CITATION: *Inquest into the death of Haidar Ali Ikhtiyar* [2014] NTMC 022

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0096/2013
DELIVERED ON:	3 November 2014
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HEARING DATE(s):	6 – 8 October 2014
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Death in Federal custody; Detention of asylum seeker; Psychological Care and Treatment; Suicide.

REPRESENTATION:

Counsel Assisting:	Jon Tippett QC
Dept. of Immigration:	John Agius SC
Serco Australia Pty Ltd:	Sonia Brownhill

Judgment category classification:	A
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IN THE CORONERS COURT
AT DARWIN IN THE
NORTHERN TERRITORY OF AUSTRALIA

No. D0096/2013

In the matter of an Inquest into the death of

HAIDAR ALI IKHTIYAR
ON 16 JUNE 2013
AT WICKHAM POINT IMMIGRATION DETENTION CENTRE

FINDINGS

Mr Greg Cavanagh SM:

INTRODUCTION

1. On 15 June 2013 at 8.10am the deceased, Haidar Ali Ikhtiyar, client number ZAP050, waved at some other clients and staff at Wickham Point Detention Centre where he had recently been detained, tied a rope to a crossbeam on a first floor railing, tied the rope to his neck and at 8.20am he dropped over the first floor railing thereby hanging himself. At 8.25am his body was discovered. At 8.28am his body was cut down and trained medical staff commenced cardio pulmonary resuscitation (CPR) attempts.

2. Ambulance officers arrived at the deceased at 8.56am. They noted there were no signs of life. CPR was conducted over a total period of approximately 40 minutes. It had been commenced by Wickham Point Staff and then was continued by the ambulance paramedics after their arrival. No signs of life were detected over that period. At 9.11am Ambulance Officer Virginia Dowson declared that Haidar Ali Ikhtiyar was deceased. He was 62 years of age.

3. The deceased's activities immediately prior to his death, including the hanging, were captured on CCTV footage taken between 7.59am and 8.28am on 15 June 2013 (Folio 28). While the CCTV cameras were at times

monitored however due to the large number of cameras at the centre it was not deemed to be practical to monitor all of them.

4. The investigating officer Detective Senior Constable Tanja Ward recorded in Exhibit 1 that: "It is unknown where the rope used in the hanging originates from, however enquiries indicate that the rope may be from a laundry bag (issued to clients when they first arrive at the detention centre) or from a sporting net (such as a soccer of tennis net). It is clear on the evidence, however, that the ligature came from within the detention centre".

5. Pursuant to section 34 of the *Coroners Act* ("the Act"), I am required to make the following findings:

> "(1) A coroner investigating –
>
> (a) a death shall, if possible, find –
>
> (i) the identity of the deceased person;
>
> (ii) the time and place of death;
>
> (iii) the cause of death;
>
> (iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

6. Section 34(2) of the Act operates to extend my function as follows:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

7. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

> "(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.
>
> (2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the

administration of justice connected with a death or disaster investigated by the coroner.

(3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

8. Where there has been a death in custody, pursuant to section 26 (1) and (2) of the Act a coroner:

"(1) Must investigate and report on the care, supervision, treatment of the person being held in custody; and

(2) May investigate or report on a matter connected with public health or safety or the administration of justice that is relevant to the death.

DECEASED'S BACKGROUND

9. The background of Haidar Ali Ikhtiyar is set out in some detail in the Investigating Officer's covering Report at Exhibit 1; Folio 1.

10. He was born in Takhta Chinar, the Shahristan District in Afghanistan. In the course of Immigration processing he used the birth date of 31/12/1950, however he was unsure of his exact date of birth.

11. His ethnicity was Hazara. He is Shia by religion. His mother tongue was Dari, but he also spoke Urdu, Hazari, Farsi (Persian) and Pashtun.

12. Haidar left his country of birth due to problems associated with the Taliban. He went to Pakistan but he found that the Taliban were killing Hazaras there also so he decided to leave.

13. He worked in the construction industry from the age of 15 both in in Afghanistan and Pakistan.

14. Haidar's only education seems to be associated with the study of the Koran which he undertook between the years of 1960 to 1961. He was able to read the Koran.

15. He married on a number of occasions. His first marriage ended in tragedy when his wife, son and daughter were killed in a motor vehicle accident 16 or 17 years ago.

16. Mr Ikhtiyar's journey to Australia took him from Quetta to Islamabad then by plane to Muscat in Oman transiting to Dubai. From Dubai he flew to Brunei and then on to Jakarta.

THE DECEASED AND HIS JOURNEY TO AUSTRALIA

17. Haidar Ali Ikhtiyar was what is colloquially known as an "asylum seeker". On 19 March 2013 he boarded a boat with approximately 100 other people in Indonesia to journey to Australia. He had earlier entered Indonesia illegally on a false passport having travelled there by aircraft. While in Indonesia he had registered with the United Nations High Commissioner for Refugees as a refugee. The boat trip was precarious. The engines failed amid storms and the vessel drifted helplessly until the deceased and the other passengers and crew were rescued by the Australian Navy. Mr Ikhtiyar was detained under section 183(3) of the *Migration Act* on 25 March 2013.

18. The deceased was initially taken to Christmas Island for processing. At that time it was noted that he was experiencing panic attacks and symptoms of anxiety. In the course of processing a history of mental health issues was recorded that included anxiety, depression and post-traumatic stress disorder. He did however make telephone contact with his immediate family, his fourth wife Mahsome and his four children of that marriage who resided in Bururi, Quetta Parkistan.

19. Subsequently his detention history has been:

- Phosphate Hill APOD (Alternative Place of Detention) 25/03/2013 - 27/03/2013;
- North West Point – 27/03/2013 – 18/04/2013;
- Wickham Point IDC (Immigration Detention Centre) – 18/04/2013 – 29/04/2013;
- Northern Immigration Detention Centre (NIDC) – 29/04/2013 – 15/05/2013 (COONAWARRA);
- Wickham Point IDC – 15/05/2013 – 15/06/2013.

MEDICAL TREATMENT OF THE DECEASED

20. During the deceased's detention his medical condition was attended to by various medical practitioners, psychologists, psychiatrists, mental health nurses and counsellors. The medical notes set out at Exhibit 1; Folio 23 indicate that the deceased did not express thoughts of self-harm, suicidal ideation or harm to others. Whenever those issues were raised with Mr Ikhtiyar he would respond by saying suicide was against his religion and that he would not engage in it for fear of causing his family severe embarrassment. The deceased was the first Hazara and the first person of the Muslim faith to take his own life in an Australian detention centre.

21. He was reviewed regularly by psychologist Jagjit Ahuja, who gave evidence at the inquest and who noted that religion and family were strong "protective factors" (against suicide). On 14/06/2013 the deceased was seen by psychologist Ahuja who concluded he had no desire to self harm or to harm others however the deceased was put on the PSP or psychological support patient list and his medical situation was to be considered at a PSP meeting on 17 June 2013 (Exhibit 1; Folio 23). The clinical notes run over some 90 pages. The clinical notes also support the conclusion that the deceased was closely monitored medically during his detention.

22. Haidar Ali Ikhtiyar's treatment over the period of his detention was reviewed by Dr Peter Young MBBS FRANZCP Medical Director, Mental

Health Services, International Health and Medical Services who concluded that he received an appropriate standard of care in detention. In particular he found that "assessments of suicidality (sic) were conducted appropriately and were adequately documented" as set out in Exhibit 1; Folio 69. The doctor had never been employed at Wickham Point but had been employed by IHMS since August 2011. At the time he gave evidence he had ceased that employment.

SUICIDE AND SELF-HARM

23. Although he did not convey any feelings of self-harm to medical personal the deceased expressed from time to time a desire to return to Afghanistan voluntarily. He felt he had become old and his future in Australia was not clear. He had also discovered that he was no longer wanted by his wife who apparently intended to take up with another man. He felt that he had been duped into coming to Australia by his wife just so she could get rid of him (Exhibit 1 Folio 23; entry 4 June 2013).

24. On 31 May 2013 client service officer Mehdi Jafari (a SERCO employee) made a security information report to Jason Benefield, another SERCO employee stating the following (Exhibit 1; Folio 19);

> "For the last few days I am observing 1 x Client Ikhtiyar Haidar Ali, ZAP050 who looks stressed and isolated from the clients. My initial enquiry from the other clients of the same nationality resulted that client Ikhtiyar Haidar Ali ZAP050 save(sic) asked several time how to commit suicide. Mr Ikhtiyar H Ali remained in NIDC for a while and asked one client how to commit suicide.
>
> I personally worked in NIDC on 15/05/2013 and Mt Ikhtiyar H Ali met me in medical at approximately 1000 and told me that he is not sure what will happen to him here in Australia, as he is getting week and old and therefore he wants to go back to his country."

25. The information contained in the report was not passed on to those responsible for the deceased's daily care and treatment. Psychologist Ahuja gave evidence that if he had become aware of the information he would have

possibly placed the deceased on the psychological support program and monitored him more closely. However in every other respect the deceased gave no indication of self-harm. Further the information report was made two weeks before the death and in the intervening period a number of countervailing factors to self-harm were observed by psychologist Ahuja. The medical notes (Exhibit 1 Folio 23) show that the deceased was seen by Nicole Melidonis, psychiatrist, in the presence of Dr Ahuja on 30 May 2013 and she noted that the deceased was "not suicidal".

26. On 4 June 2013 the same psychiatrist reviewed the deceased who observed that he was "feeling better on the new medication" but that he was also feeling a lot of worry about information to the effect that his wife was divorcing him and had plans to take his four children and remarry.

27. On 6 June Dr Melidonis observed in her notes (Exhibit 1; Folio 23) "Denies any suicidal thoughts. Has hope for the future that things will improve for him and he will see his children again. Religion (he is a Muslim) a protective factor … His flatmate has reported to Jagjit (psychologist) that Haidar is improving". She set out a plan for the deceased's future care and supportive therapy in conjunction with Ahuja.

28. On 8 June mental health nurse Anthony Gunter recorded the following observations, "Client arrived on time for consult was neat and tidy in appearance, reactive in mood, sleeping and eating well, nil overt psychotic symptoms (sic), nil thoughts of harm to self or others".

29. On 14 June 2013 at 14:24 psychologist Ahuja recorded that the deceased "Currently reports interacting with friends and walking around the compound. Client reports nil disturbance in appetite stating that he is attending meals area for three meals but reports eating minimal amount of food but reports gaining weight attributing it to medications."

30. Psychologist Ahuja was able to communicate effectively with the deceased as they both spoke Urdu. It appears that no observations were made by him on 14 June that would indicate or forewarn him, or for that matter any person, of an intent by the deceased to take his own life the following morning. If it was concluded by staff at WPIDC that such an intent did exist or that there was a real and present risk of such an intent being prosecuted there were facilities for the deceased to be placed on 24 hour observation and medical care was readily available at the centre to meet such a situation.

31. The Detention Services Manual at Chapter 6 deals with Psychological Support Programs (Exhibit 1; FOLIO 21). It observes that it is notoriously difficult to distinguish between suicidal gestures (actions resembling suicide attempts while not being fully committed) and genuine suicide attempts (actions taken with intent to die). It is also noted that the causes of suicide and self-harm are particularly complex. It acknowledges that little research has been conducted on self-harm and suicide among persons in immigration detention, the existing evidence base coming from prison and community settings. However the deceased did fall into various categories of risk as set out in the manual from time to time, they being:

- Known psychiatric illness – PTSD;
- Separation from family and significant others;
- Increased risk following negative visa decisions;
- Emotional stress;
- Depression;
- Agitation;
- Social isolation;
- Talk of suicide.

32. The protective factors against persons taking their own lives are set out in the manual and those that applied to the deceased's circumstances included:

- Effective clinical care (clearly provided on the evidence);
- Easy access to a variety of clinical interventions (also confirmed by the evidence);
- Cultural and religious beliefs that discourage suicide and support self preservation (also supported on the evidence as no Muslim detainee had attempted to self harm in the manner engaged in by the deceased).

33. The inquest was held over a three-day period in which ten witnesses were called. One witness, a Mr Morteza Tahmaseba, mistakenly appeared at the wrong location for a video link to take his evidence. It was decided that rather than be held up by the witness, and as all parties regarded his evidence as entirely uncontroversial, his statement to police under tab 65 of Exhibit 1 was sufficient to cover his evidence at the inquest.

RELEVANT CIRCUMSTANCES SURROUNDING THE DEATH

34. There is no evidence of the involvement of any other person or any suspicious circumstances relating to the death of the deceased and no report is required under s. 35(3) of the Act.

35. The deceased did sustain injuries whilst in detention but all the injuries observed by Dr Sinton, the Forensic Pathologist, were either self inflicted or caused by the application of cardio pulmonary resuscitation during the sustained efforts to revive the deceased by medical staff and ambulance paramedics.

36. A crime scene was established shortly after the deceased was discovered hanging from a railing. Photographs were taken by police investigators and statements were obtained from 47 relevant witnesses. The response by police and emergency services was prompt, appropriate and efficiently undertaken.

37. The closed circuit television footage of the incident was obtained shortly after the deceased's death which graphically shows the deceased trying rope to the railing of a first floor then around his neck, climbing over the side of the railing and dropping to his death.

38. The deceased was seen at 8.20am on CCTV footage dropping from a railing after attaching a rope to a cross beam and placing the rope around his neck. At 9.11am Ambulance Officer Virginia Dowson declared that Haidar Ali Ikhtiyar was deceased. The CPR had been carried out competently and by experienced medical personal. It is highly likely death occurred prior to 8.28am when he was cut down and it was observed that there were no vital signs.

39. The inquest specifically focussed on the medical attention provided to the deceased by IHMS staff employed at the Wickham Immigration Detention Centre.

40. Psychiatrist Dr Peter Young who gave only brief evidence due to an incident arising in the courtroom requiring a person to be provided with assistance, however his evidence both in his statements (Exhibit 1; Folio 69) and to the inquiry was significant. Having reviewed the medical notes and conferred with the clinicians responsible for the care of the deceased he concluded that the deceased received appropriate care to a standard greater than would a person in the Australian community who exhibited the same type and degree of symptoms. He made the point that the note taking by the medical staff was thorough and detailed and that the deceased had access to medical staff regularly who appropriately dealt with his complaints. The medical notes are extensive having regard to the fact that they were taken over a short period. I find that the deceased received appropriate medical care that responded to his various mental states which varied from time to time but never came with an expressed suicidal ideation

41. Psychologist Jagjit Ahuja was the deceased's primary clinician while he was detained at the Wickham Point Immigration Detention Centre. He gave comprehensive evidence of the deceased's condition over the period of a month before his death. Dr Ahuja spoke Urdu, a language the deceased was fluent in. I accept that psychologist Ahuja had the necessary clinical experience to attend to the deceased's needs. At times Dr Ahuja went out of his way to ensure that the deceased attended his appointments and received his prescribed medication. He gave evidence of an occasion when he attended at the deceased's quarters to ensure the deceased was attended to.

42. Dr Ahuja also made the very important point, which I accept, that because he and the deceased could communicate easily he was able to develop a rapport with the deceased. He considered that that allowed him to treat the deceased in a more relevant and effective manner by comparison to some detainees whose treatment relied on interpreters that could not always be obtained in which case the treatment had to be delayed.

43. Dr Ahuja made the point that he was not in a position to conclude that the deceased was at risk of taking his own life. He emphasised that the information for arriving at such a conclusion was not available to him. The deceased himself denied having any suicidal ideation and while he may have spoken to other detainees about suicide some weeks before his death (Jafari Report 30/05/2013 – 31/05/2013) that information was not relayed to him. Importantly he outlined countervailing factors such as the deceased engaging in activities at the Detention Centre that had earned him points which suggested to him that the deceased's involvement in the activities was beyond the peripheral. It was evidence to him that the deceased was socializing and engaging with others in a manner inconsistent with a person preoccupied with thoughts of self-harm.

44. Dr Ahuja also emphasised that he had built up what he considered to be a close relationship with the deceased and as such expected that if the

deceased did experience thoughts or symptoms that put him at risk the deceased would have told him about them. He was significantly affected by the death of the deceased. His notes indicate he was at all times concerned to act in the deceased's best interests and that is a finding that I make.

45. I accept the evidence of Dr Ahuja as reliable evidence from a competent clinician who was making every effort to attend to the deceased's many and complex needs, including attending clinical sessions with the deceased and consultant psychiatrist Dr Nicole Melidonis.

46. On 14 June 2013 Dr Ahuja's extensive notes on consultation describe a patient who is interacting with friends, who reports his appetite is ok but that he eats small amounts of food which he attributed to medication and who "currently has no desire to self harm or to cause harm to others". The psychologist, however, considered he needed more evidence based information from which to continue treatment and so he placed the deceased on the psychological support patient (PSP) list. A meeting regarding patients on the list was not scheduled to take place until the following Monday 17 June 2013.

47. Dr Ahuja expressed concern in his evidence that such a meeting did not take place over the weekend as such meetings did in other detention centres. The inquest was provided with documentation by the Department of Immigration and Citizenship to the effect that no PSP meetings take place over weekends in any of its detention centres and I find that Dr Ahuja was wrong on that count. However that does not diminish the substance of his evidence which I accept to the effect that such meetings should take place as soon as possible.

48. In particular Dr Ahuja expressed concern about the lack of communication that took place between the administrative section of the detention centre and personal responsible for the medical care of detainees. He cited the example of the movement of the deceased from one facility to another without the reason for the movement being passed on the treating medical

officers. While no doubt there may have been good administrative reason for that movement, the point made by the psychologist is that medical staff should be advised of such movements and the reason for them taking place (provided security protocols are complied with) so that that information can be factored into the care of their patients.

49. In the final analysis Dr Ahuja was at a loss to explain the suicide on the material he had. I accept that he did not have and could not be expected to have had, in the circumstances, information that allowed him to predict the event or that the deceased was at risk of such an event. As I have observed, at all times Dr Ahuja displayed competence and care as a clinician and displayed a sincere concern for his patient's condition. I also accept that if any symptoms or other information had been available to Dr Ahuja that indicated his patient was at risk of self-harm he would have taken steps in an effort to meet that risk. What steps he did take were appropriate to the circumstances as they were presented to him.

50. Mental Health Nurse Mark Wilson came to the witness box with significant experience in the field of mental health. He told the inquest that in some cases people will plan and complete a suicide in the absence of any outward indicators that they were at risk of doing so. In this case shortly before his death the deceased appeared to medical staff to be going about his daily activities without any suggestion that he was planning to take his own life. The CCTV footage shows a man waving to others in a casual manner before assembling the instrument of his own death. The fact that some persons prepare to take their own lives in the absence of any outward signs, indeed often camouflaging their intentions, is well known to the extent that the person's subsequent death comes as a considerable shock to friends and treating clinicians. It is a well known but unfortunate fact that some people go to great lengths to ensure that their plans for suicide will not be interrupted by others.

51. It would appear that the deceased fell into that category of person. He had substantial medical support that he could readily access. He had fellow Hazara in the compound with him, one of whom was his room mate, who incidentally advised Dr Ahuja in passing that the deceased appeared to be better in the period leading up to his death. He had hidden the rope, the method by which he intended to end his life, down the front of his trousers so as not to be detected. However it is unnecessary to categorise the deceased in such a particular way for the purposes of this inquest. The evidence supports the conclusion that he intended to take his own life and that he intended his decision to do so would not be foiled.

52. I have stated that the deceased was a 62 year old man at the time of his death. His date of birth has not been verified but on the Department of Immigration and Citizenship "Fingerprint Form" is said to be 31/12/1950. He had received information to the effect that his wife (30 years his junior) to whom he had four children intended to leave him and take the children and enter into a relationship with another man. He had been a labourer all his life and apart from his wife he does not appear to have other family who could support a man of his age back in Pakistan. Although he had expressed a desire to return to Afghanistan in the circumstances such a desire cannot be said to be realistic. While he vacillated on the matter it would appear that he did not consider he had a future in Australia. While we can never know with certainty it is reasonable to conclude that such factors caused Haidar Ali Ikhtiyar to take his own life.

THE MEHDI JAFARI REPORT

53. I have referred to Mr Mehdi Jafari's evidence earlier in these reasons and to his observations of the deceased in late May 2013 (Folio 19) which he subsequently reduced to a report that was emailed to a Jason Benefield (SERCO Immigration Services) on Friday 31 May.

54. I find that Mr Jafari was clearly a conscientious Client Service Officer who was concerned about observations he made of the deceased over a 24 hour period while he was on duty. It is of serious concern that the report did not end up in the hands of the clinicians who were treating the deceased. There appears to be no explanation as to why it did not. In particular Dr Ahuja said that such information was important and may have resulted in the treatment of the deceased being altered (ie the deceased being placed on the list psychological support patients earlier) to take into account such observations.

55. However I find there is no causative relationship between the failure to place the report in the proper hands and the death of the deceased. Clinical observations made of the deceased between the time of the report and his death were detailed and at times counterintuitive to conclusions that may have been based on information contained in the report. The failure to pass the information on however does again raise the point made by Dr Ahuja that communication between administration and medical personal responsible for the well being of detainees should be improved to ensure that medical attention is effective and evidence based.

56. I find that the psychiatric and medical care of the deceased was to the appropriate standard and administered by personal with the appropriate qualifications.

57. I find that in the circumstances no steps could have been taken by medical staff or SERCO employees to prevent the deceased from taking his own life.

58. I find that all appropriate assistance was provided in an effort to resuscitate the deceased once his body was discovered.

59. I find that the standard operating procedures at the Wickham Point Immigration Detention Centre were adequate to deal with an emergency of the type that occasioned the death of the deceased.

60. I further find that no member of staff or operating procedure of any of the three organisations responsible for the operation of the Wickham Point Detention Centre contributed in any way to the death of the deceased.

FORMAL FINDINGS

61. In accordance with the statutory requirements under section 34 of the Act, I make the following formal findings on the evidence in the proceedings:

i. Identity: The deceased is Haidar Ali Ikthiyar. The birth certificate under tab 17 of Exhibit 1 has the spelling of the deceased's name as Ekhtiar. However fingerprints were taken on autopsy that was matched to fingerprints in the possession of the Department of Immigration and Citizenship (Tab 79) by fingerprint expert Pauline Setter (Tab 80). The deceased was also visually identified by SERCO Welfare Officer: Julie Ann Kane (Tab 8).

ii. The time and place of death: Between 8.20 am and 8.28 am on 15 June 2013 at Wickham Point Immigration Detention Centre.

iii. The cause of death: Self-inflicted Intentional Hanging.

iv. The particulars required to register the death are as follows:
   a) The deceased was male;
   b) The deceased was of Afghani origin;
   c) A post mortem was carried out on 17 June 2013 and the cause of death was "hanging" (Exhibit 1; Tab 6);
   d) The pathologist viewed the body after death;
   e) The pathologist was Dr Terence John Sinton, Forensic Pathologist Royal Darwin Hospital;
   f) The father of the deceased was Golam Ali Ekhtiar;

g) The mother of the deceased has not been recorded on the birth certificate (Tab 17) and her name is not known;

h) The deceased was born in Takhta Chinar, the Shahristan District of Afghanistan he later travelled to Quetta Pakistan where he remained for most of his adult life until he left in 2013 to travel to Australia;

i) The deceased was not employed in any occupation at the time of his death. Immigration records indicate that he was a manual labourer in Pakistan. In Australia he remained in detention and was unable to seek employment.

THE INVESTIGATION

62. The investigation began as the responsibility of another officer but was transferred to Detective Senior Constable Tanja Ward of the Northern Territory Police who was attached to the Major Crime Squad. I commend Detective Ward for the thoroughness of her investigation. Her memorandum of 10 June 2014 setting out the salient features of the investigation and matters relevant to this inquest was of considerable assistance to my task.

63. Further I wish to acknowledge the tireless efforts of Coroner's Clerk Katherine Proctor in arranging witnesses and interpreters. The logistics of dealing with witnesses from all over the country was a difficult task.

RECOMMENDATIONS

64. I recommend that the three stakeholders administering detention centres and other like facilities in the Northern Territory and elsewhere being the Department of Immigration and Citizenship, SERCO and International Health and Medical Service examine the evidence of psychologist Dr Jagjit Ahuja and Client Service Officer Mr Mehdi Jafari to ensure that information relevant to the treatment of a patient including the reasons for the transfer of

a patient between facilities is available to all medical staff but in particular to treating clinicians

Dated this 3rd day of November 2014.

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GREG CAVANAGH

TERRITORY CORONER