QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Faysal Ishak AHMED**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2016/5444
DELIVERED ON:	5 September 2025
DELIVERED AT:	Brisbane
HEARING DATE(s):	21 January 2022, 18-19 March 2024 Final written submissions 30 June 2025.
FINDINGS OF:	T Ryan, State Coroner
CATCHWORDS:	Coroners: Death in custody; asylum seeker detained in Regional Processing Centre, fall, cause of fall, hyponatraemia, sickle cell trait, whether preventable, medical transfer from regional processing centre, health screening.

REPRESENTATION:

Counsel Assisting:	Ms S Lane
Ahmed Family:	Mr A Hartnett and Ms C DeMarco I/B National Justice Project
Commonwealth of Australia:	Mr A Berger KC and Ms K Slack I/B Australian Government Solicitor
International Health and Medical Services ('IHMS') Pty Ltd, International SOS (Australia) Pty Ltd:	Ms R O'Gorman KC I/B Moray & Agnew Lawyers
Royal Brisbane and Women's Hospital:	Mr A Dahms

INTRODUCTION

1. Faysal Ishak Ahmed (Faysal) was 30 years of age at the time of his death in December 2016.[1] He was a Sudanese refugee accommodated at the Manus Island Regional Processing Centre (RPC). He had arrived at the RPC in October 2013.

2. Under Administrative Arrangements which gave effect to a Memorandum of Understanding between the governments of Australia and Papua New Guinea, contracted service providers were responsible for the provision of health services at the RPC. The RPC was under the control of the Chief Migration Officer of the PNG Immigration and Citizenship Service Authority.

3. In January 2013, the Department of Home Affairs[2] entered into a contract for the provision of health services at the RPC with International Health and Medical Services Pty Ltd (IMHS). The contract was for the provision of services such as health screening, health advice and referral to secondary and tertiary health services. IHMS was required to provide health care which was to a level, standard and timeliness broadly comparable with that available in the Australian community, taking into account the particular health needs of transferees.

4. Between March 2014 and December 2016, Faysal presented to the Island clinic on many occasions with complaints of abdominal pain for which he was diagnosed with gastritis and reflux. He also suffered from painful sores in his mouth, flank pain, sinusitis, chest discomfort, shortness of breath and arm discomfort. He was treated for each condition at the Island clinic. Numerous tests were conducted. Although the tests did not suggest he was suffering from a serious underlying medical condition, Faysal believed he had a significant illness.

5. On 22 December 2016, Faysal was staying temporarily in Voluntary Support Respite Accommodation inside the RPC. He was captured on internal CCTV falling backwards down stairs in a secure area. The video footage appeared to indicate that he lost or was losing consciousness shortly before the fall. As a result, he suffered a life-threatening head injury. He was transferred to the medical clinic where he was assessed as being severely ill with neurological impairment. He required intubation. Overnight, he continued to show signs of worsening neurological deterioration and circulatory impairment. It was determined that urgent air evacuation to Australia was necessary, which took place on 23 December 2016.

6. Upon admission to the Royal Brisbane and Women's Hospital (RBWH) on 23 December 2016, Faysal was found to have diffuse brain swelling, a probable bleed into the brain stem, and lack of blood flow to the brain. His neurological impairment was assessed as severe, and he had evidence of multi-organ failure. He passed away on 24 December 2016.

7. At autopsy, Faysal was found to have sustained a traumatic brain injury when he fell down the stairs. He was also suffering from acute pneumonia and multi-organ failure secondary to the head injury. Signs of sickle cell disease were noted, with several features at autopsy unable to be explained.

8. As Faysal was in immigration detention at the time he died an inquest was mandatory.

[1] Faysal's passport recorded his date of birth as 4 March 1986. Migration records noted his date of birth as 20 June 1989.
[2] As it is now known.

PERSONAL HISTORY

9. Faysal was born on 4 March 1986 in Sudan. He arrived at the 'migration zone' at Christmas Island on 13 September 2013, where he was classified as an 'unlawful non-citizen' as he did not hold an Australian visa.[3] He was also deemed an 'unauthorised maritime arrival' and was not accompanied by any family members.

10. As Faysal was an unlawful non-citizen in an excised offshore place, pursuant to s189(3) of the *Migration Act,* he was considered to be detained and taken to a 'regional processing country' as soon as reasonably practicable.[4]

11. Faysal was transferred to Manus Island RPC on 9 October 2013.[5] Upon arrival, he advised that he had two brothers and a sister residing in a Sudan UNICEF camp. It was reported that his mother was deceased. He spoke Arabic but did speak some English.[6] There was little other information available about his history prior to his arrival at the RPC.

12. On 9 November 2015, Faysal was notified that he had been determined to be a refugee through the Papua New Guinea Government's refugee determination process.[7] As such, he continued to reside at Manus Island RPC as a refugee.

13. I extend my condolences to Faysal's family and friends. Faysal's family continue to reside in Sudan and were helped in the inquest by the pro bono resources of the National Justice Project. Due to the unrest in Sudan, the family were not able to connect remotely to the court, and were unable to be present for the inquest. However, the family provided the following message to the court:

> *The impact of Faysal's death on his family has been enormous, and their pain is ongoing. Faysal was deeply loved by his family and is missed every day. Faysal's brother, Suliman, said on behalf of the family, "After his death, the family lost all hope in life, and they always think about their deceased son, and from there, they lost everything, and their wishes were destroyed."*

THE INQUEST

14. 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]

15. 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.

16. A pre-inquest conference was held in this matter on 21 January 2022. A hearing plan was circulated with the proposed inquest issues.

17. On 19 April 2023, after the court received further expert reports, an updated hearing plan was circulated to those given leave to appear and submissions were invited in respect of the proposed issues and witnesses.

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[3] Ex D1, [9]
[4] Ex D1, [10]
[5] Ex B15.32, pg. 244; Ex D1, [16]
[6] Ex B15.32, pg. 14
[7] Ex D1, [20]
[8] *R v South London Coroner; Ex parte Thompson* (1982) 126 S.J. 625

18. After submissions were received on the proposed inquest issues (apart from the mandatory findings required by s 45 of the *Coroners Act 2003*) the following issues were settled for consideration at the inquest:

    1. 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;

    2. Based on the expert evidence, what was the likely cause of Mr Ishak Ahmed's collapse on 22 December 2022 and could that have been identified and prevented prior to Mr Ishak Ahmed's collapse; and

    3. The adequacy and appropriateness of the treatment and care provided to Mr Ishak Ahmed at the Manus Island Regional Processing Centre immediately following his collapse on 22 December 2016, and whether any avoidable delay was outcome changing.

THE EVIDENCE

Autopsy Examination

19. Dr Philip Storey performed an external and full internal post-mortem examination on 27 December 2016 at Forensic Pathology and Coronial Services in Brisbane.[9] A neuropathological examination of the brain, as well as a number of histology and toxicology tests, CT scan, biochemical, microbiological and virological analysis were also undertaken. Dr Storey also viewed CCTV footage of Faysal's fall at the RPC. Dr Storey's report was provided to the Court on 5 October 2018.

20. Dr Storey concluded that the cause of Faysal's death was acute pneumonia and multi organ failure, secondary to a traumatic brain injury, secondary to a fall.[10] There were no signs that he had been subject to any ante-mortem forces other than those involved in the fall down the stairs, and the various medical interventions administered subsequently.

21. Dr Storey noted that the neuropathological examination of the brain did not identify any pre-existing lesions that may have predisposed Faysal to syncope or collapse. Duret haemorrhages (small areas of bleeding) were present in the brain, as well as herniation of the brain stem through the base of the skull. Such changes were irreversible and associated with progressive neurological deterioration and 'brain death.'[11]

22. Dr Storey said that following the brain injury, multi-organ failure developed, although it was noted that the features, namely hypotension, pancytopaenia with marked anaemia, were difficult to explain.[12] It was noted that cerebral salt wasting syndrome could have accompanied the acute head injury, which leads to low serum sodium and low systemic blood pressure. It was unknown whether diabetes, which can flow from head injuries, was active.

23. Haemorrhages in the lungs were also present at autopsy. It was noted that the overall changes in the lungs were complex with prominent acute bronchopneumonia in all sections, changes of aspiration, oedema, and features of acute lung injury. The constellation of changes in the lungs were consistent with and reflected the result of Faysal's severe traumatic brain injury, rather than any of the changes having been present prior to his final presentation.[13]

[9] Ex A2
[10] Ex A2, pg. 23
[11] Ex A2, pg. 20
[12] Ex A2, pg. 21
[13] Ex A2, pg. 21

24. Examination of blood held at the RBWH showed that Faysal had the sickle cell trait (SCT). No evidence of schistosomes, for which Faysal had previously been treated was found.[14] Further, there were no specific changes to the heart to identify whether he may have been at risk of having an abnormal heart rhythm.

25. In Dr Storey's opinion, the findings at autopsy did not show any specific features that could be listed as contributors to the death, in particular the specific cause of his fall.[15] The CCTV footage suggested that there was a loss of motor control only seconds before the incident, the possible causes of which could include:

- a simple faint (which cannot be detected at autopsy);
- epilepsy (although there was no history of same); or
- vascular related pathology (although no changes were noted at autopsy).

26. Dr Storey further noted that there were some features of the death which were difficult to explain, including an enlarged spleen and whether the presence of SCT may have contributed. Systemic hypoxia and multi-organ failure coupled with recent air travel may have impacted the SCT, precipitating a sickle cell disease like crisis. It was recommended that an expert be asked to consider this aspect of Faysal's death.

27. Dr Storey also recommended that a review be undertaken by an independent primary physician in relation to Faysal's medical treatment and complaints in the years prior to his death, and whether the concerns raised were addressed appropriately.

28. Rural Generalist General Practitioner, Dr Anthony Brown, formerly the Executive Director of Medical Services for the Torres and Cape Hospital and Health Service[16], was asked to consider the appropriateness of the overall care and treatment provided to Faysal while he was held at Manus Island RPC and at the RBWH.

29. Dr Brown considered each of the categories of health care related presentations and appropriateness of the subsequent management. A summary of his opinions relevant to the issues considered at the inquest is below.

Mental health related consultations

30. Having considered the mental health assessments undertaken with respect to Faysal, Dr Brown considered his mental health was managed appropriately.[17] Further, it was unlikely he suffered from any significant mental illness or that a mental illness contributed to his death.

Headache related consultations

31. Having considered the findings at autopsy, Dr Brown noted there was no nervous system anatomical pathology which would have caused chronic headaches. Accordingly, it did not appear that headaches were a symptom of an underlying pathology, which required further treatment.[18]

Upper gastrointestinal related consultations

32. Dr Brown noted that during the course of Faysal's medical treatments his Liver Function Tests remained mildly deranged, although no chronic liver condition was found at autopsy.

[14] Ex A2, pg. 23
[15] Ex A2, pg. 23
[16] Now Chief Executive, South West Hospital and Health Service.
[17] Ex. G2, pg. 2
[18] Ex. G2, pg. 2

33. Dr Brown agreed with Dr Stylian's explanation that a chronic recurrent haemolytic anaemia was the likely cause of Faysal's deranged liver function tests.

Jaundice related consultations

34. Having considered Faysal's previous presentations, Dr Brown noted that a cause of his altered liver function tests was discovered. However, it was unlikely to have played any part in his final demise. He accepted the view of Dr Stylian that the jaundice could have been related to haemolytic anaemia.[19]

Chest pain related consultations

35. Dr Brown was of the view that the assessments of Faysal's complaints of shortness of breath and chest pain did not give cause for a suspicion as to cardiac arrythmias and there was no need to investigate further.[20] He noted that there was no significant cardiac or coronary artery abnormalities identified at autopsy.

36. Dr Brown considered the healthcare staff who assessed Faysal did not have any reason to believe he suffered from cardiac arrythmias and there was no need to investigate this further. Dr Brown suggested that it would be appropriate to request a Cardiologist to assess the ECGs carried out.[21]

Management following fall

37. Having considered the statements provided by those who assisted Faysal immediately after his fall on Manus Island, Dr Brown considered the initial management and transfer from the site of accident to the resuscitation room was appropriate. He noted that, *'the clinical handover, the formulation of a resuscitation team and planning were well performed.'*[22] Dr Brown highlighted the great difficulty in managing acutely unwell patients in a low resource environment like Manus Island RPC.

38. In Dr Brown's view, the decision to place early intraosseous access and intubate early was appropriate. The delay in placing an ETT caused by the severe trismus was unavoidable and the mitigating strategies appropriate.[23]

39. Dr Brown queried why neurological advice was not sought for five hours.[24] He noted that there was a '*significant delay'* in having Faysal transferred to the RBWH with the retrieval team not arriving until 2:15pm on 23 December 2016. While Dr Brown was cognisant of the difficulties and complexities associated with retrieving patients from remote areas, such as Manus Island RPC, in his view the delay in the arrival of the retrieval team may have impacted on the outcome in this case.[25]

Care provided at RBWH

40. Having considered the medical notes and relevant statements, Dr Brown agreed with the management of Faysal at the RBWH.[26] Given his presentation upon arrival, further care was futile and he agreed with the decision to withdraw therapy.

[19] Ex G2, pg. 4
[20] Ex G2, pg. 5
[21] Ex G2, pg. 5
[22] Ex G2, pg. 6
[23] Ex G2, pg. 6
[24] Ex G2, pg. 6
[25] Ex G2, pg. 6
[26] Ex G2, pg. 6

Haematologist

41. Haematologist and Medical Oncologist, Dr Steven Stylian, provided an expert report after being asked to consider Faysal's care and treatment while accommodated at Manus Island RPC. He specifically considered whether sickle cell disease should have been suspected and further testing conducted.[27]

42. After noting Faysal's haemoglobin level on entry to Manus Island on 13 September 2013 (175) and the results of the tests performed at the RBWH, Dr Stylian considered Faysal likely suffered from SCT.[28]

43. This diagnosis was retrospective, given the results of the haemoglobin electrophoresis, which showed haemoglobin S (HbS) of 39.4% and confirmed the diagnosis. Dr Stylian noted that SCT is not usually associated with any symptoms, and would not generally explain the multitude of symptoms Faysal presented with on Manus Island.

44. However, Dr Stylian noted there are rare forms of SCT that have symptoms similar to Sickle Cell Disease, which may explain some of the symptoms experienced as mild intermittent sickling episodes.[29] It was also possible that Faysal suffered from Pyruvate kinase deficiency, an inherited metabolic disorder which affects the survival of red blood cells and results in haemolytic anaemia. It can coexist with SCT. Faysal's recurrent episodes of jaundice resulting from proven haemolytic anaemia would be explained by this condition.

45. Sickle cell formation in SCT leading to vascular occlusion has been recognised to occur during a high fever, dehydration, and under conditions of significant hypoxia, such as air travel. In Faysal's case, Dr Stylian noted there was likely an element of sickling as there was significant hypoxia following the fall, where there was severe trismus with intubation exacerbated by aspiration pneumonia.[30]

46. While Dr Stylian considered there was likely to have been an element of sickling in this case, there were many other potent factors leading to Faysal's death, such as brain injury, aspiration pneumonia and ischaemic hepatitis.

47. Accordingly, the sickling would have been a minor contributor and not a main cause of Faysal's death.[31] Dr Stylian said it is likely Faysal suffered from a sudden collapse secondary to cardiac arrythmia, which is a known complication of SCT.[32] Apart from maintaining adequate hydration and avoiding undue physical exertion, the complication of sudden death in SCT patients is not preventable.[33]

48. Dr Stylian agreed the medical care provided to Faysal was reasonable.[34] He noted that SCT is usually a symptomless entity, and in itself would not explain the complex array of symptoms Faysal presented with. Accordingly, there would have not been a strong basis to suspect the diagnosis or carry out further diagnostic testing.[35]

49. In Dr Stylian's view, Faysal's presentation of symptoms over time would have presented a '*challenging diagnostic as well as therapeutic scenario'* for any doctor.[36] Dr Stylian noted that the presentation of recurrent jaundice could have been further pursued, and may have led to an earlier diagnosis of SCT or another cause for haemolytic anaemia. However, he said this may not have altered the subsequent events.[37]

[27] Ex A3
[28] Ex A3, pg. 3
[29] Ex A3, pg. 3
[30] Ex A3, pg. 4
[31] Ex A3, pg. 5
[32] Ex A3, pg. 4
[33] Ex A3, pg. 4
[34] Ex A3, pg. 5
[35] Ex A3, pg. 5
[36] Ex A3, pg. 5
[37] Ex A3, pg. 5

Emergency Physician

50. Dr Mark Little, Emergency Physician and Clinical Toxicologist, was provided with the relevant medical evidence including the reports of Dr Brown and Dr Stylian.

51. Dr Little's written opinion[38] noted that Faysal's complaints in 2016 revolved around chest and epigastric pain, shortness of breath, coughing and nasal congestion. His examinations were unremarkable, and observations within normal limits. He had numerous blood tests, ECGs and X-rays with most showing no abnormality.

52. Dr Little referred to the July 2016 investigations performed to investigate clinical evidence of jaundice, which showed results consistent with haemolytic anaemia, with a macrocytosis. No clear cause was established and this was an intermittent issue. He queried whether some of the symptoms Faysal described plus intermittent jaundice and an enlarged spleen on post-mortem suggest some intermittent sickling was occurring. Dr Little said that:

> *The abnormal bloods in July 2016, showing haemolysis, would have been a clue to look for potentially rarer diagnoses in Mr Ishak Ahmed, however I do acknowledge that there would have been limited resources in Manus Island to do so.*

53. Dr Little was asked to comment on the appropriateness of the treatment and care provided to Faysal following the fall on 22 December 2016, until the time of his medical evacuation, whether there was a delay in seeking neurological advice, and whether this was significant and potentially outcome changing. It was his opinion Faysal suffered a medical event that led to his fall.

> *It is my opinion that Faysal suffered a seizure due to the severe hyponatraemia and this led to his fall. While the trismus and urinary incontinence may be because of the fall, I believe this may be due to a seizure. The ongoing jaw trismus could well have indicated ongoing seizure activity.*
>
> *With all the electrolytes being low, and a fall in haemoglobin levels, Dr Isacowitz did not think Faysal was dehydrated or fluid overloaded. I believe the possible cause of this could be the 'syndrome of inappropriate secretion of antidiuretic hormone' (or SIADH). ADH is a hormone that maintains your water balance in the body and secreted by the posterior pituitary gland. Excess ADH causes water retention and would result in a fall in electrolyte and haemoglobin levels due to dilution effects. There are many causes, but they include malignancy, medications, neurological illness and injuries (including head trauma), and infectious diseases. I do not believe the head injury suffered less than 1 hour earlier is the cause of this.*
>
> *I am uncertain as to the cause if Faysal had SIADH.*
>
> *Another cause of the abnormal biochemistry results is polydipsia (i.e. drinking too much water). Sometimes this can occur due to a psychological/psychiatric illness and is known as psychogenic polydipsia.*
>
> *Dr Stylian, in his opinion, felt a cardiac arrythmia could have caused this collapse. I agree it is an important possibility, however this would not have explained his blood test abnormalities. I believe this is less likely.*

[38] Ex G3

Conclusions on inquest issues

Findings required by s. 45 of the Coroners Act

54. I am required to find, as far as possible, the medical cause of the death, who the deceased person was and when, where, and how he came by his death. As a result of considering all the evidence, including the material contained in the exhibits, I make the following findings:

Identity of the deceased –	Faysal Ishak Ahmed.
How he died –	Faysal was accommodated for over three years at the Manus Island Regional Processing Centre under an agreement between the Australian and PNG governments. After falling down stairs at the Regional Processing Centre on 22 December 2016 Faysal suffered severe neurological impairment, circulatory impairment and multi-organ failure. He was transferred to the Royal Brisbane and Women's Hospital where it was decided to withdraw treatment as he could not be revived. The cause of the fall could not be determined.
Place of death –	Royal Brisbane and Women's Hospital, Herston
Date of death–	24 December 2016.
Cause of death –	1(a). Acute pneumonia and multi-organ failure, *due to, or as a consequence of*; 1(b)**.** Traumatic brain injury, *due to, or as a consequence of* 1(c). Fall.

Based on the expert evidence, what was the likely cause of Mr Ishak Ahmed's collapse on 22 December 2022 and could that have been identified and prevented prior to Mr Ishak Ahmed's collapse.

55. Faysal was a Sudanese refugee who had been brought to the Manus Island RPC in October 2013. During his three years at the RPC, he presented to the medical centre on many occasions with complaints of abdominal pain, painful sores in his mouth, flank pain, sinusitis, chest discomfort, shortness of breath and arm discomfort.

56. Faysal was treated for each condition at the RPC clinic. Investigations were carried out to determine the underlying cause of his symptoms. The investigations did not find any significant clinical abnormalities or any explanation for the raft of symptoms Faysal reported. Faysal maintained that he had a significant illness, and made a number of complaints alleging that he was not receiving adequate health care. In December 2016, 33 refugees from the Sudanese Community on Manus Island RPC put in writing their concerns about Faysal's health, which they described as getting 'worse and worse'.[39]

57. At just after 10:15pm on 22 December 2016, Faysal was captured on internal CCTV falling backwards down a short flight of stairs in the Voluntary Respite Support Accommodation area of the RPC. Faysal was alone when he fell. The medical experts who viewed the CCTV, including the forensic pathologist, were of the view that Faysal lost or was losing consciousness shortly before he fell.

[39] Ex B15.32, pg. 241; Ex B23.3

58. As a result of the fall, Faysal struck his head on the concrete floor at the bottom of the stairs and suffered a life-threatening head injury. He was taken to the medical clinic where he was assessed as being severely ill with neurological impairment. He required intubation and ventilation.

59. Despite these interventions, Faysal showed signs of worsening neurological deterioration and circulatory impairment. At 11:40pm, the Senior Medical Officer contacted International SOS and requested a medical evacuation as soon as possible.

60. Faysal was evacuated to Australia and admitted to the RBWH Emergency Department just after 11:20pm on 23 December 2016. A CT scan showed diffuse brain swelling, a probable bleed into the brain stem, and lack of blood flow into the brain. On admission to the Intensive Care Unit, Faysal's neurological impairments were assessed as severe, and he had evidence of multi-organ failure. Despite interventions his condition was not survivable. Support was withdrawn, and Faysal died at 1:20pm on 24 December 2016.

61. Forensic pathologist, Dr Storey, found Faysal had sustained a traumatic brain injury when he fell down the stairs. He was also suffering from acute pneumonia and multi-organ failure secondary to this head injury.

62. After performing the autopsy, reviewing Faysal's medical records and watching the CCTV footage of the fall, Dr Storey was unable to identify a specific cause for Faysal's fall. He was unable to find any pathological features during his investigations which could be listed as contributors to Faysal's death.

63. However, Dr Storey noted that blood taken at the RBWH showed that Faysal had SCT. After reviewing Faysal's extensive medical presentations on Manus Island, which he described as a "*bewildering array of symptoms over the few years he was in detention,*" Dr Storey recommended that a specialist clinical haematologist consider Faysal's medical history to determine whether his symptoms could be related to the finding of SCT. Dr Storey also recommended that a primary care physician review the records to assess whether the treatment that Faysal received in the years preceding his death was adequate.

64. Expert reports were obtained from three medical witnesses, Dr Brown, Dr Stylian and Dr Little. Each gave evidence during the inquest. Each of the experts provided an opinion as to the cause of Faysal's collapse, based on his medical records and their viewing of the CCTV footage.

65. Dr Stylian's view was that Faysal likely suffered from a sudden collapse secondary to cardiac arrythmia, a known complication of SCT. He said that, apart from maintaining adequate hydration and avoiding undue physical exertion, the complication of sudden death in SCT patients was not preventable, and the mechanism linking SCT with sudden death is not well understood.

66. Professor Grantham also indicated that Faysal's ECGs had been normal and there was no indication for a diagnosis of a cardiac condition as a cause for collapse.[40]

67. Dr Brown agreed that, from his review of Faysal's medical records, there was no evidence that Faysal had any predilection to, or had suffered any prior cardiac arrythmia. Therefore, there was no way for his treating practitioners to have predicted or prevented the fall.

68. Dr Little proposed an alternative explanation for Faysal's fall, based on the low sodium level shown in a blood sample taken from Faysal around 45 minutes after his collapse. Dr Little considered that Faysal suffered a seizure due to severe hyponatraemia which led to his fall.

[40] Ex D17, pg. 5

69. Dr Little said that the observations of jaw trismus by the paramedic who attended Faysal, as well as the doctors in the medical clinic could have indicated ongoing seizure activity. Dr Little's evidence was that he was aware that a blood test conducted the day before Faysal's collapse showed Faysal's sodium levels were within the normal range. However, he confirmed a seizure could still occur where the severe hyponatraemia had an acute onset, as appeared to be the case with Faysal.

70. Dr Little was not able to identify the cause of the hyponatraemia, but suggested it could have been due to excess production of antidiuretic hormone (SIADH), drinking an excessive amount of water, or both. He said it would have been difficult to diagnose SIADH on Manus Island given Faysal's fluctuating symptoms. Blood test results showing normal sodium levels would have precluded SIADH. Dr Little also agreed that there was nothing to suggest to treating practitioners that Faysal had polydipsia.

71. At the inquest, Dr Brown and Dr Stylian were both asked to comment on Dr Little's view of the cause of Faysal's fall. Dr Brown agreed that, where there was a sodium level as low as 117mmol/L, and there were no cardiac abnormalities found at autopsy, seizure due to severe hyponatraemia was a more likely cause of Faysal's collapse than a cardiac arrythmia.

72. Dr Stylian disagreed with Dr Little's explanation for the severe hyponatraemia. He said:

> *The tests that were done the day prior were completely normal. The hyponatremia, so the low sodium level, occurred after the collapse. It was not there before the collapse. And there's a…there's a reason for that. When you get haemolysis, fluid inside the red cells gets released and the – and the sodium level becomes diluted in your blood. So there's a reason why the sodium went down. Haemolysis would be the cause.*
> *…*
>
> *And therefore, low sodium causing a seizure is probably not the scenario that would explain his collapse*

73. All three doctors agreed, given that Faysal had had a number of blood tests over his time at the RPC detention, none of which indicated low sodium levels, it would not have been possible for his treating team to have predicted or prevented a seizure caused by severe hyponatraemia.

Medical treatment

74. Dr Brown's report comprehensively reviewed all of Faysal's presentations over the course of his detention. He confirmed in his evidence that each of his symptoms was managed appropriately. In his view, none of the presenting symptoms had any relationship with the cause of Faysal's death.

75. Dr Little advised that, overall, the treatment and care of Faysal by health staff on Manus Island was appropriate. He noted that:

    a. The health staff were operating in a remote location with limited resources.
    b. Assessing Faysal would have been difficult, with no clear objective abnormality on examination or investigation, with the overlying issue of a person living on Manus Island and unable to travel to Australia as a refugee.
    c. Initial investigations and treatments were reasonable and reassuring, but there appeared to be an anchoring bias to previous clinical diagnoses. Faysal's condition with repeated presentations was put down to anxiety and/or psychosomatic problems.
    d. Abnormal bloods in July 2016, showing haemolysis, would have been a clue to look for potentially rarer diagnoses. However, there would have been limited resources in Manus Island to do so.

76. With respect to Faysal's conviction that he had a serious illness, and his repeated visits to the medical centre, Dr Little noted that "*In emergency medicine management, there is always the clinical concern with repeated presentation of the same presentation that an undiagnosed condition exists."*

77. Dr Little was concerned that, at Manus Island, there did not appear to be any system in place by which Faysal's condition could be reviewed by a specialist clinician. Such a step may have led to further investigations and possibly another diagnosis. However, Dr Little acknowledged in his evidence that it was difficult to say whether escalation to a specialist general physician, for example, would have prevented the outcome in Faysal's case.

78. Dr Brown and Dr Little were asked in cross-examination whether, given Faysal's symptomology, and the fact that sickle cell anaemia is more prevalent in people of African descent, they would have expected Faysal's treating practitioners to consider and test for sickle cell anaemia.

79. While both doctors acknowledged that it might have been a condition which should have been considered, Dr Brown thought it was reasonable for there to have been no consideration of the possibility of sickle cell anaemia in circumstances where Faysal's symptoms were relatively mild and intermittent.

80. Dr Little was unsure what capacity there was at Manus Island for testing of this kind. In his view, Faysal should have been referred to a specialist. Both doctors deferred to Dr Stylian when asked questions about appropriate tests for sickle cell anaemia and appropriate treatments.

Sickle cell trait

81. In his evidence, Dr Stylian explained that sickle cell disease, or sickle cell anaemia, was an inherited blood disorder which affected the red blood cells and could cause anaemia and episodes of pain due to blocked blood vessels (known as sickling).

82. Dr Stylian noted that, having considered Faysal's haemoglobin level upon entry to Manus Island on 13 September 2013, and the results of the tests performed at the RBWH, Faysal likely carried the SCT, rather than having sickle cell disease.

83. Dr Stylian explained that, unlike sickle cell disease, the SCT is not usually associated with any symptoms and would not generally explain the array of symptoms Faysal presented with on Manus Island. However, Dr Stylian did note that there are rare forms of SCT that have symptoms that are similar to Sickle Cell disease, which may explain some of the symptoms Faysal experienced as mild intermittent sickling episodes.

84. In Dr Stylian's view, there would have not been a strong basis for Faysal's treating practitioners to suspect that Faysal had the SCT or to carry out further diagnostic testing. Faysal's symptoms over time would have presented a 'challenging diagnostic' for any doctor. While noting that the presentation of recurrent jaundice could have been further pursued, which may have led to an earlier diagnosis of SCT, this may not have altered subsequent events.

85. With respect to jaundice, Dr Stylian said Faysal's bloodwork and the symptoms of recurrent jaundice were consistent with a diagnosis of chronic recurrent haemolytic anaemia, a blood disorder in which the red blood cells die faster than they can be replaced by the body. Dr Stylian was not able to determine the exact cause of the haemolytic anaemia, although he suggested that possible causes were a dominant form of HbS (haemoglobin S) and a co-existing Pyruvate kinase deficiency, which can co-exist with SCT.

86. Dr Stylian was also asked whether Faysal's SCT may have affected his condition after his fall. Dr Stylian explained that, following Faysal's fall, there would have been significant hypoxia - inadequate oxygen delivery to the tissues. Dr Stylian confirmed that although those with SCT are usually non-symptomatic, under certain conditions, such as where the person has a high fever, is dehydrated, or where there is significant hypoxia, an episode of sickling can occur. Dr Stylian thought it likely that there was an element of sickling in Faysal's case. However, this would have been unlikely to have contributed to his death in the circumstances.

87. After considering the competing expert evidence, I am unable to determine whether the most likely cause of Faysal's collapse was a sudden cardiac arrythmia, as posited by Dr Stylian or a seizure caused by acute severe hyponatremia as proposed by Dr Little.

88. I also agree with the expert evidence that either condition could not have been identified and prevented prior to Faysal's collapse.

89. On the basis of the expert opinions of Dr Brown, Dr Stylian and Dr Little, I conclude that the medical treatment and care given to Faysal at the Manus Island medical clinic was, overall, appropriate and sufficient.

90. As Dr Little suggested, referring Faysal to a specialist physician may have led to further investigations, and a possible diagnosis of ither his haemolytic anaemia, the SCT, or both.

91. However, the expert evidence was that neither of these conditions fully explained Faysal's raft of symptoms. Nor would these diagnoses and any treatment for these conditions have been likely to prevent his collapse on the stairs and consequent head injury.

The adequacy and appropriateness of the treatment and care provided to Mr Ishak Ahmed at the Manus Island Regional Processing Centre Immediately following his collapse on 22 December 2016, and whether any avoidable delay was outcome changing.

Emergency Treatment and Evacuation

92. The circumstances of Faysal's emergency treatment and evacuation were set out in detail in a significant number of statements, documents and audio files which were before the court.

93. Mr Gillard, Director of Medical and Security Assistance, Air Transport Services, IHMS, provided a detailed timeline of the IHMS's engagement with International SOS to organise Faysal's medical evacuation.

94. Mr Whitfield, Commander of the Offshore Operational Co-ordination Branch of the former Department of Immigration and Border Protection, outlined the role of the Department in the process of the medical evacuation. The Department also provided other relevant documents, including correspondence, quotes and reviews relevant to the transfer.

95. On the basis of this evidence, a timeline of Faysal's emergency treatment and evacuation, and the significant points in the treatment and evacuation process was established. The times referred to are Australian Eastern Standard time, which is the time that events occurred both on Manus Island and in Brisbane.

96. At 10:17pm on 22 December 2016, a code blue for assistance was called by Wilson Security following Faysal's fall. CCTV shows that Faysal had been pacing back and forth at the top of the stairs which led from the deck to the lounge area, had clutched his chest, and then fallen backwards down the stairs, landing on the back of his head on the concrete landing.

97. Paramedics attended and observed Faysal lying at the base of a set of concrete steps. The security guards present advised that Faysal had fallen down the steps, which were approximately 1m in height.

98. Faysal was unconscious and unresponsive and had been incontinent of urine. He was breathing, and paramedics were able to feel a carotid pulse. Due to the mechanism of injury, he was treated with spinal precautions.

99. Faysal had an increased respiration rate and his heart rate was 126 beats per minute. His GCS was 5 and there was no verbal response, although he was responding to painful stimuli. There was significant vomit around the mouth and lips and a haematoma to the occipital region of the skull with minimal blood loss. Faysal had significant trismus of the jaw, which was unable to be opened.

100. Faysal was mobilised using a cervical collar and transferred using spinal precautions to the clinic via stretcher. Monitoring continued during the transfer. Due to the short distance, an ambulance was not used.

101. During the transfer, the IHMS medical team arrived, including emergency medical officer, Dr Isacowitz, Senior Medical Officer, Dr Stockil and health services manager – Registered Nurse Pantry. Primary Health care nurse Sebulon was already in the clinic when Faysal arrived.

102. Dr Stockil noted that the team's priority was to stabilise Faysal who was in a critical condition. He and Dr Isacowitz had intubated Faysal by 11:28pm. Faysal was observed to be responding well to ventilation and by 11:46pm oxygenation was recorded at 100%.

103. It was obvious to the clinical team that Faysal had sustained severe head injuries that required a higher level of care than could be provided at Manus Island RPC. Dr Stockil and Dr Isacowitz agreed that Faysal was stable enough at that stage for Dr Stockil to leave the clinic to make arrangements for Faysal's urgent transfer.

104. At 11:40pm, Dr Stockil contacted the International SOS Global Assistance Centre (GAC) and advised of Faysal's fall and suspected intracerebral bleed. He advised that a CT scan was needed and likely neurosurgery. A medical evacuation was requested as soon as possible.

105. At 00:10am on 23 December 2016, X-Rays were taken of Faysal's skull, cervical spine and chest using a mobile X-Ray machine. The imaging revealed that there was no fracture of the skull and no bony injury observed on the cervical spine. The chest x-ray was compared to an earlier one taken on 21 December 2016, and it was noted that there was patchy infiltration present which was not on the earlier image. Dr Isacowitz was of the view that this suggested it was likely there had been aspiration.

106. By 00:46am, International SOS had requested two air ambulance providers, LifeFlight and Tropicair, to provide their availability to conduct the evacuation and a quote for the service.

107. By 3:20am, correspondence and phone calls between IHMS and the Department had resulted in an 'in principle' approval for the evacuation with an estimated cost of $130K to $150K.

108. Mr Whitfield noted that the usual way IHMS obtained Australian Government approval for a transfer was by sending a Request for Medical Movement to the Department accompanied by a quote for the cost of the evacuation.

109. At 3:22am, IHMS sent the Request for Medical Movement for Faysal to the Department. At this stage, discussions were still continuing with LifeFlight and Tropicair to determine which service could provide a timely evacuation.

110. At 3:30 am, Dr Isacowitz contacted IHMS Medical Director, Dr Souvannavong, to discuss Faysal's condition. It was agreed that his prognosis was 'very poor' given the neurological injuries present. It was decided that some input from a neurosurgeon would be of assistance, with arrangements to be made by Dr Souvannavong likely with the RBWH.

111. GAC sought medical updates from the clinic at 3:30 and 4:00am and were advised that Faysal was stable but in a critical condition. GAC were attempting to seek assistance from a neurosurgeon to provide some guidance as to Faysal's ongoing management. Dr Isacowitz advised Dr Stockil that Faysal had been largely stable throughout the evening but had recently started to deteriorate. His pupils were observed to be larger, fixed and dilated.

112. At 4:16am, IHMS provided the Department with a quote for the evacuation by Tropicair.

113. At 4:20 am, Dr Isacowitz was contacted by the GAC advising they had an on-call neurosurgeon, Dr Sophia, on the phone from the RBWH. Having been provided the clinical overview, Dr Sophia suggested that an anti-seizure drug be sourced and administered before he arrived at RBWH.

114. I accept Dr Isacowitz's explanation for the delay in consulting with Dr Sophia. He acknowledged that, with the benefit of hindsight, he could have requested other staff members to coordinate obtaining an earlier neurosurgical opinion. However, his understandable focus was on attempting to stabilise Faysal in his critical state and to establish a cause for his collapse. I also accept that there was no delay on the part of Border Force officials in approving the requests to source neurological advice.

115. At 4:32am, IHMS was formally advised that Faysal's transfer had been approved. At 5:03am International SOS contacted Tropicair to "activate the mission". Tropicair was, at that stage, scheduled to leave Port Moresby for Manus Island at 10:00am Manus Island time. International SOS made attempts throughout the morning to move the departure time forward.

116. At 5:30am, following advice from Dr Sophia, Dr Isacowitz administered mannitol. It did not appear to have any impact. A loading dose of Phenytoin was also administered. At around 10:30am, Faysal became hemodynamically unstable. No myocardial events were noted, however, sedation with Propofol and Midazolam was ceased immediately. Intravenous adrenalin was commenced in addition to be a noradrenalin intravenous infusion drip. Faysal continued to be maintained on a noradrenaline infusion. A femoral pulse was unable to be detected at this time.

117. At 13:30 a further call from GAC was received advising that an intensive care consultant from RBWH was on the line to provide advice. Advice as to the insertion of a central line and an arterial line to assist in the administration of inotropes during the flight was received. It was thought at this time that the outcome for Faysal was quite poor.

118. Following delays at Port Moresby, the Tropicair team arrived at Momote Airport on Manus Island at around 2:15pm. A detailed handover was provided by Dr Isacowitz to the anaesthetist and flight nurse. Assistance was provided to transfer Faysal to the ambulance, and he was taken to the airport for evacuation. The aircraft departed Manus Island for Port Moresby at 4:07pm.

119. At 4:53pm the aircraft arrived in Port Moresby for refuelling and departed for Brisbane airport at 7:18pm. The aircraft landed in Brisbane at 10:36pm, and Faysal arrived at the RBWH at 00:30 on 24 December 2016. This was around 26 hours after he sustained his head injury.

120. During the course of the transfer, Faysal required a significant amount of noradrenaline and was unstable with poor gas exchange. His pupils remained fixed and unreactive.

121. Mr Gillard's evidence considered whether there had been any avoidable delays in Faysal's evacuation process. Mr Gillard noted the following circumstances which affected the evacuation:

- As night landings were not possible at Momote Airport, the earliest that Faysal could have been evacuated was at first light at approximately 0600 on 23 December 2016.
- A clinic handover of the patient, rather than an airport handover, added time (approximately three hours) to the evacuation. It was determined that a clinic handover was best in Faysal's circumstances.
- Tropicair is International SOS's preferred service provider as it is based in Papua New Guinea, and does not require permits or visas for its crew to operate. A foreign service such as LifeFlight does. Tropicair's timeframes for evacuations were often more reliable as they did not experience delays associated with obtaining the necessary permits and approvals from PNG.
- Tropicair was delayed in departing from Port Moresby because of a delay to an earlier mission.
- By the time International SOS were advised by Tropicair of the unexpected delay in the mission attributable to a delay in the earlier mission, the window of opportunity to launch the LifeFlight mission had closed.

122. Dr Brown and Dr Little were asked to consider the post fall treatment and care provided to Faysal at Manus Island.

123. Dr Brown was of the view that the initial management and transfer from the site of accident to the resuscitation room was appropriate. He noted that, *'the clinical handover, the formulation of a resuscitation team and planning were well performed'.*[41] In forming this view, Dr Brown highlighted that there is great difficulty in managing acutely unwell patients in a low resource environment like Manus Island. Dr Little also expressed the view that the initial management of Faysal's injuries was sound.

124. Dr Brown and Dr Little raised concerns about the apparent delay by IHMS doctors in obtaining advice from a neurosurgeon. They considered that, while there is no recommended time within which such advice should be sought, it should be obtained as soon as possible, and five hours after the injury represented a delay. This criticism was made with the benefit of hindsight, and the context for the delay was established in the evidence of Dr Isacowitz.

125. Both experts also considered that there had been a significant delay in transferring Faysal to the RBWH. Dr Brown pointed to the delay in the arrival of the Tropicair team to Manus Island, while Dr Little questioned whether the "*convoluted process of approvals*" required had delayed the transfer.

126. However, both doctors agreed that neither the delay in consulting the neurosurgeon nor any delay in the evacuation was outcome changing in Faysal's case. Dr Little noted it was recognised as soon as one hour after Faysal's fall that his prognosis was poor. In Dr Little's view, even if Faysal could have been evacuated to Brisbane sooner, he would not have survived the significant head injury he sustained on Manus Island. Dr Little's evidence was that Faysal would not have survived his injuries if he had been cared for in a rural hospital within 100km of Cairns.

127. I agree with the opinions of Dr Brown and Dr Little that the treatment provided to Faysal at the RBWH was appropriate and sufficient.

[41] Ex G2, pg. 6

128. I am satisfied that the treatment provided to Faysal at the MIRPC immediately following his collapse on 22 December 2016, was adequate and appropriate. There was some delay in IHMS staff consulting a neurosurgeon, which in hindsight might be said to have been avoidable, but this was not outcome changing.

129. While the evacuation was delayed, that was inherent in the conditions on Manus Island and in the arrival of the air ambulance. Therefore, any delay could not be avoided by IHMS, International SOS or the Commonwealth. I also agree that the delays in the evacuation were not outcome changing for Faysal.

Comment under s 46 of the Coroners Act

130. Section 46 of the Coroners Act provides that, whenever appropriate, a coroner may comment on anything connected with a death investigated at an inquest that relates to public health or safety; the administration of justice; or ways to prevent deaths from happening in similar circumstances in the future.

131. At the conclusion of the inquest, counsel for Faysal's family submitted that I should comment in relation to two matters connected with health care provided by IHMS in RPCs and in onshore immigration detention:

    1. offering optional testing for 'sickle cell conditions'[42] (SCCs) to patients receiving services in immigration detention or RPCs, with particular attention to individuals whose countries of origin are the African and Indian subcontinents, and the Middle East; and
    2. ensuring that patients receiving treatment in RPCs are informed about the option to obtain second medical opinions (which should include the policies/procedures relevant to the provision of those opinions).

132. The family's written submissions in support of the proposed comments noted that Dr Stylian's evidence was to the effect that SCCs are more prevalent among persons from Africa, the Middle East and India.

133. The evidence was that Faysal had SCT but this condition could only be diagnosed following a blood test. It is generally asymptomatic and cannot be cured. However, individuals with SCT can pass the mutation on to their children and SCT can cause other complications.[43] The family submitted that whether a particular sickle cell condition could be treated or cured is not particularly relevant, and that the provision of diagnostic testing for SCCs served the public health needs of asylum seeker and refugee populations, and conforms with the contractual objective to provide heath care "broadly comparable with that available in the Australian community, taking into account the particular health needs of transferees."

134. With respect to a proposed comment about second opinions, the family noted Dr Little's evidence that:

    - While initial investigations and treatments were reasonable and reassuring, there appeared to be an "anchoring bias" to previous clinical diagnoses.
    - In emergency medicine there is always the clinical concern with repeated presentations of the same presentation that an undiagnosed condition exists.
    - There did not appear to be any system in place by which Faysal's condition could be reviewed by a specialist clinician, which may have led to further investigations and possibly another diagnosis.

[42] SCT and SCD
[43] See Ex G1.1

135. Submissions from IHMS (joined by the Commonwealth) opposed the first proposed comment on the basis that there was insufficient evidence at the inquest about whether it was appropriate to offer testing for sickle cell conditions to all individuals in immigration detention and regional processing centres, as distinct from circumstances in which such testing was clinically indicated.

136. It was also submitted that there was no evidence about the feasibility of requiring all individuals to be offered testing, or any evidence about what further services should be offered to those who receive positive results (such as further medical testing or treatment, including psychological support or counselling).

137. IHMS submitted that if the first comment was to be made, testing should be offered to all individuals, as a focus on individuals based on their country of origin would create uncertainty for medical practitioners as to which individuals should be offered testing.

138. IHMS also submitted that both proposed comments should be directed to the Commonwealth as that would better reflect the contractual arrangements between the Commonwealth and the entities providing health services on its behalf in immigration detention or in RPCs, including that those entities might vary over time, and that the Commonwealth would bear the costs of such testing.

Further proposed comment

139. Having regard to the submissions from IHMS and the Commonwealth, I invited submissions from the Commonwealth on the following proposed comment:

> *That the Commonwealth give consideration to issuing directions to entities providing health services on its behalf in immigration detention or medical facilities in regional processing countries that the entities should:*
>
> - *offer testing for haematological disorders (such as sickle cell trait or sickle cell disease) to individuals in those facilities; and*
> - *inform patients about the right to seek a second medical opinion and be informed about the matters in any policy or procedure which explains how a second medical opinion can be sought.*

140. The first limb of the proposed comment is broadly consistent with the US Centres for Disease Control and Prevention's January 2025 Guidance on Screening for recently resettled refugees.[44] This guidance was said to be based on "accepted best practices in refugee clinical care, with references to peer-reviewed literature."

141. The CDC's January 2025 Guidance notes:

> *Inherited hematologic disorders should be considered in any refugee who has anemia detected on screening, even if other potential causes exist (e.g., iron deficiency), particularly if not corrected with therapy. These disorders include a number of conditions, such as thalassemias and sickle cell disease, as well as enzyme or cell membrane defects. Most of these conditions are autosomal recessive. Therefore, it is important to both identify symptomatic refugees who are homozygous for an abnormal gene and to detect heterozygous carriers since their offspring may be affected by the disease.*

[44] www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/laboratory-testing.html

142. The proposed comment was opposed by the Commonwealth on the following grounds:

- the recommendation goes well beyond the factual substratum arising in Faysal's circumstances which occurred in a regional processing centre, not in immigration detention, the latter being subject to policies and procedures relevant to Australia's onshore immigration detention network which were not considered in the Inquest;
- it would be beyond the scope of the Commonwealth's role to issue a direction to relevant entities to the effect that they should offer testing for haematological disorders because under the relevant administrative arrangements it was the responsibility of service providers to ensure that persons such as Faysal had access to health services (not the Commonwealth).
- the possible recommendation concerning testing for haematological disorders is not based on evidence that is before the Coroner; and
- it would also be beyond the scope of the Commonwealth's role to issue a direction to relevant entities to the effect that they are required to inform patients about the right to seek a second medical opinion and the related policies and procedures.
- in accordance with IHMS's contractual responsibilities, IHMS already had a Second Medical Opinions policy which recognised a person's right to obtain a second medical opinion from another healthcare provider or expert where a patient is concerned with the opinion that has been offered.

143. The scope of the role of a coroner to comment under s 46 of the *Coroners Act* is broad. Muir J (as he then was) held in *Doomadgee v Clements*[45]*:*

> *"[29] Section 46(1) does not make coroners roving Royal Commissioners empowered to make findings and recommendations in respect of the matters described in paras (a), (b) and (c) of s. 46. Comment under s. 46(1) must be on a thing "**connected with**" the **death** under investigation and that thing must "**relate to**" public health or safety, the administration of justice or "ways to prevent deaths from happening in similar circumstances in the future" (emphasis added). There is no justification, however, for construing s. 46(1), by reference to s. 3(d), as if it contained the qualification that any comment be directed to the prevention of deaths from causes similar to that of the accident. Section 46(1) is clear and unambiguous. It contains no such limitation and is consistent with the purpose expressed in s. 3(d). Section 14A of the Acts Interpretation Act 1954 does not enable a court to rewrite an Act in light of its purposes instead of construing it.*
> *[30] 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.*
> *[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. Section 46(1), being remedial in nature, should be construed liberally.*
> *[32] "Public health or safety" and "the administration of justice" are also broad subject matters with indefinite boundaries.*
> *…..*
>
> *[33] Any matter on which comment is made, as well as having the requisite relationship, must be connected with the death under investigation. But, as counsel for the Attorney-General pointed out in the course of their submissions, there is no warrant for reading "connected with" as meaning only "directly connected with"."* (emphasis added)

[45] [2006] 2 Qd R 352 at 360

144. I accept that the inquest did not consider the framework for the provision of healthcare in onshore immigration detention and that IHMS no longer provides services in that context. I also accept that the particulars of the US Centres for Disease Control and Prevention's Guidance were not the subject of evidence before the inquest.

145. However, as noted in the submissions on behalf of the family, the inquest examined Faysal's healthcare under the Regional Processing Countries Health Services Contract. An objective of that contract includes ensuring Transferees and Recipients have access to health care "*broadly comparable with that available in the Australian community, taking into account the particular health needs of transferees and recipients".* The contract also refers to empowering Transferees and Recipients with the means to manage and respond to their own health needs.

146. There was specific evidence before the inquest about testing for SCCs among refugees from specific geographic areas and the incidence of SCCs among those populations. Evidence before the inquest also referred to complaints Faysal and others had about the healthcare he received on Manus Island, and the desirability of escalating Faysal to a specialist, having regard to his frequent presentations at the RPC clinic. I consider that these are matters that are connected with the death and relate to public health.

147. The World Health Organization has recognised SCD is a significant public health issue. The WHO's current fact sheet on this topic notes that the WHO seeks to improve the lives of those affected through initiatives such as:

- raising awareness about SCD;
- early diagnosis and intervention to improve outcomes for affected individuals; and
- collaborating with governments and organisations to implement effective SCD management programs and policies, ensuring access to care and treatment.[46]

148. Taking into account the Commonwealth's position, including that it is not its role to issue directions to health service providers about testing for SCCs, or informing patients about their right to seek second medical opinions, I recommend as follows.

Recommendation

That the Commonwealth work with providers of health services to persons in immigration detention, including in regional processing countries, to raise awareness of sickle cell conditions among health professionals and transferees, including the importance of screening for these conditions and the value of such testing in understanding genetic risks.

149. I close the inquest.

[46] www.who.int/news-room/fact-sheets/detail/sickle-cell-disease