica Wardle and Jennifer Hoy from the Crown Solicitor's Office.

In closing I would like to offer my sincere condolences to Robert's family. Robert's mother spoke so eloquently about her beloved son. She told us that:

> *"not only did I love him because he was my child but I feel he had so much more to contribute to his family, his children, his loved ones, friends, the community and to people like himself, navigating through life's tribulations and seeking it through a faith greater than themselves.*
> *Yes, he wasn't perfect, but he was still human with the same foibles that we all have. Yes, he made a few mistakes, but then again so have we all."*

The subject matter of an inquest is often quite technical with policies and medical terms described in their cold detail. It is important to remember that the person spoken about is more than a diagnosis, an illness or an event. He was a man who loved and was loved. Robert was a father, a son and a partner. He is someone who will be thought of and missed every day.

Findings required by s.81(1)

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.

The identity of the deceased

The deceased person was Robert Elan Peihopa

Date of death

4 April 2016

Place of death

Mr Peihopa died at Villawood Immigration Detention Centre at Villawood in Sydney

Cause of death

Fatal cardiac arrhythmia

Manner of death

Underlying chronic coronary artery disease and triggers of ingestion of methamphetamine in the hours before Mr Peihopa's death and the physical and emotional distress arising from his involvement in a fight immediately prior to his death.

I close this inquest.

Teresa O’Sullivan
Deputy State Coroner

Date: 28 November 2017