Comments on the record of investigation into the death of Mohammad Nasim Najafi
by Michelle Bui

'What they and we often fail to see is how designating a death as natural commonly misrepresents how someone died inside, implying that nothing caused or contributed to it.'

Alison Whittaker, Gomeroi poet and law scholar,
''Dragged like a dead kangaroo': Why language matters for deaths in custody'

The inquest finding into the death of Mohammad Nasim Najafi states that at the time of his death, he had been in detention for over two and a half years. The Department of Home Affairs provided Coroner Sarah Linton with various reasons as to why Mr Najafi was subjected to prolonged detention and not granted a Bridging Visa E (the only visa he was eligible for at the time due to the punitive legislative bar placed on people who sought asylum by boat after 13 August 2012). Among those reasons were difficulties with conclusively establishing his identity. In addition it is noted that,

> He also did not meet other criteria, such as providing evidence that he had health issues that could not be properly cared for in immigration detention. (para.11)

Given that Mohammad Nasim Najafi's death was arguably a result of fatally mismanaged epilepsy, in hindsight it can be questioned to what extent this assessment was accurate. As expert witness Clinical Professor John Dunne, an epilepsy specialist, noted 'in a place of detention there is a responsibility that falls on those in charge to ensure that essential medicine is actually being provided and dispensed and taken'. This fundamental responsibility was not fulfilled, yet Coroner Linton ultimately attributes Mohammad Nasim Najafi's death to 'natural causes'.

'Natural Causes' and the failure to dispense medication

In the finding, the coroner states that 'The inquest focused primarily on an issue regarding the dispensing of the deceased's essential medication for his epilepsy.'

In his oral evidence during the inquest hearing, Professor Dunne expressed the view that Mr Najafi's longstanding sleep disorder meant that attending medication rounds twice daily or collecting his Webster-pak within the prescribed hours would have been difficult for him. The coroner acknowledges this in some sections though at one point she supposes, 'This flexibility in the practice [of collecting Webster-paks after designated clinic hours] perhaps led the deceased to pay less regard to the instructions from Nurse Nugara to attend within the set hours than he should have' (para.31). This statement has several implications, firstly that the 'non-compliance' with instructions was a wilful act, and secondly that perhaps IHMS staff should adhere to rules in order to try enforce compliance, regardless of whether that meets the needs of their patients. Contrary to this, Professor Dunne, suggested that 'more flexibility in providing the deceased with a Webster-pak might have resolved the problem [of ensuring he received his critical medication]'. Altering dispensation practices would prioritise the needs and health of the patient and increase the chance of medication regimes being adhered to.

Preventable deaths and the narrative of inevitability

In the concluding section of the finding, coroner Linton writes, that Mr Najafi was 'held in various detention centres while steps were taken to try to process his application to remain in Australia on a visa. *Sadly*, that process had not been finalised prior to his death, so he never had the opportunity to live in the Australian community as he had hoped'. This fact is more than merely 'sad'. Mr Najafi, like thousands of other asylum seekers, was suspended in limbo and denied the right to apply for a protection visa. He spent the last two years of his life in a detention centre. There was no transparency around the steps that were being taken to allow Mr Najafi to be granted a BVE. Indeed, Mr Najafi believed he might still be in detention because of his epilepsy and there appears to have been no communication or explanation provided to him about the actual barriers that were preventing him from securing freedom. It is not that the use of the descriptors 'sad' and 'unfortunate' are inaccurate, it is the fact that inquest findings repeatedly use passive language to construct a narrative of inevitability. Inquests fail to mark the value of peoples' lives and the enormity of the loss that is experienced following a sudden death. In using passive language they refuse to acknowledge or underscore the intentionality of the death or killing.

Failures in Documentation: the Medication Box

One of the outstanding issues raised during the inquest hearing was how a box of medication was found in Mr Najafi's room following his death.

> It is not entirely clear how the deceased managed to access an unauthorised box of carbamazepine, which was not issued by IHMS, and unfortunately the evidence available at the inquest does not allow me to take the matter any further. I am advised that the WA Police are aware of the concerns raised by the failure to properly document the box of medication in this case and that the shortcomings in this investigation have been addressed. (para.107)

As in the case of Ali Jaffari's death, the critical issue of Serco's management of the centre in respect to contraband goods is again left unanswered. Due to poor police documentation, it cannot be determined how Mr Najafi had access to a box of carbamazepene and whether that medication was expired or otherwise and could have been taken if he missed doses from IHMS. Based on the medical evidence and the low levels of carbamazepine in his system following his death, it appears he did not take any of the medication from this box in hours before his death, or if he did it was not effective. In any event, it raises specific issues in this case but also the broader question of access to medication not issued by IHMS that could be dangerous or life-threatening in incorrect doses. Here another opportunity to make a clear determination was lost due to a compromised investigation. Earlier on in the finding, the police explanation for not adequately documenting this box of medication, as heard in oral evidence during the inquest hearing, is noted.

> While police officers were still in attendance it became apparent that the atmosphere in the detention centre was becoming *tense* as other detainees became *agitated* upon hearing news of the death and were *inciting violence* towards detention centre staff. This was said to have hampered the ability of police officers to continue to investigate at the scene and it was maintained that this was the reason why no photographs were taken of the box of medication that was seized and no video recording was made. It does not, however, explain

> why no attempt was made to take a photograph of the medication at the mortuary. (para.69)

Here police evidence refers to detainees 'inciting violence' in the aftermath of Mr Najafi's death. There is no inquiry, however, into how grief and anger among those detained at the centre was addressed in the days and weeks following Mr Najafi's death. If a coroner's court isn't the appropriate forum to raise the issue of post-death support, where can this issue be considered with some degree of transparency? To date, there appears to be no mechanism to ensure that people in detention receive appropriate support in the aftermath of a death in custody. This was borne out following the death of Saruuan Aljhelie at Yongah Hill in September 2018. Two men detained at the centre discovered him in his room and dozens were impacted by the 'riot' and fires in the aftermath. Several of the men indicated afterwards that they received minimal or no support and that being in Yongah Hill was itself triggering. Despite attempts by advocates to contact Border Force in respect to the protocol for post-death interventions and support, there was no response.

Current 'Management' of Seizures

At present, another man named Wesam - a torture and trauma survivor - also detained at Yongah Hill suffers from recurring psychogenic nonepileptic seizures (PNES) also known as pseudoseizures which are a physical manifestation of severe psychological distress. These can be triggered by situational distress, for example when he becomes overwhelmed by emotion or experiences unmanageable levels of stress. His seizures have not been responsive to medication, suggesting that the only remedy would be an environmental change or change to his circumstances. Wesam has been in detention for around 6 years and has witnessed and experienced countless traumatic events during that time as well as prior in his country of origin. Over the past few weeks at the time of writing he has suffered two pseudoseizures and has reported that it is consistently the other men detained in the camp who respond and take care of him. He articulated that he feels that IHMS pay little attention to his health and wellbeing, and that his friends seem better equipped to respond than Serco, though it should not be their responsibility. This was evident in video footage following the death of Saruuan Aljhelie at Yongah Hill and the subsequent fires. After a frustrated discussion with Serco officers, Wesam experienced a pseudoseizure. In the video you can see friends rushing to his side, however Serco officers appear oblivious as they walk away in the opposite direction. This is a condition that will not get better while he is in detention. This form of seizure could also be potentially fatal if he suffocated or sustained a head injury after falling, akin to Faysal Ishak Ahmed on Manus Island.

<u>Concluding Thoughts: No Repercussions for Failures in Care</u>

The final paragraphs of the finding reads,

> Looking back on the events leading up to the death, the most concerning feature is that, when the deceased stopped attending for his essential medication, there was no attempt by any member of IHMS to follow up with the deceased and find out why he was not attending and to try to find a solution to the problem so that he returned to compliance with his medication regime. (para.112)

> I am satisfied that, following the death of the deceased, this problem was identified by IHMS and has been properly addressed by the implementation of a new regime for critical medications that ensures that IHMS nursing staff are aware when a detainee fails to attend a medication round for critical medication and will appropriately follow-up with the detainee on each occasion. (para.113)

The tone and overall message of this finding differs slightly from Coroner King's finding into the death of Ali Jaffari. While the finding on Ali Jaffari's death refuses to acknowledge any error on the part of authorities, the finding on Mohammad Nasim Najafi's death is superficially critical in acknowledging that IHMS failed to ensure there was a reliable system for dispensing medication. Despite how 'concerning' these issues are, the outcome remains the same; **there are no consequences and no justice for Mr Najafi's death**. The 21 page long finding offers no recommendations and no further critiques other than those the coroner considers to have already been addressed by IHMS. Despite the volumes of material before the coroner, there is little more detail included in the finding than was discussed in the one-day inquest hearing.

DIBP and their contractor IHMS do not experience any material loss, however the family and friends of Mr Najafi are left grieving at the injustice of his premature death. While the coroner indicates satisfaction with changes made by IHMS in dispensing medication, as a company that has been charged with the care of hundreds of people in custody for many years, such simple procedures should have already been in place. While we cannot be sure, it's possible that if they had been Mohammad Nasim Najafi would not have had a seizure and died in a prison that caused him so much anguish in the final years of his life. The takeaway message of the finding is that the problem has been solved, however DIBP, Serco and IHMS making improvements ahead of coronial inquests to avoid adverse findings is not going to prevent deaths within a fundamentally lethal detention system. In this case it was inconsistent access to essential medication that triggered a fatal epileptic seizure, next time it will be something else. While minor 'improvements' will continue to be made, these deaths will remain ongoing until the entire detention system is abolished.

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