Comments on the record of investigation into the death of Ali Jaffari

by Michelle Bui with Suvendrini Perera

The coroner's record of the investigation into the death in custody of Ali Jaffari is 25 pages long, offers no recommendations and concludes with the final statement,

> I find that the supervision treatment and care of the deceased at Yongah Hill was reasonable and appropriate in the context of detention. (para.100)

Through these words, the detention system is once again absolved by the judicial system. Ali Jaffari's unnatural death is deemed to be a reasonable outcome, a tolerable loss for which no one is at fault and for which no one will be held accountable.

In the manner of such documents, the finding considers Ali Jaffari's death as an isolated incident, remote from both other deaths in immigration detention and the environment of Yongah Hill, perhaps the harshest of the mainland detention centres. As this dispatch is written, the men held at Yongah Hill are continuing a hunger strike and protest of their indefinite incarceration. Just yesterday, families of men held at Yongah Hill and supporters staged a protest outside the offices of the Immigration Department, calling for the release of fathers and husbands, some of whom have been jailed in this isolated environment for over five years.

'Stop Deaths in Custody: End Immigration Detention Now' protest, DIBP office, Nyoongar Country, 30 January, 2019. Photo: Michelle Bui.

The Refusal to Acknowledge the Present

The second paragraph of the finding begins, 'Yongah Hill *was* located in Northam.' But Yongah Hill is *still* located in Northam and right now people detained there have been protesting for over two weeks. Yongah Hill *is still* managed by the Department of Home Affairs and Border Force, and Serco and IHMS are *still* contracted to provide services to the centre. Indeed, many of the workers who were at Yongah Hill at the time of Ali Jaffari's death remain there today.

The use of the past tense in the second and third paragraphs of the finding repeats the same refusal to consider or acknowledge the present that was also evident during the inquest hearing. The inquest was concerned with the detention centre, its management and the private contractors involved in its operation, but the coroner made clear that that concern did not extend beyond the specified time period and the conclusion of the inquest.

The use of language in this finding erases the contemporary existence of the detention centre and the fact that the issues under consideration in this case remain ongoing. In this court and in this document, the risk of deaths in custody happening now is beyond the scope of concern. Last week another man publicly known as 'Musa' died in detention at Villawood IDC. Reports have indicated that 'Musa' had arrived in Australia on a Humanitarian Visa from Sierra Leone and was known to be suffering from mental health issues during the period he was in detention.

Mental Health Care

The mandate or focus of the inquiry was stated to be the 'supervision, treatment and care provided to the deceased while he was in immigration detention, *particularly in relation to treatment for potential mental illness and any associated risk of self-harm or suicide*.' (para.9)

The suggestion that Ali Jaffari could have been suffering from a mental illness, however was consistently dismissed or denied during the inquest. The pattern of serial self-harming that can be observed prior to his death also appears to be quite consistently viewed by mental health workers as a 'political statement' or 'protest'. IHMS's visiting psychiatrist Professor Janca characterised Ali Jaffari's history of self-harming as instances of 'demonstrative, impulsive protests' due to his frustration with being in detention for a prolonged period. In this finding, the back and forth around whether Mr Jaffari had a serious mental illness or whether his self-harm and suicide attempts were a 'protest' against his incarceration does not reach a logical conclusion. Such a conclusion would either lead to a criticism of the system of detention itself, or of the medical assessment and care provided to him. Despite the implicit acknowledgement that prolonged detention caused Mr Jaffari harm and was a significant causal factor in his self-harm and suicide attempts, there was no scrutiny or criticism of the detention system itself. This is a recurring issue in the coronial death investigation process, where there is an embedded acceptance of the immigration detention system and a consequent refusal to look at the systemic issues it poses, or place each death in this context of prolonged detention.

> The only intervention which could have prevented the deceased's suicide would have been the granting of residency. (para.95)

This one-sentence statement superficially acknowledges that freedom could have saved Ali Jaffari's life, but this fact is not explored further.

Likewise there are apparent contradictions in the view taken toward the quality of treatment that Ali Jaffari received in terms of the assessment that '*the deceased could not have received better management*' and he wouldn't have '*received more care in a public mental health ward*'. If Ali Jaffari's self-harm was arguably a product of being in the detention environment, an alternative environment might have proved to be a safer option. On the other hand, elsewhere in the findings (paras 33-34) there are passages suggesting serious mental health and behavioural problems on the part of Ali Jaffari.

There appears to be some consideration of the use or adherence to the Psychological Support Program (PSP) and Supportive Monitoring and Engagement (SME) [see section 9.7] however in the finding, the agency responsible for monitoring is not specified (para 26). These observations are conducted by Serco officers in consultation with IHMS rather than by trained mental health practitioners themselves. This process for the most part is a reactive form of risk-management where a person may be placed under observation to mitigate their ability to self-harm or suicide. Again, there were no questions raised in the inquest or finding about the adequacy of such a system that relies heavily on untrained Serco guards. At the time of Ali Jaffari's death he appears to have been placed on 'Moderate SME' with hourly observations, despite this there is no discussion around the adequacy of the SME process. The mental health care provided to Ali Jaffari was described by consultant psychiatrist, Dr Bassett, as *'benevolent and attentive care with a high degree of respect for his cultural background and his mental state'* this raises a question that cannot be answered - of whether Mr Jaffari himself would have characterised the care he received in the same way.

Systemic Issues Ignored

Ali Jaffari was faced with indefinite detention; while deportation was an eventual and likely outcome, there was no indication that he would see any form of freedom anytime soon. The coronial investigation appears to have given no consideration to how adverse 'character' assessments impact upon refugees who are barred from living in the Australian community but who cannot return home. Given the increasing proportion of people being detained due to 'character' or s501 grounds this seems like an important line of inquiry to make.

The Self-Immolation

The finding goes on to refer to the issue of how Ali Jaffari was able to set himself alight while in Serco's custody. During the inquest hearing the available evidence was inconclusive.

> One issue at the inquest was whether the deceased had lit the fire with an intention to cause burns to himself to end his life and, if so, how he had lit it. I have found that he had lit the fire, probably with a contraband lighter, and that he had done so with an intention to end his life. (para.12)

The following paragraphs concludes with,

> I have found that the supervision, treatment and care provided to the deceased was reasonable in the circumstances. (para.13)

The fact that the key question of exactly how someone was able to set themself alight in a detention centre where access to the means to do so are supposed to be restricted, remains unanswered

suggests that there is no genuine imperative to ensure that someone does not die in the same way again. The juxtaposition of the two statements: one explaining that someone in detention was compelled to suicide by self-immolation and the other suggesting that the care he received was appropriate, proposes that the service providers did all they could and it is only the deceased who assumes responsibility for his death.

In the finding, the coroner suggests that 'the premeditation distinguishes the fire from the earlier apparently impulsive, acts of self-harm.' There is no further reflection on this pattern of self-harm and whether in hindsight the serial suicide attempts by Mr Jaffari could have signalled something more serious than a 'protest' about his detention. The coroner further states that according to evidence of Sergeant Harbridge, 'There were so many people going in and out of the room after the fire had started that, if the source was a lighter, it could have been removed by any of them.'

The critical issue of management of the camp remains unaddressed in terms of how Mr Jaffari was able to access a contraband lighter. It is supposed that a lighter was used to ignite materials in his room and removed by someone prior to police investigators securing the scene. While the coroner speculates on various other issues, here there is no speculation, for example on whose interests it would serve to remove a lighter from the room. It is worth noting that Serco is the company responsible for ensuring that people in detention cannot access lighters and whose officers are certainly responsible for a significant proportion of contraband entering the centre. While it will remain unknown how the source of ignition disappeared from the room, it would certainly serve the interests of Serco to avoid the criticism associated with a contraband lighter being located in the room.

On 2 September 2018 fires engulfed the Falcon compound of the Yongah Hill Detention Centre. In the hours prior a young Iraqi man, Saruuan Aljehelie, attempted suicide. He was found by his roommate in Falcon compound and later died in hospital. Despite this large scale blaze, just a month before the inquest hearing, there was no consideration of the fact that sources of ignition appear to remain readily available in the detention centre. Surely this should be a matter of concern in respect to the coroner's supposed 'prevention' role.

Falcon Compound Yongah Hill IDC, 2 September 2018. Photos: Supplied.

The Language of Criminalisation

Language used in the finding frequently casts doubt or suspicion on Mr Jaffari, his fellow 'detainees' and his family. Mr Jaffari is discredited, Ali Reza Hussaini is treated with suspicion and it is insinuated that Ali Jaffari's brother could have triggered his suicide. Blame here is attributed to Mr Jaffari and vulnerable witnesses and survivors of his death. In contrast there is a persistent denial that those who hold real power in this context - DIBP, IHMS and Serco - bear any responsibility.

A Refugee?

> Initially, he was not accepted as a *bona fide refugee* given a lack of evidence of persecution in Afghanistan, where he claimed citizenship. However, following a review, on 14 September 2011 he was found to be owed protection. (para.15)

A refugee by definition is 'bona fide' or 'genuine'. A person is either found to be a refugee or they are found not to be a refugee. The use of these types of descriptors attempt to discredit people seeking asylum and suggest that their reasons for seeking refuge are not legitimate.

Casting Suspicion

In this finding, the coroner treats Ali Reza Hussaini - a witness who was the last person to see Ali Jaffari before his self-immolation - with suspicion, despite police investigators already ruling out criminality in this case.

> his oral evidence that he had been in detention for seven or eight years led me to wonder whether he had any relevant criminal history which had led to the protracted detention. (para.80)

The coroner goes on to outline information he requested from the Department of Home Affairs. This line of speculation criminalises a survivor and reinforces the false narrative that people in detention are potentially dangerous and cannot be trusted. It also demonstrates a lack of understanding of how easily people can get trapped in the immigration detention system and the arbitrary nature of the length of time they spend there. Like Fazel Chegeni Nejad, this man was involved in an incident while in detention and struggled to find a pathway out of detention after that point. To disclose this person's history in the finding, however, when it has no consequence in terms of determining the cause of death, seems irrelevant and inappropriate. Such matters should be allowed to remain private and confidential. Detention centre staff, for example, would not have their personal histories scrutinized and published in such a way. The coroner clarifies at the end that there appears to be no information to implicate Mr Hussaini in the death.

Implicit Blame

In speculating on the reasons behind Ali Jaffari's suicide, the coroner writes,

> It appears to me that, from a layperson’s perspective, the deceased had further potential reasons to end his life. One such reason was that, according to Mr Shah, in the time leading up to the fire he had been in touch with his brother in Pakistan about wanting to go home and that *his brother had tried to dissuade him because he would be too much of burden on the family*

> Other possible reasons were that the deceased's brother may have told him that Australian authorities were aware that he was Talib Hussain, and that he now had a criminal record and had been verbally *abused by other detainees* at Yongah Hill because of the nature of the offences. It is possible, if not likely, that these factors may have added to any sense of despair he may have had about his future.

The insensitive suggestion that family members or fellow 'detainees' were responsible for triggering Mr Jaffari's suicide contrasts with the insistence that those contracted to provide security and medical services had no role in his death. The inquest findings indicate that disproportionate scrutiny was applied to Ali Jaffari's fellow detainees and his family. Unlike DIBP, Serco and IHMS they did not have legal representation to ensure minimal scrutiny was applied to them. DIBP, IHMS and Serco, in the context of detention, were those who owed Ali Jaffari a duty of care.

Concluding thoughts

Returning to the final lines of inquest finding it is clear that the interests served in this inquest are not of Ali Jaffari, his family, those in detention or 'the public'; the interests that are served are of the State. In line with countless coronial investigations before, this inquest finding does nothing to disrupt a lethal system that inevitably and intentionally causes harm and produces death.