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Abstract

Since 2000, more than 1,500 people have died trying to reach Australia by boat or in other ways that are connected with the enforcement of border controls. This article is concerned with a subset of those deaths that can be classified as deaths in immigration custody. In the Australian context, official deaths in custody reporting has only included deaths in the custodial settings of prison, juvenile detention, and police custody, and during the apprehension of criminal suspects or escapees by police or prison authorities. Deaths that occur in immigration detention centers or while authorities attempt to take suspected “unlawful non-citizens” into Migration Act custody are not considered to be deaths in custody for the purposes of investigation and national monitoring. At least 29 such deaths have occurred in Australia since 2000. As with deaths in criminal justice settings, all of these deaths raise questions concerning duty of care, prevention of future deaths, and the use of homicide-related categories in establishing state culpability. This article examines the prospects for achieving a level of accountability for non-citizens who die in immigration custody that mirrors the procedures, however flawed, that apply within criminal justice settings.

Keywords

prevention, structural causes, immigration, death review, state culpability, homicide

Since 2000, the names or descriptions of 1,621 people have been recorded on the Australian Border Deaths database.¹ The majority of these people have drowned while trying to enter Australia by boat to lodge asylum claims, but other deaths have occurred

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inside detention centers while fleeing from police or immigration authorities, or in the community in ways that can be linked to the operation of border controls. In this article, we discuss a subset of these deaths in which this policy connection is most readily apparent because the individuals concerned are being held in custody by Australian law enforcement officials in the course of enforcing immigration controls.

Border-related deaths can occur in a wide range of contexts in relation to the external (offshore) and internal (onshore) borders (Weber & Pickering, 2011). This includes at the physical border, en route, in offshore or onshore detention, during deportation, on forced return to homeland, and even within the community as a result of the withholding of subsistence, or the promotion of conditions of extreme legal and social precariousness. Of these contexts in which border-related deaths are known to occur, deaths within immigration detention centers operated under Australian legal authority (whether located onshore or offshore), deaths while under escort during deportation or while designated authorities (police or Department of Immigration and Citizenship [DIAC] compliance field officers) are attempting to take individuals into custody under the federal Migration Act 1958, and deaths that occur during offshore interdiction operations in Australian territorial waters once individuals or vessels have come under the surveillance or control of the Australian border authorities, all generate a duty of care that could reasonably be considered to bring these deaths within the criteria of “deaths in custody.”

For the purposes of this discussion, a subset of 29 deaths in immigration custodial settings was identified from the Australian Border Deaths database² using the above criteria. The 29 deaths resulting from 24 incidents in immigration custody occurred in the custodial settings of offshore detention (2), onshore detention (17), during apprehension within the community (2), and during interdiction by the Australian border control authorities at sea (8). Some of these incidents resulted in a coronial inquest, but none were included in the national “deaths in custody” collection that is administered by the Australian Institute of Criminology (AIC) (Australian Institute of Criminology National Deaths in Custody Program, n.d.). Since s189 of the Migration Act mandates that suspected “unlawful non-citizens” (meaning any non-citizen found on Australian territory without a valid visa) *must* be taken into custody by police, immigration authorities, or other designated officers, the omission of these deaths from the national monitoring system is particularly anomalous.

We argue that the failure to classify these fatalities as deaths in custody effectively “bureaucratizes away” opportunities to consider the deaths of these non-citizens either as homicides, or as deaths arising from the specific risks associated with illegalized travel or the ongoing condition of deportability. This exclusion is achieved by rendering deaths in the immigration enforcement system as somehow “other” to the ordinary business of detention and imprisonment and the various forms of oversight and accountability that apply in these custodial circumstances. Many deaths in immigration detention do not fit a homicide finding but nevertheless raise serious questions about duty of care and state culpability. However, the system, as it stands effectively, precludes a thorough consideration of these questions. This is a significant omission in human rights protection considering the burgeoning use of offshore interdiction,

forced deportation, and administrative detention of unlawful non-citizens, not only in Australia but worldwide.

The international human rights regime provides guidance in two important ways that generally and specifically promote increased accountability for deaths in immigration custody. Under the Refugee Convention and the International Covenant on Civil and Political Rights (ICCPR), the detention of asylum seekers should be a last resort and only when noncustodial alternatives have been considered unsuitable in each individual case. The mandatory detention policy operated by the Australian government has been found to be in breach of the ICCPR prohibition on arbitrary detention on numerous occasions, beginning with *A v Australia* on April 30, 1997 (UN Doc CCPR/C/59/D/560/1993). The Optional Protocol to the Convention Against Torture (OPCAT) seeks to prevent ill treatment and promote humane conditions of detention by requiring that all places of detention are subject to independent monitoring and inspection, including immigration detention. All available evidence shows that such scrutiny can prevent ill treatment and death. Australia has yet to ratify OPCAT since signing the protocol in 2010. The kinds of deaths we identify in this article and the sorts of accountability mechanisms proposed are informed by global attempts to increase compliance with human rights mechanisms and processes (see, for example, Australian Human Rights Commission, 2013). Unfortunately, immigration custody is often seen as a form of sovereign control used to trump concerns for individual human rights.

In addition to these shortcomings in Australia's human rights record, the failure to adequately investigate deaths in immigration custody creates transnational harm by increasing the suffering of relatives in places of origin who have no way of knowing what has happened to their family members. Grant (2011) has argued that the right to family life places a duty on governments to document all border-related deaths and a right for relatives to know about the fate of their loved ones and notes that the Commissioner for Human Rights within the Council of Europe has advocated these measures.

Protocols for investigating deaths in immigration detention appear to be far more developed in the United States than in Australia. However, the independence of the investigative processes is open to question. For all deaths that occur in immigration detention facilities at federal, state, and local level, procedures and responsibilities for investigation into the death are documented in the Immigration and Customs Enforcement (ICE) Directive on Notification and Reporting of Deaths in Detention (United States Immigration and Customs Enforcement, 2009). According to the Directive, deaths that occur within, or in transit to, immigration detention facilities are investigated by the ICE Office of Professional Responsibility (OPR) who provide findings to ICE senior management, Division of Immigration Health Services (DIHS) for an independent mortality review, the Notification of Detainee Deaths DHS Office of Civil Rights and Civil Liberties (CRCL), and the Department of Homeland Security Office of the Inspector General (OIG) on request. ICE has also conducted investigations into deaths on return following deportation to assist in determining whether the cause of death was associated with time spent in immigration detention in the United States (Kay, 2011).

In the United Kingdom, persistent campaigning from immigrant support groups has brought immigration detention centers within the mandate of many of the institutions established to maintain standards in other custodial settings. Investigation into deaths that occur in immigration detention facilities, short-term holding centers, and persons under managed escort is the dual responsibility of the Prisons and Probation Ombudsman (PPO) in cooperation with the Coroners' Society of England and Wales (CSEW) (Prison and Probation Ombudsman England and Wales & The Coroners' Society of England and Wales, 2012; Prison and Probation Ombudsman England and Wales, 2013). It might be argued that these two levels of oversight increase accountability within the system. The Ombudsman will decide on the extent of the investigation required and support the coroner during the conduct of their inquest by ensuring that the full facts are brought to light. As in Australia, the coroner is an independent judicial officer with statutory responsibility for conducting the inquest into the cause and circumstances of any reportable death (Prison and Probation Ombudsman England and Wales & The Coroners' Society of England and Wales, 2012). The UK's Independent Advisory Panel (IAP) on Deaths in Custody acts as the primary source of independent advice to ministers and service leaders through the ministerial board (Ministry of Justice, Home Office, and Department of Health) on measures to reduce the number and rate of deaths in custody, including immigration removal centers. The IAP reports on the number of deaths and any recent trends in the numbers and types of deaths (IAP, 2011).

As in Australia, procedures in Canada for investigating reportable deaths differ across state jurisdictions. Deaths in custody are referred to the state coroner or Office of the Chief Medical Examiner for investigation, depending on which of these two institutions exists in the particular State. Canada is known for its use of prisons to hold non-citizens under administrative detention (Global Detention Project, n.d.). Therefore, with regard to deaths in immigration detention, the Office of the Correctional Investigator in Canada is also responsible for investigating and reviewing deaths in correctional custody. The Office does not have jurisdiction over immigration detainees held at the Canadian Border Service Agency (CBSA) or provincial detention facilities, nor over those held by CBSA on national security grounds (Global Detention Project, n.d.). The coroner or chief medical examiner will conduct an inquest if required.

We begin our discussion of deaths in immigration custody in Australia with an explanation of what triggers coronial inquests into these deaths in each state within the Australian federal system. Next, we consider whether these triggers could and should also apply to coroners' decisions to investigate deaths in Migration Act custody and to decisions to include these deaths in official tallies of deaths in custody. We then consider the 29 deaths in immigration custody in more detail to establish how and why they should be considered and treated as deaths in custody in line with the legislative responsibilities of state coroners. Furthermore, we argue that if these deaths are identified and treated as such, there is a stronger case for them to be included in the Australian Institute of Criminology's National Deaths in Custody Monitoring Program (NDICMP). Finally we discuss the difficulties in assigning individual criminal responsibility to deaths that occur in custodial settings—whether in immigration or criminal

justice settings—and explore other types of culpability such as failures in duty of care and “death by policy” that, while falling short of engaging definitions of homicide, provide valuable and potential life-saving insights. We conclude that, if all human lives are indeed equal, deaths in immigration custody must be counted, and accounted for, in official monitoring and reporting.

Coronial Inquests Into Deaths in Custody in Australia

Within the Australian federal system, Coronial inquests into “reportable” deaths are the responsibility of state coroners. It is important to consider these in some detail as the legislation is varied and complex, and many decisions about initiating inquests and the subsequent release of reports are discretionary. Of the 24 incidents from the Australian Border Deaths Database, 15 resulted in a Coronial inquest. Only eight of the resulting reports were made available for public access, accounting for the deaths of 13 persons.³ Each of the eight publicly available Coronial inquest reports was systematically analyzed to determine whether the coroner had investigated the death as a death in custody. Of the eight Coronial inquests relating to the deaths of 13 people, only two presented explicit findings in relation to the death being a death in custody.

The basic features of the different state coronial systems are summarized in Appendix 1 and in Table 1. While each state and territory has its own Coroner’s Act covering the state jurisdiction (and for Western Australia and the Northern Territory, the offshore territories),⁴ these Acts specify broadly similar procedures in terms of reporting a death and the specific responsibilities of the coroner regarding the conduct of an inquest. According to the National Coronial Information System (National Coronial Information System, n.d.), the types of deaths that must be reported to a coroner in each state include,

1. Where the person died unexpectedly and the cause of death is unknown;
2. Where the person died in a violent or unnatural manner;
3. Where the person died during or as a result of an anesthetic;
4. Where the person was “held in care” or in custody immediately before they died;
5. Where a doctor has been unable to sign a death certificate giving the cause for death; or
6. Where the identity of the person who has died is not known.

Deaths in custody clearly qualify as reportable deaths under the fourth category above, and possibly under other criteria as well. Table 1 shows the various ways in which definitions of deaths in custody are accommodated within state and territory legislation. The alternative wording of deaths “in care” used in some states applies to custodial settings including prison, community service supervision, young offender institutions and mental health facilities but excludes hospitals. Under each State Coroner’s Act (see Appendix 1), it is mandatory to conduct a Coronial inquest into all such deaths to determine the immediate cause and manner of death. In the Australian

Table 1. Deaths in Custody—State by State Definitions.

State	NT	SA	ACT	QLD	TAS	WA	NSW	VIC
Explicit definition of “death in custody”		x	x	x				
Definition of “person held in custody” where death is reportable	x				x			x
Explicit definition of “person held in care” where death is reportable						x		
List of specific locations equating to “in custody”	x	x	x	x	x		x	x
List of specific locations equating to “in custody or care”						x		

Capital Territory (ACT), the Northern Territory (NT), Tasmania (TAS), and Western Australia (WA), it is also the responsibility of the coroner, by law, to investigate and report on the degree of care, supervision, and treatment of the deceased person before death and present this in the findings of the inquest (Ting, 2011).⁵ In the remaining states, engaging this responsibility is at the discretion of the individual coroner.

Coronial inquests may also be triggered where family members of a deceased person, or persons with sufficient interest in the death, write to the coroner requesting an inquest. It is reasonable to assume that many of those who die in immigration custody will be at a disadvantage in situations where a “champion” is needed to push for a full investigation, although there is at least one example within our Australian sample (discussed later) of pressure being brought to bear by relatives and refugee supporters, including through legal action. Given that deaths in immigration custody are not explicitly identified as reportable under state laws, Coronial inquests into these deaths—although they clearly fall within the everyday understanding of a death “in custody”—will often be at the discretion of the coroner.

The particular emphasis in Australia on deaths in criminal justice contexts has a specific history arising from the Royal Commission into Aboriginal Deaths in Custody that made a wide-ranging study of the causes of overrepresentation of Aboriginal people in prisons and police custody and among those who die in those settings (Royal Commission Into Aboriginal Deaths in Custody, 1992). Coroner’s Acts were amended in response to 34 recommendations from the Royal Commission concerning the investigation of deaths in custody (Curnow & Larsen, 2009; Royal Commission Into Aboriginal Deaths in Custody, 1992). Recommendation 6 promoted an expansive definition of a death in custody including deaths in juvenile custodial facilities, deaths caused by traumatic injuries or lack of proper care, and deaths during apprehension by police or prison officers or during attempted escapes (Victorian Parliament Law Reform Committee, 2005). Recommendation 12 introduced the idea that Coronial inquests into deaths in custody should be required by law to investigate not only causes

or circumstances of deaths but also the quality of care and supervision of the deceased before death (Victorian Parliament Law Reform Committee, 2005).

For these comprehensive procedures to be applied, the death first has to “fit” the state Coroner’s Act definition of a death in custody. As is evident from Table 1, not all Australian State and Territory Coroner’s Acts explicitly define or use the term “death in custody.” Other terms include “a person held in custody” or “a person held in care,” both of which qualify as “reportable deaths.” Where definitions do exist, a “person held in custody” may be defined by reference to various types of custodial settings. These can include in police custody (in prison, in a police lock-up, or in a correctional center), being subject to an order of the State or Territory’s Mental Health Act, while in a youth detention facility, while in the care of a custodial officer, or during transfer to a place of custody. Section 23 of the New South Wales State Coroner’s Act (2009) states that a senior coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the coroner that the person has died while in the custody of a police officer or in “other lawful custody.” Only three states specifically define a “death in custody” as such. South Australia and the ACT include under their definition of a “death in custody” deaths that occur in places of detention (the precise meaning of which is not defined). The Queensland Coroner’s Act identifies a death in custody as any death that occurs under “the authority of an Act of the Commonwealth.”

No State or Territory legislation explicitly includes immigration custody under the definition of “person held in custody” (or “person held in care” in WA), or where places of custody are set out within the legislation. However, the definitions of “in custody” used by some jurisdictions leave room for wide interpretation that has the potential to include immigration custody settings and immigration enforcement circumstances. The generic reference to “detention” in the South Australian and ACT legislation could, and clearly should, encompass immigration detention. The more expansive definition applied in Queensland potentially covers all the contexts in which the 29 identified deaths occurred because immigration enforcement is conducted under Commonwealth legislation, even when state police are performing this role. Clearly “other” lawful custody could also be interpreted by coroners in NSW to include deaths in immigration custody. However, under the current coronial system and practice, these interpretations remain at the discretion of the coroner.

In the cases of Mohammed Saleh and Fatima Irfani (discussed later), the coroner in Western Australia called for deaths in immigration detention centers to be included under the definition of “deaths in care” within state legislation (WA State Coroner, 2011). The coroner used the Saleh case to highlight the fact that a person held in immigration detention does not meet the definition of a person held in care under the current legislation. In the Irfani case, the coroner acknowledged that although Mrs. Irfani was not a person “held in care” as defined by the Coroner’s Act, as a person held in immigration detention, her situation was indistinguishable from a person held in care (WA State Coroner, 2011). While these are positive developments, these cases have not sufficiently galvanized legislators to mandate robust and systematic investigation of deaths in immigration custody.

Even where inquests are conducted, further hurdles may remain in ensuring that the findings are available to the public. Across all States and Territories, once a coroner's report has been completed and delivered to the relevant ministers and next of kin, it is usually the responsibility of the Attorney General or other Minister to table the report in state parliament within a specific time limit, sometimes including their responses to the recommendations reported by the coroner (National Coronial Information System, n.d.). These formal procedures provide important opportunities to communicate lines of responsibility and debate policy interventions that might prevent further deaths. However, while Coronial inquests are often assumed to give public airing to the circumstances of deaths in custody, reports are not always made public. With the exception of Queensland, the ACT, and South Australia, it is at the coroner's discretion not to publish in situations where publication is likely to prejudice a person's right to a fair trial, or where publication of the report is considered "contrary to the public interest," a wording that is always open to wide interpretation. Of the 24 fatal incidents in our study, only eight involved publicly available coroner's reports. Moreover, strict application requirements and procedures are often in place making it difficult for researchers to obtain unpublished reports.

Jurisdictional matters add another layer of complexity to the Coronial system. Immigration detention centers, whether offshore or situated on the Australian mainland, are considered to be under federal jurisdiction, although geographically within the boundaries of state and territory administrations. Similarly, offshore interdiction (the border control equivalent, we argue, to the pursuit and arrest of criminal suspects) takes place in territorial waters under the auspices of the Commonwealth and involves federal agencies such as Australian Customs and the Australian Defence Forces. However, there is currently no federal coroner in Australia who could take responsibility for reportable deaths that occur within these Commonwealth jurisdictions so that such deaths are usually passed to the relevant state coroner. In this case, there is great potential for the coroner to feel compromised as to whether to act in the interest of the State or Commonwealth when exercising his or her jurisdiction, which can then have an impact on the reporting and outcomes of the inquest. One example of such jurisdictional difficulty is discussed below in relation to an inquest by the NSW coroner regarding several deaths in the Villawood Immigration Detention Centre.

The National Deaths in Custody Data Collection

In Australia, coronial inquests are not the only official site to have a blind spot in relation to the deaths of non-citizens in immigration custody. Deaths in immigration custody are also notably absent from the national statistical collection on deaths in custody. Reporting on the results of an inquest is an important part of accounting for individual deaths and preventing future deaths in similar circumstances. However coronial records on individual deaths are arguably too inaccessible to serve the purposes of ongoing monitoring and accountability for deaths involving a duty of care by state officials. The National Deaths in Custody Monitoring Program (NDICMP) maintained by the Australian Institute of Criminology is designed to fill this gap in relation to criminal custodial settings. The reports are developed using data from state and

territory police services, correctional and juvenile agencies, and state coroners. The ACT is the only State that has legislated mandatory reporting to the AIC within its State Coroner's Act [ACT Coroner's Act s75 (c)]. The purpose of the reporting program is to examine the circumstances of deaths in prison, police custody, and juvenile detention around Australia from a research perspective and report on trends and patterns in deaths in custody in Australia (Australian Institute of Criminology National Deaths in Custody Program, n.d.).

The NDICMP collection applies the definition of death in custody established by the Royal Commission into Aboriginal Deaths in Custody (Lyneham, Joudo Larsen, & Beacroft, 2010), namely,

- the death wherever occurring of a person who is in prison custody or police custody or detention as a juvenile;
- the death wherever occurring of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care while in custody;
- the death wherever occurring of a person who dies or is fatally injured in the process of police or prison officers attempting to detain that person; and
- the death wherever occurring of a person who dies or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention. (p. 4)

Recommendation 41 of the Royal Commission proposed that statistics and other information on Aboriginal and non-Aboriginal deaths in custody should be monitored nationally on an ongoing basis by the AIC. The NDICMP was subsequently established in 1992 to monitor and report annually on deaths in police and prison custody and juvenile detention. An important resolution of the Australasian Police Ministers' Council in 1994 extended the definition of "police custody" beyond institutional settings to include deaths during police operations (Lyneham et al., 2010). The increasing number of deaths in immigration custody has led to calls for the monitoring program to be extended to cover deaths that take place in custodial settings outside the criminal justice system (Ting, 2010). This pressure is reflected in the Foreword of the most recent NDICMP report, which states explicitly that the report "does not consider deaths in detention centers under immigration legislation" (Lyneham et al., 2010). According to some reports, the AIC has justified the exclusion of these deaths in custody simply on historical grounds:

The terms of reference that came out of the Royal Commission into Aboriginal Deaths in Custody for [the AIC] were such that we look at deaths in custody as a result of people incarcerated under the criminal law. No consideration was ever given to us looking at people detained under immigration law and our reporting on deaths in custody has been on that basis ever since. (AIC spokesperson cited in Ting, 2010)

While the AIC is currently considering a pilot study of deaths in immigration detention centers, which would be a most welcome development, the macro political

context in which the Institute has been operating has seemingly stymied its progress: first, because of the high octane political environment surrounding the use of immigration detention in Australia, and second, because of the political and practical realities of being a Commonwealth-funded research agency seeking resources to report on deaths occurring in custodial contexts operated exclusively by the Commonwealth.⁶ These may be significant macro-level barriers to achieving recognition for deaths in immigration custody on a par with the accountability procedures surrounding deaths in criminal-justice settings.

Immigration Custody Deaths as Deaths in Custody

It is also important to examine the micro-level factors that determine whether deaths in immigration custody are treated on a par with deaths in criminal-justice custody. A starting point is to identify and label as “deaths in custody” those border-related deaths that occur in the custody of government officials in the course of enforcing immigration controls. The locations of the 29 cases of deaths in immigration custody we have identified vary widely from detention centers, to hospitals, busy city streets or remote rural locations, and the dramatic setting of interdiction on the high seas (see Table 2). A full list of the 29 deaths in immigration custody is contained in Appendix 2. What unites all of these deaths, we argue, is that they occurred in a context that involved a duty of care on law enforcement officials that demands a full and open investigation.

It is not possible for us to examine in any depth the 26 fatalities that did not result in the publication of a coroner’s report, nor to investigate fully the reasons for conducting or failing to conduct an inquest. Of particular concern is the failure to conduct an inquest in relation to 7 of the 17 known cases of death in Australian immigration detention centers and the public release of only four of the 10 inquests that were conducted. As explained above, none of the 29 deaths has been counted by the NDICMP in their annual reporting. However, several of these deaths have been the subject of a Coronial inquest and treated as “deaths in custody” in that context. For those deaths in immigration custody that have been subject to a Coronial inquest, there is no obvious pattern in terms of the kinds of deaths and the circumstances surrounding these deaths that distinguishes them from deaths in similar circumstances that were not subjected to full inquiries. This confirms that the present discretionary arrangements are a fragile basis on which to seek accountability for the deaths of non-citizens in custodial settings and to facilitate research that might prevent future deaths.

The eight Coronial inquests, for which reports are publicly available, covering the deaths of 13 people in immigration custody, are discussed in this section. The deaths of Ahmad Al-Akabi, Josefa Raulini, and David Saunders during separate incidents in the NSW Villawood Immigration Detention Centre in 2010 were subject to a combined Coronial Inquest. The death by drowning in the Murray River of WahAun Chan on September 11, 2006 in rural South Australia after he ran from police following a vehicle stop has also been the subject of a Coronial Inquest. The death of Fatima Irfani on January 9, 2003 was initially the subject of a Coronial Inquest in WA; however, the inquest was later dropped because of a large delay in initiating the coronial proceedings.

Table 2. Conduct of Coronial Inquests Into Deaths in Immigration Custody in Australia Since 2000.

Type of death in immigration custody	Number of incidents	Number of deaths	Conduct of a Coroner's inquest	Public availability of the Coroner's inquest report
Onshore immigration detention	17	17	10/17 incidents	4/17 incidents
Offshore immigration detention	2	2	1/2 incidents	1/2 incidents
During offshore interdiction by Australian border control	3	8	2/3 incidents	2/3 incidents
During onshore apprehension (by DIAC or police pursuit)	2	2	2/2 incidents	1/2 incidents
Total	24	29	15	8 (relating to 13 deaths)

Note. DIAC = Department of Immigration and Citizenship.

Fatima Irfani died in a Perth hospital from a brain bleed following transfer from the remote Christmas Island Immigration Detention Centre. Fatima and NurjanHusseini drowned when their boat was intercepted at sea by the Australian border control authorities off Christmas Island on November 8, 2001. Their deaths were subject to a 2002 Coronial Inquiry in Western Australia. The drowning of five Afghan asylum seekers following an explosion on board the Suspected Illegal Entry Vessel (SIEV) 36 during an Australian navy interception at sea in April 2009 was subject to a Coronial Inquiry by the Northern Territory State Coroner, who is also responsible for the jurisdiction of Ashmore Reef and the Cartier Islands, which are targeted destinations for irregular boat arrivals. The death of WahAun Chan and the Ashmore Reef SIEV 36 explosion were the only two of these incidents to be treated as "deaths in custody." A third case, the death of HaiPhucVo, was also handled as a death in custody but the report is not available for analysis. HaiPhuc Vo was a Vietnamese man who died in a Melbourne hospital after transfer from Port Phillip Prison on January 24, 2001. The Northern Territory coroner's report on the SIEV 36 explosion directly considered the five deaths as deaths in custody because of the naval interception by the Australian Defence Force. Specific findings in relation to the custodial setting were presented within the report.

An analysis of the coroner's report and findings for each of these incidents can help to shed light on how these deaths can be treated as a death in custody and provide opportunities for coroners to explore the issue of state culpability. The analysis that follows is divided into the four immigration custody settings as presented in the definition mentioned earlier in this article: onshore detention, offshore detention, interdiction at sea by Australian border control, and during apprehension by police or DIAC officers.

The deaths of Josefa Rauluni, Ahmad Al-Akabi, and David Saunders, all occurred at Villawood Immigration Detention Centre in Sydney from September to December 2010. All three died by suicide. The findings of the coronial inquests into these deaths were presented in a combined report.⁷ It might be argued that specific border control practices and, in the cases of Rauluni and Al-Akabi, decisions by the Australian government with regard to their asylum applications, had an impact on their deaths. The Australian immigration detention system is among the harshest in the world, being mandatory in many cases, indeterminate, and immune from judicial review. Although the coroner's remit did not include these wider questions of policy, she did consider whether the close proximity in time between these deaths was indicative of systematic problems within the particular detention center involved. To this end, she examined the treatment of the men by the SERCO security company, which runs the center, the DIAC, which authorized the men's detention, and the health service staff employed at the center, and investigated whether any risk of suicide had been detected by their staff in the lead up to these deaths (New South Wales State Coroner, 2010). The coroner was highly critical of the immigration detention system, security procedures, and the healthcare system at Villawood. In first noting that DIAC retains a "non-delegable duty of care to all immigration detainees," the coroner reported that the implementation of these systems and procedures was so poor and mismanaged that SERCO staff at Villawood failed to fulfill a duty of care to these men on behalf of DIAC. This question of delegation points to the complexity in tracing the lines of responsibility within privatized detention systems.

Despite the importance of the custodial environment in which these suicides took place, the coroner made no explicit mention of these deaths as "deaths in custody" nor did she refer to Villawood Immigration Detention Centre as a place of custody. In reporting her recommendations, the coroner also faced a jurisdictional difficulty arising from Australia's federal system. While responsibility for the operation of immigration detention centers rests with the Australian Federal Government, the coroner reports to the New South Wales State Parliament, or, more specifically, to the "Minister" as directed in section 82(4) of the NSW Coroner's Act. While this may indicate a need for a federal coroner to report on incidents that occur in immigration detention centers, this recommendation was not made in the coroner's report. Instead, the coroner simply sought to direct her recommendations to the federal Immigration Minister. In the 2011-2012 DIAC annual report, the Department welcomed the NSW State Coroner's recommendations, acknowledged that further action was needed to address them, and claimed that they would be implemented as soon as possible (DIAC, 2012). However, the potential for compliance with these recommendations seems to be diminished given the cross-jurisdictional considerations.

Mr. WahAun Chan, a Malaysian citizen, drowned on September 11, 2006 after running from police officers who attempted to detain him in their police vehicle following a random breath test. Although the original action by the police concerned a potentially criminal matter, the officers formed the view that Mr. Chan may be an unlawful non-citizen when he failed to produce a valid visa. They were therefore required under s189 of the Migration Act to apprehend him. It transpired that Mr. Chan's visa had

expired some weeks before. Following his escape from custody, the police conducted a number of unsuccessful searches and his body was not found until September 20, when it was located in the Murray River around 3 kilometers from where he originally ran from the police. In conducting the inquest, the coroner justified classifying the death as a “death in custody” on the following basis:

Although it is not entirely clear how soon after this incident Mr Chan met his death, it is my opinion, having regard to all of the circumstances, that Mr Chan was continuing to evade apprehension by South Australia Police at the time of his death. Accordingly, his was a death in custody within the meaning of paragraph (b)(ii) and (c) of the definition of that expression in the Coroner’s Act 2003, and an Inquest was required to be held pursuant to section 21 of that Act. (South Australia State Coroner, 2008, p. 2)

Furthermore, the coroner reported that the search for Mr. Chan was for “a person thought to have escaped police custody when detained under the Migration Act (Commonwealth)” and not for “a person thought to have fallen in the river.” The coroner concluded in his findings that all police officers associated with the incident had acted appropriately. No findings were presented with regard to Mr. Chan’s irregular visa status or the coroner’s decision to treat his death as a death in custody. Clearly, the categorization of this death as a death in custody arose because—alone among the cases we have identified as “deaths in immigration custody”—WahAun Chan died while fleeing from police. Had the same events occurred in the context of a visa status check by immigration compliance officers, it is not clear that this death would have been classified by the coroner as a “death in custody.” The death of the South Korean citizen, Seong Ho Kang, who was struck by a taxi in Sydney on July 1, 2004 after running from an immigration raid conducted by DIAC compliance officers, was also subject to a Coronial Inquest, but the report was not publicly released. While the reasons for this are not known, this raises questions about whether DIAC compliance officers—who possess police-like powers in the context of immigration enforcement—are to be subject to similar levels of public accountability as those that apply to police.

Fatima Irfani died of an intracranial hemorrhage following her transfer to Sir Charles Gairdner Hospital in Perth from the remote Christmas Island Immigration Detention Centre on January 19, 2003. A person held in an immigration detention center, or even a “person in detention” is not included in the definition of a “person held in care” under the WA Coroner’s Act. In relation to the death of Mrs. Irfani, this meant that there was no legal ground for her death to be subject to a mandatory inquest. In this case, the coroner did agree to conduct a public inquest immediately following Mrs. Irfani’s death in the interest of justice. The coroner later commented in 2009 that this decision was based on the fact that the circumstances of her detention were “analogous to the situation of a person held in care for the purposes of the *Coroners Act 1996*” (WA State Coroner, 2011, p. 9). A time lapse of four years, reportedly because of a delay while Mrs. Irfani’s husband obtained access to legal advice,⁸ resulted in the coroner deciding to abandon the full inquest in favor of a less comprehensive review into the death based on Mrs. Irfani’s medical records. At the time of his wife’s death,

Mr. Irfani was also incarcerated in Christmas Island Immigration Detention Centre along with his three children. After receiving news of their rejected asylum claims in mid 2002, and following a failed appeal in the December of that year, the family had reluctantly agreed to return to Afghanistan. It was around this time that his wife complained of severe headaches that eventually resulted in her death, and Mr. Irfani and his children returned to Afghanistan with Fatima's body. However, in 2009 after a successful application for himself and his children, Mr. Irfani and his family returned to Australia on a Special Humanitarian Visa, where they contested the coroner's earlier decision to abandon an inquest into Fatima's death (Marr, 2010; St Paul's Anglican Church, 2012).

An appeal to the Western Australia Supreme Court in 2009 by the Irfani family against the coroner's decision to abandon the full inquest was heard in 2011. The Plaintiffs asserted that Christmas Island Immigration Detention Centre was a place of custody and argued that as the death occurred in Sir Charles Gardener hospital, Perth following transfer from Christmas Island, it should be subject to a mandatory inquest:

The plaintiffs submit that it is necessary in the interests of justice that every death in immigration detention be treated as if it were the death of a person held in care . . . It is submitted that sufficient concern has been expressed as to the medical treatment of immigration detainees for it to be in the interests of justice that an inquest be held where a detainee dies in immigration detention or shortly after release from immigration detention. (WA State Coroner, 2011, p.12).

The state coroner responded that Mrs. Irfani was not a person held in care under section 3 of the Coroner's Act 1996. The initial decision to treat Mrs. Irfani's death as a death in care at the time of her death was confirmed to be a discretionary decision and not a mandatory requirement under law. To reinforce this point, the case of Mohammed YousefSaleh, who died in Hollywood Private Hospital in Perth in 2001 following transfer from Port Hedland prison as an immigration detainee, was used by the coroner to highlight the fact that a person held in immigration detention does not meet the definition of a person held in care. In the inquest into the death of Mohammed YousefSaleh, the coroner noted that the deceased was not a person held in care, also presenting Section 3 of the *Coroner's Act 1996* to underscore that persons held in Commonwealth immigration detention facilities are not included in the definition. In the case of Saleh, the coroner recommended an amendment to include immigration detention within the statutory definition of a "death in care," but this legislative action has not been undertaken.

Issues over State versus Federal jurisdiction in terms of the coroner's powers and responsibilities also arose in the case of Fatima Irfani. The WA Coroner's Act 1996 (WA) (Christmas Island (CI) (Cth.)) has a Federal jurisdiction and confers power on the state coroner to investigate a death in an immigrationdetention center of the Territory of Christmas Island (WA State Coroner, 2011). The Plaintiff argued this point to push for the coroner to conduct an inquest into Mrs. Irfani's death. However, Mrs. Irfani died on the mainland and not on Christmas Island, allowing the coroner to exercise his

responsibilities solely under the State jurisdiction. The Irfani family lost their appeal in the Supreme Court. In his decision, the judge acknowledged the Plaintiffs' position that when a death takes place in immigration detention, it is essential to the public interest that an inquest is conducted. However, he ruled in support of the state coroner that in view of the large time lapse between the death of Mrs. Irfani, the request for a full inquest, and subsequent appeal, it was reasonable that a full inquest would not be conducted in this case. The initial delays in initiating the coronial proceedings—delays that were clearly related to the marginalized legal status and social circumstances of the surviving members of the Irfani family—proved to be extremely costly in terms of accounting for Mrs. Irfani's death.

Fatima and NurjanHusseini drowned on November 8, 2001 en route to Australia from Indonesia after the boat they were traveling on caught fire following interception by an Australian Customs Vessel and the HMAS Wollongong. The outbreak of fire forced all 164 people on board to jump into the sea. All of the other passengers were rescued alive. During the Coronial inquest, evidence was presented suggesting that the fire was deliberately lit. However, it remains inconclusive as to whether the small fire that was initially started by a passenger was intended to ignite the boat's diesel supply, resulting in the fire burning out of control. The coroner ruled the deaths to have occurred by drowning as a result of a fire on board the vessel (Office of the State Coroner, 2002-2003). In the WA State Coroner's Annual Report 2002-2003, no reference was made to the fact that these deaths occurred in immigration custody or in the context of interception by the Australian border control authorities. While the interception was acknowledged, the coroner did not make any explicit and direct connection between the deaths and the actions of Australian border control personnel in taking control of the vessel. The coroner did not treat the deaths as deaths in custody. The coroner concluded that the deaths resulted from one of the two possible scenarios—by way of unlawful homicide or by way of accident. Either way, the culpability was directed toward the unknown passenger who lit the fire, with little reference to the wider policies of offshore interdiction that shaped events or the actions of border control officials in carrying out those policies.

Specific border control practices came under a more intensive scrutiny in a case involving an explosion on board a vessel code-named the SIEV 36 off Ashmore Reef that was carrying 47 asylum seekers and crew. The fatal events occurred on April 16, 2009, during interception by the Australian Navy, resulting in the deaths by drowning of five Afghani male asylum seekers, Mohammed Hassan Ayubi, Muzafar Ali Sefarali, Mohammed Amen Zamen, AwarNadar, and BaquerHusani and injuries to other asylum seekers and defense personnel. The Northern Territory coroner concluded that the explosion was caused when passengers deliberately set fire to petrol on board the vessel that had not been secured by the naval personnel on board. Communication of a written notice issued by the Australian Naval commander warning the crew not to enter Australian waters was found to have also contributed to the disaster. Because the boat had already entered Australian waters, the passengers mistakenly believed that they were to be sent back to Indonesia from where their voyage had originated. This

precipitated drastic action by some passengers to cripple the vessel in the belief that this would prevent their forced return.

While assigning much of the responsibility for the disaster to passengers who lit the fire, the NT coroner concluded that some members of the naval boarding party lacked appropriate training, that a smaller party of six boarded the vessel and not the required eight personnel for such an operation, and that the party did not conduct a thorough search and secure operation as the petrol in the hatch and bilge, a kerosene lamp, and the lighters later used to ignite the fire were not located. Finally, the warning notice served by the Australian naval commander to the passengers on the SIEV 36 was judged to be inappropriate and also contributed to the cause of the explosion. Despite criticisms from survivors about the actions of some personnel following the explosion, the coroner commended the response of the Navy personnel at this point, particularly concerning the rescue of the passengers (Northern Territory Coroner, 2010).

In this case, the state coroner noted that the inquest was required pursuant to s26 of the Northern Territory Coroner's Act because the deaths occurred while the deceased were being held in custody of the Australian Defense Force in the Australian Territorial Waters (Northern Territory Coroner, 2010). In his report, he presented a number of findings concerning public health and safety and the care, supervision, and treatment of persons held in custody. These findings mostly concerned the interception operation and training of navy personnel, as well as the delivery of warning notices to passengers on board intercepted vessels. Furthermore, within these findings, the coroner referenced the Australian Navy Manual that recognizes that there was a duty of care on the part of the Australian Navy to navy personnel and passengers on board intercepted vessels (Northern Territory Coroner, 2010).

Conclusion: Accounting for Deaths in Immigration Custody

As this discussion has shown, coroners' legislation across Australia does not currently require deaths in immigration custody to be referred to a state coroner. As a result, reporting on deaths that occur in immigration custody is ad hoc and does not allow systemic analysis and the development of comprehensive preventative strategies. In addition, the Commonwealth-funded agency charged with monitoring deaths in custody has also determined that deaths in immigration custody are beyond its remit. A lack of official, routinized oversight results in the risks associated with border protection policies and official enforcement practices remaining largely unexamined, and the same standards of accountability expected of prison officials and police in the context of law enforcement and punishment are therefore not applied. Through these omissions, a divide is opened up between the value placed on the lives of citizens and non-citizens.

The interplay of state and federal jurisdictions in immigration enforcement and the delegation of responsibility for the immediate wellbeing of immigration detainees to private security companies add extra layers of complexity to the task of constructing a

system of monitoring and accountability within the immigration enforcement regime. However, the cases reviewed in the previous section demonstrate that there is a growing recognition of the need for legislative change to bring deaths in immigration custody into the category of reportable deaths. The pilot program announced by the Australian Institute of Criminology indicates that the inclusion of deaths in immigration custody in the NDICMP is also an achievable goal, given sufficient political will. The brief review of arrangements for the investigation of deaths in custody in other English-speaking countries set out in the introduction suggests that the involvement of a national authority, such as the Commonwealth Ombudsman, as in the British model, might provide some national coordination in relation to deaths arising under Commonwealth legislation, provided that arrangements could be made to ensure effective collaboration with coroners operating under state jurisdiction. While the immigration authorities provide this federal-level intervention in the United States, the lower number of deaths and wide range of contexts in which deaths in immigration custody occur in Australia argue against DIAC being a lead agency in this country. Clearly, any such arrangement would also fail to meet the requirements of independence and openness that are expected in relation to the accountable operation of state agencies in other contexts.

As with the recognition of deaths in custody within criminal justice settings, applying the “death in custody” label for the purposes of investigation and monitoring does not constitute an attribution of responsibility for the death—criminal or otherwise. None of the cases of deaths in Australian immigration custody discussed in this article raises obvious questions about homicide deliberately perpetrated by government officials. However, it is important to consider whether the processes for responding to this possibility are adequate within the systems described in this article. The Australian Institute of Criminology in its National Homicide Monitoring Program defines homicide broadly in terms of “a person killed (unlawfully)” (Australian Institute of Criminology National Homicide Monitoring Program, n.d.), although more specific definitions of a range of homicide-related offenses are contained within state legislation. It is at least foreseeable that a death in immigration custody could in the future be subject to a finding by a coroner of “unlawful” killing, and, indeed, two Australian jurisdictions have statutes capable of supporting prosecutions relating to failures in duty of care without applying the “homicide label.” An offense of “criminal negligence” in reference to duty of care is contained within the Criminal Codes of the Northern Territory and South Australia. Under Section 43BN of the Northern Territory Criminal Code Act 1983, the offense of negligence includes prohibitive conduct in relation to corporate management of employees, agents, or offices [Northern Territory Criminal Code Act 1983, S 43BN 4(a)]. Under the South Australian Criminal Law Consolidation Act 1935, Division 1A, Section 14, criminal liability for neglect where death or serious harm results from unlawful acts where the defendant has, at the time of the act, a duty of care to the victim. These formulations arguably have the potential to be applied in the context of Australian authorities responsible for the administration and conduct of immigration control through the use of custody.

However, in practice, tracing out the lines of responsibility is an ambitious undertaking in these circumstances in which official policies and chains of actors are involved. Assigning individual culpability for deaths in custody has proven to be a major challenge in the law-enforcement context where a substantial “margin of appreciation” is accorded to state officials in the execution of their duties, often in circumstances that are recognized to be particularly challenging. Of the 99 deaths in police and prison custody investigated in the Royal Commission into Aboriginal Deaths in Custody, not a single criminal prosecution eventuated—much to the dismay of family members and Aboriginal activists. Since then, multiple deaths of Aboriginal arrestees have attracted similar controversy, including the botched prosecution of the arresting officer in the case of the Palm Island man, Cameron Doomadgee, who suffered serious internal injuries in a police cell (Weber, 2007). The death of 21-year-old Brazilian student, Roberto Laudisio Curti, after being repeatedly tasered by the NSW Police, is another case in point. The NSW coroner found that Curti died in the course of being restrained by NSW police officers and condemned the actions of the arresting officers in the strongest possible terms (New South Wales State Coroner, 2012). Despite these strong findings, she did not recommend criminal charges be brought against the officers, apparently because of medical uncertainty about the precise cause of death.

When compared with the levels of criminal culpability applied to members of the general public, it is debatable whether a similar reluctance to spread responsibility for causing death would apply. In fact, many liberal democracies, including Australia, have made an increasing use of criminal association laws, so that individuals, often young people, who are accompanying others who commit serious or violent crimes, may be charged along with the actual perpetrators as if their level of culpability were the same. In contrast to this expanding net of criminal culpability, not one of the deaths that have occurred in Europe during the forced deportation since 1993 has resulted in a homicide prosecution, including the relatively recent death of Jimmy Mubenga on a British Airways flight in which his asphyxiation at the hands of private security guards was witnessed by a number of passengers (Weber & Pickering, 2011).

But holding particular individuals accountable for avoidable deaths is not the only valuable outcome that might arise from the investigation of deaths in immigration custody. Thorough examination of systemic factors leading to individual deaths by coroners can give rise to recommendations for improved policies and practices, as some of the cases discussed above have revealed. Moreover, even where state agents are not directly involved in the immediate events surrounding a death related to border control policies, the principle of “foreseeability” can be applied to establish some level of state culpability. The sinking of a vessel off Christmas Island in December 2010 in which the lives of 50 asylum seekers were lost is a case in point. The vessel had not been interdicted and was not under the control of Australian border authorities at the time it was foundered, and therefore, does not qualify as a death in immigration custody according to our definition. However, the failure to assume control of the stricken vessel and avert the tragedy nevertheless attracted criticism from the Western Australian coroner who concluded that rescue equipment and protocols were inadequate given the “foreseeability” of such tragedies (WA State Coroner, 2012).

More broadly still, sustained critical analysis can identify links between border-control policies themselves and avoidable deaths, irrespective of the individual actions of officials involved, arising from the heightened risks of illegalized travel and the insecurity associated with living in states of immiseration and deportability. Two of the authors have developed this argument about “death by policy” elsewhere (Weber & Pickering, 2011). Legal theorist Nicola Lacey (2007) has argued in relation to corporate manslaughter that “outcome responsibility” can be attributed where individuals play any part in “risk creating activity,” including through lawful acts. While a similar argument could be attempted in the case of criminal responsibility for deaths at the hands of law enforcement officials, there is no suggestion that these highly politicized concerns could reasonably be incorporated into Coronial investigations or processes of official monitoring that are the subject of discussion here.

Our argument here is for these deaths to be routinely investigated and systematically analyzed by a monitoring and reporting body such as the NDICMP to identify degrees of state culpability for these deaths and prevent deaths through improved policies and procedures. The investigation and counting of border-related deaths is therefore important for ascertaining culpability and for the preventative and criminological insights the process would yield. Most importantly, systematic and open inquiries might challenge the kinds of denial about state responsibility for deaths in immigration custody that Stanley Cohen referred to as “knowing and yet not-knowing” about human rights abuses (Weber, 2010). Currently in Australia, deaths in immigration custody are known-and-yet-not-known. Systematic investigation and analysis are the first steps toward identifying chains of accountability. Whenever lives are lost in the context of coercive interventions by state agents, there is a need to count and account for these deaths, whether the lives lost are those of citizens or non-citizens.

Appendix I. State Legislation and Procedures for Conducting a Coronial Inquest.

State or territory	Relevant coroner's legislation	Reportable deaths defined where the definition includes death in custody or care?	Does a death in custody warrant a coronial inquest?	Do reportable deaths warrant a coronial inquest?
Northern Territory	Northern Territory Coroner's Act 2011, and Deed of Agreement between Northern Territory of Australia and the Commonwealth of Australia of 19 September 2005 in accordance with s 11A of the Ashmore and Cartier Islands Acceptance Act 1933	Yes (Part 2)	Yes (Part 4, Division 1, S 15)	Yes (Part 4, Division 1, S 14)

(continued)

Appendix 1. (continued)

State or territory	Relevant coroner's legislation	Reportable deaths defined where the definition includes death in custody or care?	Does a death in custody specifically warrant a coronial inquest?	Do reportable deaths warrant a coronial inquest?
South Australia	South Australia Coroner's Act 2003	Yes (Part 1)	Yes (Part 4, S 21)	Yes (Part 4, S 21)
Australian Capital Territory	Australian Capital Territory Coroner's Act 1997	No	Yes (Part 3, Division 3.1, S 15)	-
Queensland	Queensland Coroner's Act 2003	Yes (Part 2, S 8)	Yes (Part 3, Division 1, S 11)	Yes (Part 3, Division 1, S 11)
Tasmania	Tasmania Coroner's Act 1995	Yes (Part 3)	Yes (Part 5, S 24)	Yes (Part 5, S 21)
Western Australia	Western Australia Coroner's Act 1996 and Coroner's Act 1996 (WA) (CI) CI=Christmas Island and Coroner's Act 1996 (WA) (CKI) CKI = Cocos(Keeling) Islands	Yes (person held in care) (Part 1, S 3)	Yes (death in care) (Part 4, Division 1, S 22)	Yes (Part 4, Division 1, S 19)
New South Wales	New South Wales Coroner's Act 2009	Yes (Chapter 1, S 6)	Yes (Division 2, S 23)	Yes (Part 3.2, Division 1)
Victoria	Victoria Coroner's Act 2008	Yes (Part 1, S 4)	Yes (Part 5, Division 1, S 22)	Yes (Part 4, Division 1, S 14)

Appendix 2. Deaths in Australian Immigration Custody, Case by Case. (recorded January 2000-November 2012).

Date	Immigration custody setting	Number of deaths	Personal details	Incident details
22-Dec-2000	Onshore immigration detention center	1	VilliamiTanginoa, Tongan, male, 52 years old	Died after plummeting from basketball pole at Maribyrong Detention Centre, Melbourne after altercation with guards.

(continued)

Appendix 2. (continued)

Date	Immigration custody setting	Number of deaths	Personal details	Incident details
24-Jan-2001	Onshore detention center (transfer to hospital)	1	HaiPhuc Vo, Vietnamese, male	Died in Western General Hospital, Melbourne after being transferred from Port Phillip Prison.
23-Jun-2001	Onshore Immigration detention center (transfer to hospital)	1	Mohammed Saleh, Palestinian, male, 42 years old	Died of medical condition in Hollywood Private Hospital, Perth after being transported from Port Hedland Immigration Detention Centre.
25-Jul-2001	Onshore immigration detention center	1	AvionGumede, South African, male, 30 years old	Killed himself after arriving at Sydney Airport and being detained in Villawood Immigration Detention Centre, Sydney.
01-Sept-2001	Interdiction at sea by Australian border control	1	Unknown, Afghan newborn baby	Died due to lack of medical care on board refugee vessel during Operation Relex interception at Ashmore Reef, off the coast of Western Australia; first interception post Tampa.
08-Nov-2001	Interdiction at sea by Australian border control	2	NurjanHusseini, Afghan, female, 55 years old and Fatima Husseini, Afghan, female, 20 years old	Passengers on refugee boat "Sumber Lestari" drowned during Operation Relex off Christmas Island.
13-Jan-2002	Onshore immigration detention center	1	Thi Hang Ley, Vietnamese, female	Killed herself after being put in Villawood Immigration Detention Centre, Sydney, for overstaying visa. This was her 3rd suicide attempt.
26-Aug-2002	Offshore immigration detention center	1	Mohammed Sarwar, male	Died in Nauru Detention Centre.

(continued)

Appendix 2. (continued)

Date	Immigration custody setting	Number of deaths	Personal details	Incident details
19-Jan-2003	Offshore immigration detention center (transfer to hospital)	1	Fatima Irfani, Afghan, female, 29 years old	Died in Sir Charles Gardener Hospital, Perth, of bleeding in her brain after transfer from Christmas Island.
19-Jun-2003	Onshore immigration detention center (transfer to hospital)	1	QuocKinhPhung, Vietnamese, male	Died in Western General Hospital, Melbourne, after being transferred from Maribyrnong Immigration Detention Centre, Melbourne.
16-Apr-2004	Interdiction at sea by Australian border control	5	Mohammed Hassan Ayubi 45, Muzafar Ali Sefarali 45, Mohammed Amen Zamen 38, Awar Nader 50, BaquerHusani 26, all Afghan males	Died as a result of explosion on boat codenamed "SIEV 36" during naval interception at Ashmore Reef.
01-Jul-2004	Death from pursuit by Department of Immigration Law Enforcement	1	Seong Ho Kang, Chinese, male	Run over by a taxi in Strathfield, Sydney, after being chased on foot by DIAC Law Enforcement Unit.
29-Aug-2004	Onshore immigration-detention center	1	Marc Lao Thao, French, male	Died in Villawood Immigration Detention Centre, Sydney.
25-Mar-2005	Onshore immigration-detention center	1	Unknown, male	Died in Maribyrnong Immigration Detention Centre, Melbourne.
11-Sept-2006	Death from pursuit by police	1	WahAun Chan, Malaysian, male, 27 years old	Drowned in River Murray after running from police near Waikerie on the Sturt Highway, South Australia.
13-Jan-2008	Onshore immigration-detention center	1	MrFashovar, Iranian, male, 62 years old	Died of a medical condition in Villawood Immigration Detention Centre, Sydney.

(continued)

Appendix 2. (continued)

Date	Immigration custody setting	Number of deaths	Personal details	Incident details
Unknown (reported 2008)	Onshore immigration-detention center	1	Mr Mack, Male, 76 years old	Died in Villawood Immigration Detention Centre, Sydney, following surgery for a medical condition.
29-Sept-2009	Onshore immigration-detention center	1	Puanthong-Simaplee, Thai, Female, 25 years old	Trafficked into Australia for sexual exploitation age 12, heroin addiction, died of medical condition in Villawood Immigration Detention Centre, Sydney
23-Aug-2010	Onshore immigration-detention center (transfer to hospital)	1	Unknown, Afghan, male, 30 years old	Died Sir Charles Gardener Hospital, Perth, Western Australia, of a medical condition after being found unconscious at the Curtin Immigration Detention Centre.
20-Sept-2010	Onshore immigration-detention center	1	JosefaRauluni, Fijian, male, 36 years old	Jumped off a roof at Villawood Immigration Detention Centre, Sydney, hours before he was to be deported.
16-Nov-2010	Onshore immigration-detention center	1	Ahmad al-Akabi, Iraqi, male, 40 years old	Committed suicide at Villawood Immigration Detention Centre, Sydney, after refugee application was rejected twice.
08-Dec-2010	Onshore immigration-detention center	1	David, Saunders, British, male, 29 years old	Committed suicide at Villawood Immigration Detention Centre, Sydney.
18-Mar-2011	Onshore immigration-detention center	1	MiqdadHussain, Afghan, male, 20 years old	Found dead in detention center in Weipa, near QLD, by staff. Suspected suicide.
27-Mar-2011	Onshore immigration-detention center	1	Mohammad Asif Ata, Afghan, male, 19 years old	Found dead in detention center, Curtin, Western Australia by other detainees. Suspected suicide.
Total		29		

(continued)

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Notes

1. The database is maintained by the authors and is hosted on the Border Crossing Observatory website, www.borderobservatory.org. The analysis presented in this article reflects the database, which includes the identified incidents of deaths in custody, from the period January 2000- November 2012.
2. During the course of reviewing this article (March-May 2013), another four deaths in immigration custody have been reported in the Australian media and identified as deaths in immigration custody by the Border Crossing Observatory's Australian Border Deaths Database. Given that these deaths happened so recently, they will not be included in this article's discussion of reporting and reviewing deaths in immigration custody in Australia. It is not yet known whether a Coroner will investigate any of these deaths. These most recent deaths include, March 29, 2013, the death of a pregnant woman aged 22 years and a 4-year-old boy, both Afghan, who drowned when their fishing boat was intercepted at sea by Australian Customs 15 nautical miles off the coast of Christmas Island. A 33-year-old Papua New Guinean male fell out of a window and died while receiving treatment at Liverpool Hospital in Sydney. He was transferred to hospital from Villawood Immigration Detention Centre to receive medical treatment. On May 1, 2013, a 35-year-old Sri Lankan man died shortly after arriving at Christmas Island Immigration Detention Centre of a cardiac arrest.
3. The eight Coronial inquests publicly available for the following 13 deaths in immigration custody were analyzed for this article, Mohammed Saleh (WA), Nurjan and Fatima Hussein (WA), and Fatima Irfani (WA); The Ashmore Reef Explosion resulting in the deaths of Mohammed Hassan Ayubi, Muzafar Ali Sefarali, Mohammed Amen Zamen, Awar Nader, and BaquerHusani (NT); WahAun Chan (SA), JosefaRauluni, Ahmad al-Akabi, and David Saunders (joint NSW Coronial Inquest).
4. For offshore territories including Christmas Island and the Cocos (Keeling) Islands—the locations in which unauthorized boat arrivals are most likely to occur off the northern coastline of Australia—Western Australia has territorial jurisdiction over any deaths that may occur. The Northern Territory has territorial jurisdiction over any deaths that occur on Ashmore Reef under a Deed of Agreement between the Northern Territory of Australia and the Commonwealth of Australia.
5. See also ACT Coroner's Act 1997, S 74, Northern Territory Coroner's Act 2011, S 26 1(a), Tasmania Coroner's Act 1995, S 28 (5), and WA Coroner's Act 1996, S 25 (3).
6. The overwhelming majority of other custodial settings included in the national deaths in custody collection reflect a duty of care owed by states and territories.
7. Full details of the deaths of the three men are provided in the coroner's report findings in the inquests into the deaths of JosefaRauluni, Ahmed Obeid Al-Akabi, and David Saunders at Villawood.
8. Full details of this hiatus can be found in WA State Coroner (2011).

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