QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Hamid KHAZAEI**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2014/3292
DELIVERED ON:	30 July 2018
DELIVERED AT:	Brisbane
HEARING DATE(s):	25 August 2015; 4 December 2015; 10 June 2016; 28 November – 2 December 2016; 6-9 December 2016; 13-17 February 2017; 20-21 February 2017. Submissions June 2017 to September 2017.
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: Death in custody; asylum seeker detained under the *Migration Act* 1958 (Cth), transfer to regional processing centre, clinical deterioration, sepsis, arrangements for medical transfers from regional processing centres, health care in regional processing countries.

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper
Ms Goldaneh Khazaei:	Mr Stephen Keim SC and Mr Justin Harper I/B Stacks Gouldkamp Lawyers
Commonwealth of Australia:	Mr Andrew Berger I/B Australian Government Solicitor
International Health and Medical Services ('IHMS') Pty Ltd, International SOS (Australia) Pty Ltd and various employees of IHMS and International SOS:	Mr Geoffrey Diehm QC and Ms Melinda Zerner I/B Moray & Agnew Lawyers
Mater Health Services Brisbane Ltd and Dr Jeff Presneill:	Ms Jennifer Rosengren I/B Minter Ellison Lawyers
Doctors for Refugees:	Mr Gerard Mullins and Mr Ben Wessling-Smith I/B Maurice Blackburn Lawyers

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INTRODUCTION

1. Hamid Khazaei, an Iranian citizen, entered the 'migration zone' at Christmas Island on 7 August 2013 on board Suspected Illegal Entry Vessel 823 *Gadsden*. As Mr Khazaei did not hold a valid visa, he became an 'unlawful non-citizen' and was detained under the *Migration Act 1958* (Cth).

2. On 6 September 2013, Mr Khazaei was transferred to Papua New Guinea (PNG) by officers of the Department of Immigration and Border Protection (DIBP)[1]. Mr Khazaei was transferred to PNG under the Regional Resettlement Arrangement between PNG and Australia, signed several weeks earlier on 19 July 2013. He was taken to the Regional Processing Centre (RPC) located at the PNG Naval Base on Manus Island. Manus Island is a remote tropical island located 821km by air north of Port Moresby. The distances between Cairns and Brisbane from Manus Island by air are 1650km and 2890km respectively.

3. The Manus Island Regional Processing Centre (MIRPC) was established after the Report of the Expert Panel on Asylum Seekers was released on 13 August 2012. The Report included a range of disincentives, including the establishment of processing centres in PNG and the Republic of Nauru (Nauru). The expert panel had been tasked in June 2012 to provide a report on the best way to prevent asylum seekers undertaking boat journeys to Australia.

4. The RPCs were subsequently established under agreements with the PNG and Nauru Governments. Under the agreements the Australian Government is responsible for the costs associated with the operation of the centres. The transfers of asylum seekers to Manus Island started on 21 November 2012.[2]

5. To support the operation of the RPCs, DIBP entered into contractual arrangements for the delivery of services including health care, garrison support and welfare. The provision of health care to asylum seekers on Nauru and Manus Island was initially governed by a 'Heads of Agreement' between DIBP and International Health and Medical Services (IHMS), a subsidiary of global health and security company International SOS. IHMS has been providing detention health services at facilities within Australia since 2003.

6. Mr Khazaei became ill on Manus Island after initially presenting to the IHMS clinic on 23 August 2014 with flu-like symptoms and a small lesion on his leg. He was unable to be treated at the IHMS clinic on Manus Island. His condition rapidly deteriorated and he was eventually transferred to the Pacific International Hospital (PIH) in Port Moresby on 26 August 2014, after requisite approvals were obtained from DIBP officers. Although he was detained under the law of PNG at that time it was necessary for his transfer from Manus Island to Port Moresby to be approved by Australian Government officials.

[1] Now part of the Department of Home Affairs

[2] Manus Island was also used as a RPC under the policy known as the 'Pacific Solution' between 2001 and 2004.

7. Mr Khazaei's condition continued to deteriorate at the PIH, which at that time lacked an intensive care unit, and he was transferred by medevac on 27 August 2014 to the Mater Hospital in Brisbane. A clinical examination at the Mater Hospital on the morning of 28 August 2014 revealed a Glasgow Coma Score of 3 and absent brainstem reflexes consistent with a profound brain injury. The Mater Hospital had received no handover in relation to Mr Khazaei's clinical management at the PIH.

8. Mr Khazaei was 24 years of age when he was declared deceased at the Mater Hospital on 5 September 2014. He was survived by his mother, father and two brothers in Iran.[3] I extend my condolences to Mr Khazaei's family and his friends.

9. As Mr Khazaei was refused entry on arrival at the Brisbane Airport[4] on 27 August 2014, he was again detained under the *Migration Act 1958* from the time he entered Australia until his death. An inquest into his death was mandatory as he died in custody in Queensland.

10. While the lawfulness of Mr Khazaei's detention in PNG was not an issue that fell within the scope of this inquest, I note that in April 2016, the PNG Supreme Court found the detention of asylum seekers or transferees held at the MIRPC breached constitutional rights to personal liberty and was illegal.[5]

11. However, the High Court of Australia subsequently determined that the decision in *Namah v Pato* did not mean that past and potential future actions of the Commonwealth were invalid or precluded under the Constitution or under the *Migration Act 1958.*[6]

12. The High Court also noted that the PNG Supreme Court in *Namah v Pato* did not find that entry into the Regional Resettlement Arrangement, the 2013 Memorandum of Understanding or the 2014 Administrative Arrangements was beyond the power of the PNG Minister, the National Executive Council of PNG or contravened any provision of the PNG Constitution.

13. The MIRPC was closed in late 2017 as a consequence of the decision of the PNG Supreme Court. The men previously detained at the RPC were relocated to alternative accommodation in transit centres at Lorengau. Medical services to those men were initially provided by IHMS. However, the PIH has recently assumed responsibility for the provision of those services.

[3] Exhibit C8

[4] Exhibit C8

[5] *Namah v Pato* (2016) SC1497

[6] *Plaintiff S195/2016 v Minister for Immigration and Border Protection* [2017] HCA 31

Summary of conclusions on issues

14. Mr Khazaei's death was preventable. Consistent with the evidence of the expert witnesses who assisted the court in this matter I am satisfied that if Mr Khazaei's clinical deterioration was recognized and responded to in a timely way at the MIRPC clinic, and he was evacuated to Australia within 24 hours of developing severe sepsis, he would have survived.

15. The following is a non-exhaustive summary of the conclusions reached in these findings in relation to the issues identified for consideration at this inquest:

- the initial medical care provided to Mr Khazaei at the MIRPC clinic from the time of his presentation on the afternoon of 23 August 2014 to the morning of 24 August 2014 was adequate and appropriate;
- no antibiotic was available at the MIRPC clinic to safely and effectively treat the range of infections commonly found in a tropical setting, including the infection suffered by Mr Khazaei;
- there was no recording system in place at the MIRPC clinic to comprehensively track and review Mr Khazaei's deteriorating clinical observations;
- there was a failure to recognise Mr Khazaei's clinical deterioration at the MIRPC clinic;
- Mr Khazaei should have been intubated and aggressively resuscitated while at the MIRPC clinic and prior to his transfer by air to Port Moresby;
- there were a number of significant flaws in the arrangements for Mr Khazaei's transfer from the MIRPC, including a lack of a documented approval process, resulting in a missed opportunity to transfer him on a commercial flight to Port Moresby on the afternoon of 25 August 2014;
- by the morning of 26 August 2014, Mr Khazaei was experiencing septic shock involving acute respiratory depression and hypoxia. At that time he needed to be transferred to a critical care facility in Australia;
- on 26 August 2014, Mr Khazaei was transferred from Manus Island to Port Moresby. The clinicians who received Mr Khazaei at the PIH on that day did not have the necessary clinical skills to deal with his presentation. The significant delay in responding to his critical care needs at the PIH led to cardiac arrest after which Mr Khazaei's condition became irretrievable.

16. Having regard to those conclusions, it would be possible to characterise the circumstances that led to Mr Khazaei's death simply as a series of clinical errors, compounded by failures in communication that led to poor handovers and significant delays in his retrieval from Manus Island.

17. However, attributing responsibility for those events solely on failures by individual clinicians tasked with his care and others responsible for arranging his transfer from Manus Island is not helpful when looking for ways to prevent similar deaths from happening in future. It is important to consider the broader context in which Mr Khazaei's death occurred in order to find ways to prevent similar incidents.

18. While this inquest was not focused on the policy of offshore processing, Mr Khazaei's death occurred in the broader context of Australia's immigration policy framework. That framework required that he be relocated to a small remote island in a developing country in order for his claim for asylum to be processed under PNG law. Although Mr Khazaei was not sent to PNG to be punished, he had been detained on Manus Island for almost 12 months at the time of his death.

19. As outlined in these findings, Mr Khazaei was entitled to receive care that was "*the best available in the circumstances and broadly comparable with health services available within the Australian community*". While all those involved in his health care were well intentioned, the health care he received on Manus Island was not commensurate with the care he would have received in a remote clinic in Cape York – the benchmark applied in this matter. Similarly, the health care he received from the PIH in Port Moresby (as it was then configured and staffed) was not adequate. The inquest highlighted many practical and operational issues associated with delivering the appropriate standard of health care in a remote offshore processing centre.

20. It would be possible to prevent similar deaths by relocating asylum seekers to other places, such as Australia or New Zealand, where better health care would be provided. However, I acknowledge such an approach is highly unlikely in the absence of a fundamental revision of the broader policy framework for minimizing the number of "unauthorized maritime arrivals" that offshore processing seeks to address.

21. The Australian Government retains responsibility for the care of persons who are relocated, for often lengthy periods, to offshore processing countries where standards of health care do not align with those in Australia. It is incumbent on the Australian Government to implement sustainable systems for the delivery of health care that meet the requisite standard. Those systems should also be subject to ongoing and independent scrutiny on behalf of the Australian community, which is required to meet the ongoing and considerable costs of the current arrangements.

22. The Australian Government has assessed that the cost of offshore processing is significantly less than the cost of continuing to allow boats with asylum seekers to arrive in Australia, which have previously been estimated at $11 billion.[7] On the basis that very significant budget savings have been achieved as a result of offshore processing, a substantial enhancement of the investment in the provision of necessary health care for asylum seekers in regional processing countries is justified. Similarly, where adequate health care cannot be provided in a regional processing country the cost of a transfer to Australia should not be a relevant consideration in the approval process. Decisions about medical transfers should be based on clinical considerations.

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7 www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/NauruandManusRPCs/Report/c05

CORONIAL JURISDICTION

23. An inquest is a fact finding exercise and not a process for allocating blame. The procedure and rules of evidence used in criminal and civil trials are not adopted. "*In an inquest there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish the facts. It is an inquisitorial process, a process of investigation quite unlike a trial*."[8]

24. The primary purpose of an inquest is to inform the family and the public about the matters required by s 45 of the *Coroners Act 2003*, including how the person died and what caused the person to die. However, it is recognised that there are limits in terms of the remoteness of particular events in assessing causation. In *Re Doogan; Ex parte Lucas-Smith*[9] it was held:

> *A line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative. The point where such a line is to be drawn must be determined not by the application of some concrete rule, but by what is described as the "common sense" test of causation affirmed by the High Court of Australia in March v E & MH Stramare Pty Ltd (1991) 171 CLR 506 ; 99 ALR 423 . The application of that test will obviously depend upon the circumstances of the case and, in the context of a coronial inquiry, it may be influenced by the limited scope of the inquiry which, as we have mentioned, does not extend to the resolution of collateral issues relating to compensation or the attribution of blame.*

25. In the context of Mr Khazaei's death I have been mindful of both hindsight bias and outcome bias. Hindsight bias refers to the tendency of those with knowledge of an outcome to overestimate the predictability of what actually occurred relative to alternative outcomes that may have seemed likely at the time of the event. Outcome bias refers to the influence of knowledge of the eventual outcome on the retrospective evaluation of clinical care.

26. In appropriate cases, a coroner can also make recommendations with a view to reducing the likelihood of similar deaths. As a result, a coroner can make preventative recommendations concerning public health or safety or ways to prevent deaths from happening in similar circumstances. The power to make recommendations should be construed liberally. As Muir J confirmed in *Doomadgee v Clements*[10]:

> *The expressions "connected with" and "relates to" are of wide import and connote a connection or relationship between one thing and another. The closeness of the connection or relationship is to be "ascertained by reference to the nature and purpose of the provision in question and the context in which it appears". The expressions are "capable of including matters occurring prior to as well as subsequent to or consequent upon" as long as a relevant relationship exists.*

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[8] *R v South London Coroner, ex parte Thompson* (1982)126 S.J. 625
[9] [2005] ACTSC 74
[10] [2006] 2 Qd R 352 at 30-31

The purpose of s 46(1)(c) is self-explanatory. The purpose of the other two paragraphs of the subsection is to empower the Coroner to address the topics specified in them with a view to exposing some failing, deficiency or wrong and/or suggesting measures which may be implemented for the public benefit.

27. A coroner is prohibited from including in the findings or any comments or recommendations any statement that a person is, or may be, guilty of an offence or civilly liable. However, the *Coroners Act 2003* provides that if, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed an offence, the coroner must give the information to the Director of Public Prosecutions in the case of an indictable offence and, in the case of any other offence, the relevant government Department. Information about a person's conduct in a profession can be given to the disciplinary body for that profession if the coroner believes the information might cause the body to inquire into or take steps in relation to the conduct.

28. The findings of a coroner must be based on proof of relevant facts on the balance of probabilities. The principles set out in *Briginshaw v Briginshaw*[11] are applicable. This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard. A coroner also is obliged to comply with the rules of natural justice and to act judicially. This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding.

PRELIMINARY ISSUE

The extent to which submissions can be made by those granted leave to appear.

29. It was submitted on behalf of IHMS and International SOS that the submissions made on behalf of Mr Khazaei's family extended beyond their right to make submissions, and that they should be removed from the record. It was submitted that the family's right to make submissions was limited in the way set out by the High Court in *Annetts v McCann*[12], where the Court considered s 24(1) of the *Coroners Act 1920* (WA). That section provided:

At any inquest, any person who, in the opinion of the coroner, has a sufficient interest in the subject or result of the inquest -
(a) may attend personally or by counsel; and
(b) may examine and cross-examine witnesses; provided that such examination and cross-examination -
(c) is relevant to the subject of the inquest; and
(d) is conducted according to the law and practice of coroners' inquests, and the coroner shall disallow any question which, in his opinion, is not relevant or is otherwise not a proper question.

[11] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361
[12] (1990) 170 CLR 596

30. In *Annetts v McCann,* the majority in the High Court found that s 24(1) gave 'interested parties the absolute right to attend the inquest, to examine and cross-examine witnesses, and to be represented by counsel'. The Court also held that persons with a sufficient interest had a limited right, by reason of the common law right to natural justice, to make submissions with respect to matters which may be the subject of adverse findings concerning their interests. Unlike s 24 of the *Coroners Act* 1920 (WA), section 36 of the *Coroners Act* 2003 provides:

> *(1) The following persons may appear, examine witnesses, and make submissions (emphasis added), at an inquest -*
> *(a) a police officer, lawyer or other person assisting the Coroners Court;*
> *(b) the Attorney-General;*
> *(c) a person who the Coroners Court considers has a sufficient interest in the inquest.*

31. This issue was considered in *R v Tennent; Ex parte Jager*[13] where s 52(4) of the *Coroners Act* 1995 (Tas) was examined. That section relevantly provided:

> *(4) A person who the Coroner considers has a sufficient interest may appear or be represented by a barrister, or a legal practitioner …, call and examine or cross-examine witnesses, and make submissions, at an inquest.*

32. In *Tennent*, Cox CJ said that *Annetts v McCann* did *"not directly support the proposition that the right to make submissions given by the Act, s 52(4) must be similarly confined. Nevertheless, that right, in common with the right to call and examine or cross-examine witnesses is, in my view, circumscribed by the sufficiency of the interest of the person seeking to exercise it."*

33. Submissions on behalf of IHMS and International SOS asserted that the express reference to "make submissions" in s 36(1) should not be taken to mean that the "right to address is on the whole of the subject matter generally". They argued that a construction that did not conform to *Annetts* was inconsistent with the linkage required in the section to the person having a "sufficient interest", and that the limitation imposed on public interest interveners under s 36(3) demonstrated the limitation.

34. It is significant that s 36(1) of the *Coroners Act 2003* provides explicitly for the right of parties with a 'sufficient interest' to make submissions. In my view, the limitation on the right to make submissions that was held to exist in *Annetts v McCann* does not apply to an inquest under the *Coroners Act 2003.*

35. This conclusion is supported by a consideration of the legislative history of s 36(3) in relation to public interest interveners. Section 36(3) was inserted by the *Coroners and Other Acts Amendment Act 2009.* It is clear from the explanatory notes that accompanied that Act that no limitation was envisaged on the capacity of other persons with a 'sufficient interest' to make submissions. The relevant explanatory notes provided:

[13] (2000) 9 Tas R 111

The Bill extends the rights of such persons because it is currently unclear whether they qualify for standing under the "sufficient interest test".

…..

The Bill limits the right of public interest interveners to making submissions on matters on which the coroner can make comments under section 46(1) and examination of witnesses only with the leave of the coroner. This can be justified on the basis that it is in the public interest that hearings are not unnecessarily protracted and the purpose of granting standing to public interest interveners is appropriately served by the right to make submissions on the areas in which they have special expertise.

….

Transitional provisions ensure that the restriction will not apply to a person whom the court may have already considered has a sufficient interest in a particular inquest but who has not yet exercised the person's right to appear.

36. It is clear from the explanatory notes to the relevant amendments that before the amendments public interest interveners given leave to appear had a broad right to make submissions. That right needed to be preserved by the transitional provisions.

37. In my view, the family has a sufficient interest to make submissions with respect to the factual findings which the coroner is required to make, as well as recommendations under s 46. This approach has been consistently adopted in Queensland under the *Coroners Act 2003*.[14]

38. A wider view of the family's capacity to make submissions has been adopted under the State Coroner's Guidelines 2013. Section 14 of the *Coroners Act 2003* enables the State Coroner to issue guidelines to coroners about the performance of their functions in relation to investigations. Section 14(5) provides that a coroner must comply with the guidelines to the greatest extent possible. Accordingly, the guidelines will prevail over judicial authorities that suggest a different approach. The Guidelines do not limit the right of family members to make submissions to matters which may be the subject of adverse findings concerning their interests.

39. Chapter 2 of the State Coroners Guidelines[15] note that

The Coroners Act 2003 represents the most significant reform of the coronial system in Queensland's history. One of its most important features is the explicit recognition it gives to the rights and needs of bereaved families during the coronial process.

[14] See, for example, State Coroner Barnes, *Findings in the inquest into the death of Michael John Eddy*, 12 February 2007, p 7.
[15] The Rights and Interests of Family Members

40. The Guidelines also provide at 2.11

Opportunity to be heard

> *Families who are given leave to appear at inquest have the right to examine witnesses and make submissions. It is generally appropriate for the coroner to invite submissions from a family who does not appear provided all the parties are given an opportunity to consider and respond to them.*

41. Chapter 9 of the Guidelines[16] also provide

> *Some parties may only have an interest in some of the issues that will be canvassed at the hearing and may therefore be granted leave only to the extent necessary for them to protect those interests.*
>
> *Those given leave to appear have a right to examine witnesses and make submissions, unless they have been granted leave to appear as a public interest intervener under s.36(2), in which case, the right of appearance is limited to examining witnesses only with the leave of the coroner and making submissions only on those matters on which the coroner may make comments under s.36. (emphasis added)*

42. While the Act specifically limits the scope of submissions of a public interest intervener, there is no limitation placed on a person granted leave to appear under s 36(1). In addition, in this matter there was no limitation sought or imposed on the family at the pre-inquest conference or otherwise during the inquest in relation to the matters on which the family would be able to make submissions.

43. The interpretation urged by IHMS and International SOS would place the family in a more restricted position in terms of its capacity to make submissions than a public interest intervener. I do not consider that outcome to be consistent with the objectives of the Act.

44. A similar approach has been taken under the *Coroners Act 2009* (NSW), which does not contain a specific provision enabling persons granted leave to make submissions. Notwithstanding that interested persons have no right to make submissions on matters other than questions of possible adverse comment, it is recognised in that jurisdiction that "the coroner does have a discretion to hear from interested persons on matters which are broader than those in respect of which they have a right to be heard."[17]

45. Even if the view was taken that limits that may exist, or be imposed by a coroner, on the rights of the family to make submissions at an inquest, I do not consider that those limitations would operate to prevent a coroner from receiving submissions from a person granted leave to appear on the issues raised generally in the inquest, where those submissions might assist the coroner in reaching findings under s 45 or making

[16] Inquests
[17] *Waller's Coronial Law and Practice in New South Wales*, 4th Edn, p 43.

any comments and recommendations under s 46. Section 37(1) of the *Coroners Act 2003* provides that the Coroners Court may inform itself in any way it considers appropriate.

46. Notwithstanding, a number of the submissions from the family asked me to consider matters outside the scope of the inquest, including breaches of common law duties, contract and of Commonwealth legislation. Even if the facts I have found were suggestive of such breaches, as noted above, it is not my role to make findings with respect to civil or criminal liability. It would also be unfair to reach conclusions about such matters when they were not directly in issue in the inquest and witnesses were not asked directly about them. It would also be unfair to make adverse findings against individuals who were not given the opportunity to appear and give evidence at the inquest.

THE INQUEST

47. The inquest opened with several pre-inquest conferences between August 2015 and June 2016. Following the pre-inquest conferences, the issues to be investigated at the inquest were settled as follows:

    i. The findings required by s. 45 (2) of the *Coroners Act* 2003; namely the identity of the deceased, when, where and how he died and what caused his death;
    ii. The adequacy and appropriateness of the medical care provided to Mr Khazaei at the Manus Island Regional Processing Centre Clinic from 23 August 2014 – 26 August 2014.
    iii. The adequacy and appropriateness of the transfer arrangements for Mr Khazaei to be taken from the Manus Island Regional Processing Centre Clinic to the Pacific International Hospital, including the decision to transfer Mr Khazaei to Pacific International Hospital, as opposed to an Australian hospital.
    iv. The adequacy and appropriateness of the medical care provided to Mr Khazaei during the transfer from the Manus Island Regional Processing Centre Clinic to the Pacific International Hospital.
    v. The adequacy and appropriateness of the medical care provided to Mr Khazaei while at the Pacific International Hospital, including treatment by the International SOS clinicians stationed at the Pacific International Hospital.
    vi. The adequacy and appropriateness of the document 'Heads of Agreement relating to the provision of health services on Nauru and Manus Island', dated 14 September 2012, particularly with respect to provisions relating to medical evacuation, medical facilities, and medical treatment for sepsis.
    vii. The adequacy and appropriateness of the policies and procedures in place at the Manus Island Regional Processing Centre, in August 2014, relating to the recording of medical observations, the treatment of sepsis and medical evacuation.
    viii. The adequacy and appropriateness of any steps taken by International Health and Medical Services, International SOS, and the Department of Immigration and Border Protection, to prevent a similar death from occurring in the future.

48. Leave to appear under s 36(1) of the *Coroners Act* 2003 was granted to Mr Khazaei's family, the Commonwealth of Australia, the Mater Hospital, IHMS and International SOS and the PIH. Leave to appear under s 36(2) was granted to Doctors for Refugees.

49. Evidence was heard from a total of 32 witnesses over two sittings, from 28 November 2016 – 9 December 2016 and 13 February 2017 – 21 February 2017. Comprehensive written submissions comprising many hundreds of pages were received from counsel assisting and those represented at the inquest between June 2017 and September 2017. Those submissions have been of assistance in the preparation of these findings. I also acknowledge the high degree of cooperation in the inquest process from all those granted leave to appear.

50. Further brief submissions were received from Dr King on 19 June 2018 and from the PIH on 22 June 2018. Those submissions were made in response to notice of possible adverse comments provided to Dr King and the PIH.

51. Proposed witnesses employed by the PIH in Port Moresby were not made available to give evidence. The PIH elected to withdraw from the inquest due to cost considerations, noting that all information shedding light on Mr Khazaei's care at the PIH had been ventilated thought statements provided by PIH staff. I had limited capacity to compel the involvement of the PIH or the attendance of the relevant witnesses from overseas. Communications between the Coroners Court of Queensland and the PIH were tendered.[18] Sworn statements from each of the clinicians involved in Mr Khazaei's care at the PIH were in evidence.[19]

BACKGROUND AND JURISDICTION

52. I was assisted with respect to the nature of Mr Khazaei's detention, by an explanatory statement produced by the DIBP.[20]

53. On 7 August 2013, Mr Khazaei entered the 'migration zone'[21] at Christmas Island. He became an 'unlawful non-citizen' because he did not hold a valid visa.[22] Mr Khazaei was detained pursuant to section 189(3) of the *Migration Act 1958*.[23]

54. On 6 September 2013, Mr Khazaei was taken to PNG by officers of DIBP exercising powers pursuant to s.198AD(3) of the *Migration Act*. Under s. 198AD(11) of the *Migration Act* Mr Khazaei ceased to be detained for that Act, when DIBP officers began to exercise the powers in s.198AD(3) of the *Migration Act*.[24] Mr Khazaei was transferred to PNG under the Regional Resettlement Arrangement between PNG and

[18] Exhibit H4.
[19] Exhibits D1 – D11.10.
[20] Exhibit A7.
[21] s.5(1) *Migration Act 1958*.
[22] s.14 *Migration Act 1958*.
[23] s.189(3) *Migration Act 1958*.
[24] Exhibit A7, paragraph 8.

Australia signed on 19 July 2013. Mr Khazaei was taken to the Relocation Centre located at the PNG Naval Base in Lombrum, Manus Province, PNG.

55. Pursuant to appointments made by the PNG Minister under s.150 of the PNG Migration Act on 5 September 2012 and 14 August 2013, and by operation of s.150 of the PNG Migration Act, the Manus Island RPC ('MIRPC') was at all times under the control and management of the Chief Migration Officer of the PNG Immigration and Citizenship Service Authority ('ICSA').[25]

56. On 27 August 2014, officers brought Mr Khazaei to Australia pursuant to section 198B of the *Migration Act*. Mr Khazaei did not hold a visa that was in effect upon entering the migration zone at Brisbane, and accordingly he became an unlawful non-citizen. It followed that, in accordance with section 189(1) of the *Migration Act*, Mr Khazaei was detained. He remained in detention, for the *Migration Act*, from 27 August 2014 until his death on 5 September 2014.

57. The *Coroners Act* 2003 at section 10 defines '*custody'* to mean:

> "*…detention, whether or not by a police officer, under –*
>
> *……*
>
> *(d) the authority of an Act of the Commonwealth."*

58. At the time of his death Mr Khazaei was detained pursuant to the power conferred by s. 189(1) of the *Migration Act.* It follows that, because Mr Khazaei died in custody, section 27(1)(a)(i) of the *Coroners Act 2003* mandated that an inquest be held into his death.

59. The explanatory notes for the *Coroners Act 2003* note that the requirement for an inquest to be held into all deaths in custody in Queensland was enacted to implement recommendations arising from the 1991 report of the Royal Commission into Aboriginal Deaths in Custody. Recommendation 11 of the report was:

> *That all deaths in custody be required by law to be the subject of a coronial inquiry which culminates in a formal inquest conducted by a Coroner into the circumstances of the death. Unless there are compelling reasons to justify a different approach the inquest should be conducted in public hearings. A full record of the evidence should be taken at the inquest and retained.*

60. Recommendation 12 from the Royal Commission's report provided:

> *That a Coroner inquiring into a death in custody be required by law to investigate not only the cause and circumstances of the death but also the quality of the care, treatment and supervision of the deceased prior to death*.

61. While all Australian governments have committed to implementing the RCIADIC recommendations, the death of a person in a regional processing country would not ordinarily be the subject of an inquest. For example, had Mr Khazaei's death occurred in PNG, the *Coroners Act 1953* (PNG) contains no requirement for an inquest to be held in relation to a death of a person detained in immigration detention.

[25] Exhibit A7, paragraph 12.

Personal History

62. When Mr Khazaei arrived at Christmas Island in August 2013, he told officials he was from Iran, and that he had been born in Tehran on 12 February 1990. He identified as a Farsi man of the Shia Muslim faith. Mr Khazaei's DIBP records indicate that he undertook military service in Iran for a period 18 months from 2010. He then went to work in his uncle's store in Tehran as a salesman until mid-2013. He stayed in Indonesia from June to August 2013 after paying to travel there with a people smuggler. It was recorded that he decided to leave Iran because of a fear of torture and imprisonment after conflict with a cleric.[26]

63. Persons at the Manus Island RPC who knew Mr Khazaei were interviewed by officers from the Queensland Police Service to gather personal information about Mr Khazaei. Those persons were Omer Taha, Hossein Nejad Mostafa and Adel Mareood. Audio recordings of these interviews as well as a transcript or synopsis, were in evidence.[27]

64. Mr Taha said that Mr Khazaei was well known by everyone at the RPC. He was considered polite and respectful to all, regardless of religious or cultural differences, and was well liked. Mr Taha said that while he was not a close friend of Mr Khazaei, his roommate, Mostafa, was a close friend, and was also from Iran.

65. Mr Mostafa said that he had become friends with Mr Khazaei in Indonesia before travelling to Australia. They came to Australia on the same vessel and were housed in the same room on Manus Island where, by this time, they had become close friends.[28] Mr Mostafa said that before arriving on Manus Island, Mr Khazaei did not complain of any medical issues. He was one of the fittest and healthiest people Mr Mostafa had known.

66. Records from IHMS confirmed that, before the onset of Mr Khazaei's symptoms in August 2014, he had relevantly presented once before with cellulitis.[29] On 1 October 2013, he had presented to the medical clinic with a boil on his right arm. It was drained and dressed, and intravenous antibiotics were administered.

67. On 2 October 2013, Mr Khazaei presented again at the medical clinic. Further antibiotics were given, and the boil re-dressed. He presented again the next day with worsening pain in the right arm, fever and nausea. Cellulitis was diagnosed. The wound area appeared dirty and infected, a clean dressing was applied, and he was admitted to the clinic for 24 hours of intravenous antibiotics.

68. On 4 October 2013, he was reviewed, and his condition had improved. He did not present again until 11 October 2013, at which time the wound was reported to have improved and simple pain relief and dressings were provided.

69. Other than the episode of cellulitis in October 2013, Mr Khazaei was being treated for ongoing dental pain from January – August 2014. In March 2014 he presented with acute diarrhoea. He had no other medical issues while at the MIRPC.

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[26] Exhibit C8
[27] Exhibits A3 - A3.1 (Taha); A5 - A5.1 (Mostafa); A4 – A4.2 (Mareood).
[28] Exhibit A5, p 1 paragraph 2.
[29] Exhibit B17, pp 64 – 70.

OVERVIEW FROM 23 AUGUST 2014

Observations 23 – 24 August 2014

70. Mr Khazaei initially presented to nurse Lina Kadada at the MIRPC clinic late in the afternoon of 23 August 2014.[30] Nurse Kadada requested for the General Practitioner ('GP') on duty, Dr Norma Kutson, to review Mr Khazaei.[31] I heard evidence from Dr Kutson at the inquest. She confirmed she had been a general practitioner in Port Moresby for twelve years,[32] and had been working for IHMS for the last four years.

71. Mr Khazaei reported a 2-day history of feeling generally unwell with fever, general body aches, chills/rigor, a sore throat and a runny nose. Dr Kutson's evidence was that these were Mr Khazaei's *"main concerns."*[33] Examination revealed a temperature of 38.3°C, but otherwise normal observations.[34] Dr Kutson recalled being told about something on Mr Khazaei's leg in conversations with Nurse Kadada. Dr Kutson recalled that he was covered by a thick blanket. Mr Khazaei quickly lifted the blanket to show Dr Kutson his leg before covering it again. Dr Kutson described this as *"diverting me to focusing on giving something to address his issues about his sore throat."* Dr Kutson accepted that Mr Khazaei seemed uncomfortable exposing his leg to her.[35]

72. Dr Kutson described seeing on the mid-anterior portion of Mr Khazaei's left leg a *"small lesion."*[36] While she did not specifically recall an interpreter being present for her examination, her evidence was that it was her usual practice to have an interpreter available in the event that someone was going to require some form of treatment, such as intravenous antibiotics.[37] She also recalled that Mr Khazaei could speak and understand English *"quite well."*[38]

73. Dr Kutson noted a diagnosis of pharyngitis and prescribed intravenous normal saline, Ceftriaxone and Paracetamol. He was to continue Cephalexin oral tablets three times a day, and Panadeine Forte for pain relief. Dr Kutson explained during her evidence the basis for her prescription of the antibiotic, Ceftriaxone, considering Mr Khazaei's concerns and the lesion on his leg. Her evidence was that when Mr Khazaei presented, his chief complaint was fever, body aches, and a runny nose and sore throat that he had been experiencing for two days. In an environment where infections can spread rapidly, her choice of antibiotics was to cover a broad spectrum of infections.[39]

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[30] Exhibit B12.11, p 1; Exhibit B17, p 10 (entry at middle of the page); Exhibit B4.
[31] Exhibit B8; B8.1; T 1, p 75 from line 40.
[32] T 1, p 70 from line 32.
[33] T 1, p 76 at line 19.
[34] Exhibit B12.9; Exhibit G2 page 5.
[35] T 1, p 76 from line 32.
[36] T 1, p 76 at line 36.
[37] T 1, p 77 from line 12.
[38] T 1, p 77 at line 25.
[39] T 1, p 78 from line 9; and line 29.

74. Dr Kutson kept Mr Khazaei in the clinic overnight to continue with the antibiotics and fluids. She was concerned that his temperature was high and did not want to send him back to the compound until his temperature had stabilised, despite Mr Khazaei's request to leave the clinic.[40]

75. Mr Khazaei was monitored overnight by two paramedics, Rafael Cruz and Nedine Owen.[41] Both gave evidence at the inquest.[42] [43] Dr Kutson recalled providing a verbal handover to the effect that Mr Khazaei wanted to go home, but he was not allowed to if his temperature remained high.[44] Dr Kutson documented her medication plan in the electronic medical record.[45] She advised the paramedics to call her overnight if there were concerns about Mr Khazaei's temperature.[46]

76. Mr Cruz recalled that Mr Khazaei had a fever, and the aim was to get the fever down.[47] He expected Mr Khazaei to be a *"fairly routine patient."*[48] The sore on Mr Khazaei's leg was found. It was described by Mr Cruz as *"noticeable"*[49] and by Ms Owen as *"a bite."*[50] Mr Cruz did not think the sore had been specifically addressed. As Mr Khazaei was scheduled to be reviewed in the morning, it was appropriate for the paramedics to leave it for the doctor.[51] Ms Owen confirmed that the doctor would determine clinical treatment.[52]

77. Mr Cruz recalled that interpreters were not engaged when speaking to Mr Khazaei over this shift, as he did not find that he had trouble communicating with Mr Khazaei. This evidence was corroborated by Ms Owen.[53] Mr Cruz explained that presentations to the clinic with fever were *"very common"*[54], and the risk of infection on Manus Island was *"quite great."*[55] When asked about Mr Khazaei's observations over the course of this shift[56], Mr Cruz confirmed that the fever was not responding to treatment, his temperature remained high and his heart rate fast.[57]

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[40] T 1, p 80 from line 11.
[41] Exhibits B2 – B2.5 (Cruz) and B11 – B11.8 (Owen).
[42] T 1, p 9 from line 45.
[43] T 2, p 84 from line 18.
[44] T 1, p 80 from line 39.
[45] Exhibit B17, pp 10 (entry towards bottom of page) -11.
[46] T 1, p 81 from line 17.
[47] T 1, p 16 from line 38.
[48] T 1, p 17 at line 16.
[49] T 1, p 17 at line 35.
[50] T 2, p 90 at line 33.
[51] T 1, p 18 from line 2.
[52] T 2, p 90 from line 9.
[53] T 2, p 91 from line 41.
[54] T 1, p 21 at line 41.
[55] T 1, p 22 at line 2.
[56] Exhibit B17, p 10 (entry at middle of page).
[57] T 1, p 21 from line 36; Exhibit B2 paragraph 11.

78. Dr Kutson received a call from Mr Cruz at around midnight,[58] asking whether another dose of IV paracetamol could be administered to Mr Khazaei. Mr Cruz could not specifically recall whether he or Ms Owen made this call.[59] Dr Kutson recalled that she received a call asking for approval to give a second dose of IV paracetamol. It was her practice to have the paramedics call a second time to make sure that what was administered had worked.[60]

79. On the morning of 24 August 2014, Mr Khazaei was seen by Dr Leslie King, a US trained emergency physician. Dr King gave evidence at the inquest as well as providing written statements.[61] Dr King commenced her shift at the clinic at 0800 hours and was aware that Mr Khazaei had been admitted overnight. She observed that he had not improved despite the administration of intravenous ceftriaxone and paracetamol.

80. Dr King examined Mr Khazaei and noticed a small pustular crusted lesion on his anterior left lower leg. She described it in her evidence as small pustules, which were superficial, and located right on the anterior aspect of his tibia.[62]

81. Dr King confirmed that Mr Khazaei could speak English, but as it was *"pretty limited"*[63] she engaged an interpreter for her examination. The observations taken by Dr King at the time of this examination were recorded in the electronic medical record at 0929 hours:

> *"Appended at 24/08/2014 09:29:*
>
> ***Subjective:***
> *24 yo male admitted overnight for high fever and generalized unwellness. ; Pt given maintenance rate IVF, Perfalgan 1g x1 dose, and Rocephin 500mg IV without relief of symptoms. ; Pt examined upon my arrival at 8am with assistance of Farsi translator.*
>
> ***Objective:***
> *Pt very dehydrated with dry mucous membranes. ; Febrile 40+, diaphoretic with skin hot to touch. ; Mild erythema pharynx, TMs*
> *WNL bilaterally. ; Heart/Lungs/Abd unremarkable. ; Skin noteworthy for approx. 1.5-2 cm abscess to midpoint of ;LT anterior tibial*
> *region. ; Slt honey colored crusting noted over this lesion. ; Pt has second lesion approx. 4cm in LT groin region with similar*
> *description which he would only show to male doctor (Mathew).*
>
> ***Assessment:***
>
> ***Cellulitis/Abscess***
> ***Plan:***

[58] T 1, p 103 at line 37.
[59] T 1, p 22 from line 13.
[60] T 1, p 82 from line 20.
[61] T 4, p 89 from line 4; Exhibit B6 – B6.4.
[62] T 4, p 91 from line 31.
[63] T 4, p 91 at line 22.

Pt given 2L NS over 2 hours, Perfalgan 1gIV, Ibuprofen 400mg PO, and Benzocaine Penicillin 3g IV with marked improvement. ; Pt will continue with another 24hrs of IV Penicillin. ; Advised if wounds/fever don't improve, male doctor would lance or drain these abscesses."[64]

82. Dr King assessed Mr Khazaei as having "*cellulitis/abscess*"[65], and she commenced treatment for that, as well as repeating the test for malaria.[66] She added Benzylpenicillin to the antibiotic mix, while continuing the intravenous administration of Ceftriaxone, fluids and paracetamol.[67] Initially, Mr Khazaei's condition was noted to improve. Dr King confirmed that she saw him throughout her shift that day. At least initially, his fever resolved and he *"looked a lot better."*[68]

83. The handwritten clinical records for 24 August 2014 begin at 1400 hours. A set of observations was taken and recorded at this time by Jonathan Warrel, a primary health nurse who gave evidence at the inquest.[69] Mr Warrel was the only nurse looking after Mr Khazaei over this shift, which ended at 2200 hours.[70] Mr Warrel recalled that his instructions over this shift were *"that he was – he was quite sick, and our observations should be done hourly."*[71] The notes confirm the plan was for IV antibiotics to continue. At 1530 hours, it was noted that Mr Khazaei was shivering and vomiting fluids.[72] His heart rate and temperature had also started to climb. [73]

84. Dr Shane Stockil, a GP, commenced the afternoon shift on 24 August 2014 and became aware of Mr Khazaei soon afterwards through discussions with Dr King and Dr Muis. I heard evidence from Dr Stockil at the inquest[74], in addition to his written statements which were tendered.[75] Dr Stockil recalled that he was asked to familiarise himself with Mr Khazaei to see if *"there was any new light I might be able to shed on the case,"*[76] and give feedback about any concerns to Dr King and Dr Muis.

85. Dr Stockil examined Mr Khazaei and noticed the soft tissue injury on the lower half of his leg, which was described as a type of eschar, with a scab-like covering. The lesion reminded Dr Stockil of the type of eschar typically seen from a tick bite.[77] Dr Stockil's evidence was that Mr Khazaei's glands in the inguinal region at the top of the leg were swollen, indicating an infection had *"come in from somewhere."*[78]

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[64] Exhibit B17, p 10 (entry at top of page).
[65] T 4, p 91 at line 37.
[66] T 4, p 91 from line 47.
[67] Exhibit B6.1, paragraph 19; Exhibit B6.3.
[68] T 4, p 92 at line 18.
[69] T 2, p 3 from line 15; Exhibits B16 – B16.1.
[70] T 2, p 5 from line 1; page 8 from line 42.
[71] T 2, p 5 at line 43.
[72] T 2, p 19 from line 19.
[73] Exhibit B12.11 from page 2.
[74] T 5, p 86 from line 37.
[75] Exhibits B14 – B14.2.
[76] T 5, p 88 at line 13.
[77] Exhibit B14, paragraph 13.
[78] T 5, p 88 at line 37.

86. Dr Stockil requested a Weil Felix blood test, which tests for the types of infections born from ticks, spiders and insects, and a repeat full blood count test.[79] He confirmed the blood samples were sent to Australia for the appropriate testing to be conducted.[80] Dr Stockil explained *"basically, we were trying to work out what type of infection might have been coming in through the skin or into the blood."*[81] He also explained the difficulty in determining the exact type of infection, given time limitations in accessing test results. His evidence in this regard was that a blood culture would grow the organism and would also show resistance to any antibiotics or which antibiotic might work for his condition. However, this would only come back after about seven to 10 days in the laboratory. He said they were still having to treat blindly until he could get those results to try and use specific antibiotics.[82]

87. Dr Stockil said that throughout the afternoon of 24 August 2014 Mr Khazaei's blood pressure started to drop, and his pulse rate started to go up. This indicated that there were some haemodynamic changes happening in the body which Dr Stockil considered "*usually relate to shock or - sepsis, or infection of some sort*."[83] Dr Stockil described the changes as slow, becoming more evident throughout the evening. Dr Stockil's evidence was that Mr Khazaei was still communicative and able to ambulate in the afternoon. However, as the evening progressed he needed a wheelchair to get to the toilet and to move to have cigarettes away from the clinic.[84]

88. At 2115 hours, Mr Khazaei's observations were recorded as temperature - 39.6°, blood pressure - 110/64, pulse rate - 134 and oxygen saturations - 99%.[85] Dr Stockil referred to the protocol in place at the clinic that if staff were not happy with something they would alert the doctor in the chain of command. He specifically recalled speaking with Dr King over the telephone later that night, between 2130 hours and 2200 hours. He recalled reading out Mr Khazaei's observations to draw Dr King's attention to the drop in blood pressure, hypotension, tachycardia and the spike in Mr Khazaei's fever.[86] Dr Stockil recalled that Dr King was not too concerned about the observations because she had placed Mr Khazaei on a new antibiotic (Benzylpenicillin) which required 24 hours to start working.[87] Dr Stockil accepted this approach by Dr King as normal medical practice. Dr King told him that that she would assess Mr Khazaei in the morning, check his response to the antibiotic and then decide whether to change to other antibiotics and to organise a "fly out".[88]

[79] T 5, p 88 from line 40.
[80] Exhibit B14, paragraph 14.
[81] T 5, p 89 from line 2.
[82] T 5, p 89 from line 14.
[83] T 5, p 89 at line 35.
[84] T 5, p 89 from line 41.
[85] Exhibit B12.11, p 3.
[86] T 5, p 90 from line 14.
[87] T 5, p 90 from line 17.
[88] T 5, p 90 from line 22.

89. However, Dr King was adamant that she was not contacted by anyone over the course of that evening. While Dr Stockil's recollection of events did not assist her recall,[89] Dr King accepted that, from her attendance at the clinic the following morning, "*I would share his concern that here we are giving the guy meds and fluids, an antipyretic, and he's not responding, he's not improving with the medicines that we are doing so I would – I would concur with that thinking…*"[90]

90. Mr Cruz and Ms Owen were again on shift overnight on 24-25 August 2014. Ms Owen recalled that there had not been much change in Mr Khazaei's condition, and he was still being administered intravenous antibiotics and paracetamol. Her instructions were to *"monitor his temperature and condition."*[91] Ms Owen explained that Mr Cruz and Dr Stockil dealt mainly with Mr Khazaei as he was a male Muslim patient, and female staff did not generally get involved in their physical examinations.[92]

91. Mr Cruz could not recall whether Mr Khazaei's fever had made any progress over this shift. He did recall that the blood pressure was very low and they struggled to keep it at a healthy level.[93] Mr Cruz spoke highly of Dr Stockil.[94] He called Dr Stockil at 2330 hours to request medication to help Mr Khazaei to sleep.[95] At 0140 hours, Mr Cruz called Dr Stockil again as Mr Khazaei was complaining of severe pain in his leg. Mr Cruz was concerned about administering more pain medication given his low blood pressure. Dr Stockil recommended the administration of some Panadeine. [96]

92. Dr Stockil recalled the phone calls as detailed by Mr Cruz,[97] and that there were no major changes in Mr Khazaei's vital signs. After his initial call to Dr King, Dr Stockil did not see any reason to call her again throughout the evening.[98]

93. Mr Cruz was asked in his evidence whether he could describe any differences in Mr Khazaei's presentation over this shift in comparison to the previous shift. Mr Cruz's evidence was that his blood pressure was very low. He described this as a bad sign, and a good indicator that he was still very sick after being an inpatient for almost 36 hours.[99]

94. Mr Cruz recalled that, over his second shift on 24-25 August 2014, there was a "*general consensus"*[100] that Mr Khazaei required a higher level of care. Mr Cruz confirmed that Mr Khazaei was not improving, and in fact was deteriorating.[101] However, he also noted his temperature had improved from the previous night.[102]

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[89] T 4, p 93 from line 1.
[90] T 4, p 93 from line 47.
[91] T 2, p 91 at line 20.
[92] T 2, p 91 from line 33.
[93] T 1, p 30 from line 2.
[94] T 1, p 28 from line 20.
[95] Exhibit B2, paragraph 20.
[96] Exhibit B2, paragraph 21.
[97] T 5, p 90 from line 40.
[98] T 5, p 91 from line 17.
[99] T 1, p 32 from line 15.
[100] T 1, p 33 at line 35.
[101] T 1, p 33 from line 35.
[102] T 1, p 68 from line 3.

Despite this, Ms Owen recalled Mr Khazaei turning off the air conditioning and saying he was cold. She recalled he would come and sit outside because it was too cold inside the clinic. When Ms Owen was asked whether these actions were consistent with fever and the other symptoms he was displaying, her evidence was *"---Yes, he had that the whole time he was in our care."*[103]

Medical care on 25 August 2014 and the request for transfer from Manus Island

95. Dr King commenced her shift at 0800 hours on 25 August 2014 and conducted another review of Mr Khazaei. She noted that he continued to be very unwell, with no improvement as a result of the Benzylpenicillin. Azithromycin was added to the antibiotic mix.[104]

96. Dr King's evidence was that Mr Khazaei had been admitted for some 36 hours and had been administered *"many of the things that we are capable of giving in this setting with our limited med supply."*[105] As Mr Khazaei was not improving, Dr King informed the Senior Medical Officer ('SMO'), Dr Marten Muis, also a GP, *"we need to evacuate him."*[106]

97. I heard evidence from Dr Muis[107] who also provided written statements.[108] Dr Muis had only arrived on Manus Island on 24 August 2014 and had seen Mr Khazaei wheeled around outside having a cigarette. He also noticed Mr Khazaei in the emergency room.[109] Dr Muis did not have any contact with Mr Khazaei until the morning of 25 August, when Dr King told him that she wanted Mr Khazaei *"off the island."*[110] When asked whether Dr King gave a timeframe in which she wanted Mr Khazaei moved, Dr Muis recalled that *"she wanted him off that day, yes."*[111]

98. Dr Muis conducted a brief examination of Mr Khazaei to make sure he agreed with Dr King's recommendation. He then made a phone call to his immediate supervisor, Dr Anthony Renshaw who was the Area Medical Director for IHMS based in Sydney.[112] Dr Renshaw gave evidence during the course of the inquest, and a number of statements from him were tendered.[113] Dr Muis was aware that there was a commercial flight leaving that afternoon to Port Moresby which the outgoing SMO, Dr Richard McGrath, was booked on.[114] Dr King informed him that Mr Khazaei was well enough to catch that flight with Dr McGrath as medical escort.[115]

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[103] T 2, p 93 at lines 19-20.
[104] Exhibit B6.1, paragraph 33.
[105] T 4, p 94 from line 5.
[106] T 4, p 94 at line 12.
[107] T 3, p 2 from line 10.
[108] Exhibits B10 – B10.14.
[109] Exhibit B10, paragraph 8; T 3, p 5 from line 15.
[110] T 3, p 6 at lines 35-36.
[111] T 3, p 6 at line 39.
[112] T 3, p 7 from line 37.
[113] Exhibits B13 – B13.27 (1st statement); Exhibits B13.28 – B13.33 (2nd statement).
[114] T 3, p 10 from line 7.
[115] T 4, p 94 from line 28; day 3, p 10 from line 12.

99. It is clear from the evidence that the clinicians on Manus Island primarily involved in the transfer process were Dr Muis as the SMO, and registered nurse, Lyn Baczocha, as the Health Services Manager. At the inquest Ms Baczocha confirmed her role at the clinic was administrative in nature.[116] Aside from Dr King telling Ms Baczocha that Mr Khazaei needed to be transferred off Manus Island, it is clear that Ms Baczocha did not otherwise have anything to do with the logistics or the organisation of his transfer.

100. Dr Renshaw's evidence was that there was a Medical Evacuation Response Plan ('MERP') in place and on site at the time. His evidence was that this document would normally form part of the induction of a new SMO to the site.[117] Dr Muis was shown a copy of the MERP which was in place at the time.[118] His recollection was that he *"vaguely recalled reading that after the event"*, *"probably three to four days later."*[119] Ms Baczocha recalled it was part of her role to show new doctors around the clinic, and to explain *"where things were and how the clinics were run, when - what times the clinics were."* She confirmed that, to her knowledge, this process was done verbally, with no documentation provided to guide how the clinic was to be run.[120]

101. Dr Muis contacted Dr Renshaw by phone, and his recollection of that phone call is extracted from his inquest evidence as follows:

> "*I told him that we had this client who had been there for 36 hours, what the history was: he presented with a sore throat, but then we'd noticed the blister, that he was not getting worse more rapidly, but he was certainly not getting any better, and that the emergency physician, Dr King had seen the patient and had advised me to get him off island that day. He agreed with that fairly quickly and that's when things get a bit hazy. I don't know whether it was Dr Renshaw who told me that I had several choices or whether that was with a later discussion with the Assistance Centre.*"[121]

102. Dr Muis also told Dr Renshaw about the afternoon commercial flight on which Dr McGrath could act as medical escort. Dr Renshaw's evidence was that he specifically recalled Dr Muis mentioning this, as it was unusual for there to be an afternoon flight off Manus Island.[122] Dr Muis could not recall anything being said during this phone call to indicate it was unlikely that Mr Khazaei could be transferred that same day. In terms of the timeframe for transfer, Dr Muis told the inquest:

> *"---No. By 11 or 10 o'clock that morning, on Monday, I had seen two or three documents which said for urgent transfer off island, so I presumed that meant urgent transfer off island, and I was getting phone calls and passport requests for – from Wilson Security, who were going to go with the patient - - -*
>
> *Yes?--- - - - because no one could travel on domestic airplanes without security being there, so I thought had – that was all very much in progress.*"[123]

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[116] T 3, p 64 from line 16; page 65 at line 32.
[117] T 4, p 30 from line 32.
[118] Exhibit B13.1.
[119] T 3, p 5 from line 8.
[120] T 3, p 66 from line 37.
[121] T 3, p 8 from line 46.
[122] T 4, p 36 from line 24.
[123] T 3, p 9 from line 12.

103. Ms Baczocha confirmed during her evidence that she was aware of different categories for transfers to assist in determining the level of urgency to attach to any given transfer. She explained that a medical emergency would mean an air ambulance, and an urgent transfer would mean *"get them as – there, as quickly as possible – possibly, on a commercial flight, if they were able to."* There were also non-urgent transfers to Port Moresby for routine medical appointments. Ms Baczocha confirmed that Mr Khazaei's case, on this particular day, was urgent but not a medical emergency. [124]

104. Dr Renshaw explained that the most ideal situation was for Mr Khazaei to be on the afternoon flight with Dr McGrath as the medical escort.[125] Dr Renshaw's evidence was that it was *"perfectly possible"* to achieve a booking for Mr Khazaei on the flight at 1730 hours that day, even with the process for such booking commencing at or about 1030 hours.[126] At the time of his phone call to Dr Muis, Dr Renshaw did not consider that a transfer to Australia was required. He explained:

> *"---Because the instructions from the Department were that if a condition could be treated in Papua New Guinea, that was the action that was to be done. This man had a condition that needed a certain number of inputs, that being IV antibiotics that – a wider range that could be made available in a remote site setting. He needed access to a microbiological laboratory. He needed inputs from specialists such as infectious disease specialists. He needed access to a surgeon, potentially. All of those things were available in Port Moresby.*"[127]

105. Dr Muis then called the International SOS Assistance Desk, located within the Global Assistance Centre in Sydney. The relevant call logs and audio recordings were tendered at the inquest.[128] The evidence was that there was an International SOS Assistance desk, and an IHMS Assistance desk. Although separate, both operated on the same floor of the Global Assistance Centre in Sydney.[129]

106. Dr Muis spoke mainly with Dr Yliana Dennett who, at the time, was a coordinating doctor working for International SOS. I heard from Dr Dennett at the inquest. She also provided a written statement.[130] The conversation is reflected in the call log, which confirms the information was entered in the system at 10:36:53am. As the phone call between Dr Muis and Dr Dennett must have taken place at or about 1030 hours, the phone call between Dr Muis and Dr Renshaw would have taken place sometime before 1030 hours. The call log recorded:

> *"Received a call from site medic- Martin*
> *Pt is a 24 y.o. Iranian male*
> *PMH : recurrent skin infections*
>
> *2 days ago he presented with a an infected blister in the anterior left shin area and fever*

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[124] T 3, p 69 from line 3.
[125] T 4, p 38 from line 44.
[126] T 4, p 39 from line 45.
[127] T 4, p 36 from line 40.
[128] Exhibit B152, p 1; Exhibit B152.11 (first 2 calls NDOSYD1-NDOSYD2).
[129] T 5, p 75 from line 1.
[130] Exhibits B166 – B166.5.

started on oral antibiotics but no improvement
yesterday changed to IV antibiotics
today he presents with a swollen, red and tender lower leg
also has a red mark tracking to the groin area
c/o tender left groin area
enlarged lymph nodes on palpation
currently receiving Penicillin Iv, Ceftriaxone IV and Erythromycin PO

there is a commercial flight today Manus- POM
the SMO Dr Richard Mcgrath is already booked to travel on his flight and could accompany the pt.
RFA: transfer (ticketing) to POM for further treatment

advised this is medically appropriate
will proceed as above
thanks

CDYD"[131]

107. After Dr Renshaw had finished the call with Dr Muis, he contacted the IHMS Assistance desk *"to warn them that there would be some documentation coming"* and to *"prepare them for completing that documentation to send to the department."*[132] Dr Renshaw recalled that he spoke with Laura Zhai, a coordinating registered nurse working for IHMS. I heard from Ms Zhai at the inquest.[133] Dr Renshaw's evidence was that he informed Ms Zhai during this call that the documentation needed to articulate that Mr Khazaei needed to be moved because of a risk of infection. He "*recommended that she review the – the documentation that comes in and make sure that it's clearly articulated so that it was clear for the Department to understand the need for it to be approved quickly*."[134]

108. Ms Zhai recalled Dr Renshaw informing her *"there was a gentleman unwell on Manus, and he was unwell with cellulitis and needs to be moved off to PIH for further treatment."* Ms Zhai was not provided with any details as to proposed flights, only that it was an urgent transfer.[135]

109. At the time, Dr Renshaw was at Sydney airport awaiting a delayed flight to Canberra. After speaking with Ms Zhai, Dr Renshaw made a call to Caroline Gow, the DIBP Health Liaison Officer, at 1229 hours.[136] Ms Gow's evidence was that her role was to act as the liaison person for the initial escalation of transfers off Manus Island.[137] Her contact details were contained in the MERP in the list of DIBP emergency contacts.[138] Dr Renshaw's evidence was that his call to Ms Gow was made in the absence of documentation. He wanted to verbally escalate the transfer request to the DIBP in case there were delays with the documentation.[139] After hearing from Ms Gow and

[131] Exhibit B152, pp 1-2.
[132] T 4, p 37 from line 31.
[133] Exhibits B163 – B163.3.
[134] T 4, p 41 from line 4.
[135] T 9, p 6 from line 26.
[136] T 6, p 39 from line 31.
[137] Exhibits C5 – C5.6.
[138] Exhibit B13.1, p 10.
[139] T 4, p 38 from line 1.

Dr Renshaw at the inquest it is not clear what was said during this phone call, particularly whether Ms Gow was made aware of the 1730 flight that day.

110. During his call with Ms Gow, Dr Renshaw was asked whether it was an emergency evacuation, to which Dr Renshaw replied *"No, we need to get him off the island though"*.[140] When asked to clarify this in terms of whether it was an emergency or not, Dr Renshaw's evidence was that the most ideal solution was to get Mr Khazaei on a flight that day so that he could be admitted that day. He told Ms Gow that there was a slot in the afternoon flight. He also said that there was already a doctor booked on that flight. This would mean that the Department would not need to arrange another ticket for a medical escort. This was a far preferable solution and that is why he stated that he made specific mention of this in his telephone call to Ms Gow.[141]

111. Ms Gow's recollection of the conversation with Dr Renshaw was that the reference to a flight was *"the next commercial flight"*, which was scheduled for 1100 hours the following day - 26 August 2014.[142] She recalled that she *"wrote what Dr Renshaw said to me."*[143] Dr Renshaw was asked about this possibility during his evidence, to which he said he could not recall, but that *"there may have been some discussion about alternates."*[144] He reiterated that his first and foremost recommendation was for Mr Khazaei to be on the commercial flight that afternoon.[145] Ms Gow's evidence was that she did not know there was a flight scheduled for 1730 hours that day.[146] She said she was unable to check for herself the flight schedule for Manus Island.[147] Ms Gow disagreed with Dr Renshaw's recollection of that conversation where he said *"if we miss today's flight, it may be a problem."*[148] When asked whether she recalled Dr Renshaw saying this, her evidence was *"absolutely not."*[149]

112. After the Renshaw-Gow phone call it appears that Dr Dennett at the International SOS Assistance desk, and Dr Muis on Manus Island, both completed their own version of a document headed 'Part A: Recommendation for Medical Movement' ('RMM'). Dr Muis' RMM was sent to Ms Zhai. Ms Zhai included in her materials to the court a copy of this RMM form.[150] The form states the recommendation as *"transfer detainee to Port Moresby for further treatment of ascending cellulitis left leg."* The clinical condition of Mr Khazaei is noted as "*in pain with swinging temps around 38C*." The reasons for the transfer are stated as "*has had 36 hours of IV and oral antibiotics with deterioration of condition*."[151]

[140] Exhibit B13, paragraph 17.
[141] T 4, p 38 from line 34.
[142] Exhibit C5, p 2-3; T 6, p 44 from line 32.
[143] T 6, p 65 at line 7.
[144] T 4, p 39 from line 12.
[145] T 4, p 39 from line 22.
[146] T 6, p 44, from line 45; page 75 from line 10.
[147] T 6, p 65 from line 1.
[148] Exhibit B13, paragraph 17.
[149] T 6, p 47 from line 14.
[150] Exhibit B163.2.
[151] Ibid.

113. Dr Dennett's RMM was sent from the International SOS Assistance desk, to the IHMS Assistance desk at 1229 hours.[152] Before the RMM was sent, Dr Dennett had spoken with her Medical Director, Dr Annie Yap, who agreed with the recommendation for transfer.[153] This RMM was in addition to a medical report compiled by Dr Dennett and sent to the IHMS Assistance desk at approximately 1137 hours.[154] Dr Dennett's RMM provided more information than Dr Muis' RMM, in the form of a narrative about why the transfer needed to happen. The same narrative was included in the medical report which Dr Dennett said was an *"internal medical report"*.[155] The relevant part of the RMM was:

> "*We do recommend immediate transfer to Port Moresby with a medical escort for further treatment. There is a commercial flight leaving Manus to Port Moresby today at 1730. The medical officer Dr Richard McGrath booked already on this flight (end of his rotation) and can act as a medical escort if approved. Please confirm if we can organise Mr Khazaei's transfer and receiving care in Port Moresby.*"[156]

114. With regard to her discussion with Dr Dennett about the recommendation for transfer, Dr Yap was asked if she considered at this time whether a transfer to Australia was appropriate. Her evidence in this regard is extracted as follows:

> *"---Certainly the gold standard for medical review is to Australia, but looking at the medicine that was presented to me, the medical information and the working diagnosis of skin infection at that point in time, we decided that the main consideration that's most important here is to actually get the patient off Manus Island without any delay for a medical review, for a medical assessment [indistinct] investigations [indistinct] necessary and also re-evaluation of the antibiotics that he was already on and all this could be done at PIH, Port Moresby. So certainly Australia was considered, but that, we think, would delay, if anything, his transfer off Manus Island and bringing him to Port Moresby PIH would be the most expedient choice, hence we considered this as a reasonable choice of destination of transfer."*[157]

115. Clive Gillard was the International SOS Operations Manager in charge of identifying suitable air ambulance services, tasking those services, arranging the ground transport from airports and other logistics.[158] He confirmed that he had a conversation with Dr Yap about available flight options, and they were looking at the best way to get Mr Khazaei off Manus Island that day.[159]

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[152] Exhibit B166.3; Exhibit B166 paragraph 15.
[153] T 5, p 62 from line 6.
[154] Exhibit B166 paragraph 12; Exhibit B166.2
[155] Exhibit B166.2; T 4, p 6 from line 18.
[156] Exhibit B166.3.
[157] T 5, p 62 from line 26.
[158] Exhibits B167 – B167.9.
[159] T 8, p 25 from line 45.

116. Mr Gillard confirmed that the commercial flight at 1730 hours was identified, and it was known that there was already a doctor booked on that flight who could act as the medical escort. Mr Gillard also confirmed that he checked availability for the flight and was able to confirm that *"there were seats available both for Mr Khazaei, our escort, who already had a flight seat booked and for any accompanying security that would be required."*[160]

117. Meanwhile, Ms Baczocha confirmed that an officer from the DIBP, in the position of 'Manus Transfers Officer', was stationed at Manus Island. In terms of the process of a transfer, Ms Baczocha recalled that it was quite normal for her to liaise directly with the DIBP officer onsite.[161] On this occasion, the DIBP officer in the Manus Transfers Officer role was Jessica Costello.[162]

118. In her evidence, Ms Baczocha accepted Ms Costello's recollection of a conversation between them, which occurred at about 1130 hours, as quite plausible.[163] As a result of the conversation, Ms Baczocha's expectation was that the transfer would happen that day. Her experience was that patients had been approved to board commercial flights within a similar timeframe. [164]

119. Ultimately, the RMM sent to the DIBP for approval was completed by IHMS, specifically Ms Zhai.[165] The timestamp on that form was 1055 hours. The clinical condition of Mr Khazaei is extracted from the form as follows:

> *"This client requires review and admission at Pacific International Hospital – Port Moresby for treatment of worsening ascending cellulitis to his left leg.*
>
> *Admission at Lorengau Hospital – Manus, is not recommended. There is a lack of microbiological investigative diagnostics. This limitation, compounded with the lack appropriate antibiotic treatment will lead to progression of this infective process.*
>
> *This client has exhausted all antibiotic treatment that is available on Manus Island.*
>
> *This client is already displaying symptoms of deterioration, despite treatment with available antibiotics, in the way of fevers, rigors and localised swelling and pain.*
>
> *IHMS Assistance recommends urgent transfer to Pacific International Hospital. A medical escort is recommended on a commercial flight."*[166]

120. The RMM stated the risks as "*Risk of infection spreading, leading to sepsis – life threatening widespread systemic infection."*[167] The RMM was sent by email to Ms Gow, the DIBP HLO, at 1232 hours.[168]

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[160] T 8, p 26 from line 15.
[161] T 3, p 70 from line 36.
[162] Exhibits C4 – C4.10.
[163] T 3, p 70 from line 26.
[164] T 3, p 70 from line 44.
[165] Exhibit B13.2.
[166] Exhibit B13.2, p 2.
[167] Exhibit B13.2, p 3.
[168] Exhibit B13.2, p 1.

121. Relevantly, the transfer information from Dr Dennett's RMM and medical report referred to above indicating the 1730 flight was not included on the RMM from Ms Zhai (IHMS) to Ms Gow (DIBP). Ms Zhai was asked what information she had regard to in completing the RMM to the DIBP, aside from that provided to her by Dr Renshaw. Ms Zhai's evidence was that she did not recall. She said she may have reviewed the Apollo file to see what the current situation was with Mr Khazaei. She did not recall sighting any recommendation for medical movement form from International SOS about the case.[169]

122. Ms Zhai's evidence was that in terms of usual practice, it was not the case that in completing a RMM from IHMS, she would have a RMM from International SOS to refer to.[170]

123. Dr Renshaw also had a conversation with Dr Dennett, the details of which were entered by Dr Dennett on the International SOS call log system at 1257 hours.[171] Dr Dennett recorded that Dr Renshaw had expressed doubt about whether the approval from DIBP would be forthcoming that day. Her file note was relevantly:

> *"-that notification has been sent to the Dept of Immigration*
> *-that most likely they wont come back with approval today*
> *- usually it takes longer*
> *-most likely they will approve it in 1-2 days*
> *- he advised to look for alternative nurses from Manus or POM."*[172]

124. While Dr Renshaw did not recall the specifics of this conversation with Dr Dennett, his evidence was that *"in my experience it was not unusual for the Department to approve movements in that time period."* When asked whether he had commenced any plans for contingencies if the DIBP approval was not received that day, Dr Renshaw's evidence was:

> *"And given your knowledge of that, did you start making any plans at all for contingencies in the event that this approval for that afternoon flight did not happen?---Well, the – the – the – the – the flight in the morning would have required – at that time, would have required an escort to be made available.*
>
> *Yes?---And so the purpose of – of – of making that note around the – the possibility that the movement would not be approved was in order to plan for a contingency, that being availability of an escort to do the movement the next morning.*
>
> *Okay. In terms of a contingency plan, was there any thoughts as to just saying, "We need an [indistinct] ambulance. Let's organise that for today"?---At that point, no."*

125. Dr Dennett was also told by Dr Renshaw that the IHMS Assistance desk would take over the case from that point on. Dr Renshaw explained that this was the normal practice, and the case was simply transferred to a dedicated team at the IHMS Assistance desk. His evidence in this regard is extracted as follows:

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[169] T 9, p 7 from line 15.
[170] T 9, p 7 from line 34.
[171] Exhibit B153, p 143-144.
[172] Exhibit B153 at page 144.

> *"The reason for that was that once International SOS were no longer involved in arranging an escort or – or, potentially, an air ambulance, and once everything was being arranged by IHMS and/or the department, the IHMS assistance team would be managing the case.*
>
> *Okay. And in that respect, for International SOS to become involved in the case once more, that would be something that they would need to be provoked to do that. Is that right?---It was very easy for them to be involved again. They would do what's known as close the case on a reactive basis, which means - - -*
>
> *Yes?--- - - - the case was still live. It's simply not being [indistinct] that the team is not being tasked with any actions."*[173]

126. Notwithstanding, when asked why he did not make contact again with Dr Muis on 25 August 2014 to seek an update on Mr Khazaei's condition, Dr Renshaw's evidence was that *"the case management of this case, my expectation was that this would be done by the International SOS Assistance Centre as that was the normal process."*[174]

127. The relationship between International SOS and IHMS in this regard was explained further by Mr Gillard. He said:

> *"International SOS and IHMS had two distinct roles in the management of these type of patients. In particular, IHMS took responsibility for all monitoring of the patient onsite and the communication with the department. International SOS was purely responsible for movements of patients. So for this patient [indistinct] we had already missed the opportunity to undertake that flight on that date, and we had no indication as to when the next movement would be authorised. And at this point we would close out the file, pending any further authorisation, at which point with would then re-open our file on our side – again, all that information is still retained – and then re-evaluate our options at that stage.*"[175]

128. Dr Renshaw went to Canberra, where he was attending meetings with DIBP officers throughout the afternoon. He said that while email communication would be difficult, he was able to receive phone calls during those meetings.[176] He also explained that, in the event that he was unavailable and a matter required urgent escalation, there was a *"very extensive 24 hour emergency assistance centre that is readily accessible by all members of staff at any point."*[177]

129. Dr Renshaw could not recall making any efforts throughout the afternoon to see where the approval for Mr Khazaei's transfer was at, or whether he had made the afternoon flight. He was in meetings with the relevant DIBP officers and did not take any steps to direct others to clarify what was happening with the approval or to chase it up.[178]

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[173] T 9, p 43 from line 25.
[174] T 4, p 62 from line 8.
[175] T 8, p 28 from line 17
[176] T 9, p 44 from line 6.
[177] T 9, p 44 from line 16.
[178] T 9, p 44 from line 26.

The DIBP response to the Recommendation for Medical Movement

130. The RMM was sent by Ms Zhai to Ms Gow via email at 12:32pm on 25 August 2014. Ms Gow confirmed that while she holds qualifications as a registered nurse, the position of Health Liaison Officer was not a clinical role, and her qualifications as a nurse were not a requirement for the position.[179]

131. Ms Gow explained that she was the first DIBP officer involved in the transfer approval process. She referred requests for transfer to the Director of Health Operations, Amanda Little, who would then send it to the Assistant Secretary, Paul Windsor. It was finally sent to the First Assistant Secretary, John Cahill, for approval. Ms Gow confirmed if the Assistant Secretary was away or unable to be contacted, the request could bypass that role, and be escalated from the Director directly to the First Assistant Secretary.[180] Mr Windsor confirmed that he had been told by Mr Cahill that if he could not be contacted, Mr Windsor could exercise his own discretion to approve any request for transfer.[181]

132. Ms Little also confirmed that, while she holds qualifications as a registered nurse in addition to advanced nursing and critical care, the position of Director Health Operations was not a clinical role, and her qualifications in that regard were not a requirement for her position.[182]

133. Ms Gow explained why, in her experience, it could take up to 72 hours for approval to be obtained for a transfer, regardless of whether it was identified as 'urgent' or 'non-urgent'. However, she also explained how a request for a medical evacuation (medevac) would be treated differently:

> "*With a medevac, there's a – there's an absolute degree of urgency. So when IHMS request a medevac, that means that they want them off – they want the client off as soon as possible. So, therefore, that is expedited quite hastily, and again approval is sought. We would then get the person as – in Jess' role to start working on things on the island to get that approval. It's up to IHMS to actually book the air ambulance and to send an email to the department with costings, and then it would be approved.*
>
> *So, in your experience, what kind of approval timeframe would you expect for a medevac?---I would expect that would be – that would be quite quick.*
>
> *Same day?---Absolutely, within a couple of hours, if not an hour."*[183]

[179] T 6, p 41 from line 14.
[180] T 6, p 42 from line 22.
[181] T 6, p 91 from line 47.
[182] T 7, p 4 from line 44.
[183] T 6, p 43 from line 46.

134. Ms Gow's evidence was that, following her phone call with Dr Renshaw at 12:29pm, she called Ms Little. During this call Ms Gow explained Mr Khazaei's condition, and that Dr Renshaw wanted him off Manus Island. In terms of urgency, Ms Gow told Ms Little that Dr Renshaw wanted Mr Khazaei on the 1100 hours commercial flight the following day.[184] Ms Gow told Ms Little that she would send the request to her once it was received.

135. Ms Little's recollection of the conversation differed slightly to Ms Gow's, in that Ms Little recalled Ms Gow saying, with reference to Dr Renshaw, *"I have told him that the next available commercial flight is around 11 am tomorrow."*[185] Ms Gow disagreed with Ms Little's recollection in this regard.[186] Ms Little also recalled that *"Ms Gow mentioned there was a flight later in the day, and she had explicitly checked with Dr Renshaw if the 11 am flight was suitable."*[187] However, Ms Gow was adamant that she had no knowledge of a flight at 1730 hours that day.

136. Ms Little recalled telling Ms Gow that she would be in meetings for the afternoon.[188] While Ms Gow did not remember Ms Little saying this, she accepted that she may have.[189]

137. Ms Little's evidence was that at the time of her call with Ms Gow, the next flight 'available to the department' was 1100 hours the following day. She said that Ms Gow would have conducted the checks in this regard to confirm that this was the case. When asked to clarify what she meant by 'next flight available to the department', Ms Little confirmed that there was a flight scheduled for later that day, but it was not necessarily 'available to the department'. When asked why that was, her evidence was that DIBP 'did not take up the whole plane' and the ability to put people on any flight had a 24 hour lead-in to meet airline requirements. She was not aware of checks carried out to see whether Mr Khazaei could be transported on the 1730 hours flight.[190]

138. Ms Little's evidence of her expectation of IHMS in the situation where the 1730 hours flight was the preferred option was as follows:

> *"I would've expected that if he needed to be on that 5.30 flight from a clinical perspective, that IHMS would have said that we needed to push to get him onto that 5.30 flight, and that would be – then fall into the bailiwick of Jess Costello to liaise with the airlines to negotiate working with – inside their time – their stipulated timeframes to the department."*[191]

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184 T 6, p 45 from line 10.
185 Exhibit C1.1 paragraph 25.
186 T 6, p 47 from line 3.
187 T 7, p 36 from line 4.
188 Exhibit C1.1, paragraph 25.
189 T 6, p 50 from line 1.
190 T 7, p 9 from line 12.
191 T 7, p 36 from line 34.

139. Ms Gow's evidence was that once she received the RMM from Ms Zhai, she reviewed it and saw no information included in the RMM to suggest the medical transfer was urgent enough to warrant a medevac.[192] When asked about the Clinical Priority Access Criteria (CPAC) category on the top of the RMM, which stated '1: Urgent', Ms Gow's evidence was as follows:

> "*CPAC category is the ratings that IHMS use to categorise their patients from urgent to very urgent or right through from routine to urgent.*
>
> *Okay. At the time of assessing this form did you have any detailed knowledge as to what the CPAC categories meant?---I did understand what the CPAC categories were, yes.*
>
> *Okay. And what did you understand urgent to mean?---Urgent to me is – can be immediate, but urgent – this is a bit confusing, if I can just clarify a little bit.*
>
> *Yes, indeed?---There can be urgent which is a medevac or can – there can be urgent which is urgent commercial. So the word urgent in this respect was sometimes used in different categories from IHMS."*[193]

140. Ms Little confirmed that it was possible for an 'urgent' medical transfer to occur by commercial flight. Her evidence was that in terms of the category of any given transfer, she would rely on the information provided by IHMS to determine the urgency of the transfer.[194]

141. Taking into account the CPAC category used, in addition to the additional information contained on the RMM form, Ms Gow assessed the urgency of the request as "*an urgent transfer that we needed to get onto the next available commercial flight that we could get the client onto."*[195] In terms of the timeframe for approval of this request, being an urgent request for a commercial flight, Ms Gow said that she was not concerned that it needed to be approved within the hour, or in the next two hours. Her evidence was that they were aiming for the 11:00am flight the following day, so there was time to put arrangements in place.[196] She explained that the situation would have been very different, and expedited, if the request from IHMS had been for a medevac.[197]

142. At 1315 hours Ms Gow sent an email to Ms Little providing details of the transfer, which was a summary of the RMM completed by Ms Zhai. The email was marked as 'urgent' and for Ms Little's *"consideration and escalation for approval*."[198] Ms Gow's evidence was that Ms Little was often in meetings and, in her experience, Ms Little would often check emails during meetings.[199] Ms Gow's evidence was that, in order to make the intended 11:00am flight the following morning, DIBP approval would have to be received within a couple of hours of the request being sent. She accepted that

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[192] Exhibit C5, paragraph 15.
[193] T 6, p 48 from line 1.
[194] T 7, p 7 from line 5.
[195] T 6, p 48 from line 21.
[196] T 6, p 48 from line 36.
[197] T 6, p 48 from line 33.
[198] Exhibit C5.2.
[199] T 6, p 50 from line 41.

this would mean the approval would need to be received by approximately 1430 hours on 25 August 2014[200] although this was largely an assumption on her part.[201]

143. Ms Little's evidence was that she was in meetings between 1230 hours and 1700 hours. She told Ms Gow that she would be in meetings, and *"normal practice would be that she could have – she could call me if she needed to at any time."*[202] Ms Little expected Ms Gow's email notification about the transfer to find its way to her inbox at some point. When asked what the process would be if a request for transfer needed escalation while she was in a meeting, Ms Little's evidence was:

> "*---So, the approval process is not linear. There's activities that happen concurrently and by that I mean I don't wait until – my normal practice was not to wait until I had the approval from my escalation points was to the FAS through – through the assistant secretary. So my normal practice would be to have logistics and operational planning happening in – in parallel. The branch that I worked in which was the detention health branch was extremely busy and there would often be multiple priorities at a time, so my expectation is, and to my statement, that my request was to have the logistical planning happening and what that meant is that if my senior management line, who were also equally as busy, were not able to approve until anywhere within that 24 hour or the agreed timeframe period it did not adversely affect the – the actual effecting of the medical transfer because the logistics were already in play.*"[203]

144. Over the ensuing hours, Ms Gow did not hear from Ms Little, nor did she take any steps to find out where the approval was up to. When asked during her evidence why she did not take any steps in that regard, her evidence was that it was her responsibility to send it to the director, and then the director's responsibility to forward it on.[204]

145. At 1528 hours, Ms Costello sent an email to Ms Gow[205], wanting to know where the approval was up to. Ms Gow replied to Ms Costello, copying Dr Renshaw, at 1537 hours, stating *"this case has gone to the executive for approval."* Ms Costello's evidence was that there was no recourse for her, from that point, to pursue the approval with Ms Gow. She had just sent an email and took Ms Gow at her word that she was following up with the DIBP executive. She did not feel that she could circumvent Ms Gow and contact the executive directly.[206]

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[200] T 6, p 51 from line 15.
[201] T 6, p 84 from line 27.
[202] T 7, p 10 from line 2.
[203] T 7, p 10 from line 16.
[204] T 6, p 51 from line 10.
[205] Exhibit C4.7.
[206] T 6, p 8 from line 32.

146. Ms Costello called Ms Gow to see where the approval was up to at 1715 hours that afternoon. Ms Costello's evidence was that she was told by Ms Gow *"it was still with the executive and that she would email me when the approval came through."*[207] That call prompted Ms Gow to call Ms Little, to see whether the approval had progressed.[208] Ms Little then read Ms Gow's email at approximately 1730 hours[209] and told Ms Gow that she would progress the matter.

147. Ms Little did not recall considering the transfer request before the 1730 contact with Ms Gow. Dr Renshaw could have been in one of the meetings with her that afternoon and Ms Little confirmed that during previous meetings involving Dr Renshaw, there had been instances where she would discuss clinical recommendations or requests for movement. Ms Little knew that Dr Renshaw was involved in Mr Khazaei's transfer request but could not recall whether discussing the request with Dr Renshaw occurred to her at the time.[210]

148. Dr Renshaw recalled that Ms Little was involved in one of his meetings that afternoon and he knew that she would be involved in the approval process for Mr Khazaei's transfer. He did not raise the transfer with Ms Little because *"There would have been no indication for me to do so without – and that information which would have been relayed to Ms Little by Ms Gow."* His evidence was that throughout the afternoon he was in meetings, and therefore had no idea whether the transfer had been approved, or not.[211]

149. Ms Little explained that her role as Director in the transfer approval process was to consider whether the medical transfer request contained sufficient information.[212] She confirmed that there were times where she had deemed the information on previous transfer requests to be insufficient, and on a *"semi-regular"* basis she would go back to IHMS with *"clarifying questions."*[213]

150. Ms Little reviewed the contents of the RMM prepared by Ms Zhai. She decided that she needed to seek clarifying information with respect *to "the availability of pathology services, the availability of antibiotics supply and stock and, basically, those matters."*[214] Ms Little was not satisfied of a number of things, some of which included that there was the occurrence of, or the risk of sepsis, or that a transfer to Lorengau hospital should be ruled out.[215] At 1802 hours, Ms Little emailed Dr Renshaw outlining these matters, as follows:

> *"Hi Anthony,*
>
> *I have received this urgent request for transfer to POM for inpatient treatment of cellulitis of this Transferee's leg. I am wondering why this can't be managed at Lorengau Hospital? From my understanding this would require IVI antibiotics,*

[207] T 6, p 9 from line 4.
[208] T 6, p 52 from line 4.
[209] T 7, p 11 from line 36.
[210] T 7, p 11 from line 4.
[211] T 4, p 64 from line 21.
[212] Exhibit C1.1, paragraph 23.
[213] T 7, p 6 from line 1.
[214] T 7, p 12 from line 15.
[215] Exhibit C1.1, paragraph 30.

which could be done either as an inpatient or as an outpatient / or perhaps at the IHMS clinic. The NOC is for antibiotic treatment not sepsis.

The NOC states "There is a lack of microbiological investigative diagnostics. This limitation, compounded with the lack appropriate antibiotic treatment will lead to progression of this infective process. This client has exhausted all antibiotic treatment that is available on Manus Island…" which appears to be the reason for transfer.

Grateful if you could clarify what this means:

- *Regarding "a lack of microbiological investigative diagnostics"; If blood cultures are needed: are these able to collected and processed at Lorengau / sent to POM for sensitivities? Similarly processing of swabs. Logistically this should be easier than sending a person with escorts for results that will take several days*
- *Regarding "lack appropriate antibiotic treatment": I'm not sure what this means – first line treatment should be quite common antibiotics, with several options available pending sensitivities. Even using something "unusual" should be able to be managed locally*
- *Regarding "This client has exhausted all antibiotic treatment that is available on Manus Island." Is there a supply issue that we are unaware of? Again, these should be brought in rather than the person being transferred if this is the case.*

DIBP staff on island are being pushed for this urgent transfer in the next 18 hrs however I don't have adequate information to be able to escalate at this point if this is still warranted.

Regards,

Amanda."[216]

151. Ms Little was cross examined extensively at the inquest about this email to Dr Renshaw. She explained during her evidence that she was not challenging the request for transfer but asking questions to clarify the request, so that was clear to the Assistant Secretary and First Assistant Secretary.[217] She described her role in the approval process as *"I'm not a decision-maker; I'm an escalator in this process."*[218]

152. Ms Little agreed with the general proposition that the decision about whether a patient requires a higher level of medical care is a medical decision and is best made by those who are treating the patient. She also agreed that the treating clinicians are best placed to know what the condition of the patient is and are best placed to know when all available treatment options have been exhausted.[219] Having accepted those matters, when Ms Little was asked what basis she had to question the recommendation that had been made, her evidence was:

> "---*So my basis for questioning the recommendation is not to question the clinical recommendation, but to seek clarification of the information supplied within that*

[216] Exhibit C1.4.
[217] T 7, p 14 from line 1.
[218] T 7, p 53 from line 34.
[219] T 7, p 14 from line 10.

> *recommendation, so that when I escalated the recommendation for approval, I was, in fact, streamlining the process and avoiding any toing and froing from – with further questions. So part of my job was to gather all the information, ask the clarifying questions so that I was able to, I suppose, pre-empt any questions that might come back to me from my – from the approval process."*[220]

153. Dr Renshaw read Ms Little's email at 1850 hours when he arrived back in Sydney in the company of Dr Mark Parrish, the Regional Medical Director of IHMS.[221] Dr Renshaw said that he was surprised at the content of Ms Little's email, and briefed Dr Parrish on the situation. Dr Renshaw agreed that it was customary for a provider of a health service to justify their service to the purchaser of that service. However, he explained that *"I felt that we had made the rationale very clear to the department that Lorengau was not a suitable location, and I felt that as a doctor I had provided sufficient rationale for this man to be moved offsite."*[222]

154. Shortly after reading the email, Dr Renshaw called Ms Little.[223] He explained the reasons Mr Khazaei was not able to be managed on Manus Island. Ms Little's evidence about this call was:

> *"So my recollection is that my, you know, I sent the email and Dr Renshaw called me back to clarify the questions. And, in that, he – he confirmed that when I asked about investigations and availability of the investigations, that they weren't available at – the pathology tests required were not available at the Lorengau Hospital. He, also, confirmed that statement around exhausting antibiotic treatment was not – they had used all the antibiotics available on the shelf, but, rather, had reached the end of the treatment options available at the RPC."*[224]

155. When it was put to Ms Little that Dr Renshaw had essentially confirmed the information which was already contained in the RMM, Ms Little's evidence was that *"He clarified .. and answered the questions that I had asked."*[225]

156. Shortly after the conversation with Dr Renshaw, Ms Little emailed the Assistant Secretary, Mr Windsor, at 1924 hours. The email forwarded the transfer request for his consideration and further escalation for approval.[226] In doing so, Ms Little confirmed that she was still aiming towards approval being obtained in time for the 1100 hours flight the following day. Ms Little clarified that as long as the operational and logistical matters were taken care of, the approval could theoretically come through right up until the time of departure. However, this was noted to not be the normal process. [227]

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[220] T 7, p 14 from line 22.
[221] T 4, p 45 from line 35; Exhibit B12.
[222] T 4, p 45 from line 41.
[223] Exhibit B13, paragraph 22; Exhibit C1.1, paragraph 32.
[224] T 7, p 14 from line 42.
[225] T 7, p 15 from line 4.
[226] Exhibit C1.5.
[227] T 7, p 15 from line 10.

157. Mr Windsor did not read Ms Little's email until the following morning when he arrived at work at around 0830 hours.[228] Over the course of the evening of 25 August 2014, Mr Windsor did not receive any calls from Ms Little to prompt him to look at her email.

158. Mr Windsor confirmed that for emergency situations out of hours, the mobile numbers for senior DIBP officers including himself, Mr Cahill, and Ms Little could be used so that relevant approvals could be obtained. This was confirmed by both Ms Little[229] and Mr Cahill[230] during their evidence.[231] Mr Windsor's evidence was:

> "*IHMS quite commonly would call me after hours about emergency cases or possible emerging urgent cases if there was someone they were keeping an eye on that they were concerned about and could foreshadow that there might be a need for emergency management out of hours*.
>
> *Yes. Thank you. And you received no such calls or notifications for this particular matter over that night of the 25th of August?---That's correct*"[232]

Clinical Care 25-26 August 2014

159. For the remainder of 25 August 2014, while the transfer request was being processed, Mr Khazaei's care was monitored mainly by Dr King. Dr Muis' evidence was that he called the IHMS Assistance desk at approximately 1530 hours that afternoon, making a note in the electronic clinical record.[233] He had not, in the lead up to that call, examined Mr Khazaei again, but had been receiving updates from Dr King and others involved in Mr Khazaei's care at the clinic.[234] Dr Muis' evidence was:

> "*---Lyn Baczocha, the HSM, and Leslie were very keen to take him to the airport, and that was about 20, 25 minute drive by very rough road – four-wheel drive – so they wanted to get ready. And we had not – I had not heard anything so, I thought, "Well, I better check up to see what's happening." So that was the reason for that call.*"[235]

160. Dr Muis' recollection of the phone call is extracted from his evidence, as follows:

> *"---I was – I rang up and said, "Look, we thought we had an agreement this morning or we made a request this morning for an urgent transfer and we are under the impression that this patient's going with the outgoing SMO this afternoon at 5. We haven't got much time left: can you tell us what's happening?" The person I spoke to went away for a while and then came back to me and said, "No, it's not happening because we haven't obtained a visa." They went into some kind of story of people in detention centre, even if they're on Papua New Guinean soil, were not regarded as Papua New Guineans, therefore had to apply for a visa and – I mean it was all really double-dutch to me but – I still don't really understand. I thought they had an agreement with the IPP, but I don't know. And they said, "No, it was*

[228] T 6, p 92 from line 11.
[229] T 7, p 17 from line 16.
[230] T 7, p 96 from line 7.
[231] T 7, p 17 from line 16.
[232] T 6, p 94 from line 35.
[233] Exhibit B17, p 7.
[234] T 3, p 12 from line 33.
[235] T 3, p 12 from line 47.

> *not going to happen." And I said, "Well, what are the other alternatives." And they said, "Well, if it had been a bit earlier, we could've sent a – an urgent evacuation plane." But because the airstrip there was daylight only, they couldn't do that either. So he said, "Very sorry, but you're on your own and you're going to have to keep this overnight."*[236]

161. The call log was tendered at the inquest[237], and showed the following note relating to this call made by Dr Muis:

> "*551073 289809 Call from Dr Martin Muis - MANUS Wanting an update on movement to POM CRNLZ advised that client is waiting for a visa and CNRLB advised it is highlight unlikely it will happen today Telephone Admin Inbound IHMS - Site 0 959 25/08/2014 15:32 1 959 25/08/2014 15:32 Jessica Abadee.*"

162. Ms Zhai ('CRNLZ') had limited recollection of the call.[238] A statement was provided by Ms Leah Bluhdorn ('CNRLB' in the above note).[239] Ms Bluhdorn remembered the phone call and being told that approval from the DIBP was outstanding. At the time of the call, there was approximately 1 – 1.5 hours before the commercial flight was scheduled to depart. Ms Bluhdorn drew on her experience and said it was unlikely Mr Khazaei would be transferred on the commercial flight if DIBP approval had not been received.[240]

163. Approval from the PNG ICSA was also required before a transfer off Manus Island could occur. This was to alert PNG authorities of incoming aircraft at the Port Moresby airport. The evidence confirms that this approval was received by the DIBP at 1619 hours.[241] Ms Baczocha was asked during her evidence whether, having received this approval at 1619 hours, there would have been enough time to make the commercial flight with Mr Khazaei scheduled for 1730 hours. Ms Baczocha said they would have been able to *"just"* make the flight. [242]

164. Though not referred to in the clinical records, Dr King and Dr Muis both gave evidence surrounding their consideration of administering the antibiotic Gentamicin. Dr Muis explained that he had never used Gentamicin before, and Dr King had said that she *"was not keen to use it at all"* due to the potential toxicity of the drug and the lack of laboratory facilities.[243] Dr Muis' evidence was that ultimately Dr King was his superior, and he deferred to her opinion on the issue.[244] Dr King's evidence in this regard was as follows:

> *"I think we had a few drugs – we did not have a huge amount but we did talk about and I specifically remember having a very long conversation about it.*

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[236] T 3, p 13 from line 15.
[237] Exhibit B149.2, p 17, reference 551073.
[238] T 9, p 9 from line 28.
[239] Exhibit B171.
[240] Exhibit B171, paragraphs 17 – 23.
[241] Exhibit C4.3.
[242] T 3, p 94 from line 35.
[243] T 3, p 14 from line 23.
[244] T 3, p 14 from line 24.

> *Yes?---And we decided against – we weren't really adamant. I don't know want to say that I was being hard mind or anyone else was. We decided against it just at the time because we had no lab and we had – specifically, we had no chemistry and we could not monitor his renal function so we had no way of monitoring toxic or non-toxic gentamicin levels. We knew he was dehydrated, we knew he was febrile, we were really afraid for his kidneys. I mean, I have damaged people's kidneys even under the best circumstances with gentamicin so I just felt afraid – just in that setting with having no information to give him [indistinct] – so that was where I stood on the issue and that was the decision that was made and why. So, you know, if someone felt forcefully that we should have, I don't think I would have argued if this – you know, I was amenable, I just – I felt the need to be careful with that particular medication."*[245]

165. Dr King accepted that Gentamicin, though toxic to the ears and kidneys could, quite reasonably, be administered as one single large dose. If someone had suggested that as a proposed course, she *"would not have been militant about that."*[246] She explained that she was American trained, and *"we just do not use a lot of gentamicin because it's just considered so toxic."*[247]

166. When asked why the decision was not documented in the clinical records, Dr King explained that there was *"no specific reason."*[248] She documented as much as she could, given how sick Mr Khazaei was, and the fact that she had other patients to care for.

167. Dr King recalled seeing Mr Khazaei when she left her shift on 25 August 2014. She noticed *"he was up and walking around and looking good and he was good enough, we thought, for a commercial airline flight."*[249] He did not appear to be out of breath at all, and no incidents involving shortness of breath were brought to Dr King's attention. She could not recall being made aware of any reports of Mr Khazaei's IV line becoming disconnected. In terms of the administration of fluids over the evening of 25 August 2014, relevant medical records were put to Dr King:

> "*The chart shows that the IV was reinserted successfully at 2150 hours after several attempts, and shows that at 2300 hours there was 300 mils of normal saline with a fast push, and at 2330 – sorry – and at 2330 hours, one litre with a fast push. Were you aware of that?---Again, yes. But that still was not what I ordered. You know, he was required – at that point he would've had a much higher fluid requirement than that. So I guess he's getting things in drips and drabs and bits and bobs; not in the way that I ordered it, is the point that I was making.*
>
> *I see. And you would say the same thing, would you, concerning it being recorded in the chart at 0300 hours that the normal saline was being continued to keep the vein open, being, you would understand - - -?---Right. Yeah.*
>
> *- - - a maintenance dose?--- I never wrote for it. Yeah, right. Yeah, I never wrote for a keep vein open dose. No.*

[245] T 4, p 96 from line 1.
[246] T 4, p 101 at lines 39-40.
[247] T 4, p 101 from line 42.
[248] T 4, p 96 from line 21.
[249] T 4, p 96 from line 44.

All right. That, you would say, is at a lower rate than what you were anticipating or requiring to be done?---Yes."[250]

168. Mr Khazaei was monitored by Ms Owen overnight from 25 August 2014 to the morning of 26 August 2014. She recalled starting her shift that night and being surprised that Mr Khazaei was still there. She had been led to believe that he would be *"leaving the day before."*[251] Her instructions over the course of the shift were *"to monitor his temperature, maintain his pain relief and administer any antiemetic if he required it if he was vomiting or was sick."*[252]

169. The observations recorded overnight show that between 0120 hours and 0330 hours, Mr Khazaei's oxygen saturations started falling (92% to 86%). However, by 0715 hours they had risen again to 95%. The notes from 0715 hours on 26 August 2014 confirm that Mr Khazaei was feeling unwell with a headache, cold and nauseas. He had vomited twice. [253] Ms Owen phoned Dr Muis twice over the course of the shift, at 2300 hours and again at 0020 hours. Dr Muis recalled at least one of these phone calls in his evidence.[254] Dr Muis provided Ms Owen with advice to administer Panadeine Forte, Ibuprofen and an anti-emetic, Ondanestron. Ms Owen's evidence was that 'blackness' had developed around Mr Khazaei's wound on his left leg. He was unable to bear weight on his left leg.[255]

170. Ms Owen recorded her observations in the electronic medical record, and these are extracted as follows:

> ***"Progress Notes*** *Note added on 4:02 AM :*
> ***Subjective:***
> *Ongoing treatment in patient L) leg cellulitis*
> ***Objective:***
> ***A Febril temp 36.6 SOB***
>
> ***Assessment:***
> *2300 hr 37.3 temp 100/65 Bp HR140 Spo2 92%*
> *;Panadine Forte 500mg/30mg x 2 oral under consult Dr Martin*
> *Ibrophen 200mg x2 oral under consult Dr Martin*
> *300mls normal saline 0.09% IV fast push*
> *2330 Hr. 37 temp 92/59 Bp - HR137 - Spo2 94% room, Resp Rate 26*
> *;1 Ltr normal saline 0.9% fast push*
> *0020 Hr. ;Ondanestron tab 4mg oral Dr martin*
> *0120Hr. 36.6 temp 95/59 Hr 130, Spo2 92% room, Rep Rate 26*
> *300Hr. 36.6 temp 108/ 74 HR 119 Spo2 86% room, Resp Rate 26*
> *Iv Ceftriaxone 1gm flushed normal saline 0.9%*
> *Iv normal saline 0.9% TKVO*
> *330Hr. Refused ; Pain relief Panadine Forte + phengargen + ibprofen*
>
> ***Plan: OBS every 2hrs***"[256]

[250] T 4, p 106 from line 44.
[251] T 2, p 93 at lines 41-42.
[252] T 2, p 93 from line 35.
[253] Exhibit B12.11 from page 7.
[254] T 3, p 15
[255] T 2, p 105 from line 15.
[256] Exhibit B17, p 6.

171. Ms Owen agreed that Mr Khazaei's vital signs were inconsistent with his physical presentation. When asked to explain how vital signs are weighed against physical presentation, her evidence was:

> *"---It's – you don't just look at numbers and his – we – we look at patient – patient's conditions, and you know, we just don't treat figures and numbers, we treat patients and people. So, you know, if somebody has got – and I know what you're meaning, someone's got an oxygenation saturation of about 87, you look at the whole picture, you know, he's just come back from the toilet having two or three cigarettes, he was not short of breath, he was sitting there talking to us, you know, he was – and his normal self."*[257]

Transfer to Port Moresby – 26 August 2014

172. Craig Palmer was a DIBP officer on Manus Island who was responsible for managing the onsite relationship with the PNG ICSA.[258] Mr Palmer recalled being contacted on the morning of 26 August by Ms Costello, shortly after he started work at 0715 hours. Ms Costello informed him that the approval for Mr Khazaei's transfer had not yet been received from the relevant officers in Canberra. Mr Palmer asked for the approval to be expedited, by calling and emailing Mr Matheson, the most senior DIBP officer in PNG.[259]

173. There was also a further discussion between Ms Costello and Ms Baczocha that morning at about 0810 hours, during which Ms Costello asked Ms Baczocha about a 'fitness to travel approval form' for Mr Khazaei. Ms Baczocha told Ms Costello, among other things, that Mr Khazaei was no longer fit to travel on a commercial flight.[260] Ms Baczcocha also recalled contacting Mr Palmer that morning. Mr Palmer's recollection of that conversation was that it occurred just before 0830 hours, and he was told Mr Khazaei now required a medical evacuation. Mr Palmer also passed on this update to Mr Matheson.[261]

174. Mr Matheson passed on the concerns from those on the ground at Manus Island to Mr Windsor via an email sent at 0802 hours[262], and a text message sent at 0805 hours. It was the text message which prompted Mr Windsor to consider the email sent to him the previous evening by Ms Little.[263]

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[257] T 2, p 94 from line 42.
[258] Exhibit C12.
[259] Exhibit C12, paragraph 10; Exhibit C3.3.
[260] T 3, p 87 from line 5.
[261] Exhibit C12, paragraphs 10-11.
[262] Exhibit C3.3.
[263] Exhibit C3.2.

175. When Dr King attended the clinic for her shift at 0800 hours, she noticed that Mr Khazaei had deteriorated since the previous evening. Dr Muis recalled Dr King approaching him and saying *"there is no doubt he is now an emergency."*[264] Dr Muis also recalled Dr King saying that Mr Khazaei was likely in septic shock and developing acute respiratory depression.[265] Dr King did not recall saying this but her evidence was that she *"would certainly say that that is correct."*[266]

176. Dr Muis described Mr Khazaei's deterioration, compared to his appearance the previous day:

> *"---He was the most awful colour that I'd ever seen a human being. He had noticeably deteriorated. He was a sort of a grey purpley colour. He was breathing very rapidly, probably well over 30. He seemed confused. If you went anywhere near him and tried to put a mask on or anything like that, he would put his arms up and/or strike out. His observations that I'd been given at the time, his oxygen sets were low, his BP was low and his pulse was – I can't remember for sure – 130, 140.*
>
> *And if you can provide a comparison to what he looked like to you on this particular morning to when you'd left him the day before?---Completely different. I mean, I'm only a GP, but I've never ever seen anybody deteriorate that fast. He – the previous night he was ill - - - but he was rational, he was conscious, he had a normal skin colour. I mean, he had a sort of Middle East brownish skin colour, not white, but the next morning he looked awful. That's a medical term. He was just grey-blue."*[267]

177. Mr Khazaei's observations from the morning of 26 August 2014 confirm he had deteriorated significantly.[268] His transfer was now deemed by both Dr King and Dr Muis as very urgent, and the transfer request was revised to indicate he required a medevac.[269] Dr Muis immediately phoned Dr Renshaw and advised him of the change in situation, and that an emergency medevac was required.[270] Dr Renshaw recalled that this phone call occurred at about 0830 hours. He was informed by Dr Muis that there *"had been a distinct change in this gentleman's clinical condition, such that he now required an air ambulance movement."* He recalled Dr Muis mentioning septic shock.[271]

178. Immediately after speaking with Dr Muis, Dr Renshaw phoned Ms Little and *"told her that the patient had deteriorated significantly and therefore we needed the department's approval for launch of an air ambulance."* Dr Renshaw recalled that Ms Little seemed to agree with that and told him it would be considered. Ms Little's evidence was that there was no mention at the time about the possibility of a transfer to Australia, rather than Port Moresby.[272]

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[264] T 3, p 15 from line 27.
[265] Exhibit B10, paragraph 29; T 3; page 15 from line 35.
[266] T 4, p 98 at line 3.
[267] T 3, p 16 from line 23.
[268] Exhibit B12.11, p 8; T 3, p 17 from line 17.
[269] T 4, p 98 from line 10.
[270] T 3, p 17 from line 39.
[271] T 4, p 48 from line 30.
[272] T 7, p 16 from line 39.

179. At 0838 hours, Mr Windsor sent an email to Mr Cahill which forwarded the transfer request for his urgent consideration. It was stated in the email that "*IHMS would like to get him on a flight to POM this morning*."[273] Ms Little thought that the call with Dr Renshaw occurred minutes after the email from Mr Windsor came through. In terms of the sequence of events that morning, Ms Little said *"- I think I, approximately, it was, sort of, almost concurrently. But the – I think the call was, probably, minutes afterwards. But, you know, more than one thing happening at once, at the time."*[274]

180. The request for transfer was approved by Mr Cahill via email just three minutes later, at 0841 hours.[275] At 0859 hours, Ms Gow sent an email to Ms Costello confirming the transfer was approved and that a medevac was now required. Ms Costello replied via email asking whether the approval extended to the medevac. A further email from Ms Gow to Ms Costello was sent at 0903 hours, confirming that verbal approval had been given, presumably with respect to the medevac.[276] It appears Ms Little was not included in these emails, as she sent a subsequent email at 0905 hours explaining the updated need for a medevac.[277]

181. Dr Muis also called the International SOS Assistance desk, and spoke to Dr Stewart Condon.[278] I heard from Dr Condon at the inquest.[279] Dr Condon entered a file note of that conversation on to the system 'New Case', and from the records it was ascertained that Dr Muis' call was made close to 0845 hours.[280] From that file note, it is clear that Dr Muis provided a history, including the attempt to transfer Mr Khazaei the previous day on a commercial flight. The observations provided by Dr Muis to Dr Condon during this phone call were very concerning to Dr Condon:

> *"the heart rate is fast, the blood pressure is low, the saturations, which for a normal person fit and healthy should be 98 to 100 per cent on room air, were low. We tend to accept down to 94, 95 per cent at times, but 93 is low and a respiratory rate of 26 is high. So almost all of them are concerning, yes."*[281]

182. Dr Condon agreed with the recommendation made. The advice provided by Dr Condon included the application of oxygen, though no particular method of doing so was discussed.[282] Dr Muis produced to the inquest a copy of the RMM form he completed and believed he sent to the International SOS Assistance desk, which is time-stamped 0845 hours.[283]

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[273] Exhibit C3.4.
[274] T 7, p 15 from line 42.
[275] Exhibit C3.5.
[276] Exhibit C5.4.
[277] Exhibit C1.8.
[278] Exhibit B152, p 3-4; B152.11 (3rd call NDOSYD14).
[279] Exhibit B151.
[280] T 2, p 65 from line 27.
[281] T 2, p 31 from line 21.
[282] Exhibit B152, p 3.
[283] Exhibit B10.6.

183. Following the call with Dr Muis, Dr Condon said he formed the view that the recommendation from International SOS should be for a transfer by air ambulance to Brisbane. Dr Condon was of the view that *"Port Moresby was no longer medically appropriate, as the PIH would not have been able to provide definitive care to this man."*[284] His evidence was:

> *"---I remember that we were recommending him to leave Manus Island.*
> *……*
>
> *So the recommendation was for an air ambulance movement off Manus Island. I remember the – I made the recommendation that he travel to Brisbane, as a centre of medical excellence, that he have a ground ambulance on both ends and then he'd be admitted on arrival to the hospital."*[285]

184. Dr Condon explained that, as a general procedure, medical retrievals also involved a discussion around any available local options. His evidence was that a recommendation for transfer to the PIH would be *"an alternative if, for example, we weren't able to move him to Australia, which would be our real recommendation, but it would be a secondary alternative."*[286] Dr Condon could not recall if the PIH was explored as an option for Mr Khazaei on 26 August 2014.[287]

185. Dr Dennett gave evidence about her experience with having medical transfers to Australia approved, and how this may have impacted on the recommendation made for Mr Khazaei's transfer, as follows:

> *"---The medical care in Port Moresby is a step up from the medical care in Manus – on Manus Island.*
>
> *Yeah?---We usually do not recommend transfers to Port Moresby. However, experience has shown that the department was very reluctant to bring patients to Australia, and we knew that if we – if we recommend transferring to Australia, it would not be approved.*
> *---*
>
> *So we knew that a transfer would not be approved, so – and this patient was not well, so in his best interest – in his best interest, we considered that it would be not the best option at the time, but it would be a step up in an upgrade of care, and that's why we put that to the department."*[288]

186. Dr Renshaw's evidence confirmed the MERP provided for medical transfers to Port Moresby and Australia.[289] In terms of medical transfers for transferees (those persons housed at the MIRPC who were not expatriates or stakeholders), Dr Renshaw explained that there was a directive from DIBP that consideration be given first and foremost to Port Moresby being the receiving centre of care. Dr Renshaw confirmed that it was only when local options had been deemed inappropriate, that

[284] Exhibit B151, pp 2-3.
[285] T 2, p 32 from line 34.
[286] T 4, p 33 from line 10.
[287] T 4, p 33 at line 9.
[288] T 4, p 15 from line 5.
[289] Exhibit B13.1, p 4; T 4, p 32 from line 30.

Australia would be considered as the receiving centre of care.[290] He confirmed that the local hospital on Manus Island, Lorengau, was not used as *"It was thought that the hospital did not provide a satisfactory level of care for the conditions that we were seeing."*[291]

187. Dr Muis could not recall any discussion over this particular morning about Mr Khazaei being transferred anywhere but Port Moresby. His evidence in that regard was:

> "*No. No. I was told that our port of call was always the private hospital in Moresby. There was a small hospital at Lorengau. We were told specifically not to go there.*
>
> *Yes?---And we were also told specifically not to use the public hospital in Moresby. No.*
>
> *So were you aware at all that a transfer to Australia was even an option?---No.*"[292]

188. Mr Cahill confirmed that he was aware that there was a requirement to consider all medical options in Port Moresby, for transferees who required a medical transfer, before a transfer to Australia would be considered. He explained his understanding of this requirement, as follows:

> *"---So, essentially, there was a progressive escalation of treatment options. So if a transferee became ill and the treatment was no longer available – satisfactory treatment was not available at Manus Island, at the medical facility there, then the next escalation point would be the East Lorengau Hospital and if it was not possible to obtain the necessary treatment there, then the next escalation point was Port Moresby Hospital – Pacific International Hospital and after that, of course, transfer to Australia. It was open to IHMS, making the clinical recommendations, to make judgments about the availability of that treatment and give us advice about those matters. So, you would necessarily need to work through that hierarchy in order to obtain a transfer to Australia.*
>
> *Yes. And indeed, when you say advice on those matters, that would extend to advice as to the most appropriate place for receiving care for that patient?---Correct.*"[293]

189. Mr Gillard and Dr Yap explained what happened to Dr Condon's recommendation for a transfer to Australia. Mr Gillard confirmed that at about 0915 hours Dr Condon approached him to provide an update on Mr Khazaei. Dr Yap was present during that conversation.[294] The update was to the effect that an urgent air ambulance was now required. The place of transfer was discussed, and Mr Gillard's recollection about that was as follows:

> "*The discussion at the time was that Brisbane would've been a definitive care for Mr Khazaei. But, given the – the stance of the department that local care must be exhausted before any movement to Australia would take place, that – Port Moresby would be the next step up from Manus, but it would not be definitive care, and that would follow our usual procedure where we provided the recommendation*

[290] T 4, p 32 from line 45.
[291] T 4, p 32 from line 39.
[292] T 3, p 20 from line 14.
[293] T 7, p 96 from line 29.
[294] T 8, p 68 from line 6.

to definitive care that they said in their recommendation that the next step up – however, not being definitive care – would be Port Moresby."[295]

190. Dr Yap's evidence about this conversation with Dr Condon accorded with the recollection of Mr Gillard.[296] Dr Yap explained during her evidence that, had she pushed for a transfer to Australia on this particular morning, it would have resulted in *"significant delays with obtaining approvals.*"[297] Mr Gillard confirmed that the content of his discussion with Dr Condon was reflected in the updated recommendation which was drafted, and sent to the 'ManusACComms' inbox at 0932 hours.[298] Mr Gillard confirmed that this inbox was a group inbox, and whichever IHMS team member was staffing it that particular morning *"would've taken that email and passed it on and upwards through to the department."*[299]

191. Dr Renshaw's evidence was that he recalled seeing the updated recommendation on the morning of 26 August, and *"I used elements of the wording. I edited the form, as is part of my role, and I sent the edited version of this notification of case to the department."* Dr Renshaw's evidence was that he rephrased the wording and made a number of corrections so that it was appropriate for review by DIBP.

> *"The forms that were sent from the International SOS team needed to be phrased in a particular way, and it needed to be made extremely clear to the department what the recommendation was. In particular, the recommendation needed to fit the departmental policy at the time. That being that cases needed to be managed in Port Moresby if services were available.*
> *….*
>
> *There are two options presented there, both of which are reasonable and so the option that the department requires us to use is treatment in Port Moresby.*"[300]

192. Dr Renshaw's edited form[301] was sent via email to Ms Gow, Ms Little (and others) at 1018 hours. When asked why there was no mention of Brisbane, or Australia as a possible transfer destination in the form he edited, his evidence was as follows:

> "*Because it was not a question of what the gold standard of care was. It was what was available and what was appropriate - - for this particular case.*
>
> *Yes. Okay. And to your knowledge, the Pacific International Hospital in Port Moresby had appropriate facilities that could manage the case?---It absolutely did and not – not only that, it was also by far and away the most expeditious way of getting this man to a higher level of care.*
>
> *Yes. So indeed the fastest option as well?---Yes.*"[302]

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[295] T 8, p 29 from line 16.
[296] T 8, p 68 from line 41.
[297] T 5, p 109 from line 38.
[298] Exhibit B167.2.
[299] T 8, p 29 from line 45.
[300] T 4, p 50 from line 17.
[301] Exhibit B13.5.
[302] T 4, p 51 from line 15.

193. Mr Gillard confirmed that shortly after sending the updated recommendation, Dr Condon confirmed that he had spoken with the PIH, and received confirmation that the PIH would accept Mr Khazaei.[303] This was confirmed by the relevant call logs and by Dr Condon during his evidence.[304] Dr Condon accepted that by the time the modified RMM left International SOS bound for the relevant staff in IHMS, he had already been in touch with the PIH to confirm that it would accept the patient. He had made no similar preparatory steps to any hospitals in Australia.[305]

194. In terms of taking preparatory measures to secure the PIH as a receiving centre of care without approval having been provided by the DIBP, Mr Gillard clarified why this is done, as a general process, as follows:

> *"Yes, most definitely, because as a matter of best practice and due diligence we'd proactively secure as much as possible that could be done without receiving authorisation so that when authorisation did come through, if there was a time delay in that or if we had a limit to the time to action it once the authorisation was received, we were already ahead of the – the curve."*[306]

195. While awaiting approval for the transfer on 26 August 2014, Mr Khazaei had been moved to the resuscitation bay. Dr King cared for him along with nurse, Kila Koupere.[307] Mr Khazaei's observations at 0900 hours are set out in the handwritten clinical record, with the oxygen saturations recorded at 77%, blood pressure at 146/100, pulse rate at 104, respiratory rate at 42, and temperature at 37.3°.[308]

196. Ms Koupere confirmed that Mr Khazaei was moved to the resuscitation bay because *"we needed to put him on some oxygen and give him more support."*[309] Dr King confirmed that she had applied oxygen by way of a non-rebreather mask connected to an oxygen cylinder, which Mr Khazaei was largely cooperating with. She recalled that they may have commenced a second intravenous line at that time as well, *"because he was starting to get, like, really just delirious and inappropriate and, you know, that sort of thing."*[310]

197. In addition to her written statement on the issue,[311] Dr King confirmed in her evidence that she considered intubating Mr Khazaei at this stage. Her evidence on this point was as follows:

> *"Did you consider intubating Hamid at this point in time to assist in the provision of oxygen?---Yeah, we did. And I remember – this was another conversation that we kind of had at length in that it depended a lot [indistinct] things I was not controlling, like the medevac – who was coming. So if we were sending him intubated, then we needed to make – as I recall, it would've required a different team to arrive and it would've made another delay. But I don't recall – I don't know if that's true exactly.*

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303 T 8, p 30 from line 15.
304 Exhibit B153, pp 135 – 136; T 2, p 70 from line 27.
305 T 3, p 74 from line 11.
306 T 8, p 30 from line 23.
307 T 3, p 119 from line 18.
308 Exhibit B12.11 at page 8.
309 T 3, p 122 from line 27.
310 T 4, p 98 from line 25.
311 Exhibit B6.1 from paragraph 54.

> *Okay?---So I remember we discussed it. We – because we had to actually – I think we discussed and possibly before. The thing is, keeping him long term intubated was not really something I wished to do. I did not think we were in the right setting for that. Intubating him and then just simply [indistinct] or intubating and having him retrieved was a different matter. But we couldn't really get any – at least, I couldn't get any clarity on when exactly anyone was arriving and at what capacity. So how long were we going to have to keep him ventilated? Because, again, medications were an issue, meaning how long could we keep him sedated, was also what I was thinking as well.*
>
> *Okay?---So I did consider it. But then when it kind of stretched on and on and on, I kind of shied away from it because I – you know, in retrospect, I may have acted differently, but that was the thinking at the time."*[312]

198. Dr King expanded on her concerns about intubating Mr Khazaei as follows[313]:

> *"So looking back on it now, in retrospect, are you saying that you perhaps would have intubated Hamid at this time?---I mean, I think – it's hard to say. Because, the thing is, we were having this discussion, you know, right when we first got there, at 8 o'clock. Hamid still did not leave until almost 4. So he would've had to have been intubated all day. And did we have the capacity for that in that clinic? Did we have the capacity to transfer him that way? Meaning we took him in the ambulance to the airstrip. Now, did the medical team coming have the capacity to take an intubated patient? You know, we had to factor in all those things. And if that was not the case, then that would've made even a further delay. So it's easy to say all of that now, now that we know the outcome and now that we know the story. But in the middle of it, that was a very hard decision because there were too many factors we did not know."*[314]
> ….
>
> "*You know, things like that. I – you know, it would've completely eliminated this whole debate, should I have intubated him on the tarmac. I mean, you really shouldn't be doing that on any circumstance. But in PNG, with limited resources and inadequate power and questionably trained staff, that's really a hard decision to make. You know, I think to say, would've, could've, should've, ad you're sitting comfortably in Australia is very different than working in the environment that I was working in.*"[315]

199. Dr Muis' statement covered his discussions with Dr King about intubation.[316] Each of the concerns raised by Dr King in her statement were put to Dr Muis in his evidence, and he recalled discussing each concern with Dr King at the time.[317] Dr Muis confirmed that it was not a matter that intubation was not performed due to the necessary equipment being unavailable or otherwise inoperable.[318] The evidence established that the clinic had a dedicated resuscitation trolley and a mechanical ventilator in the resuscitation room. A number of the other clinical staff were trained

[312] T 4, p 98 from line 32.
[313] These are reiterated in Dr King's further submission of 19 June 2018.
[314] T 4, p 99 from line 8.
[315] T 4, p 102 from line 24.
[316] Exhibit B10, paragraph 40.
[317] T 3, p 45 from line 28.
[318] T 3, p 49 from line 36.

in intubation and ventilation. Other patients had previously been intubated and ventilated at the clinic.

200. The electronic medical record contains a note added at 1058 hours that *"Pt about to leave in air ambulance. All paperwork completed and Dr King will accompany pt to plane and hand over."*[319] The last clinical note for Mr Khazaei at the clinic was made at 1230 hours.[320] It was after this time that Mr Khazaei was placed in an ambulance and taken to the airport. Ms Baczocha was organising the ambulance and Dr King was to accompany Mr Khazaei to the plane and conduct the handover.[321] Nurse Koupere also accompanied Dr King to the airport. She described the trip to the airport:

> "*It was a bit difficult [indistinct] on the rough road. Obviously, we tried our – I tried my best to keep on the oxygen on him and make him comfortable as much as I could throughout the whole process, heading to the airport."*[322]

201. The trip to the airport was *"a minimum of half an hour"*, depending on road conditions.[323] The road was described by Dr Muis as "*a rotten road. It had huge pot holes in it."* [324] Ms Koupere recalled that she monitored Mr Khazaei en route to the airport, and that he had a decrease in oxygen saturation levels during the trip to below 95%. Ms Koupere could not recall if any of her observations were documented in any way.[325]

202. The aircraft arrived at the Manus Island airport at approximately 1400 hours.[326] The aircraft was a Cessna Citation CJ3, chartered from Tropic Air in PNG. An International SOS registered nurse, Erica Tattersall, and an anaesthetist from the Port Moresby General Hospital, Dr Arvin Karu, took over care of Mr Khazaei for the flight.[327]

203. Ms Tattersall's evidence was that she had initially been notified of Mr Khazaei's case on 25 August 2014, to assist with the transfer of Mr Khazaei from the commercial aircraft to the hospital. However, she was subsequently informed later in the day that Mr Khazaei was not travelling on that flight.[328] Dr Karu's evidence was similar in this respect.[329] On the morning of 26 August 2014, Ms Tattersall received a call from the International SOS Assistance desk advising that Mr Khazaei required transfer to the PIH. She was informed that it *"was now probably going to be an air ambulance medevac"*.[330]

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[319] Exhibit B17, p 5.
[320] Exhibit B12.11, p 10.
[321] T 3, p 21 from line 33.
[322] T 3, p 124 from line 32.
[323] T 3, p 82 from line 18.
[324] T 3, p 46 from line 33.
[325] T 3, p 130 from line 4.
[326] Exhibit B159.3.
[327] Exhibits B159 – B159.12 (Tattersall); and Exhibits B5 – B5.4 (Karu).
[328] T 5, p 5 from line 11.
[329] T 9, p 57 from line 40.
[330] T 5, p 6 from line 12.

204. Ms Tattersall recalled being provided with some information about Mr Khazaei's medical condition and confirmed at no stage was she informed he was septic, though she recalled the mention of cellulitis. Ms Tattersall was provided medical information from the International SOS Assistance desk via an email sent at 9:38am, which was a copy of Dr Condon's file note of his conversation with Dr Muis that morning.[331] That email has the following reference to sepsis in a section summarising Dr Condon's advice to Dr Muis:

> *"I advised:*
> *-that I would suggest adding some flucloxacillin for better staph cover*
> *-that it does sound like he does need to move off site- provisional diagnosis of cellulitis not responsive to treatment locally,*
> *sepsis*
> *-that I would also suggest using some fluids, oxygen and also an IDC*
> *-that we would appreciate the notification form for the case from offshore as per normal procedure"*[332]

205. Dr Karu confirmed in his evidence that he made a call to the International SOS Assistance desk in Sydney at about 1045 hours and spoke to Dr Condon. The file note of that call and the audio were tendered at the inquest.[333] While the recording was unable to be sufficiently heard by Dr Karu over Skype during his evidence, Dr Karu did confirm that he had recently listened to the call.[334] Dr Karu's understanding of the diagnosis, if any, of sepsis at that stage was quite unclear. He had called the International SOS Assistance desk to clarify the information provided. He understood that Mr Khazaei had a leg abscess which had deteriorated and perhaps become more infected and required collection from the Manus Island airport.[335]

206. When Dr Karu was asked what he thought he would be dealing with clinically upon arriving at Manus Island he said that he had an idea that the patient had sepsis, and an infection that was getting out of control and appeared to be deteriorating - a patient we thought would need "full monitoring and full care". [336]

207. Dr King recalled Mr Khazaei's presentation as *"he was just completely sick"* when the flight crew arrived.[337] He was not only septic, but dehydrated and delirious. Ms Tattersall recalled that Mr Khazaei did not have an IV line connected, nor did he have an oxygen mask on his face. She was told that *"he had pulled it, or them, out."*[338] Mr Khazaei's observations were not being monitored in any independent way. Dr Karu corroborated the evidence of Ms Tattersall in this regard.[339] Ms Tattersall provided some photographs to the court of the airport tarmac and marked where she recalled Mr Khazaei was waiting for them.[340] She recalled that Mr Khazaei "---*was in the sun, and it was a very bright day. There might have been some cloud, but he was not in cloud*

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[331] Exhibit B159.2; Exhibit B152, p 2.
[332] Exhibit B159.2, p 1.
[333] Exhibit B153, p 127 (file note); Exhibit B152.11 (audio file NDOSYD31).
[334] T 9, p 60 from line 5.
[335] T 9, p 60 from line 21.
[336] T 9, p 61 from line 30.
[337] T 4, p 100 at line 18.
[338] T 5, p 14 from line 10.
[339] T 9, p 62 from line 21.
[340] Exhibit B159.15; T 5, p 11 from line 18.

cover."[341] She provided the photos to the inquest so that the situation on the ground could be understood.[342]

208. In terms of the handover conducted by Dr King to the retrieval team, the typed notes from the retrieval team state "*Handover taken. To all questions told to refer to notes (large pack was given)*."[343] Ms Tattersall informed the court that as she walked towards Dr King, she recalled Dr King holding a brown manila envelope. When asked whether she could recall seeing Dr King referring to any documents within that manila envelope, Ms Tattersall gave evidence that Dr King indicated "it was all in the file*". [344]*

209. Ms Tattersall recalled the extent of the handover, to the best of her knowledge, as follows:

> *"---It was not a case of the two of us stood there and got a handover and then proceeded to work. So the initial – as we walked towards them, and got right towards them, realising what was happening, it was a bit more of a – Dr Karu and I, sort of, engaged with who I now know is Dr King, I believe, and he quickly said to me to go back to the aircraft to fetch sedation. And he then continued to talk to Dr King. So that handover, as such, I did not hear the majority of.*"[345]

210. Dr Karu's evidence was that he approached Dr King to *"ask about the patient – yeah – get a bit of history or – or some information on his treatment."[346]* The conversation which ensued was not long or detailed. Dr Karu recalled briefly being told that the patient was 'sick'. When he asked for more information regarding medications, other treatments and the like, he was advised that *"it was all in the notes"*; which is something he was told a couple of times. He recalled being handed a folder with notes inside. The content of this folder was not explained to him to any extent, rather it was simply handed to him. [347]

211. Ms Koupere had a limited recollection of the events at the tarmac and was not involved in any discussions with the flight crew.[348] Dr King was asked about the extent of her handover to Dr Karu. Dr King recalled that she had *"all of the paperwork, all the documentation."[349]* She recalled explaining that she had been caring for Mr Khazaei the entire time and the antibiotics that had been administered. She explained that Mr Khazaei had not responded to the antibiotics, and she relayed *"what her thoughts were, etc etc."[350]*

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[341] T 5, p 12 from line 4.
[342] T 5, p 12 from line 44.
[343] Exhibit B159.9, p 2.
[344] T 5, p 13 from line 28.
[345] T 5, p 13 from line 14.
[346] T 9, p 63 from line 10.
[347] T 9, p 64 from line 20.
[348] T 3, p 125 from line 1.
[349] T 4, p 99 at lines 24-25.
[350] T 4, p 99 at line 27.

212. Dr King did not recall the flight nurse or the doctor being unhappy, or asking a lot of questions, or otherwise seeming concerned. Dr Karu's recollection of the handover was put to Dr King for response during her evidence, and her evidence in this regard was that Dr Karu had very few questions and did not raise any concerns or issues with her.[351]

213. Dr King recalled that there were no discussions with the flight crew about whether Mr Khazaei should be intubated:

> *"I would not – I would have supported and helped them, had they thought he needed that – had they thought they needed that for safe transport. If they had the equipment there with them – we had our little [indistinct] bag. You know – I mean, we could have done it. I had no issue with it whatsoever. They did not say a word. They did not seem to think they needed anything. And, I mean, I'm very familiar with helping medevac crews get what they need, because once they're kind of stuck in the jet [indistinct] is that – to help them as best as you can before they get in there.*"[352]

214. In her evidence, Dr King placed the onus on intubating Mr Khazaei on to the flight crew.[353] She explained that she did not want to *"impose my will"*[354] on the flight crew, and *"you have to follow what their wishes are."*[355] Dr King also accepted in her evidence that she *"could have been more hardcore and just insisted, hey, we're doing this"*[356], and stepped in and intubated Mr Khazaei herself.[357] In her supplementary submission of 19 June 2018, Dr King asserted that Dr Karu was "*on the phone with ??? possibly the receiving hospital during our entire encounter*" and she "*did not speak to him directly but communicated fully with the flight nurse*". This is clearly inconsistent with the evidence of Ms Tattersall and Dr King.

215. Ms Tattersall's evidence was that she only knew what Mr Khazaei's oxygen saturation levels were once they had him loaded on the aircraft and that there was no suggestion from Dr King or Ms Koupere that there were any problems with his oxygen saturations whatsoever.[358] Dr Karu corroborated Ms Tattersall's evidence in this regard.[359] She *"definitely did not ask"* Dr King and the others why Mr Khazaei had not been intubated, and she was not sure if Dr Karu asked.[360] Ms Tattersall did not discuss the prospect of intubation with Dr Karu. Ms Tattersall could not recall Dr Karu saying anything to her about a provisional diagnosis of sepsis being made.[361]

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[351] T 4, p 99 from line 33.
[352] T 4, p 99 from line 43.
[353] T 4, p 100 at line 26.
[354] T 4, p 100 at line 28.
[355] T 4, p 100 at line 27.
[356] T 4, p 100 at line 25.
[357] T 4, p 100 from line 36.
[358] T 5, p 17 from line 3.
[359] T 9, p 64 from line 35.
[360] T 5, p 14 from line 36.
[361] T 5, p 33 from line 30.

216. Dr Karu said that he considered whether Mr Khazaei needed to be intubated:

> "*Did you consider intubating Mr Khazaei before he was placed on the flight?---Yes, when I – when I saw the saturation like, he was – mister – the patient was moving around, he was a little bit sweaty, and I sort of thought that we had to move him to the plane and once he settled down, then we can – we kept good – good observations on him, but – yes, the saturation was a little bit low, but if – if – I did not really think that – or I did not really think it – we had to do any intubation on the – on the tarmac. It – because – because it's hot out there and it is not ideal sort of situation.*"[362]

217. It is clear that Dr Karu made a clinical decision at the time about what he perceived to be the best interests of Mr Khazaei.[363]

218. Ms Tattersall confirmed that Mr Khazaei required sedation, and Midazolam was administered. She recalled that they were not sure if Mr Khazaei was agitated, or uncooperative. She thought at the time that the agitation might have been due to a level of hypoxia.[364] Dr Karu's evidence was that the appearance of agitation "*could have been due to a number of things*." He said that he may have been confused or restless, he may have been uncomfortable under the sun, he could have been hypoxic, or in pain from the cellulitis.[365]

219. The aircraft was equipped to safely carry an intubated patient, even in severe turbulence.[366] Dr Karu was familiar with the type of aircraft having worked with patients on the same model several times previously.[367]

220. Ms Baczocha's evidence was that the most suitable location to handover Mr Khazaei was not something that was discussed on site at the clinic. Rather, the decision was made by head office, and communicated to those onsite via the Plan of Action.[368] Ms Tattersall thought it might have been to expedite the transfer, because *"the ground time in Manus can extend the whole mission by up to three hours, due to the road conditions."*[369] Further to Dr Karu's evidence that the tarmac was *"not the ideal situation"*, he explained that as the flight doctor, he did not have any say about where a patient is received by the flight crew.[370]

221. Mr Gillard's evidence surrounding the Plan of Action provided context about the decision to receive Mr Khazaei at the tarmac.[371] He explained that the Manus Island airport was a 'daytime only' airport. While there were lights that could be used for take-off after dark, they were used intermittently and there was no guarantee that they

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[362] T 9, p 65 from line 13.
[363] T 9, p 82 from line 18.
[364] T 5, p 15 from line 5.
[365] T 9, p 62 from line 42.
[366] T 5, p 15 from line 32.
[367] T 9, p 62 from line 14.
[368] Exhibit B159.4.
[369] T 5, p 16 from line 27.
[370] T 9, p 65 from line 29.
[371] T 8, p 31 from 16.

would be operational. He said that it would have been inappropriate to plan for a potential night time take-off.

222. Mr Gillard explained that organising an evacuation off Manus Island required the consideration of a number of factors, including *"the actual time to [indistinct] up an aircraft – so, to get the aircraft ready, to final flight plans, to have the crew ready, to have the aircraft fueled, medical team ready, equipment prepped, et cetera, et cetera. Pardon me. We then have flight time from Port Moresby up to Manus, and then the time to get out to the centre was probably around an hour on a good day. [indistinct] not particularly good terrain, so the roads are – they're not the smoothest roads from – from the airport to the – to the detention centre. And, certainly, to – you know, I would not want to, in general, undertake that with a minimum of at least an hour each way to-and-from the centre. Plus, there's an hour to package the patient at – at – at the detention centre in preparation for movement."*[372] He also explained that to organise an evacuation where the flight crew received the patient at the Manus Island clinic, would need to involve a flight at first light so *"that we have sufficient time to be able to undertake all of this without unduly increasing aviation risk."*[373]

223. Once Mr Khazaei was loaded on the plane, Ms Tattersall commenced administering oxygen via a non-rebreather mask at a conservative rate of 6L/min.[374] Ms Tattersall explained her reasoning for this as *"---I couldn't tell you the reason for that choice, other than to, perhaps, see what the response was, and adjust accordingly."*[375] Ms Tattersall later increased the oxygen to 10L, and then to 12L. She recalled that when she initially connected the oxygen, saturations levels were less than 60%.[376] Once Mr Khazaei was loaded on the aircraft, Ms Tattersall said *"it became obvious quite quickly"* that the diagnosis was either sepsis or septic shock, which came as a surprise when compared with the medical information provided previously.[377] Ms Tattersall explained the difference between the two diagnoses in her evidence, as follows:

> *"---Septic shock involves many systems within the body, so not just a localised sepsis of skin or something like that. So it involves your kidneys. It involves your lungs. It can involve your brain, your liver. So there's multi-organ failure in septic shock and that's a critical situation, where sepsis is more – generally, we talk about sepsis of a wound. It could be a localised area.*
>
> *And sepsis, someone can be generally unwell, but not in a situation where you talked about of being in septic shock?---Correct.*
>
> *And it would be the case, wouldn't it, that if you had some information that a patient had sepsis, that it would be very different to information that a patient was in septic shock?---Correct."*[378]

[372] T 8, p 31 from line 33.
[373] T 8, p 31 from line 45.
[374] T 5, p 17 from line 10.
[375] T 5, p 17 from line 17.
[376] T 5, p 39 from line 23.
[377] T 5, p 33 from line 45.
[378] T 5, p 57 from line 27.

224. The records from the flight confirm the aircraft left the Manus Island airport at 1434 hours, and handover was given to the PIH emergency doctor at 1700 hours.[379] Dr Karu's evidence was that he called the International SOS Assistance desk in Sydney and spoke with Dr Condon to provide an update as they were about to take off. This was standard practice.[380] Dr Karu explained that the observations put forward by him during this call were taken while Mr Khazaei was still on the tarmac, and not yet loaded onto the plane. Those observations are extracted from the file note of the phone call as *"Last set of obs, now: RR 30, BP 190/90, HR 110, sats 88-89% on 6-78L."*[381]

225. Dr Condon did not provide any advice to Dr Karu that Mr Khazaei should be intubated, nor did he contact the PIH to provide an update as to Mr Khazaei's deteriorating condition.[382]

226. Over the course of the approximately two hour flight to Port Moresby, it was noted that Mr Khazaei's pupils were still reacting to light, he was agitated and confused, and his Glasgow Coma Score was 12/15.[383] Severe turbulence was experienced throughout the flight, which made medical care difficult. The notes indicate the turbulence caused the oxygen mask to fall off and administering medication via the IV line was difficult.

227. During the flight Mr Khazaei's oxygen saturations were between 77% and 92%. Ms Tattersall conducted a blood gas analysis using an i-STAT machine, with a very small sample of blood.[384] The result showed Mr Khazaei's pH as 7.112, his pCO2 (carbon dioxide) at 63, a higher level than his pO2 (oxygen) which was at 33.[385] However Ms Tattersall was not sure whether the sample obtained was venous blood or arterial blood. Because of this, the result could not be relied upon.[386] She accepted evidence that it was a possibility it was arterial blood, and therefore that the pCO2 reading indicated a level of hypoxia.[387] When asked, if this possibility was accepted, what she could have done during the flight to try and address this, her evidence was as follows:

> "*I think the intentions had been to try, but this was all through severe turbulence, while I was in fact trying to test this or just after, that is when I hit my head on the ceiling in this turbulence. It was too dangerous to move in this aircraft.*
>
> *So in terms of what you could do, are you saying that it was limited due to the severe turbulence?---Very much so.*"[388]

[379] Exhibit B159.3.
[380] T 9, p 64 from line 45.
[381] Exhibit B153, p 118.
[382] T 2, p 78 from line 24.
[383] Exhibit B159.9.
[384] T 5, p 55 from line 39.
[385] Exhibit B159.10.
[386] T 5, p 18 from line 37.
[387] T 5, p 20 from line 11.
[388] T 5, p 20 from line 16.

228. Dr Karu also gave evidence about the limitations of managing Mr Khazaei's airway mid-flight.[389] It seems that, mid-flight, Dr Karu had come to the view that Mr Khazaei required invasive airway management. His evidence was:

> *"There was this – I had to make – I knew the saturations were low and, you know, patient needed some, you know, invasive airway but I just – when I weighed up the situation, I was worried that, like, if I had to give him a – [indistinct] and some muscle relaxant, you know, to paralyse and then intubate.*
>
> *Yes?---And – and if there wouldn't have been enough time, I would have to leave him and go back to my seat. And I would be caught in a situation where, you know, the patient would be like in big serious trouble, so I am sort of, in my mind I said, "If I can keep him supportedessly breathing, that was the most important – that was the best plan I thought was – for him, yeah."*[390]

229. Upon landing at Port Moresby, Mr Khazaei was placed in an ambulance and transferred to the PIH, accompanied by Ms Tattersall and Dr Karu. Ms Tattersall said that Mr Khazaei's observations did not change significantly during the trip to the PIH. However, she explained that due to the road conditions and the amount of road work going on in Port Moresby at the time, the observations taken could not be relied upon. It took around seven minutes to get to the PIH. [391]

230. When Mr Khazaei was being unloaded from the aircraft, the objective was to expedite his journey and get him to the PIH as quickly as possible. Ms Tattersall's evidence was that instituting further oxygen management on the tarmac at Port Moresby would only contribute to a delay in getting Mr Khazaei to the PIH.[392] Dr Karu considered intubating Mr Khazaei once he was offloaded from the aircraft, but ultimately decided that the *"situation was not ideal"* and he did not think he should take the risk of intubating Mr Khazaei on the tarmac, which involved paralysing him, when the PIH was not far away.[393]

231. When they arrived at the PIH, they were met by registered nurse Robert Miazek, who was employed by International SOS and stationed at the PIH as part of a team in place to provide medical care to employees of the Australian Federal Police (AFP). Mr Miazek assisted with unloading Mr Khazaei from the ambulance. Mr Khazaei was noted to be responsive to voice commands and breathing independently through his oxygen mask. He was drowsy, but otherwise responsive.[394] When asked for her opinion about Mr Khazaei's presentation at this time, Ms Tattersall said:

> *"---I would say that he was a very ill man in need of definite ongoing medical care, which, in our telephone conversation to Sydney, was he needs to be moved to Australia."*[395]

[389] T 9, p 66 from line 4.
[390] T 9, p 67 from line 5.
[391] T 5, p 21 from line 17.
[392] T 5, p 21 from line 31.
[393] T 9, p 67 from line 23.
[394] T 5, p 22 from line 21.
[395] T 5, p 22 from line 9.

232. Mr Miazek gave the following evidence when asked whether he considered Mr Khazaei's condition to be within the capacity of the PIH to manage:

> *"Well, I knew the PIH, there were – at the PIH, there were routine surgeries performed including the patients being intubated and ventilated and being put to sleep for the duration of the procedure so I knew there were necessary skills on site at PIH to manage potentially unwell patients. That's why I was not – that's why I was under the impression that just by looking at that patient briefly, as he was being transferred to the hospital, that the PIH – it was not beyond PIH capacity to manage at this stage and with very limited background information at that stage."*[396]

233. Dr Karu's evidence was that he provided a handover to the PIH emergency doctor, Dr Joseph Aina. Ms Tattersall was not involved in this conversation and did not hear any part of it.[397] Dr Karu recalled that Dr Aina seemed to be a junior doctor. He explained his reasoning for saying this, as follows:

> *"But – that – that's because, you know, when I heard about a patient like – by this time – I – I, you know, knew how sick the patient was and I – I sort of thought that, a more definitive area was the best thing for him. And I did tell – tell the doctor, look, the patient needs either positive-pressure ventilation or intubation, and I think, when I mentioned that, I think he sort of immediately went on to try and call his boss or consultant or whoever – whoever was his – is in charge of him – or in charge of ED there. So, I sort of – well, I'm not sure if he was not sure what to do, or maybe he just wanted to – because the patient was quite sick, and he wanted to get his boss involved, I'm not sure about that, yeah.*
>
> *Yes?---It's just that he – as soon as I mentioned, you know, it was a more advanced airway, I think he probably wanted to get his superiors to help him or something."*[398]

234. Ms Tattersall gave similar evidence and recalled that the doctor who received Mr Khazaei seemed unsure of his next action, "*---As I recall, he actually said so, that he'd phoned – he gave a name – again, I can't remember who that was – for advice."*[399] Staff from the PIH assisted with transferring Mr Khazaei from the stretcher onto the Emergency Department bed. Ms Tattersall did not believe that any of these staff were doctors.[400] She advised them that Mr Khazaei needed airway management.[401] She did not see her advice in this regard being implemented in any way by PIH staff, and it was not her place as a non-PIH staff member to do anything in order to have her advice followed.[402]

235. Once inside the emergency department, Ms Tattersall's evidence was that *"the person who I'm assuming was the doctor came behind the curtain and did a fairly cursory – he came to look quickly at the patient, and then left again."* Dr Karu recalled *"I remember, I think I told one of them assisting the ED there to, like, increase the oxygen up and – I – it is just – I sort of did not feel good leaving quickly. I wanted something done about the airway and*

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[396] T 10, p 8 from line 31.
[397] Exhibit B159, paragraph 66.
[398] T 9, p 68 from line 18.
[399] T 5, p 23 from line 5.
[400] T 5, p 23 from line 1.
[401] Exhibit B159, paragraph 67.
[402] T 5, p 23 at line 32.

stuff…."[403] Dr Karu did not see any of the PIH staff do anything to manage Mr Khazaei's airway. He left the emergency department about 15 minutes later.[404]

236. Dr Karu's written statement indicated that he then spoke to the International SOS Assistance desk and advised that Mr Khazaei needed an urgent transfer to Australia for optimal care.[405] However, at the inquest, after he listened to the audio of the relevant phone call,[406] he clarified if he did mention a transfer to Australia, it was not over the phone.[407]

237. Mr Khazaei's observations were relayed to Dr Evelyn Wong at the International SOS Assistance desk during this phone call, and are extracted below as per the file note of that phone call:

> *"Handed over to PIH ED*
> *During flight quite tachypnoeic and breathless*
> *Midazolam to keep sedated*
> *Sats 68% lowest highest 94% on 10L oxygen continuous*
> *BP 172/95 highest*
> *Maintained good MAP throughout*
> *RR 28-40*
> *Maintained good urine output 140mls in 2 hrs*
> *Temp 37.2 axillary*
> *Normal SR,.tachycardic*
> *HR 110-130*
>
> *Upon h/over to PIH*
> *Still under a bit on sedation, but still moving*
> *Sats 73-77% on 1 OL oxygen via rebreather*
> *BP 170/100"*[408]

Care provided at the Pacific International Hospital – 26-27 August 2014

238. The PIH at Port Moresby is a privately operated hospital, unrelated to IHMS or International SOS. However, IHMS and International SOS had a number of staff who operated out of the PIH, pursuant to a variety of agreements. Cher McIntyre was one such IHMS employee who was at the PIH when Mr Khazaei arrived. I heard from Ms McIntyre at the inquest.[409] Ms McIntyre's evidence provided valuable context to the evidence provided by the PIH clinicians in their written statements.

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[403] T 9, p 68 from line 35.
[404] T 9, p 68 from line 42.
[405] Exhibit B5, paragraph 32.
[406] Exhibit B152.11 (audio file NDOSYD50); Exhibit B153, pp 115-116 (file note of audio).
[407] T 9, p 57 from line 7.
[408] Exhibit B153, p 116.
[409] Exhibits B170 – B170.2.

239. Ms McIntyre confirmed that upon Mr Khazaei arriving at the hospital, he was taken to a curtained cubicle. Her evidence was that, every now and then, she and her colleague Tracy Dawson would look through the curtain and could see very clearly that Mr Khazaei was very unwell.[410] She confirmed that he was not intubated at this time and was being provided oxygen via a non-rebreather mask.

240. Ms McIntyre's evidence from this point in time relates to Mr Khazaei's care in, what is termed by the PIH clinicians the 'ER Acute Zone'.[411] He was in his own cubicle which had a curtain. Mr Khazaei's initial care was from Dr Aina Kagl, the attending junior medical officer in the ER at the PIH. Dr Kagl assessed Mr Khazaei as having *"developed septicaemia, secondary to the leg cellulitis and was in septic shock."*[412] His initial observations recorded in the PIH clinical notes at 1700 hours were as follows:

> *"BP 162/84 P 132 T 36.5C SpO2 70% RR 60 BSL 8.5"*[413]

241. The rostered on-call Consultant was unwell and unable to attend at the hospital. Consequently, at 1730 hours, Dr Kagl contacted Dr Ronald Galicio, a Consultant in Internal Medicine and Cardiology. Dr Galicio was out with his family at the time but gave initial advice over the phone for further investigations and medications.

242. Ms McIntyre's observations of those caring for Mr Khazaei were that *"despite him being so unwell, there seemed to be absolutely no sense of urgency from the Pacific International Hospital staff."*[414] She clarified this during her evidence by saying that when she did look through the cubicle curtain, or when the curtain was open, she was surprised that there was no staff member in the cubicle with Mr Khazaei. Her evidence was that *"there was no one caring for him at all times."*[415] At approximately 1800 hours, Ms McIntyre recalled her colleague, Ms Dawson ask the emergency doctor *"why aren't you intubating him?"*[416]

243. Ms McIntyre's evidence was that she and Ms Dawson were becoming extremely alarmed. In her statement she said *"it seemed that the staff at the PIH either did not realise how ill the patient was, or if they did, they did not know what to do."*[417] At 1850 hours, just before Mr Khazaei was intubated, Ms McIntyre reported Mr Khazaei's deteriorating condition to the IHMS Assistance desk in Sydney.[418] A transcript of that call was tendered at the inquest.[419] Ms McIntyre informed the IHMS Assistance desk that *"they had decided to intubate him"* (reference to the PIH clinicians) and that Mr Khazaei would be admitted to the ICU.[420]

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[410] T 10, p 35 from line 37.
[411] Exhibit D1.2, paragraph 17.
[412] Exhibit D1.2, paragraph 21.
[413] Exhibit D13, p 5.
[414] Exhibit B170, paragraph 26.
[415] T 10, p 36 from line 13.
[416] Exhibit B170, paragraph 29.
[417] Exhibit B170, paragraph 30.
[418] Exhibit B170.2, paragraph 9.
[419] Exhibit B170.2, transcript relating to call 557353 marked 'CM-D'.
[420] Exhibit B170.2, paragraph 9; transcript relating to call 557353 marked 'CM-D'.

244. It was at about this time that Dr Galicio and his wife Dr Melissa Galicio, an Anaesthetist at the PIH, attended the PIH. Dr Ronald Galicio reviewed Mr Khazaei. At 1820 hours, Mr Khazaei received intravenous chloramphenicol, flucloxacillin and bicarbonate.[421] At 1855 hours he was intubated by Dr Melissa Galicio, and connected to oxygen at a rate of 10L/min. Dr Ronald Galicio's statement about the timing of the intubation indicates:

> *"We had a plan to intubate the patient from very early on but because the patient was so restless we needed to get the IV line re-established in order to sedate the patient so Dr Melissa could proceed with the intubation. The IV line also had to be re-established so that we could provide the other treatment and management the patient needed.*
>
> *I recall that we struggled with the patient for a considerable period of time before Dr Melissa was successful in re-establishing an IV line."*[422]

245. After intubation, ventilation was being provided manually by way of an ambu-bag.[423] Observations recorded in the clinical notes at 1945 hours are as follows:

> *"BP 141/84 P 134 SpO2 65% RR 33"*[424]

246. Just before these observations being recorded, Ms McIntyre made another phone call to the IHMS Assistance desk (1930 hours), a transcript of which was also tendered.[425] In terms of the difference in Mr Khazaei's presentation between this phone call, and the call at 1850 hours, Ms McIntyre's evidence was that he was now intubated, but despite the manual ventilation being conducted, the oxygen saturations were constantly low. In that regard, Ms McIntyre recalled observing a reading of between 60%-70%.[426] Ms McIntyre informed the IHMS Assistance desk of his deteriorating condition and asked to speak with Dr Renshaw. Ms McIntyre was informed that the update would be passed on to Dr Renshaw.[427]

247. Dr Ronald Galicio ordered that Mr Khazaei be transferred to the ICU so that he could be hooked up to a mechanical ventilator.[428] Sometime before 2030 hours, the Galicios left the hospital to take their children home. Dr Ronald Galicio did not arrive back at the hospital until just after 2230 hours.[429] He returned to the hospital after being contacted by Dr Agnes Ambelye, the Duty Medical Officer on shift that night.[430]

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[421] Exhibit D13, p 11.
[422] Exhibit D2.1, paragraphs 35 – 36.
[423] Exhibit D2.1, paragraph 40.
[424] Exhibit D13, p 5.
[425] Exhibit B170.2, transcript relating to call 557457 marked 'CM-F'
[426] T 10, p 39 from line 4.
[427] Exhibit B170.2, transcript relating to call 557457 marked 'CM-F'.
[428] Exhibit D2.1, paragraph 43.
[429] Exhibit D2.1, paragraph 58.
[430] Exhibit D7, paragraph 2.

248. At 2045 hours Dr Ronald Galicio received, via the mobile application Viber, the chest x-ray images which in his opinion, demonstrated diffuse radio-opacity bilaterally being consistent with pulmonary oedema.[431] The significance of this diagnosis, which was incorrect, was explained by Dr Glied during his evidence, as follows:

> *"---But then when I suddenly understood that he was treating him for cardiopulmonary oedema, I was a little bit worried about that. And I did not found any reason to support this heart procedure. And I was treating the patient for a septic shock, with multi-organ failure and status post-cardiopulmonary arrest, and which includes, basically – or which means basically the opposite medical management of this case."*[432]

249. Almost two hours after being intubated, Mr Khazaei was still being managed in the emergency department. The PIH facility (as it was at the time) had no internal lift between the ground floor where emergency was located, and the first floor where the ICU was located. In order to transfer a patient from one floor to the other, it was necessary to wheel the patient outside the building, along an uncovered concrete path and then up a narrow uncovered concrete ramp. The concrete ramp was described to be *"relatively steep and tight and was also very slippery when wet."* Heavy rain made the use of the ramp unsafe, such that transfer of Mr Khazaei to the ICU could not occur until the rain stopped.[433]

250. Dr Renshaw's evidence was that he received a call from Dr Condon at the International SOS Assistance desk at about 2100 hours. Dr Condon indicated that Mr Khazaei was being manually ventilated and was unsure why that was the case. He also told Dr Renshaw that a chest x-ray had been conducted, and Mr Khazaei's illness was being treated as a chest infection.[434] Dr Renshaw was concerned because *"in the context of somebody with sepsis, these sort of respiratory symptoms indicated a potential that the patient had gone into acute respiratory distress syndrome."*[435] Dr Renshaw had a discussion with Dr Parrish, and it was decided that the best course of action was to activate the team of International SOS clinicians based at the PIH. Dr Renshaw's evidence was that this Team was comprised of a surgeon, an anaesthetist, an emergency physician and a theatre nurse. They were embedded in the PIH to provide services for personnel of the AFP, as part of a wholly separate contract that International SOS had with the AFP. They were not contracted to provide care to transferees and had not been previously used to assist with the medical care of a transferee at PIH.[436]

251. Dr Renshaw's evidence was that there were logistical hurdles to overcome before the AFP Team could be called to assist. The Country Medical Director for PNG at the time was Dr Kalesh Seevnarain, and he ultimately needed to be contacted to seek approval from the relevant AFP Commissioner. The call logs from the International SOS Assistance desk confirm that notes from various phone calls relating to the activation of this Team were entered on the system from 2109 hours.[437] There were

[431] Exhibit D2.1, paragraphs 48-49.
[432] T 11, p 31 from line 13.
[433] Exhibit D4, paragraphs 39 – 40.
[434] Exhibit B13, paragraph 28.
[435] T 4, p 51 from line 47.
[436] T 4, p 52 from line 11.
[437] Exhibit B153, pp 106 – 113.

a number of phone calls entered on the log, leading to a call which was entered on the system. By 2203 hours, Dr Seevnarain had the approval to activate the Team.[438] The call logs confirm that the MERP did not list the phone numbers required, and the quality of the phone connection on some calls was an issue.[439]

252. Dr Seevnarain gave evidence to the inquest.[440] He recalled being contacted by the International SOS Assistance desk on the night of 26 August 2014 and being connected to Dr Evelyn Wong and Dr Yap.[441] The call log for this call indicates that the file note was entered onto the log at 2140 hours. Dr Yap's evidence was that she was concerned at this time that Mr Khazaei was being manually bagged:

> *"This is very concerning, because manually bagging a patient is not a definitive stabilisation, it's just as a temporary measure to bring along the correct machines, Oxylogs, putting him on the right settings and then transfer him on to those respiratory support, those machines, as a definitive respiratory support.*
>
> *Yes?---The fact that he had – he was being manually bagged and I remember quite well that, in fact, he was being bagged for the last hour, for an hour at least, was deeply concerning."*[442]

253. Dr Seevnarain's evidence was that his reaction to the proposed activation of the International SOS AFP Team was it *"would probably be in breach of our contractual obligations to the Australian Federal Police and that I required some kind of – a higher level of approval before I could give them an answer about whether we would actually commit to that – to providing that service or not."*[443]

254. Dr Seevnarain contacted the on-call Duty Officer, who then contacted the Commissioner for the AFP project. The approval was fed back through to Dr Seevnarain, and this was confirmed to the International SOS Assistance desk in a phone call which was entered onto the call log at 2203 hours.[444] Dr Seevnarain then proceeded to contact various members of the International SOS AFP Team and told them to go to the PIH. He also proceeded to the PIH.[445]

255. At approximately 2130 hours Mr Khazaei was transferred to what was referred to in the evidence as the 'PIH ICU'.[446] He was being hand ventilated, and received intravenous midazolam by infusion at 10 mg/hr. At the time of transfer, his observations were recorded in the clinical notes as follows:

> *GCS 3 BP 129/78 P 129 T 35.9C RR 30 SpO2 72%.*[447]

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[438] Exhibit B153, p 106.
[439] Exhibit B153, pp 109 – 111.
[440] Exhibit B158 – B158.5.
[441] Exhibit B153, pp 108-109, call NDOSYD59.
[442] T 5, p 72 from line 6.
[443] T 11, p 43 from line 22.
[444] T 11, p 43 from line 35; Exhibit B153, p 106 call NDOSYD64.
[445] T 11, p 44 from line 28.
[446] Exhibit D3, paragraph 6.
[447] Exhibit D13, p 15.

256. It was at about this time that Ms McIntyre and Ms Dawson attended a nearby hotel to look for the International SOS AFP Team. Ms McIntyre thought they might be able to convince this Team to review Mr Khazaei due to their grave concerns. She was unaware of discussions between the International SOS Assistance desk, Dr Seevnarain and Dr Renshaw. Meanwhile at the PIH, Mr Khazaei was under the care of Dr Ambelye, who reviewed him at 2145 hours. Dr Ambelye considered that Mr Khazaei had only been ventilated for a very short period of time, so it was appropriate to monitor his progress on the mechanical ventilation, before initiating any further intervention.[448]

257. While Ms McIntyre and Ms Dawson were trying to locate the International SOS AFP Team, the Team had in fact been activated to assist in the care of Mr Khazaei.[449] Ms McIntyre and Ms Dawson arrived back at the PIH at about 2230 hours, to find the International SOS AFP Team in the ICU. Registered nurse Robert Miazek, and paramedic David Bresler, were the first to arrive at the hospital, sometime around 2210 hours.[450] Dr Richard Glied, an anaesthetist with specialist ICU accreditation, and Dr Christian Rosburger, a surgeon, arrived at the hospital soon after. Written statements were tendered from each clinician. I heard oral evidence from Dr Glied and Mr Miazek during the course of the inquest.[451] Both were impressive witnesses.

258. Mr Miazek described the scene he was presented with, upon attending at the PIH, as follows:

> *"---When we arrived at the PIH, I stepped out of the ambulance and I proceeded immediately to intensive care located on the first floor of the PIH hospital. And when I went into the room – when I saw the patient in the beds on the left-hand side, I immediately noticed alarms going off by the ventilator alarm – ventilator was alarming –and the monitor with patient's vital signs were also alarming. It was – there was a nurse – there was a male nurse – stood – on the other side of the bed - - -*
>
> *Yes?--- - - - not attending the patient. And there was a female, either a nurse or a doctor [indistinct] national female stood at the feet of the bed."*[452]

259. The evidence from the relevant PIH clinicians was that there was no discussion with them to the effect that the International SOS AFP Team were coming[453], and the PIH clinical notes document that they took over without any hand over.[454] Mr Miazek was asked about the extent of his discussions with the PIH staff upon him entering the ICU, and he recalled he asked the male nurse *"What's going on? What's the – what's the problem"*. Mr Miazek described how the male nurse *"did not seem to be in any urgency"*, and *"he did not really provide me with anything – with any useful information about the patient at the – at the time."*[455]

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[448] Exhibit D7, paragraph 15.
[449] Exhibit B153, p 106, call NDOSYD64.
[450] Exhibit B169, paragraph 8.
[451] Exhibits B168 – B168.1 (Rosburger); Exhibits B169 – B169.1 (Bresler); Exhibits B3 – B3.2 (Glied); Exhibits B9 – B9.2 (Miazek).
[452] T 10, p 9 from line 40.
[453] Exhibit D7, paragraphs 20 – 21.
[454] Exhibit D13, p 16.
[455] T 10, p 10 from line 34.

260. Mr Miazek approached Mr Khazaei and looked at the vital signs monitor. He noticed that the heart rate was about 150 and the oxygen saturations were in the *"low eighties."*[456] There was no recent blood pressure reading. The ventilator screen showed inconsistent tidal volumes (amount of air being pumped into the lungs), most of the volumes being very low. Mr Khazaei was breathing very fast and was in distress. Mr Miazek said that when he looked at the ventilator, and then looked at Mr Khazaei, *"there was certainly something not right, either with the patient or with the ventilator."*[457] Mr Miazek suspected that the ventilator was blocked, or there was some sort of obstruction in Mr Khazaei's lungs or the ventilator tubing.

261. Mr Miazek described how he went into *"life preservation mode"* and reached for the ambu-bag, also described as a Bag-Valve-Mask with Reservoir ('BVMR'), which was connected to the oxygen cylinder via tubing. His intention was to manually ventilate Mr Khazaei to rule out that there was an obstruction in the lungs.[458] He noticed there was a tear in the ambu-bag. His evidence was *"Basically, you know, the bag was useless to me. There was a – there was a tear. The bag was damaged. It was… broken."*[459] As the PIH nurse was unable to provide a spare ambu-bag, Mr Bresler ran to collect a spare from the AFP Team ICU, which was situated around 10 metres down the corridor.[460]

262. Mr Miazek said that it was at this point that Dr Glied arrived. Dr Glied gave evidence of the level of knowledge he had of Mr Khazaei's case upon attending at the PIH, as follows:

> *"---I cannot recall the exact wording. I can record that the essential information we got was that there was a critical patient and we even did not know who the patient belonged to. So we have had basically no information. We just did know that we had to go – to move quickly to Pacific International Hospital and we have had no idea in what condition, what type of patient we will attend, and we even have not been sure where the patient was. We assumed the patient was still in the emergency department because this would be more natural. When we arrived at the emergency department, that was not confirmed. The patient was already at the ICU ward, so we had been activated without a clear base of information but for me, that's natural in emergency situations. When you are called to a real emergency situation, you normally do not have complete information. You just go there and start to work and see what you can do.*"[461]

263. Dr Glied found that there was no relevant data shown on the vital signs monitor. The ventilator showed very low tidal volumes, and this was the reason for the ventilator alarming. The evidence confirms that Dr Glied immediately took the lead in the care of Mr Khazaei. He gave evidence that *"I tried to understand this as soon as possible but then my next look was to the patient. We are normally trained – when we have too much problems with the machines – like – the ventilator was alarming, the monitor was alarming – we just don't care about the machines, we look at the patient."*[462] Dr Glied conducted an

[456] T 10, p 10 from line 40.
[457] T 10, p 10 from line 39.
[458] T 10, p 11 from line 46.
[459] T 10, p 11 from line 22.
[460] T 11, p 36 from line 28.
[461] T 11, p 5 from line 34.
[462] T 11, p 6 from line 47.

examination of Mr Khazaei. He checked the central pulse and found a low heart rate, but he could not feel a radial pulse. Dr Glied saw this as a positive sign, as at least there was still some cardiac activity. Mr Khazaei's skin was noted to be a very dark blue/grey colour, he was very sweaty and the skin was very cool to touch.[463] His pupils were wide and non-reactive, and he *"was expecting that the patient would end up in cardiac arrest very soon."*[464]

264. Dr Glied explained his level of interaction with the PIH clinical staff in the ICU, and the quick deterioration of Mr Khazaei at the inquest. After Mr Bresler returned with the AFP Team ambu-bag, he attempted to reconnect the PIH ventilator to no effect:

> "*At that stage, when I tried to get the information, the development of the deterioration of the patient was so dynamic – so quick – that I, after a few seconds, just did not care anymore about the information because it was not relevant anymore because the patient was going to end up in cardiac arrest very soon, and my only idea was to try to avoid that the patient getting cardiac arrest. And when the paramedic came back with our monitoring and with our bag valve, we, of course, changed the equipment immediately - - -*
>
> *Yes?--- - - - and then I saw on our monitoring that we have had some electric activity but there was no oxygen saturation wave on the monitor which means that we have – it meant – have had – may have had an electric activity but without any cardiac output. The pump was not working so I checked, immediately, the central pulse and found out that we – that I couldn't reconfirm the central pulse I found one or two minutes before. And that was the moment when we started basic life support."*[465]

265. This cardiac arrest occurred at 2224 hours. The clinical notes confirm that CPR was commenced at 2224 hours and continued to 2310 hours. There was further CPR at 2310 hours until 2321 hours, and finally from 2327 hours to 2330 hours. During this time Mr Khazaei was resuscitated with adrenaline, central line access, commencement of adrenaline and noradrenaline as an inotrope and continued on intravenous flucloxacillin and chloramphenicol.[466]

266. When asked to comment on the assertion made by the PIH clinicians that the ventilator had been working correctly before the arrival of the International SOS AFP Team[467], Dr Glied found it *"difficult and hard to believe that the ventilator was working properly."* Dr Glied acknowledged that he was not present in the room previously and could not say definitively what had been occurring before his arrival.[468] Dr Glied's evidence was that upon conducting a further assessment, he saw that one of the intravenous lines had been inserted beside the vein, not in the vein, meaning no fluid was being administered to Mr Khazaei. He described this as *"basic care for ICU or emergency department in a critical patient."*[469]

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[463] T 11, p 7 from line 10.
[464] T 11, p 11 from line 33.
[465] T 11, p 8 from line 31.
[466] Exhibit B12.6.
[467] Exhibit D10, from paragraph 13.
[468] T 11, p 9 from line 5.
[469] T 11, p 9 from line 16.

267. Dr Glied was also asked about what, in his opinion, caused Mr Khazaei to go into cardiac arrest. He explained that it could not be possible for cardiac arrest to occur as a result of something he or his team did in the short time that they were involved before the cardiac arrest in a young man such as Mr Khazaei:

> *"My problem is that when you have a strong man – a young man – who, most likely, did not have had any relevant past medical history before – which means he's not born with a cardiac problem – he has no disability known before – he was [indistinct] a few days before or a few weeks before a healthy, strong man – then it needs a lot of little disasters following one after the after. None of them caught up timely and resolved and then, finally, you end up in a disaster but it cannot possible that we – with a fully scaled team and with correct working equipment – are able to make a little mistake and just this – the end of – or – the final reason of a cardiac arrest."*[470]
>
> …
>
> *"And this always – perhaps you know this from pilots when they do their error mistakes, they compare this with a cheese and they land on one part of the cheese and then you have different slices of cheese and the lights go through the holes of the cheese. And when you have a screen on the other end and when the light passes through all the slices of cheese then you have the final error or the final disaster. So it is difficult for the light to go all through all the slices. It must be – it's a chain of causes and which was medical problems, technical problems, pharmaceutical problems – it must come a lot of things together to have a sudden cardiac arrest."*[471]
>
> …
>
> *"---He has had a severe lung problem, based on the lung failure. And he was in a severe septic shock almost at peri-arrest. And this does not happen with a young, stable man in a few minutes."*[472]

268. Mr Khazaei was transferred to the AFP Team's ICU at 0055 hours on the morning of 27 August 2014. He was stabilised and departed PNG by air ambulance to the Mater Hospital in Brisbane on the afternoon of 27 August 2014. Dr Glied stayed with Mr Khazaei until about 0800 hours when he was relieved, to prepare for boarding the air ambulance to Brisbane. Dr Glied was asked what his opinion was of Mr Khazaei's prognosis at this time. He confirmed that from his first assessment, Mr Khazaei had been showing early signs of brain death. He also explained the complications of diagnosing brain death.[473] Dr Seevnarain also explained that Mr Khazaei had a constant Glascow Coma Scale of 3 and features of brain death. As the ICU was designed for the stabilisation of acute trauma only, there was no ability to manage him for more than a few hours. The decision for a medical evacuation was made:

> "*---it's in such cases where a person may be deemed to be neurologically dead, you need to assess the patient at the time you make the diagnosis and then, I think, at 24 hours later to confirm that your findings are correct. You also need to have the ability to, I think, bring him off sedation to ensure that the sedation is not having an effect on whatever reflexes you are seeing. Yes. In this particular situation, what had happened was we were not capable of maintaining Mr Khazaei for more than I'd say – you know, for that 24-hour period."*[474]

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[470] T 11, p 10 from line 5.
[471] T 11, p 10 from line 15.
[472] T 11, p 34 from line 1.
[473] T 11, p 11 from line 17.
[474] T 11, p 47 from line 44.

Admission to the Mater Hospital ICU – 27 August 2014 to 5 September 2014

269. Mr Khazaei arrived at the Mater Hospital at approximately 2200 hours on 27 August 2014. He was found to be on high dose adrenaline and nor-adrenaline, he had fixed and dilated pupils, he was unresponsive to painful stimuli and he was assessed as having acute respiratory distress syndrome and established oliguric renal failure.[475]

270. The main clinicians involved in Mr Khazaei's care at the Mater Hospital were Dr Shane Townsend (Director of Intensive Care) and Dr Jeffrey Presneill (Deputy Director of Intensive Care). Statements from each of these clinicians were tendered at the inquest.[476]

271. A subsequent swab from Mr Khazaei's left leg lesion grew *Chromobacterium violaceum*. On 2 September 2014, brain death was diagnosed by Dr Townsend and Dr Karnik (ICU consultant). On 3 September 2014, brain death was confirmed by Dr Joyce (Director of ICU, Princess Alexandra Hospital).

272. On 5 September 2014, supportive care measures were withdrawn and Mr Khazaei died. Although it was not an issue for the inquest, there is no evidence that the team at the Mater Hospital ICU had any medical options available to them to salvage Mr Khazaei's condition or otherwise prevent his death.

[475] Exhibit E1, paragraph 14.
[476] Exhibits E1, E2 – E2.1.

MEDICAL CAUSE OF DEATH

273. On 9 September 2014, a full internal autopsy examination with associated toxicology, CT scans and a review of the medical records was conducted by forensic pathologist Dr Philip Storey. A copy of Dr Storey's autopsy report was tendered at the inquest.[477] Dr Storey also gave evidence to the inquest.[478]

274. Two ulcerated lesions, one larger than the other, were observed on the distal left lower leg. Dr Storey explained the term 'ulcer' in his evidence to the inquest, as "*any lesion of the skin in which the surface of the skin is broken, and therefore, there is exposure of the underlying layers of the skin. The implication being that the skin normally provides a barrier to infection and therefore, any breakage of the skin renders more liable – that area more liable to infection.*"[479] Dr Storey explained that both lesions had features to suggest they were longstanding, and both were in the region towards the ankle.

275. The larger lesion had a very black base, an irregular border, showed signs of healing and signs it had been previously treated. Dr Storey estimated it was at least two weeks old. The smaller lesion also showed signs of healing, though these features were not as advanced as the larger lesion. Dr Storey estimated it could have been only several days old.[480]

276. External examination also showed discolouration to the fingers of the left hand and similar discolouration to the toes of both feet. Dr Storey explained this was consistent with features seen in cases of severe sepsis.[481] He explained that the discolouration was the "*end process of the hypoxia or low oxygen levels reaching the fingers and toes in the context of a septic event*."[482]

277. Internal examination showed focal coronary atherosclerosis in the left main coronary artery. On microscopic examination, Dr Storey was able to find narrowing of up to 70%.[483] He said that it was unusual for such a severe area of narrowing to be present in a man of Mr Khazaei's age.

278. Focal abscesses were seen in the left groin, spleen and the liver. Dr Storey explained that these abscesses usually form secondary to an infection.[484] The distribution of the abscesses seen in Mr Khazaei confirmed systemic infection, in the sense of a blood born infection that had settled into these particular organs.[485] Dr Storey aged the abscesses as forming roughly two weeks before death.

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[477] Exhibit A2.
[478] T 14, p 4 from line 37.
[479] T 14, p 7 from line 22.
[480] T 14, p 7 from line 31.
[481] T 14, p 8 from line 7.
[482] T 14, p 8 from line 12.
[483] T 14, p 8 from line 20.
[484] Exhibit A2, p 16.
[485] T 14, p 10 from line 8.

279. Dr Storey explained that while Mr Khazaei was still alive at the Mater Hospital a leg ulcer swab was taken. The results confirmed positive for growth of *Chromobacterium violaceum*, which in turn, was deemed to be the likely causative organism for his leg ulcers.[486] Dr Storey confirmed during his evidence that it was this positive test which prompted him to conduct genetic testing.[487]

280. Dr Storey explained that *Chromobacterium violaceum* is an unusual, rare infection which is statistically associated with a condition called Chronic Granulomatous Disease (CGD).[488] CGD is a genetic disease associated with defective functioning in certain immune cells. Dr Storey's evidence was that the genetic testing found a defective Neutrophil Cytosolic Factor 1 gene, or NFC1 gene, one which is associated with the development of CGD.[489] When giving evidence about the type of genetic defect found, Dr Storey said:

> "---*There was, indeed, found a defective gene that's been associated with the development of Chronic Granulomatous Disease. Now, there is a spectrum of – there are a number of potential genetic defects, the major one is what we call a x linked gene, but that was not the gene that was isolated in this case. It was a gene that's responsible for about 20 to 25 per cent of cases of Chronic Granulomatous Disease and the most important thing to note about that, is that it's generally tends to be associated with a less severe clinical form or expression of the disease; tends to effect people later in life. The x linked form tends to affect children rather than people as they become adults, whereas this tends to affect people who are a little bit older.*"[490]

281. I also heard evidence from Dr Drew Wenck, an Intensive Care Specialist and current Director of the Intensive Care Unit at Cairns Base Hospital. Dr Wenck provided evidence on a range of matters, one of which was CGD.[491] He confirmed it is a congenital disorder of the neutrophils (white cells) which results in a reduced ability to kill bacteria. Dr Wenck's evidence was that CGD has variable expressivity, or a variable phenotype. He explained this in his evidence as follows:

> "---*But the important point about this disease is that it's got a – what we call – what's called "variable expressivity". So in other words, a variable phenotype. So in other words, you could have the genes which may – there's multiple genes that code for it. And that may or not may not result in the full expression of the disease. So you might have a child who's got a severe form of this, where they die in childhood, or they have severe growth retardation, or the disease – you might have the genotype, but you're entirely asymptomatic from it because there's not enough of those genes to have produced the full expression.*
>
> *Right. And for somebody who does display the full expression of the underlying process, what would that be called?---Well, they would not have survived childhood.*

[486] Exhibit A2, p 16.
[487] T 14, p 10 from line 45.
[488] T 14, p 11 from line 4.
[489] T 14, p 11 from line 13.
[490] T 14, p 11 from line 13.
[491] T 16, p 19 from line 20.

Yeah, okay?---And if they did, they would have been in a – they would have had to have a lot of admission to hospital; they would have been lucky to have survived childhood if they had the severe form of the disease."

282. I am satisfied from this evidence that Mr Khazaei did not have the full expression of CGD. Dr Wenck explained his opinion, taking into account Mr Khazaei's known history of infections, as follows:

> *"we had no reason to suspect he had chronic granulomatous disease. It is a few boils when someone moves to a tropical environment; that's extremely common. When I used to work on Thursday Island the – all the nurses and teachers that arrived there from Brisbane and places like that would often present with multiple boils simply because they weren't used to the tropical environment and how easy it is to get skin infections. Any little nick – they did not realise you have to clean it and put iodine on it and things like that because it's – in a tropical environment, there's so much more bugs that are just floating around. And so it's not unusual to get a few boils. I would not have diagnosed chronic granulomatous disease on the basis of what Mr Khazaei presented with in the past.*"[492]

283. Dr Storey confirmed the presence of global hypoxic-ischaemic brain injury, which he aged at approximately ten days post resuscitation from cardiac arrest.[493] He said that, in the history he was provided with, there was a well-defined time of cardiac arrest, though the exact circumstances remained unclear.[494] Dr Storey explained if a person survives cardio-respiratory arrest, and there is significant downtime during cardio-respiratory arrest, there is a certain sequence of events which are set in train which, in totality, are called hypoxic-ischaemic encephalopathy. Severe hypoxic-ischaemic encephalopathy results in brain death.[495] In Dr Storey's opinion, the cardio-respiratory arrest was "*germane to the subsequent development of hypoxic ischaemic encephalopathy*."[496]

284. Dr Storey's autopsy report structured the formal cause of death as follows:

> **"CAUSE OF DEATH**
>
> *1(a). Hypoxic-Ischaemic Encephalopathy,* due to or as a consequence of*;*
> *1(b). Cardio-respiratory Arrest,* due to or as a consequence of*;*
> *1(c). Severe Sepsis,* due to or as a consequence of;
> *1(d). Left Lower Leg infection with* Chromobacterium violaceum*.*
>
> Other significant conditions*:*
>
> *2. Chronic Granulomatous Disease; Coronary Atherosclerosis.*"[497]

285. Dr Storey explained that the underlying cause of the brain death was hypoxic-ischaemic encephalopathy, something which is strongly correlated with cardiac arrest. Dr Storey was able to determine that there had been at least one episode of

[492] T 16, p 19 from 43.
[493] T 14, p 12 from line 26.
[494] T 14, p 12 from line 34.
[495] T 14, p 12 from line 37.
[496] T 14, p 13 from line 9.
[497] Exhibit A2, p 21.

cardiac arrest at the PIH at the appropriate time interval, suggested by the neuropathology, for the hypoxic-ischaemic encephalopathy to have arisen. It followed that Dr Storey determined the underlying medical cause of the hypoxic-ischaemic encephalopathy was the cardiac arrest which occurred on 26 August 2014 at the PIH.[498]

286. Dr Storey also accepted as a plausible hypothesis that Mr Khazaei had experienced an emerging hypoxic-ischaemic encephalopathy over the course of the evening of 26 August 2014, rather than an encephalopathy that was caused by a sudden cardiac arrest.[499] Indeed, Dr Storey accepted that it was reasonable to consider that, if it were accepted that Mr Khazaei had fixed and dilated pupils before the episodes of cardiac arrest, that he had suffered severe brain damage as a result of evolving hypoxia on the background of sepsis.[500] When asked whether the prolonged hypoxia was encompassed within the description of severe sepsis as stated in the formal cause of death, Dr Storey confirmed that it was, as follows:

> "*STATE CORONER: So the prolonged hypoxia – that encompassed within your description [indistinct] sepsis?---That's correct.*
>
> *So there's no need to consider whether there should be an addition reference to that?---I don't believe so. When I wrote "severe sepsis" under the guidelines of the definitions as they stood at the time I wrote this death certificate, I understood that to include the – sort of – sustained hypoxia that this man had experienced over the 24 or so hours before his cardiac arrests.*
>
> *And you're saying you don't need to interpret that as a linear chain, necessarily? There are - - -?---That's correct.*
>
> *- - - simultaneous processes happening?---Yes.*"[501]

287. I also heard evidence from Dr Mark Little, a Consultant Clinical Toxicologist and Emergency Physician at Cairns Base Hospital. Dr Little confirmed that Mr Khazaei having fixed and dilated pupils when the International SOS clinicians arrived was a clear indication that he had suffered a degree of brain damage before they arrived.[502] Dr Little did not agree that the brain damage was the ultimate cause of the cardiac arrest, rather than the underlying sepsis. Dr Little's opinion was that the lack of oxygen (and thus the high carbon dioxide levels), the low pH levels and the acidotic condition all contributed to the cardiac arrest.[503]

288. Dr Storey explained that the underlying cause of the cardiac arrest was severe sepsis. Dr Storey's evidence was that when he issued the death certificate, the term 'severe sepsis' had a succinct definition which involved multi-organ dysfunction.[504] Part of the parameters of multi-organ dysfunction included hypoxia at a level less than

[498] T 14, p 14 from line 23; page 30 from line 35.
[499] T 14, p 31 from line 4.
[500] T 14, p 31 from line 17.
[501] T 14, p 32 from line 4.
[502] T 15, p 73 from line 18.
[503] T 15, p 73 from line 22.
[504] T 14, p 15 from line 7.

90mm/Hg. Dr Storey took from Mr Khazaei's medical notes that there had been multiple measurements of Mr Khazaei's oxygen, in the 24 hours before he went into cardiac arrest, at levels lower than 90mm/Hg, both on room air and supplemented oxygen.[505]

289. During his evidence, Dr Storey was taken to test results from both the Mater Hospital and from 26 August 2014 while at the PIH and asked whether multi-organ failure was evident on 26 August 2014 at the PIH. Dr Storey's evidence in that regard is extracted as follows:

> "*All right. So does that indicate that at the time that those bloods were taken – whatever particular time that was – on the afternoon/evening of the 26th of August, that this multi-organ failure that was apparent by the time of his admission to the Mater was not yet in train?---Not necessarily. I think that the inference I would draw from that is that he does have multi-organ failure at the Mater, and that has been contributed to, I would think, from his episodes of cardiorespiratory arrest, but I think he does have evidence of multi-organ failure before that – his hypoxia, his lung changes on chest X-ray, which is before cardiac arrest. I think these are – these are pointing to the fact that he's already developed a degree of multi-organ failure. They haven't – don't appear to have affected the liver or the kidney at that point in time, and I'm sure that his episodes or cardiorespiratory arrest have contributed further to his multi-organ failure, and I'm sure that they've contributed to those results that were seen – that you've shown to me from the Mater Hospital.*
> *…*
>
> *---So what I'm saying is, yes, there has been a change in the parameters of liver and renal function between PIH and the Mater Hospital in Brisbane, which, to me, suggest that the multi-organ failure evident on the results from the Mater Hospital in Brisbane have been contributed to by his cardiorespiratory arrest at PIH. In other words, they have developed subsequently to his cardiorespiratory arrest, although, those PIH results you showed me predate the cardiorespiratory arrest, but even – and yes, there is that change, but at the time that he's arrived at PIH, even before he's had the cardiorespiratory arrest, I think he's showing evidence of multi-organ dysfunction. Maybe not the same – in the same parameters, and the parameters you've shown me have been contributed to by the further added insult of cardiorespiratory arrest. That would be my interpretation of what you've showed me.*"[506]

290. The underlying cause for the severe sepsis was determined to be the left lower leg infection from *Chromobacterium violaceum*. Dr Storey explained that he came to this view due to the very prominent lower leg features, particularly the larger of the two ulcers, combined with the internal abscesses in the liver, groin and spleen.[507]

291. In terms of contributing factors, Dr Storey's evidence was that the CGD had likely predisposed Mr Khazaei to contracting the infection with *Chromobacterium violaceum*, but it did not cause him to contract the infection.[508] In this respect, Dr Storey clarified that he was aware of cases involving persons who did not have CGD,

[505] T 14, p 15 from line 10.
[506] T 14, p 29 from line 16.
[507] T 14, p 15 from line 37.
[508] T 14, p 15 from line 43.

who still contracted an infection with *Chromobacterium violaceum*. Coronary atherosclerosis may have resulted in sudden cardiac arrest at any time, but Dr Storey felt in the overall context of the death its role was contributory. In Mr Khazaei's state of chronically lowered or sub-acutely lowered oxygen levels over the 24 hours before his cardiac arrest, this may have primed his myocardium to have a sudden cardiac arrest in concert with the coronary atherosclerosis. It was in this sense that Dr Storey considered that coronary atherosclerosis did not cause the death, but rather contributed to it.[509]

292. Dr Storey was asked whether he was able to say how long somebody could experience oxygen levels of less than 90% on room air before they became medically irretrievable. His evidence in this respect was:

> "*That is an extremely difficult question to answer, because it depends on their pre-existing state how robust they are, how fit they are, how old they are. In this particular man, made more difficult because it's not just the hypoxia that has a deleterious effect on his health or that determines whether he's going, he's likely to suddenly and spontaneously have a cardiac arrest, but, also, all the other deleterious effects of sepsis. He's in multi-organ failure, this man. He's also got a coagulopathy. He's also got liver dysfunction. He's also got renal dysfunction and his mental state is depressed, so, even the various automatic functions of the brain. So, he is actually more likely or more at risk, and not just from the hypoxia, but because the hypoxia is a part of a spectrum of – of conditions that characterise the – what we used to call – severely septic state*."[510]

293. I accept the medical cause of death as stated in Dr Storey's autopsy report,[511] as the definition of severe sepsis includes the reference to prolonged hypoxia, and the cardiac arrest referred to in 1(b) is a reference to the cardiac arrest/s which occurred at the PIH on 26 August 2014. The evidence that Mr Khazaei had fixed and dilated pupils before those episodes of cardiac arrest is consistent with a period of prolonged hypoxia having caused severe brain damage.

[509] T 14, p 16 from line 3.
[510] T 14, p 16 from line 24.
[511] Exhibit A2, p 21.

EXPERT EVIDENCE

294. The inquest was assisted by two court-appointed experts, Dr Mark Little and Dr Drew Wenck.[512] While separate reports were provided by each expert, those reports were prepared by each doctor in consultation with the other.

295. Dr Little is a Consultant Clinical Toxicologist and Emergency Physician who is currently employed as a Senior Staff Specialist at the Cairns Hospital. In addition to his qualifications and experience in emergency medicine, Dr Little is an Associate Professor at James Cook University College of Public Health and Tropical Medicine. He holds a number of qualifications in the area of tropical medicine, in addition to having experience in providing humanitarian aid and medical assistance outside of the tertiary hospital environment. [513]

296. Dr Wenck is an Anaesthetist and Intensive Care Specialist, who is employed as the Director of Intensive Care at the Cairns Hospital. In addition to his qualifications and experience as an anaesthetist and intensivist, Dr Wenck is an Associate Professor at James Cook University Medical School.

297. Dr Little provided two reports addressing a number of specific questions.[514] Similarly, Dr Wenck provided two reports which addressed similar questions.[515] While Dr Little's evidence focused on the emergency medicine aspect of the investigation, in addition to the documentation and processes relating to the medical retrieval, Dr Wenck's evidence focused on the intensive care aspect of the investigation.

298. Dr Little explained that sepsis is a daily presentation to the emergency department at CBH and is a significant cause of death in the hospital setting. Given the tropical environment experienced in Cairns, Dr Little explained that many unusual infections are seen at the CBH that would not be experienced in southern parts of Australia.

299. In providing his opinion, Dr Little utilised the contractual provisions contained within the document 'Regional Processing Countries Health Services Contract' between the Australian Government and IHMS ('the contract'), a copy of which was tendered.[516] When answering the questions posed to him in his written reports, Dr Little confirmed that the standard of medical care which was to be provided to Mr Khazaei was "*to be broadly comparable to what we provide in Australia, and that's, again, why I tried to sort of think of what could be provided in a location on the Western Cape*."[517]

300. Dr Little also explained the level of interaction he has, in his work at the CBH, with patients who are flown to Cairns from PNG. He said that Cairns is the closest major hospital to PNG, and most days of the week there would be someone transferred from PNG to CBH. In terms of his experience in this regard, and his experience dealing with the quality of the medical care provided in PNG, Dr Little gave evidence

[512] T 15, p 2 from line 24 (Little); day 16, p 3 from line 25 (Wenck).
[513] T 15, p 3 from line 10.
[514] Exhibits G2 – G2.3.
[515] Exhibits G1 – G1.3.
[516] Exhibit C10.6.
[517] T 15, p 6 from line 22.

that the care is "*very variable*"[518] His evidence explaining this statement is extracted as follows:

> "*Sometimes the care can be reasonably approaching care that we'd receive in Australia, but often it's not and we're very aware that the care in Papua New Guinea – it's a developing country, it's a resource poor country – is not the same to an Australian standard.*"[519]

301. When asked during his evidence whether the standard of medical care required pursuant to the contract was a reasonable standard of care to be achieved on Manus Island, Dr Little explained there certainly was the opportunity for that standard to be achieved.[520]

302. Dr Little's evidence was separated into phases according to various timeframes. The first phase related to Mr Khazaei's initial presentation to the Manus Island clinic on 23 August 2014, from 1728 hours through to 0800 hours on 24 August 2014. Dr Little gave evidence that the initial assessment conducted by Dr Kutson was, in retrospect, incorrect. However, taking into account the information and symptoms as known to Dr Kutson at the time, the initial assessment was reasonable.[521] Dr Little concluded that it was reasonable to think at that time that Mr Khazaei's symptoms were consistent with a localised infection. The initial course of placing Mr Khazaei on ceftriaxone and paracetamol was appropriate.[522]

303. The second phase related to Mr Khazaei's time at the Manus Island clinic from 0800 hours on 24 August 2014 to 0800 hours on 25 August 2014. Dr Little's evidence was that Dr King correctly identified that there was a lesion on Mr Khazaei's shin, and she presumed this to be the cause of the infection. Dr King placed Mr Khazaei on intravenous benzylpenicillin, paracetamol and ibuprofen, and Dr Little noted that throughout the day, Mr Khazaei appeared to improve.[523]

304. Dr King's decision to alter the antibiotic regime from ceftriaxone to benzylpenicillin was, in Dr Little's opinion, not unreasonable in the circumstances:

> "*---It's sort of splitting hairs, I think. It's – it probably wouldn't be the antibiotic that we would use for a skin infection in Australia, but it's not an unreasonable choice of antibiotics. You know, the purist might say that you – you should have stayed with ceftriaxone or used another – another antibiotic, but I think it's – it's maybe not the best choice, but it's not an unreasonable choice to use at that stage.*"[524]

[518] T 15, p 3 line 36.
[519] T 15, p 3 from line 36.
[520] T 15, p 31 from line 45.
[521] T 15, p 7 from line 10.
[522] T 15, p 7 from line 9.
[523] T 15, p 8 from line 12.
[524] T 15, p 8 from line 32; also see page 10 from line 1.

305. Dr Little confirmed that Mr Khazaei's observations began to deteriorate, to the point where Dr Stockil became concerned enough to contact Dr King during the evening. Dr King informed him, to the effect that, the benzylpenicillin should be given 24 hours to take effect. In Dr Little's opinion, this was a reasonable course of action to take, in terms of allowing an antibiotic sufficient time to take effect.

306. However, it had also been more than 24 hours since Mr Khazaei had been admitted to the clinic, and it should have been cause for concern that he was not improving.[525] Dr Little considered that the fact that Mr Khazaei was not improving, coupled with the remoteness of the clinic from other suitable care options, should have led to a more detailed look at his observations and consideration about transfer.[526]

307. Dr Little's evidence was that it would have been prudent at this stage, even as a preliminary measure, for the Manus Island clinicians to warn the medical coordinators at the International SOS Assistance desk of the situation and perhaps flag that a medical transfer might be required. At this stage, more consideration should have been given to what medical care Mr Khazaei might have required.

308. Dr Little was asked about the adequacy of the documentation of Mr Khazaei's observations and medications/fluids administered over this period. His evidence was to the effect that the observations were in multiple locations. Some were handwritten and others were electronic, which made it difficult and confusing to get an accurate overall picture of how Mr Khazaei was progressing.[527] In preparing his report, Dr Little plotted all of the observations he found in each of the records under the Queensland Adult Detection and Deterioration System (QADDS). The records were such that this process took Dr Little over a day to complete. A copy of the QADDS chart, which plotted the observations from the Manus Island clinic, was tendered at the inquest[528], as was a separate chart relating to the observations from the medical retrieval.[529] The QADDS charts are attached as appendices 1 and 2.

309. Dr Little's opinion was that within 18 hours of Mr Khazaei presenting at the clinic, he met the criteria for severe sepsis.[530] By referring to the completed QADDS chart, Dr Little was able to say that from about 1740 hours on 24 August 2014, Mr Khazaei's observations, particularly his blood pressure, was beginning to satisfy the diagnostic criteria for severe sepsis.[531]

310. Dr Little's opinion was that, if a system similar to that involving the QADDS chart had been in place at the Manus Island clinic at the time, the clinicians might have noticed Mr Khazaei's deterioration much earlier.

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[525] T 15, p 9 from line 2.
[526] T 15, p 9 from line 6.
[527] T 15, p 10 from line 11.
[528] Exhibit G2.1.
[529] Exhibit G2.2.
[530] Exhibit G2, p 43; T 15, p 29 from line 40.
[531] T 15, p 30 from line 2.

311. The third aspect of Dr Little's evidence related to Mr Khazaei's time at the Manus Island clinic from 0800 hours on 25 August 2014 to 0800 hours on 26 August 2014. Dr Little's evidence was that this was the stage "*where the wheels start coming off*".[532] Dr King and Dr Muis had both identified that Mr Khazaei required medical evacuation. Mr Khazaei was continued on penicillin, which Dr Little noted he had been receiving for 24 hours with no difference to his clinical condition. Dr Little's evidence was that he would have expected more thought at this stage with regard to the strategy as to which antibiotics to use.[533] He agreed with the assessment that Mr Khazaei needed to be evacuated, preferably on 25 August 2014.

312. Dr Little's evidence was that a number of factors combined led to the less than optimal outcome of Mr Khazaei not being transferred off Manus Island that day.

313. Dr Little's view was that the initial report made by Dr Muis to the International SOS Assistance desk did not adequately portray Mr Khazaei's true clinical condition. There was no mention of Mr Khazaei's observations, or the fact that he suffered a number of episodes of hypotension (systolic blood pressure below 100). The persistent tachycardia which had been occurring for some hours was also not articulated to the International SOS Assistance desk.[534] Dr Little explained the information which might have been useful for Dr Muis to provide, as follows:

> "*---So I think it would have been prudent to say that – what antibiotics he had been on, his observations maybe over the last four or six hours. The fact that it was spreading or deteriorating and he looked a lot worse, I think would have been the important thing to say, and I think it really goes around the observations of the patient. I think, if – if that had been articulated, and also I think, one of the witnesses. There's no real timeframe given about how urgently and my reading of the whole – or the documents you sent was, I don't think anyone actually understood what urgent meant. I think urgency seemed more around what mode of transport as opposed to timeframe.*"[535]

314. Similarly, Dr Little was also asked whether the request for medical transfer form, which was sent from IHMS to the DIBP, adequately portrayed Mr Khazaei's true clinical condition. Dr Little said that this was a request form being drafted by a clinician, which was going to be received and reviewed by a non-clinician. Dr Little felt that the request form could have been more succinct in terms of how unwell Mr Khazaei was, and it could have included a specific timeframe for transfer. Dr Little's evidence was:

> "*---but I felt that the problem was no one understood what urgent meant. You know, the recommendations seemed to be up to 24 hours, which, from my point of view, that's not urgent. In emergency medicine if you present to an emergency department, urgent means you're being seen within 30 minutes, so I think the fact there was a lack of time for people to move to me really weakened this recommendation.*"

[532] T 15, p 10 at line 43.
[533] T 15, p 10 from line 45.
[534] T 15, p 11 from line 22.
[535] T 15, p 11 from line 35.

315. Dr Little's impression of the overall process for medical transfer of a patient off Manus Island was one of confusion. He pointed out that the decision whether or not to transfer a patient to a higher level of medical care is a clinical one, to be made on a clinical basis. His evidence on this point is extracted as follows:

> "*So the Australia College for Emergency Medicine along with the College of Anaesthetists Intensive Care has a protocol for the transfer of critically unwell patients, and it really talks about having a clear line of communication, one call – a senior clinician taking over all responsibility for the care, and then an identified appropriate facility, senior clinicians then managing the patient that's transferred, and the impression I got with this whole process is, personally – and, again, I did not know the system and understand the system very well – I found it very confusing. It appeared that you had IHMS and then you had International SOS, and it bounced between these two organisations, and then they had to get – permission from Canberra and the Commonwealth Department to transfer the patient to Port Moresby, and I found that compl – that process very complicated, confusing, and, ultimately, slowed down the process of transfer for Mr Khazaei.*
>
> ---
>
> *I'm a doctor. I'm not a politician or a bureaucrat, and I must admit I don't understand why you had to get permission to transfer a patient for a – clinical reasons. I would have thought in establishing the process between the Department of Immigration and Border Protection and IHMS there would have been ground rules established so that if a person needed to be urgently transferred that that process would happen, and if there were – if it had gone outside whatever guidelines had been established, then I would have thought that that would have been reviewed at a later stage, whether it was a meeting or there was financial penalty or whatever process was established beforehand, so I did not really understand why a bureaucratic process was slowing down a clinical process when a patient – you know, clinicians had decided this person needed to be transferred to a high level of care*."[536]

316. Dr Little agreed that the DIBP had an obligation to spend tax-payer money in an appropriate way, and in a way which could be justified. However, he felt that when it came to the preservation of human life, money should be a secondary issue. His evidence is extracted as follows:

> "*---I think that's a reasonable suggestion; however, this is the preservation of life, and, you know, we – we – the government spends a lot of money rescuing lone sailors who sink their boats in the Southern Ocean. We spent tens of million dollars looking for a plane – you know, the Malaysian aircraft that's crashed in the sea, and we're looking for dead bodies. I worked in Cairns on the weekend, so you look at the amount of money we've spent with the – the young gentleman who's had his leg bitten off with a shark. When it come – my feeling is, when it comes to preservation of life, that's a secondary issue, and, really, we should be looking after the patient's life.*"[537]

[536] T 15, p 13 from line 17.
[537] T 15, p 16 from line 4.

317. Dr Little disagreed with the decision by Dr King not to administer Gentamicin to Mr Khazaei. Taking into account that US trained physicians are generally reluctant to use the drug, Dr Little pointed out that it is included in the Australian Therapeutic Guidelines and is a commonly used drug in Australia and New Zealand, including places where Dr King had previously worked.[538] His opinion was that, as a one-off dose, administering Gentamicin to Mr Khazaei would have been reasonable in the circumstances. Even if the decision not to use Gentamicin could be justified, Dr Little noted that nowhere in the clinical records was there any detail of any consideration of administering Gentamicin, and the reasons it was decided not to administer it.[539]

318. Dr Little made the point during his evidence, with reference to a case study, that while infections with *Chromobacterium violaceum* carry significant mortality, there have been survivors. While Dr Little and Dr Wenck both confirmed that an antibiotic called Meropenem would be used to treat infections with *Chromobacterium violaceum* in Australia, this drug was not available at the Manus Island clinic. The study referred to by Dr Little suggested that many isolates were sensitive to Gentamicin, so it is possible that this would have worked if it had been administered to Mr Khazaei. However, Dr Little could not otherwise quantify the extent of that possibility.[540]

319. A common thread in the evidence from various clinicians on Manus Island was that Mr Khazaei appeared to be well despite his deteriorating clinical observations. Dr Little's evidence with respect to this was as follows:

> "*So, unfortunately, this is the problem with sepsis; young people cope a lot better than older people with sepsis and can look remarkably good for a long period of time before they suddenly collapse; their condition deteriorates quite dramatically. They have very good coping mechanisms to cope with sepsis, and so that doesn't surprise me, and I think, again, it really is a situation where clinicians need to see a lot of these cases to be aware of it and, really, why the QADDS score and the Between the Flags that New South Wales – most state health departments now have come up with warning charts or safety charts that really revolve around the observations for that specific reason.*"[541]

320. Dr Little's opinion was that when Dr Muis made the initial request for Mr Khazaei's evacuation on the morning of 25 August 2014, Mr Khazaei's symptoms would have been survivable if he had been transferred to a facility such as CBH. Dr Little maintained this opinion while conceding that Mr Khazaei had a type of infection that was very rare, and also that sepsis generally has a significant mortality rate.[542] He agreed that, once the commercial flight option was missed that afternoon, there was little option but for Mr Khazaei to remain at the Manus Island clinic. However, Dr Little was critical of the lack of communication over the remainder of 25 August 2014 between those on Manus Island, and those at either Assistance Desk in terms of medical updates, medical advice and overall management of clinical coordination.[543]

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[538] T 15, p 12 from line 8.
[539] T 15, p 47 from line 5.
[540] T 15, p 28 from line 39.
[541] T 15, p 12 from line 39.
[542] T 15, p 13 from line 5.
[543] T 15, p 14 from line 45.

321. Dr Little commented that IHMS had an available Piccolo Express point-of-care testing machine at the Manus Island clinic so that appropriate blood tests could be performed. Dr Little explained the process involved in using the machine during his evidence.[544] Despite evidence from Dr King and Dr Muis that the machine did not work,[545] there was testing performed and the results were tendered at the inquest.[546] Dr Little confirmed that the test results did not seem to have been looked at or considered to any extent by any of the clinicians at the clinic. Crucially, the clinicians did not have the ability to test lactate, and/or venous gas.[547] The importance of the lactate test was also explained by Dr Little during his evidence.[548]

322. The fourth aspect of Dr Little's evidence related to Mr Khazaei's time at the Manus Island clinic from 0800 hours on 26 August 2014 to the time of aero-medical transfer later that day. Dr King had examined Mr Khazaei again that morning and noted a marked deterioration from the previous day. This was confirmed by Dr Muis. Dr Little again confirmed that Mr Khazaei's rapid deterioration was consistent with how young people respond to sepsis.[549]

323. Over the course of 26 August 2014, Mr Khazaei's blood pressure continued to go up; a sign that his nervous system was trying to fight infection. Dr Little's evidence was that "*the reason his blood pressure is going up is that his body system – the autonomic nervous system – is a flight or fight response, and this gentleman is fighting to stay alive and his body's working overtime to try and keep him alive and keep him perfused while his oxygen level is deteriorating dramatically in that process.*"[550]

324. Dr Little was asked about whether the request form sent by Dr Muis to the International SOS Assistance desk on 26 August 2014 adequately portrayed Mr Khazaei's true clinical condition at that point in time. Dr Little's evidence was as follows:

> "*No, I did not think so. It's – this man is critically unwell. He's dying. And I think that would have been the first line I would start – that this man is critically unwell and he is dying. I think even in the telephone call that Dr Muis made to Dr Condon that morning - - - cited observations from about 1 o'clock in the morning, not the 7 or 8 o'clock observations which were far worse than he described. And I think that what is written – so that statement there – compared to what Dr Muis said in his statement and what he spoke seem very different. You know, the fact he was cyanosed, he was agitated, those sort of things really did not come through with that. And so for me, that really underplayed the severity of the illness and, I think, contributed to the lack of appreciation all the way through – from now in particular – the severity of this man's illness.*"[551]

[544] T 15, p 51 from line 46.
[545] T 3, p 4 from line 37; page 59 from line 16 (Muis); day 4, p 95 from line 10; page 107 from line 30 (King).
[546] Exhibit B106.
[547] T 15, p 16 from line 1.
[548] T 15, p 52 from line 8.
[549] T 15, p 17 from line 8.
[550] T 15, p 17 from line 12.
[551] T 15, p 17 from line 33.

325. Dr Little explained the significance of Mr Khazaei being cyanosed, with reference to the oxygen saturations graph he drafted[552], as follows:

> "*---So cyanosed means there's a serious lack of oxygen. So the haemoglobin in the blood is not carrying enough oxygen and if it doesn't, then the person starts going blue, which is usually a bad clinical sign there's a lack of oxygen to the patient. And that's, as we can see – as you can see there, I put the observations of 77 per cent which, with this oxygen dissociation curve, you can see that it's dangerously low.*"[553]

326. An email from Dr Abass, a psychiatrist at the clinic, was tendered at the inquest[554] which provided some detail regarding some concerns for Mr Khazaei on the morning of 26 August. Dr Little mentioned this in his report, and was asked during his evidence why he felt that significant to include. His evidence in this regard is extracted as follows:

> *"Your Honour, with the psychiatrist – no disrespect to my psychiatry colleagues – but if a psychiatrist says someone is sick, they must be really sick. And the fact that the psychiatrist was that concerned about his condition really, to me, said he was incredibly unwell – so much so that he would, you know, go and talk to a senior medical officer and express his concerns about this man being too sick to transfer. The other thing is I got the sense that maybe Dr King was a bit difficult to work with together, and he had gone to the senior – so Dr Muis was sort of the senior medical officer – and I think he was attempting to negotiate someone else to say, "Look, I've got concerns. I don't think I can deal with this. I'm going somewhere else". So I sort of got that sense as well. But if a psychiatrist says someone is sick, they must be really, really ill."*[555]

327. During Mr Khazaei's time at the clinic on 26 August 2014, he was not intubated at any stage. This decision fell on Dr King, as the emergency physician on site and, to a lesser extent, on Dr Muis as the senior medical officer on site. I heard evidence from both Dr Muis and Dr King about this decision, and written statements containing these reasons were also tendered to the inquest.[556] In his oral evidence, Dr Little responded to each of the factors put forward by Dr King as to why she did not intubate Mr Khazaei. Dr Little felt that each of the factors raised by Dr King could have been mitigated by appropriate planning.[557]

328. Dr Little was very critical of the decision not to intubate Mr Khazaei while at the clinic. Intubation was something Dr Little thought should have been considered from late in the evening of 25 August 2014.[558] However, by the morning of 26 August 2014, it was Dr Little's opinion that Mr Khazaei required intubation which he accepted would, in turn, cause the blood pressure to collapse. To respond to that collapse, Dr Little explained that Mr Khazaei would need resuscitation with inotropes (drugs to maintain heart rate and blood pressure) and the administration of different antibiotics and

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[552] Exhibit G2.4.
[553] T 15, p 49 from line 35.
[554] Exhibit B10.8.
[555] T 15, p 18 from line 6.
[556] Exhibit B6.1.
[557] T 15, p 54 from line 25.
[558] T 15, p 20 from line 19.

medications both to keep him asleep, and to paralyse him. He required aggressive resuscitation, which ultimately did not occur. Dr Little stated, "*if this was an exam and I'd given one our trainees this sort of scenario and they had not intubated the patient or come up with an appropriate strategy, I'd say that's a fatal flaw and I'd fail that student.*"[559]

329. Adding to Dr Little's criticism was the lack of any other strategy considered by Dr King, in light of the decision not to intubate Mr Khazaei. There was no communication to either Assistance Desk to discuss intubation and whether other options were available. There was no communication to the retrieval team that Mr Khazaei required intubation which might have given that team the opportunity to collect Mr Khazaei from the clinic (as opposed to the tarmac) so that he could be intubated before flight. There was no consideration of whether to use the Oxylog 3000, which provided a non-invasive form of ventilation by way of a firmly fitting mask. The advantages of non-invasive forms of ventilation, as opposed to intubation, were explained during Dr Little's evidence.[560] Ultimately Dr Little would have expected Dr King, as an emergency physician, to have been able to manage this situation.[561]

330. Dr Little suspected that Dr Karu did not get an adequate handover from Dr King. He confirmed that the clinicians from the PIH also felt they did not receive an adequate handover. It cannot be determined what information was transferred from Dr King to Dr Karu, apart from the documentation which included Mr Khazaei's medical records and medication charts. Dr Little referred back to processes,[562] and noted that there existed no standardised process pertaining to what information needed to be handed over to the retrieval team.

331. Dr Little pointed out that patients, wherever they are, can deteriorate. His evidence was that there needed to be a plan in place to deal with the possibility that Mr Khazaei might deteriorate further on the tarmac. Performing the intubation on the tarmac would have been difficult to do, but not impossible.[563] Dr Little was critical of the fact that it was not done and said that this fell below the standard of care one would expect in similar environments, like North Queensland.[564] Dr Little accepted during his evidence that the decision whether or not to intubate was one that ultimately required the exercise of clinical judgement.[565]

332. When asked how this impacted on his opinion regarding Dr Karu's decision not to intubate Mr Khazaei, Dr Little's said:

> *"…here Dr Karu has expressed his reasons as to why he did not intubate it at that point in time. And, again, as you said with respect to Dr King, you're not there in the position that Dr Karu was in, having to make the judgment that he had to make so you have to give some respect for that circumstance. Is that right?---That is. However, I would say that the patient needed to be intubated. Given all the evidence that I've seen, he should have been intubated and I think, more*

[559] T 15, p 18 from line 25.
[560] T 15, p 51 from line 12.
[561] T 15, p 18 from line 34.
[562] T 15, p 21 from line 10.
[563] T 15, p 22 from line 1.
[564] T 15, p 22 from line 2.
[565] T 15, p 76 from line 19.

> *importantly, not only did they not intubate the patient but they did not identify that the patient needed to be intubated, as evidenced by the fact there has been no communication with the coordination centre. Sorry. The assistance centre. Sorry – to say that, "I can't intubate the patient for reasons A, B and C but the patient needs to be intubated." Nor – nor is there any, at the other end when they arrived to say, "This patient needs to be intubated." So yes. They had to make the clinical decision and I accept that but I think that was the wrong decision and I think it has contributed to his death."*[566]

333. Dr Little emphasised how critically unwell Mr Khazaei was on the Manus Island tarmac, with oxygen saturations between 60-70%. Dr Little explained in his evidence what oxygen saturations are, and the significance of having the levels which Mr Khazaei had.[567] Even on supported oxygen, Mr Khazaei's saturations only rose into the 80% range, which still meant the mercury level was very dangerous.

334. Dr Little agreed with Dr Karu that Mr Khazaei needed to be transferred urgently, and that the retrieval aircraft is a very small aircraft, leaving little to no opportunity for physical procedures to be conducted in-flight. However, Dr Little also said that Dr Karu had performed medical retrievals before and these limitations were known factors which should have been considered. Dr Little reiterated that Mr Khazaei's airways required management and control, before him being placed on the aircraft. This would be the standard of care expected in Australia.[568]

335. Again, Dr Little was critical of the lack of communication with the International SOS Assistance desk about the decision not to intubate Mr Khazaei. His evidence was:

> "*This would have really – if they did not think they should have intubated the patient, this would have added to the argument, but more importantly, when the telephone call was made by Dr Karu to the assistance centre before he left, he, I believe, should have said (a) "the patient needs to be intubated, but I'm not – I can't do it so Dr Condon knew," and (b) if they had done some blood gases, these results, hopefully, would have also warned the coordination doctor that this patient was terribly ill*."[569]

336. With respect to Mr Khazaei's observations in-flight, Dr Little's evidence was that it did not really matter whether venous or arterial blood provided the results - the results were "*really bad – really, really concerning*."[570] The pH level was low, and the lactate was above 4, which supported a conclusion that there was a significant risk of mortality.[571]

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[566] T 15, p 76 from line 37.
[567] T 15, p 22 from line 22; exhibit G2.4.
[568] T 15, p 23 from line 43.
[569] T 15, p 24 from line 38.
[570] T 15, p 24 from line 26.
[571] T 15, p 24 from line 33.

337. Dr Little's evidence highlighted that there was a lack of appreciation by everybody who had anything to do with the management of Mr Khazaei's case, either medical or nursing, of just how sick he was. The only exception to this was the International SOS clinicians contracted to assist the AFP. With respect to the retrieval team, Dr Little gave evidence that they were perhaps expecting to retrieve "*an unwell patient, but not a sick patient*."[572] Dr Little's evidence on that point was:

> "*I think that they – again, it's my opinion – they were probably blinkered and surprised at what was presented in front of them. And I think in part it was that failure of communication I talked about: identifying how sick the person was and then creating a more appropriate appreciation of the – of the condition of the patient before their arrival*."[573]

338. Dr Little's evidence was that, while Mr Khazaei was getting progressively more sick as time went on, if he had been treated appropriately and aggressively before boarding the retrieval flight, it is more likely than not that he would have survived.[574] This opinion extended to when Mr Khazaei was received at the PIH emergency department, although Dr Little could not say from a neurological point of view, whether Mr Khazaei would have made a full recovery.[575] Dr Little justified his opinion by referring to the treatment provided at the Mater Hospital, in the following way:

> "*But I think – and in part, I say that mainly because of the treatment after he arrests with good Western standard intensive care, he, from an organ point of view, has survived; blood pressure, pulse, kidney function, they all improve. So I think it more likely than not he would have survived.*"[576]

339. Like Dr Storey, Dr Little was not able to say how long a patient could sustain lowered levels of oxygen before neurological defects would take effect.[577]

340. Dr Little confirmed that at the PIH emergency department Mr Khazaei required immediate "*aggressive intensive care style management to manage his condition.*"[578] Dr Little was taken to the untested evidence of Dr Melissa Galicio[579] regarding the problems posed with intubating Mr Khazaei. Dr Little's evidence was that these problems were not unusual, and Dr Little accepted that "*he would be very difficult to intubate without any drugs, and to do that, you need to get him sedated*".[580]

341. When asked whether he would agree with the proposition that the use of an ambu-bag without PEEP (Positive End Expiratory Pressure), over the period of time Mr Khazaei was in the PIH emergency department, could have resulted in interstitial oedema, Dr Little replied as follows:

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[572] T 15, p 85 from line 11.
[573] T 15, p 85 from line 11.
[574] T 15, p 22 from line 19.
[575] T 15, p 25 from line 45.
[576] T 15, p 25 from line 35.
[577] T 15, p 26 from line 11.
[578] T 15, p 27 from line 11.
[579] Exhibit D8 from paragraph 20.
[580] T 15, p 60 from line 31.

> "*---It wouldn't necessarily result in interstitial oedema but it wouldn't improve the condition and, as you've seen by his observations from Manus that morning and into the aircraft, his oxygenation has got worse and without the use of PEEP that would continue to get worse. I don't think the lack of PEEP would cause alveolar edema. I think his illness caused the alveolar edema, which worsened because he did not get PEEP*."[581]

342. Dr Little explained that the care provided was not to an Australian standard. However, he qualified this by reiterating that the PIH is in PNG, not Australia. His evidence in this regard was that the interventions that you would expect to be the standard of care in an outlying hospital in Cape York were not met. He thought that the PIH was *"caught flatfooted"* and while they recognised the patient was sick or unwell, they lacked the skills or abilities to intervene and manage the patient. [582]

343. When asked about whether the PIH was an appropriate medical facility for Mr Khazaei to be transferred to, Dr Little gave evidence drawing on his experience with patients transferred from PNG to Cairns. The proposition put to him, and his evidence is extracted as follows:

> "*Does it come down to this, ultimately, Dr Little: that your experience of the quality of care in Port Moresby and what you've been able to see as to what could be done at the Pacific International Hospital meant that the Pacific International Hospital, at any given time, might have been a facility that was capable of managing this patient in his condition on the 26th, but it might not have been?---Yeah. I think – I think – I think it's a fair – a fair – fair comment, again reflecting on patients that come to us in Cairns from Port Moresby. Now, they don't necessarily all come from the PIH, but as a general statement – I know it's very generalised – the – the quality of the trans – of the clinical care is very variable, and I'm sure that's probably clinician-led. It may well be equipment: what's available, what's working, what equipment's working that day, what medications have they actually got available to them at that stage. So it's very, very variable, and – and sometimes we get surprised at the good level of care that comes to us in Cairns, and sometimes we're not surprised at the poor level of care that [indistinct] the patient."*[583]

344. Dr Little made it clear in his written report[584] and in his oral evidence[585] that it was important to note the main cause of death was from hypoxic-ischaemic encephalopathy. In terms of when this occurred, Dr Little's evidence was that he was referring to the events of 26 August 2014 not just at the PIH, but the events which occurred before the PIH - "*I think it all contributed to it*."[586] Dr Little confirmed in his evidence:

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[581] T 15, p 75 from line 36. Records from the flight indicate that Mr Khazaei's oxygen saturations actually improved over the course of the flight – see para 181 above,
[582] T 15, p 26 from line 37.
[583] T 15, p 79 from line 13.
[584] Exhibit G2, p 43.
[585] T 15, p 30 from line 13.
[586] T 15, p 30 from line 28.

- There was no evidence to suggest that the type of infection, being *Chromobacterium violaceum*, or the underlying CGD, should have been detected at an earlier stage;
- There was no evidence to suggest that Mr Khazaei should have presented to the Manus Island clinic earlier than he did; and
- There was no evidence that the International SOS AFP team of clinicians at the PIH had any medical options available to them to save Mr Khazaei at the point he came under their care.[587]

345. When asked about the action taken to engage the International SOS clinicians within PNG to assist the AFP, Dr Little's evidence was that earlier escalation of this action may have made a difference to the outcome. His evidence in this regard was:

> "---*my feeling was, at that stage, he, more likely than not, probably would have survived, but, I suspect, may have had some neurological injury at that stage. However, it's – I think it would have helped, as evidenced by the good care that was provided by the AFP medical assistance team after – well, in that peri-arrest and then after his arrest situation*."[588]

346. Dr Little's evidence was that there "*appeared to be poor governance systems established to manage patients on Manus Island*."[589] During cross examination at the inquest, Dr Little conceded that a better way to express it was to the effect that there while there may have been processes in place, they were not necessarily followed in this instance.[590]

347. The post-death reviews conducted by both the DIBP[591] and IHMS[592] were reviewed by Dr Little. He said, regarding the DIBP review, that the recommendations contained within it were reasonable. However, Dr Little felt that the review did not go into great detail about how services were to be performed.[593] Regarding the IHMS review, Dr Little felt it could have been more detailed in a number of respects.

348. Dr Wenck estimated that approximately 80% of the admissions to the ICU at CBH relate to sepsis, based on a total of 1200 patient admissions per year. In terms of his level of experience in dealing with patients received from PNG, Dr Wenck's evidence was that the number of patients received is highly variable but might be between five and ten per year.[594] When asked about his experience with the standard of health care provided in PNG to those patients he is involved in receiving at the Cairns Hospital , Dr Wenck's evidence was as follows:

> "---*It's extremely variable. Sometimes a retrieval team will come down with – which is extremely professional and everything is well done. Other times, I've had*

[587] T 15, p 31 from line 3.
[588] T 15, p 63 from line 41.
[589] Exhibit G2, p 3.
[590] T 15, p 72 from line 18.
[591] Exhibit C6.
[592] Exhibit B147.
[593] T 15, p 32 from line 14.
[594] T 16, p 4 from line 18; page 56 from line 9.

patients arrive who have been dead on arrival, and it hasn't been properly realised by the team."[595]

349. Dr Wenck accepted during cross examination that, based on the small sample of patients received at Cairns from PNG, it to an extent self-selected those patients who met the criteria of poor quality medical care.

350. When answering the questions posed to him in his written reports, Dr Wenck confirmed that Manus Island was "*geographically and medically remote*."[596] The clinical picture he had in mind was explained during his evidence as follows:

> "*Well, firstly, it's a remote area, and it's – I have worked in a remote area myself. It's extremely difficult. You don't have very good equipment, generally speaking. You have poor diagnostic equipment, so access to x-ray and – and laboratory is not – is not good. And so you have to rely on your clinical judgment a lot, and so that's the first thing about being in a remote area. And, secondly, I got the impression, though, that this was a – a very, very sick patient, particularly when he left the Manus Island facility and to the airport and then getting on the aircraft, it was clear that the patient was extremely unwell, and the same applied when he arrived at the Pacific International Hospital, that he was an extremely unwell patient.*"[597]

351. Dr Wenck explained that *Chromobacterium violaceum* was a "*difficult infection, and it causes multiple abscesses, which can take a prolonged time to treat*."[598] It is a bacterium which grows in stagnant water in tropical and sub-tropical environments. He explained that *Chromobacterium violaceum* would never form part of an initial diagnosis, due to the number of other bacteria which would also need to be considered in that type of environment.[599]

352. Dr Wenck also explained that the bacterium is non-specific in its presentation and would present with signs typical of other infections. There would be no presenting factors to distinguish *Chromobacterium violaceum* from any other tropical infection.[600] Mr Khazaei's progression was not particularly rapid, or particularly slow. It was a progression for sepsis which was *"that of a typical septicaemic illness."*[601] Dr Wenck confirmed that the only way to detect *Chromobacterium violaceum* is by isolation of the bacterium in a microbiological laboratory, which was not an available facility on Manus Island. In Australia, it would be treated with a drug called Meropenum, which was not available on Manus Island.[602]

353. Like Dr Little, Dr Wenck gave evidence that the drug Gentamicin might have had some effect on *Chromobacterium violaceum*. The drug itself has very good blood penetration, such that it is effective at killing bacteria in the bloodstream. However, it has poor penetration to the tissues. Dr Wenck explained that one dose of Gentamicin

[595] T 16, p 18 from line 12.
[596] Exhibit G1, p 3 paragraph 3.
[597] T 16, p 6 from line 46.
[598] T 16, p 18 from line 27.
[599] T 16, p 19 from line 1.
[600] T 16, p 19 from line 10.
[601] T 16, p 31 at line 33.
[602] T 16, p 20 from line 21.

would have been administered to a septic patient like Mr Khazaei, had he been in Australia. However, Dr Wenck understood that other medical environments, like the United States where Dr King was trained, would not encourage the administration of Gentamicin due to the risk of the drug affecting the patient in other ways unrelated to their illness.[603]

354. In terms of explaining when one might make the decision to administer Gentamicin, Dr Wenck's evidence was that the risks of giving it to a very unwell patient such as Mr Khazaei were far outweighed by the benefits. Based on a risk-benefit analysis he would have proceeded in giving Gentamicin in a situation which was life-threatening.[604]

355. Dr Wenck was also taken to Dr King's evidence with respect to why Mr Khazaei was not intubated at the clinic before being transferred to the tarmac.[605] In his evidence, Dr Wenck addressed each concern raised by Dr King, and ultimately agreed with the evidence of Dr Little that, despite these concerns, Mr Khazaei should have been intubated. Dr Wenck would have expected an emergency physician with Dr King's training and qualifications to have possessed the skills necessary to perform the intubation at the clinic.[606] Dr Wenck did qualify this opinion by accepting that in America, *"the skills of the emergency department physicians is again highly variable".*[607]

356. In terms of the involvement of the retrieval team with Mr Khazaei's care, Dr Wenck's evidence was that by this stage Mr Khazaei was "*basically in extremis. In other words,…– he's got a high likelihood of dying - - - and needs urgent intervention.*"[608] In terms of the urgent intervention required, Dr Wenck explained that this involved the immediate application of oxygen, re-attainment of intravenous lines, and the induction of anaesthesia to intubate and ventilate the patient to maintain oxygenation. The patient would need to be asleep, and central venous access would need to be in place to allow for the administration of inotropes.[609]

357. Dr Wenck had regard to the evidence of Dr Karu with respect to the decision not to intubate Mr Khazaei, but did not accept the reasoning provided.[610] Dr Wenck explained that, once in the air, anything can go wrong with a patient. Due to the small size of the aircraft there is usually little opportunity to retrieve the situation mid-flight. With respect to the decision to intubate a patient pre-flight, Dr Wenck's evidence was as follows:

> "*So you've got very limited opportunity to do anything once you're in the air, and, indeed, we often, in aero-medical retrieval, intubate and ventilate the patients who don't actually require it when we first see them, because of a propensity for something to go wrong in the air. So we obviate that risk by prophylactically, if –*

[603] T 16, p 20 from line 43.
[604] T 16, p 26 from line 25.
[605] Exhibit B6.1, paragraph 54; T 16, p 36 from line 40.
[606] T 16, p 37 from line 42.
[607] T 16, p 37 from line 45.
[608] T 16, p 7 from line 44.
[609] T 16, p 8 from line 1.
[610] T 16, p 8 at line 29.

for want of a better word – intubating and ventilating the patient to – to obviate the danger of a – of a mid-flight deterioration where you can do nothing about it - - -"[611]

358. Dr Wenck said that he would likely have intubated Mr Khazaei on the tarmac, as it would have been less confined than inside the ambulance. The fact that the tarmac was not a clinical environment would not be a factor to consider in making this decision.[612] Dr Wenck referred again to the 'risk-benefit ratio' and accepted that while intubating Mr Khazaei in this environment carried with it a fatal risk, this had to be balanced against the other highly variable risks that were either known at the time or might occur mid-flight.[613]

359. Dr Wenck emphasised during his evidence that it was probable the only reason Mr Khazaei arrived at the PIH alive was that he was 24 years of age. He explained that Mr Khazaei had the physiological reserve of a young man. An older man with Mr Khazaei's observations on a difficult flight across PNG may well have died mid-flight.[614] Dr Wenck accepted under cross examination that the basic intervention of oxygen applied to Mr Khazaei by the retrieval team *"removed one aspect of the causes of death that could have occurred in that aircraft."*[615] Dr Wenck considered that, despite his observations, Mr Khazaei was still retrievable at the point when he arrived in Port Moresby. To achieve this, Mr Khazaei needed appropriate emergency treatment immediately upon arrival in Port Moresby.[616]

360. With respect to the care provided to Mr Khazaei at the PIH, Dr Wenck pointed out that while intubation did occur eventually (and seemingly uneventfully), it should have occurred immediately upon arrival.[617] After intubation was effected, Dr Wenck explained that there needed to be sophisticated ventilation in place at that point to maintain oxygenation. With reference to Dr Galicio's evidence that she struggled with Mr Khazaei for a long time to insert the cannula to allow for intravenous sedation,[618] Dr Wenck explained that this should not be a drawn out process. His evidence was that it was necessary to simply hold the patient down to get a line in to enable drugs to be injected into the vein. [619]

361. Dr Wenck explained the different methods of ventilation, and in particular the importance of using PEEP which ventilates the lungs "*to a point*"[620]. I heard evidence that the use of PEEP allows room in the lungs for oxygen and blood to interact, which in turn allows for oxygen loaded blood to proceed to the brain.[621] Dr Wenck explained that a sophisticated ventilator can maintain that level of oxygenation precisely.

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[611] T 16, p 8 from line 15.
[612] T 16, p 39 from line 5.
[613] T 16, p 47 from line 45.
[614] T 16, p 9 from line 2.
[615] T 16, p 52 from line 33.
[616] T 16, p 9 from line 10.
[617] T 16, p 9 from line 44.
[618] Exhibit D8, paragraph 20.
[619] T 16, p 44 from line 4.
[620] T 16, p 10 at line 25.
[621] T 16, p 10 from line 5.

However, in the absence of that, an ambu-bag can be utilised and the PEEP maintained by the use of an expiratory retardant valve.[622]

362. Mr Khazaei was transferred to the PIH ICU, and subsequently attended to by the International SOS team stationed in Port Moresby to assist members of the AFP. Almost immediately upon their arrival, Mr Khazaei went into cardiac arrest. Dr Wenck confirmed it would have been immediately apparent to these clinicians that "*all was not right*".[623] The oxygen saturations were low, Mr Khazaei would have probably appeared blue, and the ventilator was malfunctioning in some way. Dr Wenck confirmed the actions of the clinicians in disconnecting Mr Khazaei from the ventilator were correct.

363. Dr Wenck also referred to evidence regarding the oxygen cylinder and confirmed that the loud exploding noise was not caused by the cylinder being turned on too fast. His evidence was, in reference to the cylinder, "*it should not matter how fast you turn it on*".[624] Dr Wenck explained that the cylinders have a very high pressure, and if the equipment is faulty or has not been connected properly, it can disconnect extremely violently.[625] Once the cylinder was open, and the contents disbursed into the atmosphere, it would have been "*extremely loud – deafening; it would have been deafening and very, very off-putting*".[626] It was Dr Wenck's opinion that the cylinder was either incorrectly assembled, or defective.[627]

364. In terms of the evidence regarding the defective ambu-bag having been used to ventilate Mr Khazaei, Dr Wenck explained that with an ambu-bag the best oxygen saturations that can be achieved is 85%. With a hole in the soft part of the bag, or the reservoir part of the bag, it would be even less than 85%. This would not allow enough oxygen to be getting to Mr Khazaei.[628] Dr Wenck explained that 80% oxygen saturation is slightly above the mixed venous saturation, so Mr Khazaei "*would have been blue*."[629]

365. Dr Wenck gave evidence regarding the appropriateness of the subsequent steps of the International SOS AFP medical team, once it was realised that the ambu-bag was defective. Dr Wenck's opinion was that the actions of those clinicians were consistent with good medical practice. He said the absolute priority was to get oxygen into the patient, and nothing else mattered.

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[622] T 16, p 10 from line 29; page 13 from line 35.
[623] T 16, p 12 at lines 32-33.
[624] T 16, p 13 at line 25.
[625] T 16, p 13 from line 5.
[626] T 16, p 13 from line 13.
[627] T 16, p 13 from line 32.
[628] T 16, p 14 from line 22.
[629] T 16, p 43 at line 12.

366. Dr Wenck confirmed that Mr Khazaei going into cardiac arrest soon after the arrival of the International SOS AFP medical team was not something that could have been avoided by any of the clinicians on that team.[630] Dr Wenck explained that once cardiac arrest occurs from hypoxia, the brain is already damaged. He explained this by using the following example about how quickly brain damage occurs, which is extracted from his evidence as follows:

> *"---if I pressed on my carotid arteries now, I would be unconscious within 15 seconds because the brain requires an enormous amount of oxygen to maintain conscious – an enormous amount of oxygen and blood flow; 600 mils a minute, in fact. And so as soon as the brain is deprived of oxygen, unconsciousness occurs within 15 seconds; damage occurs within five minutes. But the heart will continue beating for some time – 10/15 minutes."*[631]

367. He expanded on the issue under cross examination, as follows:

> *"And so if we take the point at which Dr Gleid noticed the cardiac arrest, you're saying it's a fairly reliable rule of thumb to say that hypoxic brain pathology occurred about 10 or 15 minutes beforehand?---Yes. It takes – one – this is due to hypoxia. So you might have a heart – your heart might stop for cardiac reasons - - -*
>
> *Yes?--- - - - and then we do cardiopulmonary resuscitation of the patient, and sometimes we get a good outcome from that, because - - -*
>
> *Yes?--- - - - the brain damage hasn't occurred. But here, we have hypoxemia, which will cause brain damage first - - -*
>
> *Yes?--- - - - and then eventually the heart. So once you've seen the heart stopping - - -*
>
> *Yes?--- - - - then that is a – you – the horse has well and truly bolted - - -*
>
> *Yes?--- - - - in that situation of hypoxemia."*[632]

368. Dr Wenck did not agree with the evidence from Dr Ronald Galicio that the cardiac arrest was likely triggered by turning off the ventilator.[633] Dr Wenck confirmed that at the time the ventilator was turned off, Mr Khazaei already had fixed and dilated pupils, and this particular presentation does not occur instantaneously, rather it occurs over a period of some time.[634] Dr Wenck also did not agree with Dr Galicio's evidence regarding the use of frequent suctioning, describing Dr Galicio's evidence as a "*different situation – completely different situation*."[635]

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[630] T 16, p 15 from line 30.
[631] T 16, p 16 from line 8.
[632] T 16, p 23 from line 31.
[633] Exhibit D2.1, paragraph 75; T 16, p 25 from line 28.
[634] T 16, p 25 from line 28.
[635] Exhibit D2.1, paragraph 87(a); T 16, p 28 from line 34; page 29 at line 8.

369. Dr Wenck was not able to ascertain definitively what was wrong with the ventilator. His evidence was that there were "*a tremendous number of things that could have gone wrong*".[636] There could have been a problem with the ventilator itself, a problem with the setup of the ventilator, or there could have been a leak around the tube or the cuff on the tube which seals the tube from the ventilator. Another possibility was that the ventilator settings, particularly the peak airway pressure settings and the volume alarm settings, may not have been set correctly. Dr Wenck's evidence was that any part of that chain could have been incorrect and could have resulted in what was seen in Mr Khazaei's case.[637]

370. Importantly, Dr Wenck's evidence was that if Mr Khazaei had been intubated earlier, with proper ventilation in place, he would have arrived at the PIH in a healthier state.[638] However, he also said even if Mr Khazaei had been intubated and ventilated pre-flight, all of that work might have been undone very quickly given the lack of skills of the PIH clinicians, and if Mr Khazaei had still been connected to the same ventilator.

371. Dr Wenck also gave evidence regarding the steps he is required to take, at CBH, to ensure the equipment in the ICU is maintained to a sufficient standard. He explained that ventilators are "*maintained much like aircraft*"[639]. The maintenance is mandated by the number of hours, which is recorded on every machine. When a ventilator goes in for a service, a senior nurse is required to utilise a software program which is run by the ventilator, which tests all of the pressures. The integrity of all systems within the ventilator are checked. Every ventilator has a number, a history and there are certain tests mandated by the ventilator software such that the ventilator cannot be used unless those tests are conducted and passed.[640] Dr Wenck said that while these types of maintenance activities should be in place at the PIH, his evidence was that *"…I wouldn't expect them to be."*[641]

[636] T 16, p 17 from line 28.
[637] T 16, p 17 from line 29.
[638] T 16, p 41 at line 1.
[639] T 16, p 16 at line 26.
[640] T 16, p 16 from line 25.
[641] T 16, p 17 from line 2.

FINDINGS REQUIRED BY S.45 OF THE CORONERS ACT

372. The primary focus of this inquest was to make the findings required pursuant to section 45(2) of the *Coroners Act*. I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the death:

Identity of the deceased- Hamid Khazaei

How he died – Mr Khazaei died after he contracted a leg infection while detained at the Manus Island Regional Processing Centre where he was held under an agreement between the Australian and PNG governments. Despite the initial administration of antibiotics, he continued to deteriorate, and his infection led to sepsis. Although he had ongoing critical oxygen saturation levels, he was not intubated at the Manus Island Regional Processing Centre Clinic. He was ultimately transferred from Manus Island to the Pacific International Hospital by air without being intubated. After he arrived at the Pacific International Hospital there was a further lengthy delay in his being intubated and ventilated. He subsequently went into cardiac arrest. After intervention by a team of International SOS clinicians stationed at the Pacific International Hospital, Mr Khazaei was stabilised and subsequently transferred to the Mater Hospital in Brisbane, where he was declared brain dead and supportive care measures were withdrawn.

Mr Khazaei's death was preventable. His death was the result of the compounding effects of multiple errors rather than any single action or inaction. This included the failure to ensure the Manus Island Regional Processing Centre had antibiotics available to safely treat Mr Khazaei's leg infection, the failure to adequately detect and report a severely deteriorating patient, inadequate clinical care and processes surrounding clinical care across the clinical course, ineffective processes for the transfer of a patient off Manus Island, and the unfortunate expectation that adequate and intensive critical care could be provided at the Pacific International Hospital.

Place of death- Mater Hospital, Brisbane, in the State of Queensland.

Date of death– 5 September 2014

Cause of death– Mr Khazaei's death was caused by hypoxic-ischaemic encephalopathy, due to or as a consequence of cardiac arrest, due to or as a consequence of sepsis.

Conclusions on Issues

Issue 2 - The adequacy and appropriateness of the medical care provided to Mr Khazaei at the Manus Island Regional Processing Centre Clinic from 23 August 2014 – 26 August 2014

Issue 7 - Adequacy and appropriateness of the policies and procedures in place at the Manus Island Regional Processing Centre, in August 2014, relating to the recording of medical observations, the treatment of sepsis and medical evacuation.

373. Having regard to the evidence of Dr Little, I conclude that the initial medical care provided to Mr Khazaei from the time of his presentation on the afternoon of 23 August 2014, to 0800 hours on 24 August 2014, was adequate and appropriate in all of the circumstances. Based on Mr Khazaei's relatively non-specific presentation at that time, Dr Kutson's approach in commencing a broad-ranging antibiotic treatment, and keeping him in the clinic overnight, was an appropriate course of action.

374. From 0800 hours on 24 August 2014, Dr King's assessment of the cause of the infection, and changing the scope of the antibiotic regime was adequate and appropriate in the circumstances. However, by approximately 1730 hours that evening, Mr Khazaei had been admitted at the clinic for 24 hours, and while his observations had initially improved earlier in the day, by the evening they had begun to deteriorate. I accept Dr Little's opinion that, within 18 hours of his first presentation to the clinic, Mr Khazaei met the criteria for severe sepsis, a definition which is standardised and can be made clinically without the need for other investigations.

375. As the submissions on behalf of the family noted, Mr Khazaei recorded at least seven shock index readings over 0.7 on 24 August 2014. Dr Little's evidence was that this was a strong indicator of hyperlactatemia and likely mortality. Dr Stockil readily acknowledged in his evidence that the symptoms displayed by Mr Khazaei on the evening of 24 August 2014 demonstrated that there were haemodynamic changes happening in his body which Dr Stockil considered *"usually relate to shock or sepsis, or infection of some sort."* The failure by Dr King to consider possible alternative diagnoses for Mr Khazaei's condition in light of his lack of response to the antibiotic regime was inadequate medical care. There was a missed opportunity to request an urgent medical transfer on the afternoon of 24 August 2014.

376. Dr King was in charge of Mr Khazaei's care. This is supported by the evidence of the paramedics and nursing staff, and is also supported by Dr Stockil, who called Dr King during the night to discuss the antibiotic regime and Mr Khazaei's deteriorating observations. The evidence of Dr Muis, who was involved from 25 August 2014, also supported that Dr King was in charge.

377. I agree with Dr Little's evidence that, from the morning of 25 August 2014, a more detailed and thorough review of Mr Khazaei's observations was required, with a view to considering the next steps if he continued to deteriorate. Contact was not made with clinicians in the International SOS Assistance desk for clinical advice. The fact that neither of these matters was attended to, or at the very least considered, constituted inadequate medical care by Dr King.

378. From 0800 hours on 25 August 2014, the decision by Dr King that Mr Khazaei required a medical transfer to a higher level of care was appropriate in all of the circumstances.

379. The evidence, particularly from Dr King and Dr Muis, was that the clinic setup on Manus Island in August 2014 was basic. There were some limitations with respect to available medical equipment. In particular, an antibiotic was not available at the clinic that would safely and effectively treat the range of infections commonly found in a tropical setting, including Mr Khazaei's infection. The clinic should have been stocked with such an antibiotic.

380. Despite this, it was also established that there were a number of options available at the clinic that were not used or were not used to their full potential. Gentamicin was available but was not used. Dr Condon advised Dr King against its use having regard to Mr Khazaei's blood pressure and potential secondary effects.

381. I have considered the reasons Dr Muis and Dr King gave for deciding not to administer Gentamicin. Dr Muis' reliance on Dr King as the Emergency Physician was understandable. Having regard to Dr King's training in the United States, her reluctance to use Gentamicin can be appreciated. However, Gentamicin is not prohibited in that country. Regard should have been had to the fact that other antibiotics were not having any effect, and Mr Khazaei's deteriorating observations, particularly once it was realised that Mr Khazaei would not be transferred from Manus Island on 25 August 2014. I consider that Gentamicin should have been administered to Mr Khazaei as a one-off single dose on 25 August 2014. The failure by Dr King to administer a single dose of Gentamicin, the failure to document the reasons for not prescribing Gentamicin, or to seek external expert advice about the use of this medication represent inadequate health care on her part.

382. A Piccolo Express point-of-care testing machine was available at the Manus Island clinic so that appropriate blood tests could be performed. Dr Muis and Dr King both gave evidence that, to their knowledge, this machine was broken or otherwise inoperable. However, it was also established that the machine was used by someone on 25 August 2014 with respect to Mr Khazaei. The evidence confirmed that limited regard was had to the test results.

383. Apart from Dr Muis' call to the IHMS Assistance desk, for the remainder of 25 August 2014, there was a lack of communication from the clinicians on Manus Island, to either the International SOS or IHMS Assistance Desks. It was clear on the evidence that, even though the case was being managed by the IHMS Assistance Desk after the afternoon flight was not going to be reached, there was nothing to prevent the clinicians on Manus Island calling the International SOS Assistance Desk to seek advice, or to put forward detailed concerns about Mr Khazaei's presentation.

384. I accept the submission on behalf of the family that there was an obligation on the part of the senior clinicians within IHMS and International SOS, who were aware that Mr Khazaei's transfer was being delayed, to proactively contact the clinicians who were left to manage his care within the limited resources available at the MIRPC clinic. The MERP clearly spells out that the provision of medical advice and guidance to the IHMS medical team was a responsibility of International SOS. The fact that there was no further communication to or from the clinicians on Manus Island represented a systemic failure in the circumstances.

385. I accept Dr Little's evidence that Dr King should have considered intubating Mr Khazaei from late in the evening of 25 August 2014. The fact that Dr King did not intubate Mr Khazaei at the clinic after 0800 hours on 26 August 2014 was a serious failure to provide adequate medical care in the circumstances. The evidence established that the necessary equipment was available at the clinic for intubation to occur. The clinic had a dedicated resuscitation trolley and a mechanical ventilator was located on the wall of the resuscitation room. Dr King's reasons for choosing not to intubate Mr Khazaei were not supported by the evidence of other witnesses including Mr Cruz, who had experience in intubating patients.

386. While the decision was an exercise of Dr King's clinical judgement, and she had the benefit of having been at Mr Khazaei's bedside to exercise that judgement, based on Mr Khazaei's observations on the morning of 26 August 2014, he should have been intubated and aggressively resuscitated. Dr King was a trained emergency physician who should have been able to deal with any complications arising from intubation. That this did not occur was a critical error in Mr Khazaei's clinical course and contributed to his death.

387. There was no communication with the International SOS Assistance Desk, or to the IHMS Assistance Desk, about the decision not to intubate Mr Khazaei. If this decision had been communicated, it could have then been passed on to the retrieval team as a matter they would need to specifically address upon assuming care for Mr Khazaei. This represented a missed opportunity to communicate the severity of Mr Khazaei's illness to the receiving clinical teams, and for intubation to have been achieved sooner, further down the clinical course.

388. The evidence has established that the policies and procedures in place for the keeping of medical records at the MIRPC in August 2014 were not followed and were thus inadequate. Dr Little noted that the medical records were in multiple locations. Some were handwritten, and others were electronic, which made it difficult and confusing to get an accurate picture of how Mr Khazaei was progressing. I heard evidence about the Q-ADDS system, which Dr Little ultimately used to plot all Mr Khazaei's observations. There was no system in place to track clinical deterioration at the MIRPC clinic in August 2014.

389. Had an accessible system, similar to Q-ADDS, been in place at the time of Mr Khazaei's presentation, the clinicians should have more readily noticed the significance of Mr Khazaei's deterioration. The submission from IHMS was that such systems were designed for in-patient settings, and MIRPC was initially established as a primary care facility with no holding capacity. However, by the time of Mr Khazaei's death it would have been apparent that the MIRPC clinic was regularly

required to provide intensive care support for critically ill patients for periods in excess of the 20 hours specified in clause 26.2 of the Regional Processing Countries Health Services Contract, which also required the provision of artificial ventilation.

390. While IHMS submitted that Dr King had access to the relevant clinical observations to guide her management of Mr Khazaei, the lack of a recording system in the one location to track and review Mr Khazaei's deteriorating observations was a systemic flaw in his clinical course. This contributed to the inadequate appreciation of the severity of Mr Khazaei's illness. While Dr Stockil and Dr King were able to identify that Mr Khazaei was deteriorating, the absence of appropriate recording tools also meant the severity of his illness was not appreciated by others involved in Mr Khazaei's care after he left Manus Island.

391. The clinicians on Manus Island could not have been expected to know the type of infection that Mr Khazaei had. However, they should have known how to detect and treat sepsis. Dr Douglas' report noted in Australia sepsis affects 30,000 people each year with 7500 deaths and its recognition and timely management is a significant problem in Australian hospitals.[642] Dr Little also explained that sepsis is a common presentation to Australian emergency departments and there are standardised protocols to treat a septic patient. There were no such protocols in place at the MIRPC clinic in August 2014 to assist the clinicians in navigating Mr Khazaei's clinical pathway.

392. It was clear that an over-reliance was placed by all clinical staff involved in Mr Khazaei's care at the MIRPC on his seemingly healthy physical presentation, as opposed to his recorded vital signs. I accept Dr Little's opinion that while Mr Khazaei appeared quite well, this was related to his age and physical build. The fact that he deteriorated quite dramatically over the early hours of 26 August 2014 was not unexpected and should have been anticipated by Dr King as an Emergency Physician.

Issue 3 - The adequacy and appropriateness of the transfer arrangements for Mr Khazaei to be taken from the Manus Island Regional Processing Centre Clinic to the Pacific International Hospital, including the decision to transfer Mr Khazaei to Pacific International Hospital, as opposed to an Australian hospital.

393. I accept Dr Little's evidence that if Mr Khazaei had been transferred directly from Manus Island to Cairns after Dr Muis' initial transfer request, he is likely to have survived, despite the fact that he was suffering from a very rare infection which has significant mortality associated with it. From the time Dr King determined Mr Khazaei required a medical transfer on 25 August 2014, there were a number of factors which combined to produce the suboptimal outcome of Mr Khazaei remaining on Manus Island that day.

394. The MERP in place at the MIRPC clinic set out the process to be followed where a medical transfer was required. It provided all relevant contact details to commence a transfer request, and a framework to be followed for first phase, and second phase evacuation. This document was largely not followed.

[642] Exhibit C6, p 2

395. Dr Muis was not familiar with the MERP when he needed to commence the process of requesting Mr Khazaei's transfer as he only arrived on Manus Island the previous day. While it was submitted by the family that his induction was inadequate, it was also clear that he was a 'fill-in' SMO and was not going to be on Manus Island for an extended period of time. He contacted Dr Renshaw, who then instructed him to contact the International SOS Assistance Desk. While Dr Muis was in contact with the International SOS Assistance Desk (speaking with Dr Dennett), Dr Renshaw was contacting the IHMS Assistance Desk (Ms Zhai), and also the relevant DIBP officer (Ms Gow) to provide a 'heads up' of the imminent request for transfer. There was clearly a degree of urgency to the request, as it was clear from the evidence of Dr Muis and Dr Renshaw that their objective was to have Mr Khazaei on a commercial flight at 1730 hours that afternoon.

396. However, even in the very early stages of the transfer request, there were multiple personnel involved from different agencies. No documentation was exchanged to provide consistent information supporting the verbal requests. The various phone conversations that were had, particularly the conversation between Dr Renshaw and Ms Gow at 1229 hours, led to different versions about the extent of the information, some critical, that was passed on through phone calls, with no way to accurately confirm or otherwise verify what was said. This was the first fundamental flaw in the transfer arrangements.

397. The second flaw was that the true nature of Mr Khazaei's illness was not accurately portrayed by Dr Muis to either International SOS, in his phone call, or IHMS, in the RMM. In this regard I accept the opinion of Dr Little that Mr Khazaei's observations over the preceding four to six hours should have been provided, rather than current observations. The failure to accurately demonstrate his clinical deterioration and identify that he met the criteria for severe sepsis is likely to have contributed to the decision to select the PIH as the appropriate receiving centre of care instead of an Australian hospital. I also accept that it is possible that the PIH may have been able to care for Mr Khazaei if he been transferred on 25 August 2015, when he was cleared for transfer by commercial aircraft.

398. As a result of Dr Muis' phone call to the International SOS Assistance desk, Dr Dennett drafted an RMM. This RMM included specific information about the method and details of transfer, namely that there was a commercial flight at 1730 hours, upon which Dr McGrath was already booked. The evidence from the International SOS clinicians in this regard, namely Dr Yap and Mr Gillard, was that the relevant checks were conducted to confirm the availability of seats on that flight for Mr Khazaei, Dr McGrath and a security escort. This RMM was sent to IHMS because it was not the role of International SOS to send RMM's directly to the client (DIBP). That was the role of IHMS.

399. Dr Muis also sent an RMM through to the IHMS Assistance Desk (Ms Zhai). Ms Zhai then sent a RMM through to Ms Gow, for the consideration of DIBP. However, the RMM sent to the DIBP by Ms Zhai did not include the specific information about the flight details included in the RMM completed by Dr Dennett. The fact that there were multiple RMM's with respect to Mr Khazaei's transfer containing inconsistent information was the third serious flaw in the transfer process.

400. Given that Dr Muis' original RMM did not accurately portray the severity of Mr Khazaei's illness, it followed that the RMM sent by Ms Zhai also did not accurately portray the severity. The RMM should have been clearer about what 'urgent' meant, and should have provided a specific timeframe for the DIBP to work to. As Dr Little said, *"nobody understood what urgent meant".*[643] This fact, along with the specific timeframe not being specified on the RMM sent to the DIBP, was the fourth serious flaw which affected the transfer process as it progressed. It also appeared that because Mr Khazaei was originally deemed well enough to fly on a commercial flight under medical supervision, the assumption was made that he was not as sick as he actually was, and the request for transfer was also not "*urgent*".

401. The question arose as to whether, the RMM aside, the DIBP had knowledge of the flight at 1730 hours on 25 August 2014. Dr Renshaw's evidence was that the information formed part of his telephone conversation with Ms Gow at 1229 hours. Ms Gow's evidence was that she had no knowledge of the 1730 flight. While Ms Little did have knowledge of the flight, she said that flight was not necessarily "*available to the department*". She did not cause any checks to be made in that regard. Her evidence was that Ms Gow did know about the flight, and assumed that Ms Gow was conducting the relevant checks about seat availability on the flight.

402. On balance, I find that Dr Renshaw informed Ms Gow that there was a flight at 17:30 hours on 25 August 2014 which was his preference for transferring Mr Khazaei from Manus Island. It is apparent that DIBP could readily have ascertained whether that flight was available to Mr Khazaei by using its staff located on Manus Island. Ms Costello's evidence was that her objective when she commenced making arrangements was for Mr Khazaei to be on the 1730 flight. She did not finalise the process because she was waiting for approvals from Canberra.

403. The evidence highlighted a transfer process which allowed for inconsistent information to be passed on through multiple persons and channels. Each person asserted they had an important part to play in the transfer process but each had fundamentally different perspectives and differing imperatives.

404. It appeared that the medical staff were working primarily to clinical imperatives while the DIBP officers were working primarily to bureaucratic and political imperatives to keep transferees on Manus Island, or in PNG. The evidence demonstrates that this process resulted in crucial information, i.e. the importance of getting Mr Khazaei on the flight at 1730 hours, being missed, or not passed on accurately or clearly enough. The transfer process in this regard was confusing. While I appreciate the justification for the involvement of different agencies in the process, there was clearly no central point of coordination to ensure consistency.

405. The RMM sat unread in Ms Little's inbox from approximately 1230 hours on 25 August 2014, until she returned from her meetings sometime around 1700 hours. By the time Ms Little checked her emails and saw the transfer request, any prospect of making the 1730 flight had passed as safe flights at night off Manus Island could not be guaranteed. Having regard to logistics, even if DIBP had approved the movement request in the early evening, Mr Khazaei would not have left Manus Island until the morning of 26 August 2014.

[643] T 15, p 11 from line 35.

406. Over the course of the afternoon of 25 August 2014, Dr Muis called the IHMS Assistance Desk to follow up the approval, and Ms Costello sent an email to Ms Gow. Neither of these attempts made any difference.

407. The evidence at the inquest established that the DIBP had a process for the rapid escalation of approvals. On previous occasions, IHMS had contacted the Assistant Secretary or the First Assistant Secretary directly to have medical transfers approved. However, those processes were not adopted in Mr Khazaei's case. Even though Dr Renshaw and Ms Little were, at least for part of the afternoon, in a meeting together they did not discuss Mr Khazaei's transfer request.

408. Apart from Ms Costello, nobody involved in Mr Khazaei's transfer considered it necessary to escalate the request by accessing senior DIBP officials directly. I accept the submission from IHMS that it was open for Ms Costello and Ms Gow to take additional steps to progress the request for movement before 17:30 hours, and that Dr Renshaw remained unaware that the transfer was not progressing until he arrived back in Sydney that evening. As noted above this was contributed to by the failure to specify the severity of Mr Khazaei's illness by Dr Muis, and the absence of a specific timeframe for movement being included on the RMM sent by IHMS to the DIBP.

409. I accept Dr Little's evidence that the decision to transfer a patient to a higher level of medical care is a clinical one, to be made on a clinical basis. Ms Little accepted this proposition in her evidence, as did Mr Windsor and Mr Cahill. However, the process put in place by the DIBP to approve medical transfers was overly bureaucratic and lacked clear written procedures. The lack of any clear guidelines or policy document with respect to the process for medical transfers was confirmed by Mr Cahill.[644] It was only when an air ambulance was requested that the process was expedited. Where the request was for a commercial flight, as in this case, the approval had to negotiate at least four departmental employees before it was approved.

410. In the context of her email to Dr Renshaw on the evening of 25 August, Ms Little's evidence was that she was an escalator in the transfer approval process, not a decision maker. However, the exercise of this specific function as Director was not the subject of any job description or operating procedures. This was something which Ms Little did as she saw appropriate to add value to the process. Mr Windsor was asked generally about the process he adopted in reviewing RMM's that came through. His evidence in this regard is extracted as follows:

> "*My process would be to look at the form and to see whether there was sufficient detail in the form to satisfy the decision-maker, the FAS, that it was clear what the circumstances were. So, really, applying a quality control measure to ensure that, you know, it was evident from the information provided and that the FAS wouldn't be asking questions because there were clear gaps in what was being provided.*"[645]

411. When asked the extent to which he relied on Ms Little's recommendation that the transfer request be approved, Mr Windsor explained that he looked at it, but also

[644] T 7, p 103, lines 20-24
[645] T 6, p 92, from line 27.

looked at the clinical recommendation and the information included from IHMS. On the morning of 26 August 2014, he also had the benefit of the communication from Mr Matheson, so *"could see that there was sufficient there and that it should be put forward quickly."*[646]

412. Mr Windsor was taken to the relevant RMM[647] during his evidence, and asked to comment on its level of detail. His evidence in this regard is extracted as follows:

> "*If you had received this recommendation form, would that have been sufficient detail to satisfy you that the transfer needed to be approved?---Yes.*
>
> *There's nothing contained within there that you would require clarification on or further information with respect to?---Well, it indicates that he'd been admitted or had undergone treatment at the centre, that they had tried antibiotics. That was not responding. They'd exhausted the treatment that's available on Manus Island; displaying symptoms of deterioration. It's pretty compelling."*[648]

413. In Mr Cahill's evidence, he said that when considering a RMM forwarded through from Ms Little, he would place *"significant weight"* on her recommendation as to whether it should or should not be approved.[649] However, when taken to the relevant RMM during his evidence, Mr Cahill believed it contained sufficient information for him to approve the request.[650]

414. The wording of Ms Little's email to Dr Renshaw on 25 August 2014 gave the impression that the transfer request would not be progressed until Dr Renshaw answered her questions. While Ms Little was unable to recall if there had been any occasions when she did not escalate matters after requests for transfer had been received, [651] I consider that Ms Little exercised significant influence as a gatekeeper in whether the transfer request for Mr Khazaei was approved by her superiors, including the timing of the approval. It was ultimately this influence, among other things, which led to the transfer request being approved quickly by Mr Windsor and Mr Cahill on 26 August 2014, when an air ambulance was required.

415. On the morning of 26 August 2014, Dr Muis spoke to Dr Condon at the International SOS Assistance Desk and requested an emergency medical evacuation. He drafted another RMM to reflect this. I accept the evidence of Dr Little that this RMM also failed to accurately portray the severity of Mr Khazaei's illness, and that this contributed to decisions made about his care during his transfer to Port Moresby.

416. The MERP in place at the time provided with respect to transferees, that *"consideration should be made of the possibility of treatment in PNG; recommendations to move Transferees to Australia for medical treatment can be made only once local options have been considered in Port Moresby."*[652] Although the MERP was an International SOS document, Dr Renshaw's evidence was that it required approval from the DIBP. Evidence tendered

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[646] T 6, p 93 from line 3.
[647] Exhibit C3.1.
[648] T 6, p 93 from line 26.
[649] T 7, p 94 from line 32.
[650] T 7, p 95 from line 11.
[651] T 7, p 88 from line 3.
[652] Exhibit B13.1, p 10, special instructions.

at the inquest from after Mr Khazaei's death also gave the impression that this protocol may have been interpreted on a stricter basis. For example, an email from Ms Gow to Ms Zhai highlighted that "*medical transfers from RPCs to Australia are only to occur in life threatening circumstances and as a last resort"*. IHMS was required to demonstrate that it had thoroughly exhausted offshore treatment options as well as provide comprehensive detail as to why it was not possible for the required treatment to be provided offshore.[653]

417. With respect to the possible locations for transfer, Mr Windsor's evidence was that "*we had to be guided by IHMS in terms of their clinical recommendations about what care was required and where that care could be provided. If that care could be provided in Port Moresby at Pacific International Hospital, then we would've accepted that. If IHMS believed that a requisite – the requisite level of care was not available at PIH and that someone should be transferred to Brisbane or Sydney, then if they put that to us, we would consider it.*" [654]

418. Mr Cahill explained the significance of transfers to Australia during his evidence, which also provides context for the section of the MERP as extracted above. The question put to Mr Cahill and his evidence in that regard, is extracted as follows:

> *"You've spoken of the process for transfers to Australia. That was a significant matter. Why were those processes – for those transfers to Australia, why were they significant?---The Government had made clear what its policy position was, and that position was that people that had been relocated to regional processing centres would not be settled in Australia. Now, that did not remove the responsibility that Australia took to make sure that persons who actually needed medical treatment that was not available locally, they had access to that treatment in Australia. But it did involve judgments. It did involve senior visibility. It did involve a significant cost. And these were matters that were all relevant considerations.*
>
> *And what about the process for transfer: not to Australia, but to Port Moresby. Was that a significant matter for consideration?---Not in my mind, no."*

419. Dr Condon's evidence was that his recommendation, after speaking with Dr Muis on the morning of 26 August 2014, was for Mr Khazaei to be transferred to Brisbane. This evidence was given valuable context and clarification at the inquest by Dr Yap and Mr Gillard, who explained that it was agreed between them that while Brisbane would be the *"gold standard"* of definitive care, the PIH was also an appropriate option. This is further evidenced by the fact that Dr Condon had already begun making enquiries with the PIH to see if it was available to receive Mr Khazaei. He had made no similar enquiries with possible centres of care in Australia.

420. Having regard to the provisions of the MERP, I heard evidence at the inquest to the effect that requests for transfer to Australia would at times lead to significant delays in the approval process, or would not be approved.[655] The evidence also suggested that while Australia was regarded as the gold standard of definitive care, the PIH was a higher level of care which in many cases was appropriate. The closer proximity of

[653] Exhibit C1.9.
[654] T 6, p 97 from line 15.

[655] T 4, p 16 from line 15.

the PIH to Manus Island was also a significant factor when compared to Australia. These factors all required balancing in terms of the most suitable transfer location.

421. Dr Renshaw's evidence was that he had previously referred cases involving cellulitis to the PIH, and adequate care had been provided. There is no doubt that, on the morning of 26 August 2014, the PIH was the closest receiving centre of care, which could be regarded as offering a higher level of care for Mr Khazaei.

422. Unfortunately, by the morning of 26 August 2014, Mr Khazaei was also experiencing septic shock involving acute respiratory depression and hypoxia. As Dr Little said, Mr Khazaei was critically ill and dying. He needed transfer to a critical care facility in Australia. However, the gravity of his clinical presentation was not accurately represented from the clinicians on Manus Island to those involved in organising the transfer. This was a significant flaw which ultimately resulted in Mr Khazaei being transferred to the PIH; a facility which did not, on that particular day, have the equipment or the clinical skill set to manage a patient in Mr Khazaei's acute, critical condition.

423. In its final submission, the PIH asserted that the "old PIH" (i.e the level 5 facility) was not aware of Mr Khazaei's "final deteriorated critical condition", and had accepted his admission on the basis of information provided 48 hours earlier that his condition was "cellulitis with probable sepsis". The PIH submitted that it was denied the opportunity to reconsider acceptance of Mr Khazaei whose deteriorated condition prior to the transfer ideally required an intensivist to cover. The PIH would also have advised that Mr Khazaei should be directly admitted to its ICU where it could have had the necessary specialists on standby, rather than to the emergency department. Alternatively, this would have given the PIH the opportunity to advise that direct transfer to Australia or the Port Moresby General Hospital was preferable.

424. Even if it had been identified that Mr Khazaei needed to be transferred to Australia as opposed to the PIH after he had arrived at Port Moresby, the effect of the evidence given from Mr Gillard was that there was no certainty that this change in destination, and the onward movement itself, would have occurred in a timely manner.[656]

Issue 4 - The adequacy and appropriateness of the medical care provided to Mr Khazaei during the transfer from the Manus Island Regional Processing Centre Clinic to the Pacific International Hospital.

425. No clinical records were produced in relation to Mr Khazaei's care in the ambulance on the way to the airstrip from the Manus Island Regional Processing Centre. Although the evidence suggested that Mr Khazaei remained stable during this trip, there was no documentary evidence to confirm that. This is consistent with the finding that the medical records at the MIRPC clinic were generally inadequate, and that there were inadequate processes in place in August 2014 for clinical staff involved in transferring a patient for the purpose of a medical evacuation.

426. Dr King and Dr Karu gave differing versions about the extent of the handover provided by Dr King. There is no evidence that there were any protocols adopted at the time to guide an effective handover. There seemed to be no process in place to

[656] T 8, p 43 from line 16 onwards.

standardise the information received by the retrieval team. Dr King was trained as an emergency physician, and should have known the information needed by Dr Karu.

427. After hearing from both Dr King and Dr Karu, I conclude that Dr King provided an inadequate handover to Dr Karu. She provided next to no handover. She left it to the retrieval team to figure out Mr Khazaei's condition from the medical records she handed over on the tarmac. This led to Mr Khazaei's true clinical condition not being accurately portrayed to those taking over his care, and was another factor that contributed unfavourably to his clinical course.

428. I accept the evidence of Dr Little and Dr Wenck with respect to the flaws in the retrieval of Mr Khazaei. The lack of communication between those on Manus Island, both Assistance Desks, and the retrieval team, in terms of accurate medical updates, medical advice and overall management of clinical coordination all contributed to the failure to identify that Mr Khazaei was critically unwell and to aggressively manage his deterioration before he entered the aircraft. Having regard to the fact that minimal intervention was possible after the plane was in the air, it was essential for all preparatory measures to be put in place before Mr Khazaei was loaded on to the plane.

429. Dr Karu did not intubate Mr Khazaei before loading him onto the aircraft. The evidence established that the necessary equipment was available for intubation to occur, bringing the matter down to the exercise of clinical judgement. The decision was an exercise of Dr Karu's clinical judgement, and he had the benefit of having been on the tarmac to assess the conditions.

430. In fairness, I also acknowledge that Mr. Khazaei's observations improved during the course of his care under Dr Karu. He was clearly critically ill at the Manus Island airport but arrived at Port Moresby with significantly improved oxygen saturations. He also had a GCS of 12, was responsive to commands and was breathing independently through an oxygen mask.

431. However, based on Mr Khazaei's presentation and observations, and the expert opinion I consider that he should have been intubated and aggressively resuscitated after the handover from Dr King. I accept Dr Wenck's evidence that the fact that intubation did not occur was inadequate in all the circumstances.

432. Dr Karu contacted Dr Condon at the International SOS Assistance Desk to provide an update about Mr Khazaei's condition. Dr Condon did not pass on the relevant clinical update from Dr Karu to the PIH, including that his oxygen saturations were as low as 60% outside the aircraft. If this had been communicated to the PIH it would have assisted the PIH in making the necessary (perhaps improved) preparations for receipt of Mr Khazaei. The clinicians there could have turned their minds to the need to intubate him as soon as he arrived, rather than relying on a further handover. This was another missed opportunity for the critical nature of Mr Khazaei's illness to be communicated, and for intubation to have been effected sooner in the clinical pathway.

433. The evidence confirms that a handover was conducted by the retrieval team to the PIH after Mr Khazaei arrived at the PIH. Although Dr Karu's evidence was that he did not feel very comfortable leaving Mr Khazaei at the PIH, I accept that he had

provided Dr Aina with instructions to the effect that Mr Khazaei required airway management. Based on his knowledge of the PIH at the time and its capacity to handle intubation and ventilation, in the circumstances it was not entirely inappropriate for Dr Karu to expect that the PIH clinicians would implement his instructions.

434. However, I also consider that if Dr Karu was uncertain about the capacity of the receiving medical staff at the PIH to care for Mr Khazaei he could and should have assisted with his intubation at the PIH emergency department.

Issue 5 - The adequacy and appropriateness of the medical care provided to Mr Khazaei while at the Pacific International Hospital, including treatment by the International SOS clinicians stationed at the Pacific International Hospital.

435. The evidence confirmed that, upon arrival at the PIH, Mr Khazaei required urgent and aggressive resuscitation with intubation, ventilation, intravenous fluids and broad-spectrum antibiotics. This was not done. The fact that the sepsis stabilised when he was later admitted to the Mater Hospital in Brisbane suggests that his life might have been saved at this point, although the extent of his hypoxia could not be ascertained.

436. While Dr Little was unable to specify the level of brain damage Mr Khazaei might have already suffered at this time, the evidence of Nurse Miazek was that on arrival at the PIH Mr Khazaei was responsive to voice commands, his pupils were equal and reacting to light and he had a GCS of 12. I accept Dr Wenck's opinion that there was still a possibility of survival once at the PIH because the ultimate outcome was death due to a severe hypoxic event and not sepsis.

437. It is clear on the evidence that the clinicians working at the PIH on 26 August 2014 when Mr Khazaei arrived did not have the necessary clinical skills to deal with Mr Khazaei.

438. This conclusion is supported by the evidence of Dr Wenck, namely that Dr Ronald Galicio had made the wrong diagnosis, and the fact that Mr Khazaei waited for almost two hours at the PIH before he was intubated. He was largely unattended behind a curtain during this time. After that, there was a further two hour delay before Mr Khazaei was transferred to the PIH's version of an ICU. The evidence confirmed that this was no more than a high dependency unit, which had a ventilator with an alarm continuously sounding and an ambu-bag with a tear in it, combined with clinical staff operating that equipment not skilled enough to realise that the equipment was not working correctly.

439. The PIH has submitted[657] that Mr Khazaei's treatment was provided at the hospital's old facility which was a community level hospital (Level 5) under PNG Health Standards. In an acceptance of the limitations in its ability to respond to Mr Khazaei's presentation, the PIH acknowledged that the former ICU was comparable to a high dependency unit in Australia. The PIH moved in May 2017 into a purpose built facility which serves as the only private tertiary hospital in PNG. The PIH is now registered as a level 7 facility with emergency and critical care facilities and has a full time emergency specialist and intensivist.

[657] Letter from the CEO of the PIH dated 21 June 2018.

440. Having regard to Dr Wenck's evidence, I conclude that if Mr Khazaei had been intubated immediately on arrival at the PIH and provided with adequate ventilation support, in addition to intravenous fluids and antibiotics, it is likely that he would have survived. The care that was provided to Mr Khazaei by the clinicians at the PIH on 26 August 2014 was inadequate.

441. I accept the PIH's submission that its capacity to care for Mr Khazaei on 26 August 2014 was significantly affected by the quality of the handover it received, and the fact that Mr Khazaei was not intubated by Dr King on Manus Island or by Dr Karu during the flight from Manus Island.

442. The actions of Ms McIntyre on 26 August 2014 were commendable. While I appreciate that Ms McIntyre would have felt conflicted over this period of time she showed great initiative in the absence of clear direction from her superiors. From the evidence of those who were familiar with the PIH, it appeared that while it should have had the capacity to deal with Mr Khazaei's presentation, it quickly became apparent that it did not. Given that Ms McIntyre worked in the same hospital as the senior PIH clinicians, it would have been awkward in a professional sense for Ms McIntyre to overtly query what they were doing.

443. It was Ms McIntyre's action in independently contacting the International SOS Assistance Desk about her concerns that resulted in Dr Renshaw finally taking decisive action. This led to the unprecedented activation of the International SOS AFP clinical Team. As the family submission notes, it is unfortunate that it took over five hours after Mr Khazaei arrived at the PIH before this team of clinicians was called upon. The early activation of the AFP team after Dr Karu initially reported his concerns about Mr Khazaei's presentation in the PIH emergency department may have made a difference to the overall outcome.

444. While, in the context of the contractual arrangements, there was no process or guideline in place for the AFP Team to be engaged for services outside of the scope of their contract, it is clear that Dr Renshaw's request for the involvement of the AFP Team was resisted by those on duty in the International SOS Assistance Centre on that evening. Their primary concern appeared to be to avoid upsetting the business relationship with the AFP and the PIH, rather than responding to Mr Khazaei's deterioration.

445. The PIH also submitted that consideration must be given to the antecedent condition of Mr Khazaei prior to and during his evacuation to the "old PIH", and the fact that he was not intubated when handed over by Dr Karu. As noted above the PIH also asserted that it was unable to prepare sufficiently for Mr Khazaei's arrival because of the lack of information about the extent of his deterioration, and this influenced the staff who were available to care for Mr Khazaei.

446. Unfortunately, the evidence contained in the written statements of the PIH clinicians could not be tested at the inquest. That evidence defends their actions over the course of the evening of 26 August 2014. Notwithstanding, the inadequacy of the care provided at the PIH on that occasion was confirmed by the independent expert evidence provided by Dr Little and Dr Wenck. Where the evidence between the International SOS AFP Team members and the PIH clinicians differed with regard to

medical care provided, I have preferred the evidence of each member of the International SOS AFP Team who gave oral evidence at the inquest.

447. The expert evidence confirmed that the care provided by the AFP team, particularly the lead clinicians Dr Glied and Mr Miazek, was very impressive and of a standard which would be expected in an Australian hospital. By the time Mr Miazek and Dr Glied arrived, it is clear that the prognosis for Mr Khazaei was very poor as his pupils were already fixed and dilated. He was either in arrest or about to arrest. There were no medical options available to this team to prevent Mr Khazaei's cardiac arrest, or his death. The actions of the AFP team did not contribute to Mr Khazaei's death.

Issue 6 - The adequacy and appropriateness of the document 'Heads of Agreement relating to the provision of health services on Nauru and Manus Island', dated 14 September 2012, particularly with respect to provisions relating to medical evacuation, medical facilities, and medical treatment for sepsis.

448. At the time of Mr Khazaei's death in August 2014, the 'Heads of Agreement' between the DIBP and IHMS had been superseded by the Regional Processing Countries Health Services Contract, which was executed on 29 January 2013. This carried over the standards and requirements from the Heads of Agreement for the provision of health care to transferees at regional processing centres. The 2013 contract confirms that the standard of care to be achieved by IHMS is that which is broadly comparable with health services available within the Australian community.[658]

449. The other relevant provisions of the Regional Processing Countries Health Services Contract are as follows:

> *"26.2* ***Requirement for medical evacuation***
>
> *(a) At the Department's request, the Health Services Manager must obtain, coordinate and ensure the provision of medical evacuation services for Transferees and Recipients. This service must be available on a twenty-four (24) hours a day, seven (7) days a week basis and must be provided within the timeframes specified by the Department at the time of each request.*
>
> *(b) The Health Services Manager must provide emergency observation and treatment of Transferees and Recipients, especially critically ill patients for up to 20 hours, including artificial ventilation, before the Transferee or Recipient is to be evacuated."*
>
> *27.* ***HEALTH CARE ARRANGEMENTS***
>
> *27.1* ***Nauru and Manus Island***
> (a) **General**
> *(i) The Health Services Manager must provide Health Care to Transferees at each Facility by operating and managing the range of health services described in this* ***clause 27.1****.*
>
> *---*

[658] Exhibit C10.3

*(b) **Range of health services***
*(i) The Health Services Manager must operate and manage, in accordance with this **Schedule 2** and **Annexure B** (Onsite Health Services) of this **Schedule 2,** the following services:*

(G) emergency observation and treatment of critically ill Transferees and Recipients"

450. Dr Little and Dr Wenck were both clear in their evidence critiquing the care provided to Mr Khazaei that in Australia the standard of medical care is high. The standard of medical care in PNG was not the same standard as would be expected in Australia. It is important to clarify that any adverse conclusions made in these findings are underpinned by the fact that the medical care was being provided in PNG and not in Australia. I also note that the inquest was not concerned with any question of whether there was any contractual breach. This issue was focused solely on the adequacy and appropriateness of the specified contractual provisions at the time of Mr Khazaei's death.

451. A review conducted in 2010 by the Regional Medical Director for Assistance employed by International SOS, and the Global Assistance Network ('GAN'), was tendered at the inquest.[659] This review provided a description of the health care standards in PNG, and part of that is extracted as follows:

> *"The main challenges to providing healthcare in Papua New Guinea are access to healthcare, staffing shortages, limited funding and a high burden of disease. Health indicators such as infant mortality and life expectancy are remarkably poor. There is also a growing reluctance for medical professionals to work in rural areas - which is exactly where most of the resources are needed. In one recent study of medical undergraduates at the University of Papua New Guinea, none were opting to work in rural areas or in general practice. Accurate public health data is also not available, and so accurate and timely descriptions of disease profiles and their health impact is not possible. The general impression of the national healthcare system is of a crumbling and underfunded system with very little benefit to the rural communities."*[660]

452. In his position at the time as Country Medical Director for PNG, Dr Seevnarain gave evidence of some of the challenges that are commonly faced in providing medical care in PNG. His evidence in that regard is extracted as follows:

> *"PNG has some unique issues that a person in your position must deal with on a regular basis in providing medical services. The first is communications. Is that right?---Correct.*
>
> *And what are the particular communications issues that are problematic in PNG?---We frequently have cellular service that goes out. Frequent – frequently, email communication is not possible. Some circumstances – you could have just cross-cultural communication on an individual level. Yeah. There were some circumstances in which even sat nav phones, or satellite phones, did not work optimally. So it – it was quite a – a myriad of problems, actually.*

[659] Exhibit B13.30.
[660] Exhibit B13.30, p 5.

But, generally, you'd devise methods to overcome those problems for – to achieve effective communication?---Well, I'd say you'd have a number of backups in place. Like, if it was locally, you may switch to a radio, and then, a cell phone, you might opt for a landline or a satellite phone or something like that, but, you know, there would be times in which, maybe, you know, a par – a paramedic would go off into the jungle, and you wouldn't hear from them for a week, and – and you'd wonder what happened.

Travel issues: there's obviously issues about the capacity of the airports to – to operate, particularly in remote locations?---Correct. There's also – further issues with travel include night flying. PNG is typically a very – it's – it's renowned for being a high risk environment to fly in, even during the day. So very few airstrips would allow night landings.

Third issue is the provision of equipment, of quality equipment, is somewhat difficult in PNG. That's right?---Yes. That's correct.

And the fourth issue – and these – this isn't an exhaustive list, but the fourth issue, at least, is staffing and obtaining quality staff to be part of the medical community?---I'd say that is an issue."[661]

453. Dr Little and Dr Wenck's evidence was to the effect that the standard of medical care provided in PNG would vary greatly. I had no evidence before me about the clinical cohort employed at the PIH at the time of Mr Khazaei's death, which was also a public holiday in Port Moresby. In light of the evidence, it is possible that had Mr Khazaei arrived at the PIH on a different shift, he may have received an entirely different, and more adequate, level of care. The PIH submission suggests that a different cohort of staff may have been available to receive Mr Khazaei if it had been alerted to his severe sepsis. While this is plausible, equipment failure may still have been an issue, having regard to the resource intensive maintenance requirements noted by Dr Wenck.

454. The Regional Processing Countries Health Services Contract required the standard of care provided, in a country like PNG, to be broadly comparable to that available in Australia. I accept Dr Little's evidence was that there was 'definitely the opportunity' to provide that standard of care. The fact that International SOS was able to set up a very impressive team of clinicians at the PIH to meet the needs of AFP personnel stationed in PNG demonstrated that the aspirational statement about the standard of health care provided to transferees can be achieved, at least in Port Moresby. This was also demonstrated in the significant enhancement of physical facilities at the MIRPC following Mr Khazaei's death.

455. Counsel Assisting submitted that based on the evidence about the challenges of providing health care in PNG, it was questionable whether the contract provided a flawed premise in relation to the standard of care to be provided. This involves a consideration of the information that was available, before Mr Khazaei's death, about the capacity to provide medical services to a standard broadly comparable with Australian standards in PNG.

[661] T 11, p 73 from line 17.

456. I heard evidence from Dr Paul Douglas, who at the relevant time was the Chief Medical Officer for the DIBP. He gave evidence surrounding the DIBP draft final report completed subsequent to Mr Khazaei's death. He also gave evidence surrounding matters relevant to PNG, and the PIH, and a review he had been involved with before Mr Khazaei's death.

457. The review was written in July 2013, and Dr Douglas confirmed that he contributed to the report. The report was requested to review the scope of services that could be provided at the MIRPC and the Nauru RPC. He confirmed in his evidence that he had visited PNG in June 2013 to look at the scope of services which were available rather than the quality of services. His focus was *"are these services available and can they be provided to the transferees who are in those centres"*. [662]

458. Part of the report defined 'Remote primary health care services', and included some further points about that definition, and this part of the report is extracted as follows:

> *"strongly multidisciplinary extended practice that includes the provision of diagnostic and management advice via tele-health; fly-in and fly-out service models; innovative methods of practice; limited clinical diagnostic support and specialist services; different treatment protocols; primary, secondary and tertiary levels of care that require a higher level of clinical acumen; public health knowledge; cross-cultural understanding; resourcefulness; and increased responsibility.*
>
> *This parallels with Australian remote health care services.*
>
> *The understanding was to ensure client centric services are maximised in terms of what is available on site or within Papua New Guinea going forward."*[663]

459. Dr Douglas' evidence was that the definition of remote primary health care was included as *"there was often some dispute between what the department meant by remote primary healthcare services and what the contractor felt. So that was the reason for this fairly succinct clear definition, so that we're all on the same page about what we meant by remote primary healthcare services."*[664] Dr Douglas agreed that part of the report was essentially ensuring that it was understood that remote primary health care services were maximised, in terms of what was available either on site at MIRPC or within PNG.

460. When asked why it was important to maximise what was available locally, Dr Douglas said that the government policy was that with the regional processing centres "*people would stay within those centres and we should ensure that they could get as much care as they possibly could within those environments, rather than have them move away from those centres, which was against the government policy."*[665]

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662 T 12, p 37 from line 5.
663 Exhibit C6.3, p 1.
664 T 12, p 16 from line 15.
665 T 12, p 16 from line 38.

461. As part of this review, Dr Douglas visited the PIH for only a couple of hours. He did not see any clinicians working, but did view some equipment which was not checked. Dr Douglas clarified that the purpose of the inspection at the PIH was *"---To identify what range of equipment was available in the event that someone may need to be transferred form Manus Island to Port Moresby to access care."*[666] Dr Douglas' evidence was that, as a result of that visit, he was of the opinion that the PIH could provide medical services to the relevant standard. His evidence was as follows:

> *"---in terms of the equipment that was available, some of the quality assurance mechanisms they had in place and were seeking to put in place, the range of specialists available, it was certainly much better than we have seen in many regional and remote areas of Australia. So from what we could glean on that very short visit and on information provided by the hospital, we felt that it was providing a standard that would be a good supplement to a higher level of care than what was available on Manus Island."*[667]

462. When asked about the rostering arrangements for clinical staff at the PIH, Dr Douglas said that while the rostering arrangements were not observed in any way, the review team enquired about the arrangements with the PIH and was ultimately satisfied with the response received from the PIH.[668]

463. Dr Douglas agreed, however, that in terms of the provision of critical care in PNG, choice was limited. The review concluded that *"nearly all services could be provided in Papua New Guinea with a few minor exceptions, such as neurosurgery."*[669] Dr Douglas confirmed in his evidence that as part of the review team, he concurred with this conclusion.[670]

464. Dr Douglas confirmed that the MERP in place at the time of Mr Khazaei's death, specifically requiring consideration of all options in PNG before any transfer out, was consistent with Government policy.[671] Dr Douglas also confirmed that, with respect to Clause 18.1 of the contract, he was not involved in the Statement of Work, or the standards surrounding it. His evidence was that it was possible the provision was drafted without any medical input, at least from within DIBP.[672]

465. The totality of the evidence provided by the relevant IHMS and International SOS clinicians was that the PIH had the capacity to intubate and ventilate patients. This was confirmed by a number of clinicians who were based at the PIH, particularly David Johnson who was the project manager for the AFP Team and very familiar with the PIH[673] and Mr Miazek who saw Mr Khazaei as soon as he arrived at the PIH. There is no evidence that anybody involved in Mr Khazaei's transfer had any knowledge that any of the equipment at the PIH required to manage a person's airway was inoperable or otherwise faulty.

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[666] T 12, p 26 from line 8.
[667] T 12, p 17 from line 19.
[668] T 12, p 30 from line 27.
[669] Exhibit C6.3, p 12.
[670] T 12, p 19 from line 11.
[671] T 12, p 18 from line 44.
[672] T 12, p 19 from line 35.
[673] Exhibit B164, from paragraph 17.

466. Counsel assisting submitted, that considering that those organising the transfer of Mr Khazaei from Manus Island failed to accurately appreciate Mr Khazaei's condition as being one of severe sepsis, it was not unreasonable to expect that the PIH could manage Mr Khazaei's airway, at least temporarily until a transfer to Australia was arranged. The PIH submission noted that it had previously been used as a holding facility for the stabilisation of ISOS patients before a medevac was arranged.

467. As noted above, I agree with the evidence of Dr Little that it was possible to achieve the standard as set out in Clause 18.1 of the contract, and that this was a reasonable standard to be achieved in PNG. The requirement that health care be of a standard broadly comparable with health services available within the Australian community should be maintained in any agreements concerning the provision of health care to persons in regional processing centres.

468. While there were many flaws in Mr Khazaei's clinical course, the inadequacies essentially related to clinical decisions made by key clinical staff involved in Mr Khazaei's care and significant delays in his transfer from Manus Island. I accept the expert evidence that if Mr Khazaei's airway had been adequately managed, either at the Manus Island Clinic, at the stage of retrieval from Momote airport, or immediately upon arrival at the PIH, it is more likely than not that following his admission to the Mater Hospital, his infection would have resolved and he would have survived.

469. Counsel assisting submitted that "at the heart of this case" was the Australian Government policy, and the requirement of the MERP consistent with that policy, that IHMS and International SOS must consider local medical options for transferees in PNG before a transfer to Australia would be considered. Counsel assisting submitted that while the Regional Processing Countries Health Services Contract asserted that the local medical care was to be broadly comparable to that available in Australia, the most that could be said about the medical care available in PNG is that it was extremely variable.

470. Submissions from the Commonwealth acknowledged that while the standard of medical care available in PNG was varied, the Australian Government policy, and the requirement of the MERP to consider local options were not at the heart of this case and there was nothing unreasonable about the local options policy or any valid reason to criticise it. The Commonwealth submitted that Mr Khazaei was at the MIRPC because the legislation enabling his transfer there enacted very significant and high-level government policy. This policy was designed to establish a "no advantage principle" whereby asylum seekers gain no benefit in choosing not to seek protection through established mechanisms.

471. The Commonwealth submitted that the evidence supported the conclusion that, in practice, DIBP officials had never rejected the advice of IHMS that a transferee should be moved to Australia for medical treatment, and in particular within timeframes specified where that occurred.

472. IHMS submitted that the contractual arrangements relating to the provision of health services on Nauru and Manus Island were inadequate and inappropriate because of the vagueness of phrases such as "sufficient to maintain optimal health care for transferees", "broadly comparable", and the "best available in the circumstances".

473. In my view, the specific health care provided to Mr Khazaei at the MIRPC and the PIH can be compared with sufficient precision with the care that would be provided within the Australian community, accepting Dr Little's benchmark of a remote health clinic in Cape York.

474. The Commonwealth's submission also pointed to the high costs of bringing transferees to Australia and warned against conclusions based on Mr Khazaei's unfortunate outcome. However, those costs and the other matters raised by the Commonwealth need to be considered in the context of the overall policy of offshore processing and balanced against the need to preserve the lives of individual asylum seekers.

475. Offshore processing has been implemented to achieve the outcome of reducing the number of irregular maritime arrivals. It has arguably succeeded in that respect and resulted in savings in terms of housing large numbers of asylum seekers in on-shore detention centres. Doctors for Refugees submitted that I should find and recommend that detainees should not be held in offshore processing facilities. This was on the basis that Mr Khazaei's death is unlikely to have occurred if he had been detained in Australia.

476. This inquest was not an inquiry into Australia's offshore processing policy generally or the adequacy of health care in PNG. While I consider the recommendation proposed by Doctors for Refugees to be outside the scope of the inquest, the fact that Mr Khazaei's death occurred in the context of offshore processing cannot be overlooked.

477. I do not accept that the standard of health care envisaged by the Regional Processing Countries Health Services Contract cannot be provided in regional processing countries. I agree with the submission of Doctors for Refugees that the standard is appropriate, but must be adequately funded and supported by appropriate systems and training.

478. The Australian community is entitled to a high level of assurance that the standard of health care the Regional Processing Countries Health Services Contract asserts will be provided on its behalf and be met for all asylum seekers, whether they are cared for in clinics in regional processing countries or transferred to higher levels of care, including hospitals, located in the developing countries where RPCs are located. The community is also entitled to expect that when clinical advice indicates that adequate health care is not able to be provided in regional processing countries there should be no delays in transferring patients to higher levels of care in Australia. Possible mechanisms to obtain that assurance are considered under issue 8 below.

Issue 8 - The adequacy and appropriateness of any steps taken by International Health and Medical Services, International SOS, and the Department of Immigration and Border Protection, to prevent a similar death from occurring in the future.

479. Consideration of issue 8 is connected to my capacity to comment under s.46 of the *Coroners Act*. Section 46 empowers a coroner to comment on matters connected with a death relating to:

    (a) public health and safety;
    (b) the administration of justice; or
    (c) ways to prevent deaths from happening in similar circumstances in the future.

480. This issue has been overtaken to an extent by changes to the operation of regional processing centres since Mr Khazaei's death. As noted above, the PNG Supreme Court found in 2016 that the detention of persons at the MIRPC was unconstitutional. Former detainees were required to vacate the MIRPC and relocate to alternative accommodation after the centre was closed in October 2017.

481. IHMS no longer provides medical services to transferees on Manus Island and these are now provided by the PIH. I have no evidence about the contractual arrangements governing the provision of care to asylum seekers at Lorengau by the PIH. Assuming there is an agreement in place between the PIH and the Department of Home Affairs for the delivery of health services, the matters discussed under this issue will be directly relevant to that contract. The issue is also relevant to other regional processing countries.

482. Separate reviews were conducted by DIBP and IHMS following Mr Khazaei's death and these were tendered at the inquest.[674] Additional evidence was heard from Dr Douglas with respect to the DIBP review, and from Dr Parrish with respect to the IHMS review. Evidence was also heard from these witnesses, as well as Dr Renshaw, about other improvements made since Mr Khazaei's death.

483. The DIBP review was commissioned very soon after Mr Khazaei's death. It was not a full and comprehensive review, or Root Cause Analysis, of the complete circumstances leading up to the death. This was acknowledged by Dr Douglas in his evidence, where he referred to it as a 'desktop review'.[675] The review also proceeded on the basis of certain facts that were contentious.[676]

484. However, the DIBP review identified that communication processes regarding the need for medical transfer and urgency appeared ambiguous and deficient, and also identified concerns regarding the transfer process. Dr Douglas clarified in his evidence that these matters extended to IHMS and International SOS, in addition to DIBP.[677]

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[674] Exhibit C6 (DIBP review); Exhibit B147 (IHMS review).
[675] T 12, p 49 from line 26.
[676] T 12, p 71 from line 1.
[677] T 12, p 7 from line 32; page 8 from line 23.

485. The DIBP review contained a list of eight matters referred to as 'potential improvement actions'[678] The most relevant of those are summarised as follows:

- the introduction of a Medical Emergency Team calling criteria;
- all clinical staff having ready access and ability to comply with therapeutic guidelines and other clinical resources;
- establish clear guidelines for the management of presumed bacterial infections with prompt efficient transfer if patients fail to respond to first line antibiotics within set time frames;
- all clinical staff to have updated training in advanced life support including regular clinical emergency drills;
- ensure concise procedures on management of patients requiring transfer with clear pathways for escalation of concerns if deterioration occurs;
- undertake contract performance review regarding:
  - induction processes and procedures;
  - qualifications, training and skill sets of clinicians;
  - health delivery policies to examine whether adapted to meet the off-shore environment;
  - records and documentation.
- Regular internal and external independent random audits of clinical files to ensure that evidence-based quality care is being provided.

486. Dr Douglas' evidence was that sixteen recommendations from the IHMS and DIBP reviews were incorporated in a Quality Improvement Project headed up by the Assistant Secretary of the Detention Health Branch with clinicians and other staff from IHMS. Most of the recommendations had been finalised by the end of 2014.[679]

487. The IHMS investigation report included a list of matters referred to as 'areas for learning and improvement'.[680] This included, as a suggested action, the introduction of a Medical Emergency Team calling criteria, such as the 'between the flags' protocol based on charts from the NSW Clinical Excellence Commission or equivalent (e.g. Q-ADDS). It also included, among others, the following areas for learning and improvement:

- Consistency in medical records;
- Consistency in handover procedures;
- Ability to accelerate DIBP approval of medical transfers and enhance IHMS staff awareness of this process;
- Ensure the medical equipment available at MIRPC is clear and known to all staff;
- Ensuring clinical files fully reflect the care provided and observations made – the suggested action in this regard was listed as regular internal and external independent random audits of clinical files;
- Improving the criteria to engage advanced life support procedures;

[678] Exhibit C6, p 4-5.
[679] T 12, p 10 from line 26.
[680] Exhibit B147 from pages 14 – 16.

- Clarification of the capability and capacity of hospitals like PIH to care for critically ill patients; and
- Improvement in process for the identification of a deteriorating patient and escalating care appropriately.

488. Dr Parrish provided a detailed supplementary statement which was tendered at the inquest[681] which included further information about the IHMS review, and a further list of matters which overlapped with the list already contained within the review, as follows:

> - *"failure to recognise a deteriorating patient*
> - *The lack of emergency care experience of some PNG and other non-Australian staff, with a lack of clinical knowledge and skills in the management and treatment of a deteriorating patient and knowing when to call for help and inappropriate types and possible numbers of staff rostered on duty*
> - *Poor clinical record keeping*
> - *Failures in communication: at a local Manus Island level within the IHMS clinic and on handover to the air ambulance; with the Sydney Assistance Centre; with receiving care in Port Moresby; and within the Department of Immigration and Border Protection*
> - *A lack of training with respect to the equipment and its capabilities at the Manus clinic*
> - *The inability of PIH to resuscitate a seriously ill patient."*[682]

489. Dr Parrish confirmed the Quality Improvement Project as described by Dr Douglas.[683] He provided a copy of the Quality Improvement Activity by way of a table, which included details of each activity (total of 20), when it was completed, and by whom.[684] It is clear from the evidence that while DIBP did not receive a copy of the IHMS review, and IHMS did not receive a copy of the DIBP review, both parties were at least involved in the Quality Improvement Project.

490. I consider that in all the circumstances, the range of areas for clinical improvement identified as a result of Mr Khazaei's death, and the steps taken across the board, were generally adequate. As there was evidence from a variety of sources with respect to each area of improvement, the most relevant areas are considered below.

<u>Emergent, urgent and semi-urgent medical transfers</u>

491. Dr Parrish's evidence was that as a result of Mr Khazaei's death, IHMS developed improved policies and procedures to ensure that RMM forms specified the information required by the DIBP for approval. However, he also confirmed that there remained difficulties in obtaining approval for medical movements, even in cases deemed by IHMS as urgent.[685] In terms of ensuring that all information required by the DIBP is included on a RMM, Dr Parrish's evidence was that, as part of the quality

[681] Exhibits B12.12 – B12.39.
[682] Exhibit B12.12, paragraph 8.
[683] Exhibit B12.12, paragraphs 9 – 11.
[684] Exhibit B12.13.
[685] Exhibit B12.12, paragraphs 108 – 111.

enhancements following Mr Khazaei's death IHMS wanted to put in place agreed timeframes by which they would get advice of approvals. [686]

492. Dr Renshaw's evidence was that, together with the DIBP, an improved communication/approval process has been implemented relating to urgent and semi-urgent offshore processing centre medical transfers. A copy of that process was tendered at the inquest.[687] The process defines urgent and semi-urgent transfers and clarifies who is to specify the timeframe in any given case (i.e. if a transfer is marked as urgent, IHMS is to specify the timeframe). The process makes it clear that, if no response is received by DIBP with respect to an approval within the specified time frame, IHMS is to escalate the matter. The mobile telephone numbers for the relevant DIBP officers are included on the form, including the Assistant Secretary and the First Assistant Secretary. The process has been integrated into an updated MERP, which came into effect as of October 2015.[688]

493. In terms of changes made within the DIBP regarding the approval of urgent and semi-urgent requests for medical transfers, Dr Douglas' evidence was as follows:

> *".. what happens with emergency uplifts is basically a very short process these days. Within Papua New Guinea, the director, as I said, of offshore operations centre now has that overall authority to move people immediately, does not have to go back to the chain of command or the FAS-type level that used to be there. If coming back to Australia, it does require that FAS-level input still."*[689]

494. Dr Douglas was asked if there had been any clarification within the DIBP, as to what the terms 'urgent' and 'emergency' actually meant. He acknowledged that when he initially reviewed the process it was confusing. However, he considered that the officers on the ground understood the terms, and IHMS were now much more specific about timeframes in which they wanted people moved. "Emergency" means someone needs to move within 24 hours. "Urgent" cases are those requiring movement within 48 to 72 hours, where they have some time to actually engage and involve other people, and "semi-urgent" cases are to 14 days. There was ready capacity to communicate changes in circumstances to the Department by telephone.

495. Dr Douglas' evidence was that the Chief Medical Officer is now involved in certain transfers but that no clinician from DIBP needs to get involved in emergency transfers. If IHMS says a person needs to move off and they need a medevac that is arranged administratively. However, he said that "medical contestability" was involved in urgent transfers, where people need to move within the next two to five days. Those cases are referred to the Chief Medical Officer and then a transitory persons committee at First Assistant Secretary level looks at facilitating transport if care cannot be provided on site. This committee was established because of the government directive that people should not come to Australia if the service can be provided elsewhere.[690]

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686 T 13, p 27 from line 42.
687 Exhibit B13.20.
688 Exhibit B13.21.
689 T 12, p 20 from line 21.
690 T 12, p 69 from line 1.

496. Dr Little's evidence on the transfer process was that it should be led and approved 'clinician to clinician'.[691] However, Dr Douglas' outlined the administrative factors which need to be met by the DIBP, as follows:

> *"---Now in terms of the administrative approval of that process – we are working with two immigration departments in two separate countries, and we are looking at having to work through those processes over and above what that kind of care will mean. That's why the approval process with the actual removal sits with the administrative staff who have that delegation responsibility within the department. It's again why in the emergency situation we've tried to short-fuse that now – if you like – so that we can give in-principle support for movement very quickly and get that person moving under the direction of IHMS. But if it's not an emergency-type situation, then we have now asked that contestability so that we've got enough information to say "Have other things been exhausted?" to provide that care in Papua New Guinea.*
>
> *And that change with respect to situations where there's an emergency, whatever particular definition might be applied to what's an emergency, is a reflection that the process is, in those circumstances, far better handled simply between clinicians; is that right firstly?---Well, it's – no, it's not. It's – in fact, the clinicians don't get involved with anyone in those circumstances. Basically, the clinicians contact the administrative staff within the department to make that move; the department gives them in-principle support and then the clinicians contact the hospital who they need to move this person to. So it's basically making it work very similar to what it would do in an Australian context, but making sure there's that approval process ticked off very early in that process."*[692]

497. Dr Parrish was asked about what, if any, steps had been taken to ensure the consistent flow of information between the IHMS Assistance desk, and the International SOS Assistance desk, in Sydney. His evidence was that the flow of information has improved as they sit next to each other in the same centre.[693]

498. The evidence confirmed substantial improvements and clarity to the transfer process. I am satisfied that these improvements go some way to ensuring that a flawed transfer process such as that involving Mr Khazaei would be prevented from occurring in the future.

499. Counsel assisting submitted that the process for medical transfer of a patient should be led by clinicians and ultimately approved by clinicians, and that administrative requirements that need to be met should be met in parallel with the clinical approval process. It was submitted that there should be no requirement for the administrative aspects to be dealt with or satisfied before clinical approval is given.

500. IHMS agreed that the process for medical transfer of a patient should be led by clinicians and approved by clinicians.

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[691] T 15, p 80 from line 38.
[692] T 12, p 74 from line 42.
[693] T 13, p 31 from line 16.

501. Submissions on behalf of the Commonwealth noted that persons in RPCs are subject to the laws and requirements of a sovereign nation. The MIRPC was under the control of an administrator appointed under the PNG *Migration Act,* whose authorisation was required before a person could leave the centre. The Commonwealth submitted that in emergency cases these processes could be accelerated. There are many non-urgent transfers involving movements for more routine tests and these cases require persons with expertise in non-clinical matters, such as the requirements of the foreign government, before a person can move within PNG.

502. However, I have also had regard to the capacity for medevacs to be arranged without the need for a protracted approval process within the Department of Home Affairs, and the need to negotiate approval processes within sovereign nations. I also consider that clinical considerations should prevail over all other factors when a recommendation for urgent medical movement is made.

Recommendation

1. **I recommend that the Department of Home Affairs develop and implement a written policy relating to the process for medical transfers requiring Australian Government approval which has, as an overriding consideration, the health and well-being of persons transferred to regional processing countries. Under that policy the approval process for medical transfers should be led by persons located in regional processing countries with clinical training in emergency medicine.**

503. Counsel assisting also made recommendations in relation to the content of documentation used to support a recommendation for movement so that a set form, or check list, is completed, which includes information such as observations from the previous 4-6 hours and medication regimes. This would form the basis of the RMM made to the IHMS Assistance Desk. This was generally supported by IHMS and International SOS. However, it was also submitted on their behalf that the checklist should be completed by the treating clinician at the MIRPC and provided to the IHMS Assistance Centre. This information would then be used to liaise with International SOS and compile a RMM form to be sent to DIBP annexing the clinical information.

Recommendation

2. **I recommend that**

a) When an onsite clinician contacts the International SOS Assistance desk to request the medical transfer of a patient, there should be a set form, or check list, which the International SOS clinician is required to complete, including information such as:

- **An accurate picture of the clinical condition of the patient including full observations from the previous 4-6 hours, medication regimes, the effectiveness of those regimes, and physical presentation of the patient;**
- **An accurate reflection of the advice provided to the onsite clinician by International SOS;**

- **An accurate reflection of the timeframe within which the onsite clinician requires the patient to be transferred, including any flight options or transfer options that are known to the onsite clinician.**

b) The set form or checklist, as completed by the International SOS clinician, should form the basis of, or become an attachment to, the RMM made to the IHMS Assistance desk and sent to DIBP.

Medical records and other clinical documentation

504. Dr Parrish confirmed that he generally accepted the observations of Dr Little and Dr Wenck regarding the failings in documentation in this case.[694] Since Mr Khazaei's death, the following improvements were implemented to improve the quality of medical records and clinical documentation[695]:

    - Colour coded observation charts were introduced to help IHMS staff know when a patient's observations fall within a range of concern or a range of more acute concern – commonly referred to as the 'between the flags' approach;
    - Fluid balance charts were updated and improved to ensure consistency ;
    - A Practice Guideline for the clinical management of sepsis was introduced, providing an outline as to how to identify when a patient is developing a sepsis related infection and what steps should be taken in response;
    - To minimise the prospect of there being inconsistency in medical records, computer access was confirmed in all clinical rooms within the clinic at MIRPC, as far as space constraints allow;
    - The existing guidelines relating to handovers for the end of each shift, and also for handover when a patient is transferred out of IHMS care, were reviewed.

505. As Dr Little said in his evidence there are often written processes to guide health care but whether those processes are followed is another matter. Dr Parrish said in his evidence that training had been implemented to ensure staff were aware of the necessary documents, and to ensure the use of those documents. It was confirmed in the evidence by Dr Renshaw that posters had been generated regarding the availability of this documentation, to inform clinicians on how to use the documents and to ensure knowledge of the existence of those documents.[696] I also heard evidence from Dr Parrish regarding the various e-Learning tools in place for ongoing education of IHMS staff.[697]

506. I am satisfied that improvements were made to the state of the clinical documentation and guidelines in place at the MIRPC.

[694] T 13, p 13 from line 25.
[695] Each individual document is found within exhibit B12.13 by clicking on the relevant document within the table; discussion on each also included in exhibit B13 from paragraph 47.
[696] Exhibit B13, paragraph 51 & 57.
[697] Exhibit B12.12, paragraph 45 onwards; Exhibits B12.21 – B12.23.

Available facilities on Manus Island

507. Dr Renshaw confirmed that IHMS had reinforced to all staff that reliance should be placed on the Australian Therapeutic Guidelines in the administration of antibiotics. Dr Renshaw accepted that *"adherence to those guidelines ensures IHMS provides consistent medical services to a standard acceptable within Australia."*[698] Dr Renshaw provided reassurance in his evidence that a copy of the Australian Therapeutic Guidelines is available on site in hard copy, as well as electronically. Staff induction training includes education about the use and accessibility of guidelines.

508. Dr Renshaw confirmed that, after Mr Khazaei's death, an additional antibiotic was made available at the MIRPC, namely IV ciprofloxacin. This was added to include an additional broad spectrum intravenous antibiotic option, in particular for serious Gram negative infections.[699] While Dr Wenck said that Meropenum was the drug he would have used in Mr Khazaei's case, he spoke positively of ciprofloxacin as working with this type of infection.[700]

509. Dr Parrish accepted that, in August 2014, the capability and capacity of the MIRPC clinic was limited. He conceded that it was a *"sub-optimal environment from which to practice medicine, but the best available in Manus Island at the time."*[701] The evidence established that after Mr Khazaei's death, the MIRPC clinic was redeveloped significantly. A purpose built medical facility was established, which reduced the number of transfers off Manus Island to the PIH.[702] Specifically addressing one of the concerns of Dr Little, the clinic had onsite radiology facilities. Noting that the standard of care primarily relates to the personnel providing it, Dr Douglas was satisfied the equipment at the new clinic would support the level of care practised in regional and remote Australia.

510. I am satisfied that the facilities at the clinic on Manus Island were substantially improved following Mr Khazaei's death. However, those facilities are no longer operational and the PIH has assumed responsibility for the provision of medical services to transferees housed at Lorengau.

Auditing

511. Dr Parrish's evidence was that IHMS engages in an auditing process to ensure compliance with its operating standards. There are a variety of audits that occur on a daily, monthly, quarterly and semi-annual basis. Importantly, on a semi-annual basis, the MIRPC clinic underwent an audit, alternating between an audit conducted by IHMS's Sydney office, and an audit conducted by the site's Health Services Manager. In response to the audit, the auditor would create an action plan listing matters the clinic needed to address.[703]

[698] Exhibit B13, paragraph 53.
[699] Exhibit B13, paragraph 72.
[700] T 16, p 33 from line 10.
[701] Exhibit B12.12, paragraph 91.
[702] Exhibit B12.12, paragraphs 90 – 92.
[703] Exhibit B12.12, paragraphs 73 – 77.

512. Dr Parrish's evidence was that on shore clinics and the clinic at Christmas Island are accredited to the Royal Australian College of General Practitioners (RACGP) standards for health care and immigration detention. He confirmed that, at the time he was in the Regional Medical Director role, there was an aspiration for the clinics on Manus Island and Nauru to have similar accreditation. This was an ongoing discussion with the DIBP when he left the role.[704]

513. In terms of the situation regarding audits for off shore clinics, and how often they occur, Dr Parrish's evidence was that IHMS had an automated audit tool built into its electronic medical record. This would compare a number of criteria against whether that has been achieved for individual patients, for example were persons up to date with the mental health screening program and vaccinations. One of the quality improvement program actions was to put in place a standard clinical audit tool such as the RACGP's tool. When Dr Parrish left in 2015 that was an outstanding action item as it was awaiting input from the DIBP.[705]

514. Dr Douglas was asked about this in his evidence, but was unsure about the tool Dr Parrish was referring to. He said that the audit tool that DIBP was talking about as part of the improvement project was in terms of the audit tool that IHMS were independently using, as that was the only clinical audit that was happening.[706] There was some confusion between the DIBP and IHMS about the implementation of the clinical audit tool, and given that this tool would ensure that areas surrounding emergency management, observations and the use of guidelines such as the Australian Therapeutic Guidelines are audited, I make the following recommendations.

Recommendations

3. **I recommend that clinics providing medical services to asylum seekers in regional processing countries be accredited to a level equivalent to the Royal Australian College of General Practitioners Standards for health services in Australian immigration detention centres.**

4. **I recommend that the Department of Home Affairs and IHMS (and other service providers) collaborate, in conjunction with the Royal Australian College of General Practitioners, to ensure the implementation of a standard clinical audit tool at all regional processing country clinics.**

515. The 2015 review into the clinic on Manus Island conducted by the DIBP also recommended that an extended site visit be undertaken as a matter of priority and include both medical and nursing reviews. Dr Douglas' evidence in this regard is extracted as follows:

> *"that was a clear recommendation, in my written report on this occasion, that we spend time to actually do that. For your information, in terms of my role in the migration health side and the pre-migration processes, we have a very robust order process where we, overseas, go and visit our panel of physicians undertaking our*

[704] T 13, p 21 from line 11.
[705] T 13, p 22 from line 16.
[706] T 12, p 78 from line 2.

work. We observe them doing their work. We watch them undertake those physical examinations. We do the same for our onshore contractor who does that – the medical – visa medical services. We actually go and physically observe them do that work. And the recommendation here is saying that we should implement a similar sort of process within detention areas."[707]

516. Clause 43 of the Regional Processing Countries Health Services Contract enabled an audit to be conducted at any time by DIBP or its nominee. The Department was able to appoint an independent person to assist in or conduct audits on the Department's behalf. Among other things these audits could include:

(a) the Health Services Manager's operational or clinical practices and procedures as they relate to this Contract, including security procedures;
(b) the efficiency, safety and quality of the Health Services Manager's operations in relation to the provision of the Health Services;

Recommendations

5. Consistent with the outcomes of the 2015 review of the Manus Island clinic conducted by the DIBP, I recommend that as part of clinical audit processes, the Department of Home Affairs allocate sufficient and extended time to observe the clinical practices and processes at clinics providing health care to persons transferred to offshore processing countries. This will entail a medical record or inventory audit, as well as physically sitting in on medical consultations. On at least an annual basis, clinical audits should be undertaken in conjunction with the Royal Australian College of General Practitioners.

Capacity of the PIH

517. Dr Little's evidence was that the PIH would have been a reasonable receiving hospital had Mr Khazaei been transferred a day sooner (25 August 2014), as his condition had not deteriorated to a critical degree at that stage.[708] This related to the variability in the care that could be provided by the PIH, and called into question its capacity to provide critical or intensive care.

518. Mr Khazaei's death prompted reviews of the capacity of the PIH by both the DIBP and IHMS. The DIBP review was produced by Dr Douglas.[709] It was clearly stated in that report that IHMS had recommended the PIH be reviewed on the basis that it may not have provided a standard of care broadly commensurate with Australia.[710] Dr Douglas gave evidence that this was an internal DIBP report, and was not provided to IHMS or International SOS.

[707] T 12, p13
[708] T 15, p 78 from line 11.
[709] Exhibit C6.2.
[710] Exhibit C6.2, p 2; T 12, p 111 from line 28.

519. The DIBP review noted that the PIH had new facilities that are *"very impressive"* and *"provide a very high standard of facility in Port Moresby."*[711] It has a 65 bed capacity which has attained ISO accreditation (International Standards Organisation). The review noted that *"on face value the service appears to be very comprehensive of a reasonable standard, forging links with international partners including Australia."*[712]

520. Dr Douglas was asked whether he observed any of the clinicians in practice at the PIH during his visit there in 2015. While he had not observed clinicians directly, others from the Independent Health Advisory Panel, independent of the DIBP, had and were complimentary about the standards and the way that they performed in that regard.[713]

521. Dr Douglas said that he was impressed by the facilities and what the PIH had available. He said that they had very good processes to recruit and credential overseas medically-trained specialists. They were able to perform very complex procedures which had not been available in PNG before, and they were doing it at a very high standard. A number of Australian qualified specialists go and work within the facility. Dr Douglas also thought that the fact that the PIH had ISO accreditation meant that independent reviewers had come in and said that they were adhering to guidelines for equipment maintenance.

522. Dr Parrish confirmed that the other outstanding matter from the Quality Improvement Project, at least at the time when he left the role in May 2015, was the review of the health care capability of the PIH.[714] Dr Renshaw produced a copy of that review to the inquest.[715] That review noted, among other things, that *"access to specialist services in Port Moresby, while limited in a metropolitan Australian context, allow many routine admissions to be managed in the country. Present levels of critical care coverage however fall below Australian standards in terms of training, equipment availability/reliability and, most importantly, rapid access to specialist consultant input after-hours."*[716]

523. The review confirmed that the ICU offered no more than a high dependency unit, and would not be comparable to an Australian ICU due to training and staffing arrangements, especially after hours.[717]

524. As noted above, in May 2017 the PIH moved into a purpose built facility which serves as the only private tertiary hospital in PNG. The PIH is now registered as a level 7 facility with emergency and critical care facilities and a full time emergency specialist and intensivist. The PIH now offers tertiary services including an interventional cardiac catheterisation laboratory and cardiac surgery.

525. I have limited jurisdiction to make recommendations with respect to the PIH or its operations. I am somewhat assured by the advice from the PIH that it is now registered as a level 7 facility, with an ICU broadly comparable to an Australian standard. I also assume that it is providing services to asylum seekers under a

[711] Exhibit C6.2, p 8.
[712] Exhibit C6.2, p 9.
[713] T 12, p 14 from line 22.
[714] T 13, p 12 from line 8.
[715] Exhibit B13.27.
[716] Exhibit B13.27, p 4.
[717] Exhibit B13.27, p 8; T 4, p 56 from line 35.

contract with the Commonwealth which would enable regular auditing of its capacity to provide clinical care.

526. I would anticipate that the revised transfer process should see any critically ill patients from regional processing centres sent expeditiously to an ICU as a matter of course. However, as in Mr Khazaei's case it is inevitable that this is not always going to be possible or will not occur for a range of reasons, including the requirement to exhaust local options for medical care before a transfer is considered. There is a need for local critical care capacity close to persons transferred to regional processing countries.

Recommendations

6. **I recommend that the Department of Home Affairs ensure that critical care units are established in close proximity to the centres where persons who have been transferred to regional processing countries are required to live, consistent with the Standards for the Provision of Quality Emergency Medical Care developed by the Australasian College for Emergency Medicine.**

7. **I recommend that the critical and intensive care capacity of the Pacific International Hospital be benchmarked against relevant Australian standards developed by the College of Intensive Care Medicine and the Australasian College for Emergency Medicine.**

Quality of clinical staff

527. Dr Parrish gave evidence about the credentialing process for IHMS clinical staff.[718] He also spoke of the challenges and clinical issues in this respect. He noted that IHMS required clinicians to practice medicine in a very remote environment where there is backup available by telephone but there are limited resources. He said that Manus Island was *"remarkably remote"* and there were some tropical medicine challenges there that some clinicians were not aware of. There were other challenges of working in Manus Island – in rudimentary accommodation on a hot tropical humid island in a medical centre which was very basic in the early days and with patients who could be challenging, demanding and aggressive. [719]

528. I accept that a formal process was subsequently put in place for the activation of the International SOS AFP Team, such that the Team could be activated significantly faster than in Mr Khazaei's case.[720] This broadened the scope of the quality of clinical staff available in PNG and the formal process was included in the updated MERP.[721]

529. Dr Little gave evidence of the importance and usefulness of telemedicine such that specialists are available over the phone for on-the-go clinical advice and support.[722] Dr Renshaw's evidence was that telemedicine options had not been implemented at the time of Mr Khazaei's death.[723] Dr Parrish said that with the new and improved

[718] Exhibit B12.12, paragraph 22 onwards.
[719] T 13, p 15 from line 15.
[720] Exhibit B12.14.
[721] T 11, p 12.
[722] T 15, p 48 from line 30.
[723] T 4, p 69 from line 6.

clinic at MIRPC the number of visiting specialists had increased, and bandwidth had improved such that more telemedicine options were able to be provided. These measures would go some way to providing additional support for the clinical staff in such a remote area.

530. I have found that there were clearly inadequate medical decisions made during Mr Khazaei's clinical course. As is the case in clinics and hospitals in Queensland, it is one matter to be satisfied of a clinician's formal qualifications and experience, but it is an entirely different matter to be satisfied about their competency in practice.

531. The sum of the evidence confirmed that the remoteness of Manus Island, and the working conditions on the Island, were a barrier to the attraction and retention of sufficiently competent staff. The clinicians were not required to be registered in Australia, so were not the subject of the requirements of that registration process. The PNG Medical Board was responsible for the registration of all clinicians employed at the MIRPC. I have no jurisdiction to make any recommendations in relation to those processes.

532. Dr Parrish confirmed that IHMS was required to provide residents of the MIRPC with health services broadly comparable with health services available within the Australian community[724] He confirmed in his evidence that, it followed, there was a requirement for IHMS to hire practitioners who were also of that standard.[725] However, the inadequacies in clinical care identified in Mr Khazaei's case have demonstrated that this may not be practical to achieve in such a remote location.

533. I accept the submission of Doctors for Refugees that the failures evident in the system (both human and systemic) that caused or contributed to Mr Khazaei's death should not be sheeted home to a select number of medical practitioners or staff. I also agree that the failures of those staff should be recognised as the manifestation of the overall system, which was flawed and demonstrated a lack of capacity to meet Mr Khazaei's immediate health needs.

Independent investigation of deaths

534. As noted above under the discussion of coronial jurisdiction, the death of an asylum seeker transferred from Australia to a regional processing country would not ordinarily be the subject of an inquest. This inquest only proceeded because Mr Khazaei was in custody when he died in Queensland after he was transferred to Australia from the PIH. In the absence of the considerable co-operation I received from IHMS and International SOS it would not have been possible to investigate the care received by Mr Khazaei in PNG, as I would have been unable to require overseas witnesses to give evidence at the inquest. The withdrawal of the PIH from the inquest demonstrated these challenges.

535. All Australian governments have accepted that deaths in custody should be the subject of a mandatory inquest. Consistent with the acceptance of the RCIADIC recommendations, this reflects the responsibility of the State to protect and care for people it incarcerates, the vulnerability of people deprived of the ability to care for

[724] Exhibit B12.12, paragraph 66.
[725] T 13, p 16 from line 25.

themselves, the need to ensure the natural suspicion of the deceased's family is allayed and public confidence in state institutions is maintained.

536. Similarly, the Law Council of Australia's June 2013 Policy Statement on Principles Applying to the Detention of Asylum Seekers includes the following principle:

> ***12. Policy and practice in the detention of asylum seekers should be accountable, transparent, and subject to independent monitoring.***
>
> …….
>
> *(d) Whenever the death or disappearance of a person occurs during his or her detention, an inquiry into the cause of death or disappearance should be held by an independent authority, with the findings to be made available upon request, unless doing so would jeopardize an ongoing criminal investigation. Similar inquiries should be conducted into credible allegations of acts of torture and other cruel, inhuman treatment or punishment committed in detention. When such inquiries are conducted, the State should fund legal representation of interested persons if they are unable to do so.*

537. Having regard to the accepted principle that the deaths of persons held in detention should be subject to an independent investigation, I make the following recommendation.

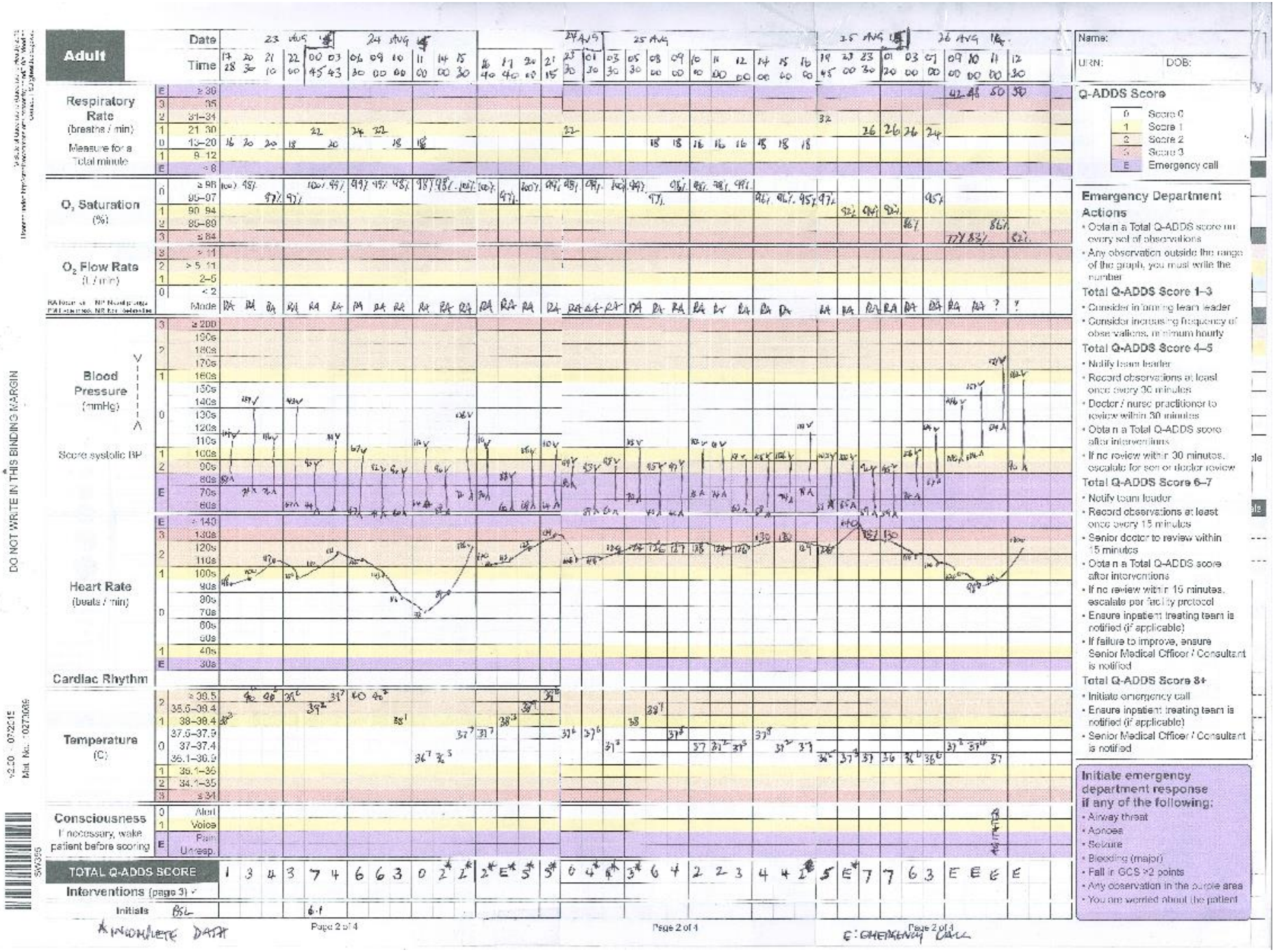
Recommendation

8. I recommend that the Commonwealth Attorney-General establish and fund a statutory framework to ensure the independent judicial investigation of the deaths of asylum seekers transferred by the Australian Government to regional processing countries. This may require that deceased persons are transferred back to Australia to ensure appropriate post-mortem examinations can be carried out. Amendments to contractual arrangements to require service providers to co-operate with such investigations would also be required.

538. I close the inquest.

Terry Ryan
State Coroner
30 July 2018

Appendix 1 – Q-ADDS Manus Island Observations



Appendix 2 – Q-ADDS Retrival Observations 26 August 2014