QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Omid MASOUMALI**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2016/1752
DELIVERED ON:	1 November 2021
DELIVERED AT:	Brisbane
HEARING DATE(s):	25 February– 1 March 2019; 2-3 September 2020; written submissions to December 2020.
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, refugee, health care in regional processing countries, immigration detention, self-harm, medical transfer of burns patient from Nauru, mental health services provided to refugees in regional processing countries.

REPRESENTATION:

Counsel Assisting:	Ms Megan Jarvis and Miss Emily Cooper
Omid's widow (Pari):	Mr Justin Harper and Mr Philip Nolan (instructed by Maurice Blackburn Lawyers)
Masoumali Family:	Mr Shane Prince QC and Mr Gim Del Villar (instructed by National Justice Project)
Commonwealth of Australia:	Mr Andrew Berger QC, Australian Government Solicitor
International Health and Medical Services Pty Ltd ('IHMS') International SOS (Australasia) Pty Ltd and employees of IHMS and International SOS:	Ms Melinda Zerner (instructed by Moray & Agnew Lawyers)
Dr McGregor	Mr Andrew Luchich (instructed by Avant Law)
LifeFlight Australia Ltd:	Mr Scott Seefeld (instructed by Minter Ellison - Gold Coast)
MNHHS:	Ms Stephanie Gallagher and Mr Aaron Suthers
RN Tracey Griffiths:	Ms Sally Robb (instructed by Roberts and Kane)
UNHCR:	Mr Dan Williams (Minter Ellison)
Mr David Nockels:	Mr Philip Walker SC (instructed by Clayton Utz)

Contents

Introduction

1. At the time of his death in April 2016, Iranian refugee Omid Masoumali had been living with his partner, Pari[1], in the Nibok Settlement on Nauru. He was aged just 24 years.

2. Omid and Pari had travelled by sea to seek asylum in Australia. They arrived on Christmas Island on 13 September 2013 on boat number 847. Omid and Pari were detained there as unlawful non-citizens as they did not hold a valid visa under the *Migration Act 1958 (Cth).*

3. After he was removed from Australia, Omid became a "transitory person" within the meaning of section 5 of the *Migration Act*.

4. The Australian Government transferred Omid and Pari to Nauru on 24 September 2013. They were transferred under the Memorandum of Understanding (MOU) between Nauru and Australia signed on 3 August 2013 by the Honourable Kevin Rudd MP, Prime Minister. The MOU gave effect to the policy of offshore processing, ensuring that any person who arrived in Australia by boat would not be resettled here.

5. Omid and Pari were detained in a Regional Processing Centre (RPC) on Nauru until 8 December 2014, when the Government of Nauru determined they were in need of international protection and granted them refugee status.[2] Omid and Pari were then released from detention and permitted to settle in Nauru. The couple had lived in self-contained accommodation at the Nibok Settlement since that time.

6. It has been held by the Federal Court of Australia that although transitory persons are required to live in sovereign states, they are entitled to the protection of Australian law. Aspects of the relationship between the Commonwealth and a transitory person may give rise to a duty of care. Central to this assessment is the fact that persons such as Omid depend on the assistance provided by the Commonwealth to sustain themselves in regional processing countries. This includes the provision of food, water, housing, security and medical services.[3]

7. On 27 April 2016, at around 9:15am Nauru time, petrol was placed on the clothing Omid was wearing. He later proceeded to set it alight in the presence of United Nations High Commissioner for Refugees (UNHCR) officials who were visiting the Nibok settlement. Video footage of the incident taken with a mobile telephone was published by media organisations shortly afterwards.

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[1] A pseudonym
[2] ExhibitD1.3
[3] *Plaintiff S99/2016 v Minister for Immigration and Border Protection* [2016] FCA 483

8. Bystanders immediately helped Omid and extinguished the fire. He was taken by private vehicle to the Republic of Nauru Hospital (RNH) where he received medical care from hospital staff together with clinicians employed by International Health and Medical Services (IHMS). IHMS is contracted by the Australian Government to provide health services to asylum seekers and refugees in Nauru.

9. Clinicians soon assessed that Omid would need to be moved to a specialist burns unit if he were to survive his burns. Arrangements were then made for Omid to be medically evacuated from Nauru to the Royal Brisbane and Women's Hospital (RBWH) in Queensland, via LifeFlight Australia.

10. The LifeFlight aircraft arrived in Nauru at around sunrise the following morning, 28 April 2016, and LifeFlight clinicians spent over two hours at Nauru Hospital stabilising Omid in preparation for the flight to Brisbane. Omid arrived in Brisbane by mid-afternoon on 28 April 2016 and was taken by road ambulance from the airport to the RBWH, arriving just after 3:00pm.

11. Omid arrived at the RBWH approximately 31 hours after receiving his burn injuries. On arrival at the RBWH Omid was assessed in the Emergency Department and transferred to the Intensive Care Unit for treatment. However, he failed to respond to the therapies provided. By around 8.30am on the morning of 29 April 2016 he was showing signs of multi-organ dysfunction with death likely 'in a few hours'.

12. While doctors considered Omid would need surgery to survive his injuries, he was not in a state to survive the surgery. It was also suspected Omid had sustained an hypoxic-ischaemic brain injury due to poor blood and oxygen supply.

13. After further reviews by intensive care and burns specialists, the decision was made to palliate Omid because his injuries were deemed incompatible with life. They included irreversible multisystem organ failure, myonecrosis of all four limbs, and renal failure with metabolic acidosis. He passed away at 12.48pm on 29 April 2016.

Coronial Jurisdiction

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*."[4]

[4] *R v South London Coroner, ex parte Thompson* (1982)126 S.J. 625

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. However, it is recognised that there are limits in terms of the remoteness of events in assessing causation.[5]

16. In appropriate cases, a coroner can also 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.[6]

17. Several submissions from Omid's family asked me to consider matters outside the scope of the inquest, including breaches of duties of care by Commonwealth officials. A coroner is prohibited from including in findings or comments any statement that a person is, or may be, guilty of an offence or civilly liable. 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.

18. 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*[7] 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.

19. A coroner 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 being given a right to be heard in opposition to that finding.

The inquest

20. When he died in Queensland, Omid was an 'unlawful non-citizen' pursuant to the *Migration Act 1958 (Cth)* and was being held in immigration detention in the company of'Directed Persons' who were security officers on shift at RBWH appointed pursuant to documentation arranged by the Department of Immigration and Border Protection.

21. Section 27 of the *Coroners Act 2003* provides that a coroner investigating a death must hold an inquest if the coroner considers the death is a death in custody. As Omid was detained under the authority of an Act of the Commonwealth, his death was a 'death in custody' pursuant to the *Coroners Act 2003,* and an inquest was required.

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[5] *Re Doogan; Ex parte Lucas-Smith* [2005] ACTSC 74
[6] *Doomadgee v Clements* [2006] 2 Qd R 352 at 30-31
[7] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361

22. Following a pre-inquest conference on 11 October 2018, the issues to be investigated at the inquest were determined to be as follows:

    i. The findings required by section 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 factors, circumstances and events giving rise to and surrounding the incident on 27 April 2016 at the Nibok Settlement in the Republic of Nauru whereby the deceased was seen to set fire to his own clothing and, in particular, the factors, circumstances and events giving rise to his decision to take that action.

    iii. The adequacy and appropriateness of the health and medical evacuation services provided to the deceased from the time of the incident until the time of his death on 29 April 2016, including whether those services were the best available in the circumstances and broadly comparable with health and medical evacuation services available within the Australian community.

    iv. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the *Coroners Act 2003*.

23. Evidence was heard from a total of 23 witnesses over a one week sitting from 25 February 2019 – 1 March 2019:

- Pari
- Billal Soubjaki
- Alan Beattie
- Russell Badley
- Chanelle Taoi
- Mehdi Diba
- Professor Suresh Sundram
- David Nockels
- Dr Peter Rudolph
- Clair Robinson
- Dr Edward McGregor
- Dr Jason Miller
- Michelle Smith
- Tracey Griffiths
- Dr Angus McDonell
- Paul Regli
- Dr Allan MacKillop
- Brian Guthrie
- Clive Gillard
- Professor Michael Muller
- Dr Mark Little
- Dr Drew Wenck

24. After the 2019 sitting I accepted into evidence additional statements, and considered further submissions in relation to an application to broaden the scope of the inquest. I had initially determined that the scope of the inquest should not be extended to consider the provision of mental health services on Nauru, and whether any gaps in those services contributed to Omid's death.

25. However, following further submissions received in response to this determination, in July 2019 I ruled that the inquest should also consider the circumstances surrounding the processing of the IHMS Mental Health Settlement Clinic Client Self-Referral form completed by Omid on 26 April 2016, and the scheduling of an appointment with a psychologist for 2 May 2016.

26. I determined that such examination would involve consideration of 'four dot points' submitted by Omid's family in seeking to have certain matters investigated related to the self-referral form. Those four dot points were as follows:

- Whether Mr. Masoumali was in fact triaged in the period after he submitted the self-referral (but before the appointment was made) or whether there was a missed opportunity to intervene in his case.
- Whether the triage (if undertaken) was properly documented, and records of the triage process were made and properly stored.
- Whether IHMS see patients quickly enough after an initial request is made to IHMS.
- Whether the form of the self-referral request is adequate to record all pertinent details, such as the date of the request by the refugee/asylum seeker, the date of triage, range of possible actions in response to the triage, the outcome of the triage, etc.

27. Consequently, a further sitting in April 2020 examined the following witnesses:[8]

- Dr Michael Dudley
- Professor Jon Jureidini
- Catherine Cleary
- Matthew Weinberg
- Dr Jill Reddan

28. Comprehensive written submissions were provided by Counsel Assisting, Miss Cooper, in February 2020 (tranche 1 sittings) and October 2020 (tranche 2 sittings) and then by those granted leave to appear from April 2020 to December 2020.

[8] Julianne Kiffen was excused from giving evidence on medical grounds.

29. The clinicians involved in Omid's care at the RNH, apart from those engaged by IHMS or LifeFlight, did not give written or oral evidence at the inquest. The evidence from the RNH was limited to handwritten hospital notes, and conversations with various RNH clinicians recounted to the inquest by other witnesses.

The evidence

30. I will not recite all the evidence contained in the exhibits and transcript. These reasons record only the evidence I consider necessary to understand the findings I have made.

Personal Background

31. When Omid arrived at Christmas Island in September 2013, he told officials he was aged 22 and was from Tehran in Iran. He had been educated to a level approximating year 12. He had started his first year at university before travelling to Christmas Island. His previous occupation was noted as shopkeeper/swimming instructor. Omid was noted to have said 'no' when asked whether there was a known history of mental health or medical problems.

32. Personal history and background information was contained in the statements of Pari and Omid's family including his mother, Ms Hesari, and his sister, uncle, aunt and grandmother. It was clear from the statements of his family members that Omid was a compassionate person who is deeply missed by his family. He had been optimistic about obtaining citizenship in Australia.

33. Ms Hesari said that Omid was her only son, and his untimely death has left her with "eternal unbearable grief". She said that he was a friendly and lovely easy-going boy. His warmth and funny manners led him to make a lot of friends. He was a loyal and supportive friend. He paid attention to his health and fitness and regularly went to the gym. He had travelled to different countries in Europe and visited his uncle in Germany on several occasions. Ms Hesari said that Omid means "dream and hope" in her language. She felt that his actions and setting fire to his clothing were an effort to attract government attention to find a solution the problems on Nauru.[9] Her son had died in a foreign country, lonely and innocent.

34. Omid's sister, Sahar, said that family was his priority, and while he called every day, he never told them about the problems he faced.

[9] ExhibitB21.

35. Pari said that she was a graphic designer and first met Omid in 2012, shortly after the death of her father. She said that he was optimistic, confident and cheeky. He became a source of support for her, "carrying me on his shoulders". Omid was positive, intelligent, kind and strong. Before arriving in Australia, he had no mental health issues.[10]

36. Pari said that she and Omid fled Iran in June 2013. Their intention was to seek asylum in Australia, which they thought was a welcoming and multicultural society. She described conditions in detention in Nauru as horrible and humiliating.[11] There were limited facilities for washing clothes and for the first six months there was no telephone or internet access.

37. There were counsellors and psychologists in the detention centre, and Pari said that she and Omid were automatically booked to see them. However, they could choose whether to see them. They saw a counsellor or psychologist together several times, but she said the only option they were given was to return to Iran. She thought the appointments were unhelpful as no assistance was provided to deal with conditions in the detention centre.[12] Pari was unaware of any self-harm attempts by Omid in detention.

38. Pari said that following release from detention they lived in a demountable building in Nibok. In the six months leading up to Omid's death they worked several jobs together. Omid had taught himself how to repair motorbikes and cars.

39. Pari said she had assumed that after being granted refugee status they would be free to leave Nauru and meet family in third countries, while waiting for a visa to enter Australia. Similarly, family members were unable to obtain a visa to visit them. She said they were prisoners on Nauru and were not given any information about the long term plan for them.

40. Omid had told Pari they would be on Nauru for 10 years but that the United Nations would come to assess the situation each six months.[13] Pari said that while she was often sad, Omid was different. He was determined to make the best of a bad situation and would look for things for them to do as a couple. He also talked about the things that they could look forward to such as children, friends and freedom.

41. A statement was also tendered from Ms Beiraghdar, who told police that she and her husband were close friends with Omid and Pari on Nauru. She recalled that Omid did not mention to her that he had any intention to kill himself. However, she did say that "people around him and at Nauru were always talking about being tired and wanting to commit suicide". She recalled that Omid was very tired, but he was tolerating the situation and trying to manage himself.

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[10] ExhibitB2.
[11] ExhibitB2.
[12] ExhibitB2.
[13] ExhibitB2, page 4. ExhibitB21.

42. Records from IHMS confirm that, on several occasions while detained at the RPC, Omid requested assistance for mental health related issues, from requesting to see a psychiatrist to attending group relaxation sessions.

43. Contact with mental health services by Omid was first documented on 6 October 2013, less than one month after his arrival on Nauru. He wanted to know how long he would be kept in detention and was frustrated with his entire future being uncertain.[14] The clinical record from 10 October 2013 indicates there were "no mental health concerns" after Omid reported that he felt like he was treated like an animal in detention. The mental health nurse told Omid to "take his concerns to DIAC" as the nurse "was here for any mental health issues".

44. Omid had three further appointments with mental health clinicians from November 2013 to March 2014. On 25 August 2014, a mental health nurse saw Omid and he spoke about stressors in RPC1. He said Omid spoke about stressors within the camp. The nurse recorded:

> *He believes his hair is falling out, even the implants that he had as a result of the unnecessary pressure he is living in. He has a very good attitude stating "what can you do! You just have to get on with it". Omid and his wife are waiting for the outcome of their RSD[15] interview and he believes it will be a negative answer. He shrugged his shoulders and smiled. Omid said he and his wife have a strong relationship and are supportive of each other. He did not want follow-up; stating he just wanted the opportunity to chat with scribe and was satisfied at completion of the consultation.*

45. In June 2015, Omid was involved in an alleged attack on another refugee with a knife. The other refugee responded with a knife, was injured and received treatment at the RNH. Omid later attended the CSS Beach House and was alleged to have threatened to kill his neighbours and burn down the Beach House if he was not allocated a new house.[16]

46. There are several relevant events that occurred in the months leading up to Omid's death that provide important context for his actions. The inquest heard evidence that after July 2015, Australian Border Force ('ABF') operating within the DHA, had placed increased restrictions on transfers of persons from the RPC to Australia. The policy in April 2016 was that medical transfers from the RPC to Australia were only to occur in life-threatening circumstances and as a last resort.

47. Evidence of previous attempts at self-harm by other refugees, including self-immolation, was led during the inquest from a variety of sources, including Pari and Mr Soubjaki.

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[14] ExhibitC4, page 71.
[15] Refugee Status Determination.
[16] ExhibitD1.3

48. Pari recalled that several weeks before Omid's incident another refugee set himself on fire in front of the detention centre. When he set himself on fire, the fire alarm sounded, and the fire was extinguished. He was treated by IHMS in the detention centre. After he was treated, he was taken to the police station and charged by police.[17]

49. Mr Soubjaki said that conversations with clients "would most likely end with a threat to self-harm or a threat to pour petrol over oneself".[18]

50. On 3 February 2016, the High Court of Australia held that the Australian Government was legally able to participate in the detention of asylum seekers in Nauru.[19] On 26 April 2016 (the day before the incident involving Omid), the Papua New Guinea Supreme Court had held that the detention of asylum seekers on Manus Island was in breach of the Papua New Guinea constitution.[20]

51. While Omid was not an asylum seeker and not detained in the RPC in the direct lead up to his death, the sum of the evidence supports a conclusion that these events contributed to an environment within the Nibok settlement that was increasingly uncertain and unsettled as at 27 April 2016.

52. This conclusion is supported by evidence given to the inquest by those who worked on Nauru, were living as refugees on Nauru, or had visited Nauru in the period leading up to Omid's death.

Contractual requirements for Omid's care

53. Evidence was given at the inquest in relation to who was contractually responsible for Omid's care once he was taken to the RNH and the standard that care was required. Most of this evidence was given by:

    - David Nockels, at the relevant time the First Assistant Secretary of the Detention Services Division of the DHA;[21] and

    - Dr Peter Rudolph, at the relevant time the Area Medical Director responsible for the provision of IHMS medical services within the RPCs.[22]

[17] It was a criminal offence to attempt suicide in Nauru until May 2016, when the *Crimes Act 2016* commenced.
[18] Exhibit B18.
[19] *Plaintiff M68-2015 v Minister for Immigration and Border Protection* (2016) 257 CLR 42.
[20] *Namah v Pato* [2016] PGSC 13.
[21] Exhibits D1; D1.5.
[22] Exhibits C3; C3.6.

54. The 'Heads of Agreement', or 'Regional Processing Countries Health Services Contract' between the DHA and IHMS[23] set out the standards and requirements for the provision of health care to transferees at regional processing centres, of which the RPCs on Nauru (referred to in the evidence as RPC1, RPC2 and RPC3) were included. The use of the term 'transferees' means asylum seekers.[24]

55. The document confirms that one of the primary objectives of the agreement is to:

> …
>
> *provide Transferees and Recipients with a range and standard of Health Care that is the best available in the circumstances, and utilising facilities and personnel on Nauru …, and that as far as possible (but recognising any unavoidable limitations deriving from circumstances of … Nauru):*
>
> *(A) ensures Transferees and Recipients have access to Health Care, to a level, standard and timeliness broadly comparable with that available within the **Australian community**, taking into account the particular health needs of Transferees and Recipients*;[25]
>
> …
>
> (emphasis added)

56. IHMS was also required to provide medical escort services on a 24/7 basis.[26] If a medical evacuation service was required, the agreement dictated that:

> *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]
>
> (emphasis added)

57. The agreement also applies to 'recipients', which is a term defined in the document to mean "a person other than a transferee nominated by the Department from time to time to receive health services at a facility."[28] When asked who that might include, Mr Nockels said that a recipient could be a service provider or a Commonwealth officer - a recipient could fit a broad range of categories as directed by the Department.[29] When asked whether a 'recipient' ever included a refugee, Mr Nockels' said DHA had not directed IHMS under the contract about that.

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[23] Exhibit D1.1.
[24] Transcript, day 2, page 77 at line 19.
[25] Exhibit D1.1, clause 6.1(a)(ii)(A) page 18.
[26] Exhibit D1.1, clause 26.1(a) page 45.
[27] Exhibit D1.1, clause 26.2(b) page 46.
[28] Exhibit D1.1, Schedule 1 (Glossary), page 23.
[29] Transcript, day 2, page 80 from line 34.

58. A second heads of agreement was in place with IHMS to manage health needs for refugees who had moved into the community. People who were in the RPC space would receive care under the broader 'transferee' descriptor.[30]

59. The 'second contract' referred to by Mr Nockels was the 'Heads of Agreement for the Provision of Settlement Health Services on Nauru'.[31] That agreement set out the scope and standard of health care that the Australian Government had arranged for IHMS to provide to asylum seekers who had subsequently been granted refugee status by Nauruan authorities.[32] While this document was primarily applicable to Omid's circumstances in the Nauruan community, it was not relevant to acute care administered by the RNH. There was no evidence of an MOU in place between the Australian Government and the RNH.

60. One of the primary objectives of the agreement was to provide a standard and range of health services, as follows:

> …
>
> *subject to Schedule 1 [Statement of Work], provide Refugees with a standard and range of health services that is the best available in the circumstances, and utilising facilities and personnel on Nauru, and that as far as possible (but recognising any unavoidable limitations deriving from the circumstances of Nauru) is broadly comparable with health services available within the* ***Nauruan community***;[33]
>
> …
>
> (emphasis added)

61. This is to be contrasted to the standard required for transferees and recipients, which required a standard broadly comparable with that available in the Australian community. The agreement also required that the services be provided by IHMS at a settlement health clinic(s) in the Nauruan community.[34] I heard evidence that this clinic was co-located with the RNH grounds.[35]

62. With respect to the provision of medical care for refugees, the agreement provided:

> *A.2.1 The Service Provider must assess and identify the health needs of individual Refugees (as referred to the Service Provider by the Department, its Settlement Service Provider(s) or by the Refugee him/herself) and tailor the Services accordingly.*
>
> *A.2.2 The Services available to Refugees under the Agreement, to be delivered by the Service Provider in the Nauruan community at the Settlement Health Clinic(s) on a needs-basis, comprise:*

[30] Transcript, day 2, page 81 from line 17.
[31] Exhibit D1.2.
[32] Transcript, day 2, page 83 from line 23.
[33] Exhibit D1.2, clause 2.2.1(ii), page 7.
[34] Exhibit D1.2, clause A.3.1, page 31.
[35] Transcript, day 2, page 84 from line 30.

a. Primary Health Services (available to Refugees for the duration of the Agreement, or as advised by the Department):

i. triage, including:
- *initial assessment; and*
- *<u>initial treatment, including primary care level first aid and basic life support</u>*

ii. provision of a clinically appropriate health care response, including:
- *assessment;*
- *Referral to Specialists, including at the Republic of Nauru Hospital, and/or other health care providers, including the Republic of Nauru Hospital;*
- *individual treatment, monitoring and review;*

…

iii. <u>cooperation with the emergency department at the Republic of Nauru Hospital, to which all emergencies will be Referred;</u> and

viii. <u>facilitation of timely transfer of Refugees for urgent medical care not available in Nauru, location and extent to be agreed by the Department</u>, and where required and available provide Referral to an appropriate medical assistance provider and medical escort services.[36]

b. Mental Health Services (available to individual Refugees for the duration of the Agreement, or as advised by the Department):

i. identification, monitoring and treatment of mental health needs by undertaking mental health screening as clinically required;

ii. provision of mental health case management plans for Refugees identified at risk or, or as having, a mental health concern;

iii. facilitation of remote access to mental health services (psychologists and psychiatrists) via Telemedicine Services as required;

iv. if directed by the Department, facilitation of outreach services in accordance with the Outreach Services Model (to be agreed by the parties no later than two (2) calendar months subsequent to the Commencement Date of this Agreement);

v. if a Refugee requires involuntary assessment and treatment under Nauruan legislation, the involuntary assessment and treatment must occur in accordance with said legislation; and

vi. access to specialist torture and trauma counselling services as required.

…

And further:

A.2.3 The Service Provider must provide the Services consistent with Nauruan standards as outlined below or otherwise agreed by the Department:

[36] Exhibit D1.2, clauses A.2.1; A.2.2(a)(i)-(ii) (vi)-(vii).

a. *primary outpatient care as per Nauruan health treatment protocols; and*
b. *prescribing and dispensing of common pharmaceuticals consistent with Nauruan practice and legislation.*

Exceptions to this are limited to:

a. *maintenance of the Nauruan vaccination schedule, supplemented by any additional vaccination requirements undertaken at the Offshore Processing Centre; and*
b. *access to Mental Health Services (including torture and trauma counselling) must be broadly comparable to that of a* ***remote community in Australia*** *and, if directed by the Department, provide Mental Health Services in accordance with the Outreach Services Model.*[37]

And further:

…

d. *refer Refugees in need of urgent medical care directly to the Republic of Nauru Hospital or other local health care providers for emergency or out-of-clinic- hours care;*[38]

(emphasis added)

63. It was established during the inquest that the two 'Heads of Agreement'[39] were different. With respect to asylum seekers and recipients, IHMS was required to provide those persons with emergency observation and treatment, especially for critically ill patients for up to 20 hours including artificial ventilation. This requirement did not extend to refugees.[40]

64. Where a critically ill refugee such as Omid required emergency observation and treatment[41], the refugee was required to be referred to the RNH. However, IHMS submitted it was that it was only obliged to 'cooperate' with the emergency department at the RNH if a patient was referred under the Heads of Agreement. If a medical transfer was required, IHMS was required to facilitate that transfer.

65. Omid was taken directly to the RNH after setting his clothing on fire. The evidence was that this meant that his evacuation would be facilitated, but in the meantime, the treatment that was required to keep him alive was a matter for the Nauruan health system.[42]

[37] Exhibit D1.2, pages 28 – 31.
[38] Exhibit D1.2, clause A.3.2 d, page 31.
[39] Exhibits D1.1 and D1.2.
[40] Transcript, day 2, page 85 from line 22; day 3, page 26 from line 17.
[41] Exhibit D1.2.
[42] Transcript, day 2, page 89 from line 1.

66. Dr Rudolph clarified the extent to which IHMS provided assistance with the facilitation of Omid's medical evacuation: providing liaison with the International SOS Assistance Centre for the evacuation, and liaison relating to his hospital admission in Australia. He said that in the meantime, any treatment that was required to keep Omid alive was primarily for the Nauruan health system to manage.[43]

67. However, while Omid was at the Republic of Nauru Hospital, he received limited assistance from IHMS clinicians. IHMS was not contracted to provide emergency treatment and advanced life support to refugees. Those services were provided on a "requested emergency Good Samaritan basis". IHMS would not provide direct treatment unless specifically requested by the hospital, and if the requested care fell within the skillset of its clinicians.[44]

68. With respect to whether there was any capacity to use equipment available at the RPC1 clinic at the RNH, Dr Rudolph clarified that Omid required surgical intervention (i.e., a laparotomy) and the RPC1 clinic was not equipped to provide those services. It was not staffed with a surgeon or an anaesthetist.[45] Even if Omid had initially been transferred to the RPC1 clinic, he was a refugee and he required surgery. Those factors meant that he was always going to be cared for at the RNH.[46]

69. Supplies were provided from the RPC1 clinic to the RNH from time to time if there was a need; but there was no formal arrangement in place. Dr Rudolph was of the understanding that the RNH had a functioning ventilator.[47]

70. The evidence also suggested that any decision to transfer Omid to the RPC1 clinic would have ultimately rested with the clinicians at the RNH. Where a patient presented who needed ventilation and resuscitation and the equipment was not available at the RNH, the doctor would be entitled to take the patient for treatment at the RPC facilities.[48]

71. However, that would only occur if the receiving doctors allowed that to happen. An IHMS doctor could not 'remove' a patient from RNH. The RPC did not have the facilities to provide the surgical and anaesthetic care required by Omid.[49] If the RNH required further support or resources to meet the clinical need in any given case, it was up to the RNH to identify that need and take steps to meet that need, whether that meant raising it with IHMS, or meeting it by other means.[50]

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[43] Transcript, day 3, page 25 from line 22.
[44] Transcript, day 3, pages 25-26 from line 36.
[45] Transcript, day 3, pages 28 from line 42.
[46] Transcript, day 3, pages 65 – 66 from line 41.
[47] Transcript, day 3, pages 29 from line 3.
[48] Transcript, day 2, pages 105-106 from line 42.
[49] Transcript, day 2, pages 111-112 from line 37.
[50] Transcript, day 3, page 44 from line 34.

72. Counsel assisting submitted that after Omid was taken to the RNH there was no Commonwealth of Australia oversight in relation to his emergency care. Mr Nockels said that the RNH was providing emergent care to refugees and there was no oversight by the Commonwealth because it was a service provided to the Nauruan community. He said that the hospital is a Nauruan hospital, Nauru is a sovereign state, and they are a sovereign government responsible for how they manage and develop services for their own people.[51]

73. The Commonwealth submitted that the reason for the differences in the contractual care requirements were clear. Once someone was found to be a refugee by the Government of Nauru their status changed - legally and practically. Granting an asylum seeker refugee status effectively placed them on the same footing as Nauruan citizens and other residents of Nauru.

74. It is not necessary to determine for the purpose of this inquest whether Omid's transfer to the RNH extinguished any obligations the Commonwealth had for his health care. However, having regard to Omid's status as a transitory person, and the way he was cared for on a collaborative basis by the RNH and IHMS while being readied for medical evacuation, it is arguable that the Commonwealth still had a degree of responsibility for his care after he entered the RNH.

75. It was also within the Commonwealth's power under the contract to designate Omid as a "recipient", arguably placing an onus on IHMS rather than the RNH to provide emergency observation and treatment for up to 20 hours, including artificial ventilation, before evacuation. In my view that is unlikely to have changed the outcome. Having regard to the clinical staff available to IHMS it is also unlikely to have been practical or feasible in the circumstances.

Omid asks to see a psychologist on 26 April 2016

76. Omid's self-referral form[52] was not dated, but noted '*Booked 2/5/16*'. The evidence confirmed that this notation referred to a booking that had been made for Omid to see a psychologist on 2 May 2016.[53] The only words written on the form about the request were "*I want to visit psychologist*".

[51] Transcript, day 2, pages 112 from line 14.
[52] Exhibit C5, page 12.
[53] Exhibit C253, paragraph 27; Transcript, day 1, page 16 from line 12.

77. It could not be established whether Omid had completed the form, or whether he had been helped by someone else.[54] It could also not be established whether Omid had dropped the form off at the Settlement Clinic in person, or it had been dropped off at one of the other sites on Nauru where refugees could leave forms for processing.

78. As noted above, the medical records showed that Omid had sought help for his mental health before, while in detention, but had not done so since November 2014, after which time he and Pari had been granted refugee status.[55]

79. The medical records showed that Omid's last contact with the IHMS Settlement Clinic (before the submission of the self-referral form in April 2016) was for a head injury in February 2016.[56]

80. I received statements relating to the processing of the self-referral form, from the following clinicians employed by IHMS at the relevant time:

- Catherine Cleary (psychologist) [57]
- Matthew Weinberg (mental health nurse)[58]
- Julianne Kiffen (mental health nurse)[59]
- Michelle Smith (mental health team leader)[60]

81. Ms Smith had given evidence during the initial phase of the inquest in 2019.[61] I heard from the other witnesses during the second phase. While Ms Kiffen was excused from giving oral evidence, her written statement was tendered. It was clear from the evidence from Ms Cleary, Ms Kiffen and Mr Weinberg that no other entity on Nauru was involved in triaging Omid's self-referral form.

82. Ms Cleary triaged Omid's self-referral form together with Mr Weinberg and Ms Kiffen. Ms Cleary had a detailed knowledge of the referral process. While she was not working out of the Settlement Clinic at the relevant time, Ms Smith was familiar with the practice for mental health referrals.[62]

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[54] Ms Smith's evidence at Transcript, day 1 (28.02.2019), page 57 at line 31 indicates the forms were 'usually' filled out by the refugees themselves. Ms Cleary's evidence at Transcript, (02.09.2020), page 12 at line 10 indicated that the form was filled out by an expatriate.
[55] Exhibit C4, page 4.
[56] Exhibit C5, pages 3 – 4.
[57] Exhibit C253.
[58] Exhibit C255.
[59] Exhibit C254.
[60] Exhibits C239.1.
[61] Transcript, day 1 (28.02.2019), from page 55.
[62] Transcript, day 1 (28.02.2019), from page 57, line 36.

83. Ms Smith stated that refugees living in the community were able to access primary and mental health services at the IHMS Settlement Clinic by way of self-referral. The relevant forms were widely available within the community in Nauru.[63]

84. Three to five requests for mental health services were received by the Settlement Clinic each day.[64] Staff at the Settlement Clinic were responsible for triaging all requests daily.[65] In April 2016, the records at the Settlement Clinic were handwritten.[66]

85. Ms Cleary's evidence was that she recalled Omid's self-referral form because it was submitted at the same time as his partner's form. She also recalled that Omid set himself alight shortly after the form was triaged. Consequently, Ms Cleary was sure that the self-referral form was triaged on 26 April 2016. It was not possible that the form had been sitting at the Settlement Clinic for some days waiting to be triaged.[67] I accept this evidence.

86. Ms Cleary said that she was not concerned about Omid's mental health at the time of triaging the self-referral form. She did not consider that the form indicated an urgent need for assessment or treatment. It was a simple request to see a psychologist for unspecified reasons. Ms Cleary said that requests of that kind were very frequent in both the RPC and the Settlement Clinic.[68]

87. Ms Cleary's evidence was that there was no information available to suggest Omid required urgent or immediate intervention. Ms Kiffen had extensive personal knowledge of the refugees and asylum seekers on Nauru and said Omid had not had any involvement with IHMS previously. He was given the next available appointment, which was within six days.[69]

88. Ms Cleary did not make any independent inquiries with those at RPC1 to check if anybody had dealt with Omid while he was an asylum seeker.[70] Ms Cleary accepted that if she had done so, she would have been privy to the records relating to Omid's mental health history as an asylum seeker.[71] However, she said that access to those records would not have made any difference to the way Omid's self-referral form was triaged:

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[63] Exhibit C239.1, paragraph 6; Transcript, (02.09.2020), page 10-11 from line 43
[64] Transcript, (02.09.2020), page 10 from line 37.
[65] Transcript, (02.09.2020), page 10 from line 31.
[66] Transcript, day 1 (28.02.2019), page 60, from line 26; (02.09.2020), page 15 from line 43.
[67] Transcript, (02.09.2020), pages 11 – 12 from line 22.
[68] Transcript, (02.09.2020), page 12, line 41.
[69] Transcript, (02.09.2020), page 13, line 19.
[70] Transcript, (02.09.2020), page 35, from line 8.
[71] Transcript, (02.09.2020), page 37, from line 10.

But I wouldn't have altered the five day appointment time, given the 18 month lapse and a complete change of circumstances from living, as I said, in a tent to living in a community with freedom and not being behind fences, I would not have changed my triage and the process, no.[72]

89. Ms Cleary was adamant Omid had been functioning more adequately as a refugee than he had been as an asylum seeker.[73] She explained that when an asylum seeker is granted refugee status, there would be a handover from RPC1 to the community staff about the refugee. This would be conducted via meetings and a handover form. Therefore, if a refugee was in the community and there were no records of a handover, it was assumed there were no significant mental health issues at the time of being granted refugee status.[74] There was no such handover form in Omid's records.

90. There were no notes made of the discussion that took place between Ms Cleary, Mr Weinberg and Ms Kiffen relating to triaging of the self-referral form.[75] Ms Cleary said that the triaging was completed by the setting of the appointment on 2 May 2016[76], and the request had been sent back to administration for contact to be made with Omid. Had it been necessary for notes to be made, a welfare check would have been required, which would also have prompted a file to be opened.[77] She deemed these measures unnecessary in this instance.

91. Ms Cleary said that if there was any information on the form to suggest Omid was contemplating self-harm, a welfare check would have been conducted[78] and a psychiatrist at RPC1 would have been contacted. If it was deemed that Omid needed supervised care, an application would have been made to the Nauruan government to have him housed at the inpatient unit at RPC1.[79]

92. The Settlement Clinic had an 'open-door' policy. It was not unusual for refugees to attend without an appointment.[80] It was also not unusual for refugees to attend the Settlement Clinic and communicate concerns they had for others.[81] The evidence confirmed that no concerns were expressed to either Ms Cleary, Ms Smith, Ms Kiffen, or Mr Weinberg about Omid's welfare in the lead up to 27 April 2016.[82] The evidence also established that Omid was aware of the pathways to seek help.[83]

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72 Transcript, (02.09.2020), page 37, from line 21.
73 Transcript, (02.09.2020), page 37, from line 32.
74 Transcript, (02.09.2020), page 56, from line 37.
75 Transcript, (02.09.2020), page 13, line 25.
76 Transcript, (02.09.2020), page 16, line 22.
77 Transcript, (02.09.2020), page 14-15, from line 45.
78 Transcript, (02.09.2020), page 13, from line 10.
79 Transcript, (02.09.2020), pages 16-17, from line 46.
80 Transcript, (02.09.2020), page 64, from line 6.
81 Transcript, (02.09.2020), pages 15, from line 25; Exhibit C254, paragraph 12.
82 Transcript, (02.09.2020), page 19, from line 29; Exhibit C254, paragraph 29; Exhibit C239.1, paragraph 15.
83 Transcript, (02.09.2020), page 60, from line 23 – 41; page 61 from line 15.

93. Weekly meetings took place between the IHMS Settlement Clinic, Connect Settlement Services, and the Torture and Trauma Team.[84] This meeting was an opportunity to discuss refugees of concern, and to talk about any refugees who might need increased contact.[85] There was no evidence to confirm that Omid had been escalated in these meetings.[86]

94. Ms Cleary allocated Omid an appointment with her for 2 May 2016, which was her first available appointment. Ms Cleary identified that the notation on the self-referral form '*Booked 2/5/16*' was her handwriting.[87] Following her noting the appointment on the form, Ms Cleary then noted the appointment in a diary.[88] The matter was then provided to administrative staff to attend to the administrative process. That process involved staff of the Settlement Clinic contacting the refugee with the details of the appointment. This was generally done via text message.[89]

95. There is no direct evidence to confirm that a text message was sent to Omid. Ms Cleary's evidence was that it was a general practice, and she could not imagine why it would not have been done for him.[90] She had never encountered a situation where a text message had not been sent. There was also no evidence that, if a message was sent, a reply was received from Omid.

96. However, it is possible that if a text message had been sent advising of the details of his appointment with a psychologist, it may not have been received by Omid because of black spots in mobile phone reception on Nauru.[91]

97. Ms Smith's evidence was that the usual practice was for a nurse to enquire with the refugee in relation to why they required an appointment before triaging the request.[92] Ms Smith said that this was important because people were asking to see a psychiatrist or psychologist 'regardless of the issue'. However, because of communication issues and blackspots, it was not always possible to speak to individual clients.[93] Ms Cleary disagreed that it was an established practice to contact the refugee to seek more information.[94]

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84 The Torture and Trauma Team were involved with anyone who came to Nauru from a hostile environment who had witnessed or experienced any form of torture or significant trauma; Transcript, (02.09.2020), page 55, from line 27.
85 Transcript, (02.09.2020), pages 18-19, from line 28.
86 Exhibit C253; Exhibit C254; Exhibit C255; Exhibit B19.
87 Transcript, (02.09.2020), page 16, line 18.
88 Transcript, (02.09.2020), page 16, line 35.
89 Transcript, (02.09.2020), page 16, from line 40; Exhibit C253, paragraph 19.
90 Transcript, (02.09.2020), page 17, from line 5.
91 Transcript, (02.09.2020), page 70, from line 38; page 70 from line 33.
92 Exhibit C239.1, paragraph 9; Transcript, (28.02.2019), pages 57-58 from line 43.
93 Transcript, (28.02.2019), from page 57, line 40.
94 Transcript, (02.09.2020), from page 25, line 4.

98. Regardless, there was no evidence of any attempt from the triage team to clarify the basis for Omid's request to see a psychologist.[95] Ms Cleary said no inquiries were made with him as "*it was on the form*". She said, "*none of it was really particularly unusual*". There was a lack of information on the form, no one else had alerted the settlement clinic with concerns and Omid had not come to the clinic himself. It was deemed appropriate to give him the next available appointment.[96]

99. Ms Smith's evidence supported this, and she confirmed that unless there was a reason to do otherwise, a request would have been treated as 'standard' and would not be given priority. A referral would be actioned between 72 hours and seven days of receipt.[97]

100. Ms Cleary was asked how it could be assessed from the self-referral form whether Omid's welfare was at stake. She said that there was no prior history. There was no collateral evidence from other agencies or from the community:

> *There was no indication from anybody in Nibok to which we visited regularly. We're talking about an island that's 20 by six kilometres. Everybody knew everybody and we were very engaged in the community generally.*[98]

101. When asked whether a person in severe distress would be able to particularise their distress on the form, Ms Cleary's evidence was that people would get help from somebody whose English language was better and it "*was not unusual for people to just come and knock on the door and say, I'm concerned about this person, my neighbour or my friend*". There were always interpreters at the settlement clinic at any given time.[99]

102. Ms Cleary agreed that a person in acute mental health distress might not have the capacity to properly communicate their condition in a written form.[100] She said that if Omid had written "*I want to visit psychologist. I feel bad*" inquiries would have been made with him.[101] She accepted it would not have been difficult to contact Omid, but did not agree that it would have been prudent to do so in this instance.[102]

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95 Transcript, (02.09.2020), from page 15, line 39.
96 Transcript, (02.09.2020), from page 15, line 6.
97 Exhibit C239.1, paragraph 16.
98 Transcript, (02.09.2020), from page 26, from line 2.
99 Transcript, (02.09.2020), from page 15, from line 23.
100 Transcript, (02.09.2020), page 28, from line 34.
101 Transcript, (02.09.2020), page 29, from line 1.
102 Transcript, (02.09.2020), page 29, from line 16.

103. Ms Smith said that visits by those such as the UNHCR representatives were often associated with an increase in threats of self-harm.[103] While Mr Weinberg agreed with this, Ms Cleary did not.[104] However, Mr Weinberg did not agree that it a UNHCR visit should have been taken into account in the triaging of Omid's self-referral form.[105]

104. Ms Smith said that there were a significant number of threats of self-harm and actual self-harm among refugees both before and after they were released into the Nauruan community. One of the reasons for that self-harm was because of their uncertainty regarding their settlement situation and feelings of hopelessness. Ms Smith agreed that the feeling of hopelessness was not something that mental health workers could adequately address. She said:

> *It's environmental reasons for their distress, and it doesn't really matter how much mental health support … if the environment doesn't change for them, it's very unlikely their mood will change*.[106]

Events of 27 April 2016

105. It is important to understand Omid's actions in the context of other events that took place on the morning of 27 April 2016, as well as his perception of the role of the various officials at the scene of the incident, including UNHCR officers. This is relevant to the question whether his actions were planned or impulsive and whether he intended to end his life with those actions.[107]

106. Pari's evidence at the inquest was that Omid first went to see if there was any work for him that morning. After he found there was no work, he returned to their demountable dwelling.

107. They then decided to head outside and take some pictures to send to their families. As they were going to do this, they noticed the United Nations cars arriving. Pari and Omid approached the UN officials to see what was happening.[108]

[103] Transcript, day 1 (28.02.2019), page 62, from line 1.
[104] Transcript, (02.09.2020), page 51 from line 16; page 73, from line 21.
[105] Transcript, (02.09.2020), page 73, from line 26.
[106] Transcript, day 1 (28.02.2019), page 63, from line 8.
[107] Refer State Coroner's Guidelines 2013, Chapter 8 – version 3.
[108] Exhibit B2 paragraph 53; Transcript, day 1, page 15 from line 18.

108. Pari recalled that she then spoke to a UN official for between 30 – 45 minutes. During this time Omid was nearby, some 7-8 metres away. While she was talking to the UN official, other refugees arrived and were observing what was happening.[109] Pari recalled that she was being asked questions by the UN official to do with her state of mind, and that she had exaggerated her responses. She did this because she wanted to convey to the UN official that "we were very miserable."[110]

109. Pari described her conversation with the UN official in negative terms.[111] Her impression was that the UN officials were "going to provide the certification allowing us to continue being kept on Nauru."[112] Pari argued with the UN official. She said that she was "really upset and frustrated at that time". People were surrounding her, so she just stood up and then called Omid to go back to their accommodation. They argued as they walked and then talked about how frustrated they were.[113]

110. Pari's evidence was that when she called for Omid, he had been standing with a group of approximately 20 people. Pari was not aware what was being said within the group as this took place while she was speaking with the UN official.[114] They then returned to their demountable together.

111. Pari's evidence was that Omid was generally a "very excited person", and he "experienced his emotions in extremes."[115] [116] On returning to their demountable, Pari described Omid as being in shock; he was upset and distressed.[117] While she wanted to get away from the area, he wanted to go back to see what was happening.[118]

112. Omid then left Pari at the demountable. Pari's evidence was that he was angry when he left, and she thought he might "do something like upend a table."[119] At the inquest Pari described Omid's anger as being at the highest level. [120] She said that he knew that she was not going to follow him back so she said, "I know whenever you're angry and leaving, so I wouldn't come to get you".[121]

113. However, after staying at the demountable by herself for a few minutes, Pari decided to go and find Omid. When she arrived at the area where the UN officials were located, she saw Omid running; he was on fire.[122]

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[109] Exhibit B2 paragraphs 56-57; Transcript, day 1, page 15 from line 26.
[110] Exhibit B2 paragraph 59.
[111] Exhibit B2 paragraph 65; Transcript, day 1, page 17 from line 12.
[112] Exhibit B2 paragraph 64; Transcript, day 1, page 17 from line 4.
[113] Transcript, day 1, page 17 from line 26.
[114] Exhibit B2 paragraphs 66-67.
[115] Exhibit B2 paragraphs 69-70.
[116] Exhibit D1.3. In February 2016 he was involved in a motorbike accident following a dispute at home.
[117] Exhibit B2 paragraph 70.
[118] Transcript, day 1, page 19 from line 8.
[119] Exhibit B2 paragraph 72.
[120] Transcript, day 1, page 29 at line 37.
[121] Transcript, day 1, page 19 from line 30.
[122] Exhibit B2 paragraph 74.

114. I heard evidence from other persons who were present for the UNHCR visit on Nauru on the morning of 27 April 2016. Chanelle Taoi was a lawyer working with the UNHCR. She gave evidence to the inquest pursuant to a limited waiver of diplomatic immunity from legal processes.[123]

115. Ms Taoi recalled that the Nibok settlement visit commenced at around 8:30am, for the purpose of:

- Monitoring the refugees' living conditions;
- Meeting with the refugees residing there to enable them to share any concerns with the UNHCR; and
- Administering mental health surveys to refugees who consented to engage voluntarily.[124]

116. Ms Taoi recalled that she was assisting a refugee family with information to do with the medical surveys being conducted, when she began to hear a man speaking loudly in a language that was not English.[125] This man was later identified as Omid. Ms Taoi did not notice that he was carrying a cigarette lighter.[126]

117. Ms Taoi said that the way Omid was speaking was 'loud and intense', and gave rise to very serious concerns for her. She felt that something was very wrong. Because she could not understand as he was speaking in Farsi, she asked the family she was speaking with through the Rohingya interpreter, "*Do you know what he's saying, and do you know what's going on?*"

118. After they indicated they did not understand, Ms Taoi immediately got up and tried to approach Omid to engage with him. She said that he was probably about seven metres away from where she was sitting. She moved within about two metres of Omid. She asked if she could speak to Omid. Her impression was that he was a bit scared, so she retreated.[127]

119. Ms Taoi then noticed that Omid's shirt was damp. She told the inquest that she vividly remembered that because it was not hot enough for him to be sweating. This made her confused and very worried. She recalled the smell of petrol but thought it may have come from a generator nearby.[128]

[123] Exhibit B17.1.
[124] Exhibit B17 paragraph 5; Transcript, day 2, from page 4 line 6.
[125] Exhibit B17, from paragraph 8.
[126] Transcript, day 2, page 5 from line 43; page 6 from line 1.
[127] Transcript, day 2, page 5 from line 2.
[128] Transcript, day 2, page 6 from line 8.

120. Ms Taoi turned to several Iranian refugees who were seated on an embankment. She asked if they spoke English and if they could help communicate with Omid. None of the refugees answered her. She noticed that one of them was recording what was happening on a mobile telephone.[129] She then began searching for a Farsi interpreter, with a view to getting some help to communicate with Omid. She took out her phone and tried to call two colleagues but was unsuccessful.[130]

121. Ms Taoi then put her phone down, stood up and moved towards Omid again. He was shouting. Ms Taoi saw Omid ignite a cigarette lighter and set fire to his shirt. Her evidence was that he tried to light it once. He then lit it again and was successful. A Farsi interpreter then came down as the incident was occurring.[131]

122. Ms Taoi told the inquest that UNHCR officials "did not know and were not made aware of these self-harm and dousing incidents that had been occurring until after". She agreed that the UNHCR would not have gone into the Nibok settlement on that day if they were aware of the risk of self-harm.

123. Billal Soubjaki was employed by Connect Settlement Services ('CSS') on Nauru. His main position was to provide housing support for refugees living in the community on Nauru.[132] On the morning of 27 April 2016, he arrived at the Nibok settlement site and began setting up tables and chairs for the UN to conduct its meetings. While he had recommended the UN visit take place in a closed environment with a register of attendees, this suggestion was not accepted.[133]

124. Mr Soubjaki said that when he arrived, there were many refugees waiting to see the UN officials.[134] He remembered there was some sort of list arranged, but it was "first in, best dressed". It appeared to him that the whole Nibok settlement site was there, just waiting around and there was quite an anxious feeling.[135]

125. Mr Soubjaki knew Omid from living on Nauru and his work with CSS. He said that when he saw Omid that morning, he recalled that his T-shirt was "quite wet."[136] He said Omid "was already doused in petrol".

[129] Transcript, day 2, page 5 from line 17.
[130] Exhibit B17 paragraph 15; Transcript, day 2, page 5 from line 26.
[131] Transcript, day 2, page 5 from line 36.
[132] Exhibit B18.
[133] Exhibit B18 paragraph 9; Transcript, day 1, page 44 from line 44.
[134] Exhibit B18 paragraph 14.
[135] Transcript, day 1, page 37 from line 24.
[136] Transcript, day 1, page 45 from line 24.

126. Mr Soubjaki was not specifically asked how he knew this to be the case or whether he saw it happen. However, he said in his statement that "the smell of petrol soon flooded the air". He remembered that Omid looked like he had "big sweat patches". He did not recall whether he was covered from head to toe but his T-shirt was quite wet.[137]

127. He said that the crowd seemed to part quite quickly as Omid made his way down and then he jumped down from the party wall. Omid started yelling in Farsi. Mr Soubjaki did not understand Farsi so could not make out what he was saying.

128. Mr Soubjaki looked back at the crowd who were watching and called for someone to interpret. There was no official interpreter who came to his aid. The UN meetings were "kind of still going on". He said that they either did not notice Omid or were not fazed by him. A young refugee male then came down and started to interpret for Mr Soubjaki. The young refugee was interpreting in a low voice, just to Mr Soubjaki. A couple of seconds later, Omid pulled out a lighter and lit the flame - "it all happened pretty quickly".[138]

129. Alan Beattie was, at the relevant time, employed by CSS on Nauru as the Manager, Economic Development. His daily duties included managing the development of employment and business opportunities for asylum seekers and refugees.[139]

130. Mr Beattie did not know Omid before 27 April 2016.[140] On that day, his role was to ensure UN officials were able to carry out their duties in an effective and comfortable way, by setting up tables and the like.[141]

131. Mr Beattie said that he was standing, surveying the scene to try and make sure they had provided a suitable environment for the UNHCR to undertake interviews, and for the refugees and asylum seekers to be as comfortable as possible.

132. Mr Beattie said that it was quite a warm day and he was trying to get people into the shade. He did not notice Omid walking down. Mr Soubjaki had tapped him on the shoulder and informed him that Omid had poured petrol over himself. Omid was two to three metres away.

[137] Transcript, day 1, page 45 from line 20.
[138] Transcript, day 1, page 38 from line 5.
[139] Exhibit B6 paragraph 14.
[140] Exhibit B6 paragraphs 18 – 20.
[141] Transcript, day 1, page 51 from line 8.

133. Omid then started to speak in Farsi. Mr Beattie said that he appeared to be trying to talk to the UNHCR staff who were conducting interviews. Several of those staff looked up at him, but paid no particular attention. Within a few seconds of him standing there, he realised Omid had a lighter and the potential of the situation.[142]Mr Beattie did not recall smelling petrol at the time.[143]

134. Both Pari and Mr Soubjaki had no knowledge of the fire being planned.[144] Mr Beattie said that the event was unexpected and certainly not something that was discussed in the planning of the day.[145]

135. However, the inquest also heard from another witness who was present that morning, Mehdi Diba.[146] Mr Diba was a refugee living on Nauru.[147] He knew Omid as being "like a neighbour" to him, in that he would sometimes see him around the Nibok settlement.[148]

136. Mr Diba recalled that he wanted to talk to the UN officials that morning, so attended the area where they had set up. He had to wait to speak to them, and during this wait he saw Omid and his partner who were talking to one of the UN officials.[149] Omid and his partner subsequently left the area, and Mr Diba remained there waiting.

137. Mr Diba said before Omid returned, he told the person sitting next to him to record his interaction with the UNHCR officials. While Mr Diba was talking to the person next to him who was preparing his phone, Omid walked in.[150]

138. Mr Diba said he could not remember who the person next to him was because it was "so intense inside the situation when he put himself on fire". He had asked him to take a video because he wanted to put it on social media or something like that. However, when Omid walked in and put himself on fire "I just lost my manner".[151]

[142] Transcript, day 1, page 51 from line 46.
[143] Transcript, day 1, page 59 from line 15.
[144] Transcript, day 1, page 38 from line 42; page 23 from line 9.
[145] Exhibit B6 paragraphs 91-92; Transcript, day 1, page 55 from line 32.
[146] Transcript, day 2, page 28 from line 5.
[147] Transcript, day 2, page 25 from line 31.
[148] Transcript, day 2, page 26 from line 10.
[149] Transcript, day 2, page 28 from line 22.
[150] Transcript, day 2, page 28 from line 38.
[151] Transcript, day 2, page 29 from line 1.

139. Recordings of the events leading to Omid being on fire were tendered at the inquest.[152] One recording[153] lasts for almost three minutes, and clearly depicts Omid wearing long dark pants and a T-shirt of a lighter colour, standing in a clearing. There is a dog close by, and one or two males who initially come and go from being near Omid, before remaining nearby. Voices can be heard on the footage. Presumably they are of the person/s capturing the footage and others in their company.

140. The recordings show Omid start speaking loudly in Farsi. He became more agitated and upset.[154] Even without knowing what Omid was saying it is apparent that it was a protest or public statement. Voices can then be heard by the person/s filming the incident saying words to the effect "*go and bring the blanket, where are the blankets*" and "*light the lighter*."[155]

141. Omid then set himself alight.[156] He was engulfed in flames very quickly.[157] Several people tried to extinguish the flames using blankets and other materials. The flames were eventually put out completely by someone dousing Omid with water.[158] Omid was alight for almost 30 seconds.

142. Russell Badley was employed as a Safety and Security Advisor with Wilson Security at the RPC in Nauru.[159] His evidence was that on 20 June 2016 (some months after Omid's death), he was approached by two Iranian men in the vicinity of the RPC. He said that the men were very concerned that they had some information that might lead to some violence or something else happening inside the centre or in the community in general.[160]

143. Mr Badley made arrangements to meet the men at a restaurant the following day, 21 June 2016, along with his colleague Damien Doolan.[161] Mr Badley said the men told him that they had information related to the death of Omid. They had a video (not a video that other people had seen). The video depicted the lead-up to the events that happened on the day Omid set his clothes alight. The men told Mr Badley that there was a lot of anger in the community about what had happened and the events that led up to that.[162]

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[152] Exhibit E4 (video & audio); Exhibit B13 (video & audio); Exhibit B3 (total of 5 videos, 2nd file labelled 'Man in Immigration Detention Sets Himself Alight in Nauru'; contains video & audio)
[153] Exhibit E4.
[154] At approximately 1:35.
[155] At approximately 2:00; also refer Exhibit B8.1.
[156] At approximately 2:13.
[157] By 2:14.
[158] By approximately 2:40.
[159] Exhibit E6; E6.1.
[160] Transcript, day 1, page 66 from line 18.
[161] Exhibit E5.
[162] Transcript, day 1, page 66 from line 36.

144. Mr Badley said he then downloaded the footage from his phone to his laptop. He compiled a report relating to his interaction with the men that afternoon, which set out what he was told.[163] That report contained the following key matters:[164]

- The video was reported to be filmed by Iranian refugee Mehdi Diba;
- The initial plan was for three refugees (including Omid) to pour petrol on trousers covering the lower half of their leg which would then be set alight with friends standing ready to put the flames out. The event was to be recorded and sent to advocates in Australia while likely seeing the men transferred to Australia with their families for medical treatment for their injuries;
- Mr Diba supplied the petrol to Omid.

145. Mr Badley subsequently brought the matter to the attention of his manager.[165] He confirmed at the inquest that he was not present for the events of 27 April 2016. He also confirmed that he had not taken it upon himself to conduct any investigation, by way of speaking with the individuals named in his report, or trying to ascertain what had happened.[166]

146. Given Mr Badley's evidence, Mr Diba was shown the footage[167], and asked about it during his evidence under direction.[168] Mr Diba said he did not hear his voice in the footage. Mr Diba did not recall during the time he was watching Omid in that clearing say "*Go and bring the blanket. Where are the blankets?*" Mr Diba also denied saying to Omid "*Light the lighter*".[169]

147. When it was put to Mr Diba that he did say "Go and bring the blankets. Where are the blankets?", he said that before he went for the UNHCR interview he was:

> "*thinking to set myself on fire, but not fully, like just a small part of my – like, down the – in the trouser, so I was thinking to – I was prepared to set that part on fire, that's why I had the blanket with me, and I was sitting on top of it. Like, I didn't tell anyone that I was planning for that one. I wanted to be, like – like, randomly happen. Like, as an accident, and so I didn't even tell the people around me. I just told them, "Just record the video", so when, like, suddenly Omid involved in that and then the video was recorded, like, it wasn't a plan that we wanted to do it. Like, if I wasn't planning to do that, maybe there wasn't any footage at all there*.[170]

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[163] Exhibit E3.
[164] Exhibit E3 page 1.
[165] Exhibit E6.1 paragraphs 19 – 20.
[166] Transcript, day 1, page 67 from line 30.
[167] Exhibit E4.
[168] Transcript, day 2, page 31 from line 32; also refer *Coroners Act 2003* s 39(2).
[169] Transcript, day 2, pages 33-34 from line 42.
[170] Transcript, day 2, page 34 from line 26.

148. When asked what would make him take such an action, Mr Diba said that he had heard the UNHCR were there:

> "*to do the investigation about the condition here for the next ten years, so if that's going to be a problem. So, if they are to remove all the issues for the next ten years – so I just wanted to make sure that's true. So, if it was true and my family was supposed to stay in that place for another ten years, I prefer to kill myself and die*".[171]

149. Mr Diba said that he only told one other person of his plan, and that was 'Badir'[172] (a reference to Mr Dekhurdi). He gave evidence that he only told 'Badir' at the point when he came and sat next to Mr Diba. Mr Diba also mentioned to 'Badir' that he had petrol and a blanket. Mr Diba clarified that he told him he had petrol and blanket, but was uncertain about his decision, "*so I'm not really sure. So, I'm just going to go and talk to them and see how it goes. If I need to stay here with my family, so then I'm going to do that*".

150. Mr Diba agreed that he was sitting there with his blanket and petrol ready when Omid walked into the area.

> *Yeah, I was ready. So, when I told him – the person next to me to record me, so suddenly Omid appeared there.*[173]

151. His evidence was that he had not seen Omid for the last few days, and Omid did not know of Mr Diba's plan that morning. Nobody knew of his plan, except for Mr Dekhurdi.[174]

152. Mr Dekhurdi was excused from giving evidence at the inquest. His written account was inconsistent with the evidence of Mr Diba.[175] He claimed not to have been present when Omid set his clothes on fire.

153. As part of the coronial investigation, two recordings of the events leading to Omid being on fire were translated by a Level 2 Farsi interpreter.[176] These translations were tendered as part of the brief of evidence.[177] Omid's words in the first recording,[178] just before he is seen to be on fire, were transcribed as follows:

> *You have made our lives miserable and hopeless.*
> *I am very tired and exhausted* (implies being fed up).

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[171] Transcript, day 2, page 40 from line 32.
[172] Transcript, day 2, page 35 at line 5; clarification at line 44.
[173] Transcript, day 2, page 35 from line 23.
[174] Transcript, day 2, page 36 from line 1.
[175] Exhibit B7.
[176] Exhibit E4 (video & audio); Exhibit B3 (total of 5 videos, 2nd file labelled 'Man in Immigration Detention Sets Himself Alight in Nauru'; contains video & audio).
[177] Exhibits B8 – B8.1.
[178] Exhibit B3 (total of 5 videos, 2nd file labelled 'Man in Immigration Detention Sets Himself Alight in Nauru'; contains video & audio).

You have peeled off our skin (implies you have tortured us a lot. We have suffered a lot). The man repeats this statement.
You want to see how miserable we are? This is how miserable we are; you have watched us enough. It's three years, you have made us feel quite miserable. This is our situation.[179]

154. Omid's words in the next recording,[180] just before he sets himself alight, were transcribed as follows:

This is my situation here and this is the situation of everyone here. We are tired (implies fed up).
You have made our lives miserable and hopeless. I am very tired and exhausted (implies fed up). *You have peeled off our skin* (implies you have tortured us a lot. We have suffered a lot). The man repeats this statement.
You want to see how miserable we are? This is how miserable we are; you have watched us enough. It's three years, you have made us feel quite miserable. This is our situation.[181]

155. Counsel assisting suggested that the recordings capturing the event should be treated with a degree of caution in terms of weight. One recording was provided to Mr Badley[182] some three months after the event with no forensic analysis conducted to ascertain whether the recording had been interfered with.[183] However, the transcriptions of the words spoken by Omid in both are virtually identical. The videos were also posted to the internet after the incident. I have no reason to conclude that recordings are not an accurate representation of the incident.

156. Once the fire was put out, other refugees took Omid to the RNH by private vehicle.[184] There was no evidence about what occurred during the transfer to the hospital.

Events following arrival at the Republic of Nauru Hospital

157. Pari's evidence was that Omid waited some two hours to receive treatment at the hospital, and that it was two hours before 'Dr Ed' arrived.[185] This is a reference to Dr Edward McGregor, who was a senior medical officer employed by IHMS. He arrived at the RNH at approximately 10:00am on 27 April 2016 after receiving a call for assistance from the IHMS Health Services Manager, Robert Grenlund.[186]

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[179] Exhibit B8.
[180] Exhibit E4 (video & audio).
[181] Exhibit B8.1.
[182] Exhibit E4.
[183] Transcript, day 1, page 70 from line 15.
[184] Exhibit B2 paragraph 79; Exhibit C2 paragraph 15.
[185] Transcript, day 1, page 21 from line 29.
[186] Exhibit C2 paragraphs 12-13.

Dr McGregor arrived with Claire Robinson who was a Clinical Team Leader employed by IHMS.[187]

158. I find that Pari's recollection of the delay is not accurate for the following reasons:

- the medical notes from the RNH suggest that the first entry dealing with Omid was made at 9:40am Nauru time,[188]
- the UN visit did not commence until 8:30am,
- Pari's conversation with the UN official was said to go for more than 30 minutes and the incident took place later,
- the time it would have taken to drive from the incident location to the RNH,[189]
- Dr McGregor arrived at approximately 10:00am.

159. Dr McGregor confirmed that his role with IHMS was to assess, diagnose and treat clients in the immigration facilities at a general practice or emergency medicine level. He was in the RPC facility referred to as 'RPC1', where a clinic operated by IHMS existed.[190] He was the senior IHMS doctor on site at RPC1, and his role also involved supervising other doctors and providing information back to head office.[191]

160. Dr McGregor clarified that after asylum seekers were granted refugee status, their medical care was transferred to the RNH, where the settlement clinic was co-located. Refugees would then access primary health care and mental health care through the settlement clinic.[192] This had been confirmed by IHMS' head office in relation to the scope of his role on Nauru.[193] His practising certificate on Nauru did not extend to the RNH.

161. Dr McGregor said that he had no role in providing services to refugees at the settlement clinic. He was available to support the GPs running the clinic if they had any clinical questions, but he was not involved in the day-to-day care of patients.[194]

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[187] Exhibit C237; Transcript, day 3, page 69 from line 1.
[188] Refer G2 page 115; it is unknown if this is a complete set of notes from the RNH.
[189] Transcript, day 3, page 67 from line 12 – the drive from the RPC clinic to the RNH was described as 15 minutes, during the day, with safe driving; the only reference as to how long it would have taken to drive from the incident location to the RNH was Pari's estimate of 3 – 4 minutes (Exhibit B2 paragraph 81).
[190] Transcript, day 3, pages 53-54 from line 40.
[191] Transcript, day 3, page 54 from line 13.
[192] Transcript, day 3, page 54 from line 21; Exhibit C2.
[193] Transcript, day 3, page 54 from line 40.
[194] Transcript, day 3, page 54 from line 31.

162. Dr McGregor said that he was approached by Mr Grenlund on the morning of 27 April 2016. He was told there was a patient with severe burns, and was asked to attend the hospital to provide support. Mr Grenlund reminded Dr McGregor that he was not to be the primary treating doctor or practising physician for the patient, and "the patient belonged to the Republic of Nauru".[195]

163. Ms Robinson's evidence was in similar terms. She said, "our role in this instance was to provide RNH staff with suggestions and advice on treatment, rather than actual provision or delivery of treatment to the patient."[196]

164. Before leaving for RNH, Dr McGregor and Ms Robinson gathered supplies from the IHMS clinic at RPC1. These supplies were burns kits, which contained intravenous fluids and burn creams, as well as several additional boxes of intravenous fluid.[197]

165. Upon arrival at RNH, Dr McGregor recalled that Omid was in the High Dependency Unit ('HDU') being treated by the emergency department physician, Dr Vuki. Dr McGregor recommended that intubation and ventilation occur promptly and before swelling of the airway became too great. He also suggested that the anaesthetist become involved due to the high risk of a difficult airway.[198] The hospital anaesthetist was Dr Eunice.[199]

166. At this initial review, Omid's burns were assessed as covering 80+% of his total surface body area. Dr McGregor was told that he was being treated with IV antibiotics in the form of ceftriaxone, amoxicillin and gentamicin, as well as a tetanus booster. An in-dwelling catheter was in place. In a hospital note recorded at 10:30am, his pulse was recorded as 110 bpm, blood pressure 120/80 and his oxygen saturations were at 98%.[200] Two litres of IV fluids had been given, and a third litre was ready.

167. Dr McGregor recalled a conversation with Omid during which there was no interpreter present. Omid conversed in English. An AMPLE[201] history was taken, and Dr McGregor asked him why he had done this. Omid's reply was that he "*wanted to die and that he wanted everyone to see it*."[202]

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[195] Transcript, day 3, page 56 from line 5.
[196] Exhibit C237 paragraph 13.
[197] Transcript, day 3, page 56 from line 16.
[198] Exhibit C2 paragraphs 20 – 22.
[199] Exhibit G2 page 119.
[200] Exhibit C2 paragraphs 23 – 24; Exhibit G2 page 116 – 117.
[201] AMPLE - Allergies, Medications, Past medical/surgical history, Last meal and Events surrounding the presentation – refer C2 paragraph 22.
[202] Exhibit C2 paragraph 22.

168. Before intubation, Dr McGregor recalled a conversation with Omid's partner. While an interpreter from the CSS team was present, his partner spoke to Dr McGregor in English.[203] She told Dr McGregor that the events had been planned. She said she was the one who was meant to self-immolate but Omid had grabbed the petrol and carried out the self-immolation before she could.[204]

169. In his evidence at the inquest, Dr McGregor confirmed this conversation. He said that there was no possibility that there had been some confusion between himself and Omid's partner. He said she was very clear and told him what was happening. He confirmed it via the Farsi interpreter.[205] Dr McGregor made a contemporaneous note of this conversation with Omid's partner.[206]

170. At the inquest, Ms Robinson also gave evidence of a conversation with Pari which had not been previously included in her statement.[207] Appropriately redacted file notes of this conference were subsequently tendered.[208] Her evidence was that at the RNH outside the HDU room where Omid was being treated, Pari said in English, confirmed by others:

> "*We're meant to do this together. We talked about it last night; we were meant to do this together*".[209]

171. Ms Robinson's evidence was that in recalling this conversation, she had never seen Dr McGregor's statement. There was no possibility that she had misinterpreted the discussion.[210]

172. At 10:24am AEST (12:24pm Nauru time), the International SOS communication log notes that a central line was being inserted and intubation was also occurring.[211] This is consistent with Dr McGregor's recollection of when intubation occurred.[212]

173. Intubation was relatively unremarkable in terms of inserting the endotracheal tube ('ETT').[213] However, the method of ventilation was via an old anaesthetic machine, as the hospital ventilator (described as a 'transport' ventilator) was not working.[214] The anaesthetic machine had only one setting (volume control), which was initially set to a tidal volume of 400ml. There is no evidence about observations of the ventilator to

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[203] Exhibit C2 paragraph 29.
[204] Exhibit C2 paragraph 29.
[205] Transcript, day 3, page 61 from line 21.
[206] Exhibit G2 page 135 – appears to be a note made by Dr McGregor at 3pm on 27 April 2016.
[207] Exhibit C237; Transcript, day 3, page 69 from line 19.
[208] Exhibits C249; C250.
[209] Transcript, day 3, pages 69-70 from line 44.
[210] Transcript, day 3, page 72 from line 25.
[211] Exhibit C143 pages 112-113 entry timed 10:24:26AM.
[212] Approximately 10:20am, refer Exhibit C2 paragraph 32.
[213] Although there was no evidence of chest x-ray being conducted to confirm placement.
[214] Exhibit G2 page 119.

ensure effective ventilation of Omid. There is also no evidence of fluid charts, observation charts or medication charts. It seems that Omid was commenced on a fluid regime consistent with the Parkland formula (% burn x weight of patient x 4 with 50% given in the first 8 hours).[215]

174. Dr Vuki had quickly identified that Omid's injuries were critical, and that he would not survive if he remained on Nauru.[216] Dr McGregor then essentially took on the role of 'doctor on the ground'. His role was liaison between the International SOS head office in Sydney, the RNH and the RBWH.[217]

175. By 11:00am AEST (1:00pm Nauruan time), a Request for Medical Movement ('RMM') form had been completed and authorised by Dr Rudolph.[218] The purpose of this form was to request that Omid be transferred to Australia for ICU admission and management of extensive burns, and to explain why that transfer was needed. The form also explained that local options (i.e., the Nauru RPC and Port Moresby) were not appropriate as they did not include specialist burns services. The form made its way through IHMS channels before being sent to the DHA for final approval. This was done immediately and had been provided verbally at 10:17am AEST.[219]

176. Meanwhile, enquiries and arrangements to secure an appropriate air ambulance were being progressed. At the inquest, Clive Gillard detailed the logistics to secure LifeFlight for the transfer. The task of organising an air ambulance was placed in context by Dr McGregor in his evidence; "it's not just a simple pick up the phone and the aircraft takes off."[220]

177. Mr Gillard has considerable experience with International SOS as an Operations Manager in charge of identifying suitable air ambulance services, tasking those services, and arranging the ground transport from airports. He had undertaken multiple transfers of severely burnt patients during over ten years in the job.[221] While Mr Gillard was not directly involved in Omid's case, he assisted the inquest by analysing relevant International SOS documentation.[222]

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[215] Exhibit H2; Exhibit G2 page 121.
[216] Exhibit C2 paragraph 17; also noting Exhibit C238 at paragraph 24 that, at 10:10am IHMS and International SOS had discussed the possibility that an air ambulance would be required.
[217] Exhibit C2 paragraphs 34 – 36; Exhibits C2.3 – C2.3.1;
[218] Exhibit C3.5; Transcript, day 3, page 29 from line 15.
[219] Exhibit D1 paragraphs 13.1 – 13.2; Exhibit C238 paragraph 26.
[220] Transcript, day 3, page 65 from line 2.
[221] Transcript, day 4, page 87 from line 41.
[222] Exhibits C238; C238.1; Transcript, day 4, page 71 from line 4.

178. Mr Gillard explained that one of the core businesses of International SOS is to find clients the most efficient, effective, and appropriate air retrieval service for the relevant incident. This involves undertaking an assessment and credentialing of the available services. Mr Gillard explained he would assess both the aircraft and the medical crew. Both need to be appropriate to move a patient safely.[223]

179. In Omid's case, enquiries were made concurrently to see who the most appropriate service provider would be. Mr Gillard said that in any triage circumstance, there is a trade-off between speed and appropriateness of care. In some cases, it may be more appropriate to wait for a higher level of care, rather than to move the patient with a lower level of care and potentially risk further deterioration, illness or injury to a patient by that movement.[224]

180. The further complexities experienced in relation to the retrieval of Omid were:

- an aircraft could not land on Nauru after dark;
- Nauru to Brisbane was a nine hour flight;
- the type of aircraft required to make such a distance;
- the aircraft had to have the capacity to carry a patient with the acuity of Omid.

181. These complications meant that for a flight to reach Nauru by dark on 27 April 2016, it needed to be in the air by 11:30am Nauru time.[225]

182. Mr Gillard explained that, taking these factors into account, LifeFlight was the only appropriate option. At 10:34am enquiries were commenced with LifeFlight.[226] There was no air ambulance available in the window between 10:34 to 11:34.[227]

183. LifeFlight advised that the earliest availability for a departure from Brisbane was at 18:00 hours that day due to crew rest requirements. As Nauru airport had no capacity for an aircraft to land at night, the fastest possible way for LifeFlight to get to Omid was to stop in Honiara (Solomon Islands) for the night of 27 April 2016, and arrive in Nauru at first light on 28 April 2016.[228]

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[223] Transcript, day 4, page 93 from line 40.
[224] Transcript, day 4, page 88 from line 7.
[225] 9:30 Brisbane time; Transcript, day 4, page 89 from line 16; page 7 from line 16; page 45 from line 32.
[226] Exhibit C143 page 111; Exhibit C238 paragraph 28; Transcript, day 4, page 73 from line 20.
[227] Transcript, day 4, page 73 from line 23.
[228] Exhibit C238 paragraph 28.

184. At 10:42am, International SOS provided LifeFlight with all known medical and logistical information regarding Omid, and requested a quotation and confirmation of the timelines.[229] This quote was provided by LifeFlight at 11:24am.[230] Mr Gillard's evidence was that, while the quote was being obtained and information provided to LifeFlight, enquiries were also being made with other, medically and geographically appropriate service providers. These providers were Tropicair, Medical Rescue and Care Flight International.[231] A chartered flight option was also considered, however the acuity of Omid's condition meant that this was not an appropriate option.[232]

185. Mr Gillard was asked about other potential options, which included whether the service provider 'Aspen' might have been engaged. Mr Gillard's evidence was that in April 2016 Aspen "did not have an asset that would've been capable of undertaking a movement from Nauru to Australia." Mr Gillard was also asked about the possibility of service providers in either Fiji, Micronesia or the Marshall Islands in April 2016. His evidence was that there were no options at these locations.

186. At 12:35pm AEST, formal activation was sent to LifeFlight to reconfirm the previous activation provided verbally.[233] I heard from various witnesses from LifeFlight who undertook the mission to retrieve Omid.[234]

- Brian Guthrie, Director of Aeromedical Support;
- Paul Regli, Chief Pilot – Fixed Wing; and
- Dr Allan MacKillop – Chief Medical Officer.[235]

187. Mr Regli explained that Nauru was a familiar destination for LifeFlight. He was aware that Nauru was beyond the range of the Lear 45 aircraft in a single leg, and would require a refuelling stop. The preferred route to Nauru is via Honiara, with a total planned flight time of 9.4 hours. As the total flight time was longer than eight hours, the crew was required to operate under limitations imposed by the Civil Aviation Safety Authority.[236] One such limitation was that the maximum flight duty period[237] was either 11 or 12 hours (depending on the flight start time). The planned flight duty period for this mission was 13.9 hours.

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[229] Exhibit C238 paragraph 29; Exhibit C143 page 109
[230] Exhibit F4 page 3.
[231] Transcript, day 4, page 73 from line 26; Exhibit C238 paragraphs 30 – 33 & 35-36 & 38-39 & 45, 50.
[232] Transcript, day 4, page 73 from line 34;
[233] Exhibit C238 paragraph 51; Exhibit C143 page 99; Exhibit F7 page 3; Exhibit F4 page 15.
[234] Refer 'F' Exhibits.
[235] Exhibits F10; F9; F2 – F2.1.
[236] Exhibit F9 from paragraphs 5 – 7.
[237] The flight duty period commences when the pilot reports for duty and when they go off duty – time is allowed in the flight duty period for pre-flight and post-flight activities – refer Exhibit F9 at paragraph 14.

188. It was explained that, due to the critical nature of Omid's condition and the need for a fast turnaround, this required a 'crew heavy' approach, meaning that the mission was undertaken in one flight duty period with no rest.[238] Practically, this meant that instead of having the standard crew of two pilots (and an overnight rest period before the return flight)[239], three pilots could be used and there would be no requirement for a rest period.[240]

189. An appropriate third pilot for the mission was identified in Brisbane.[241] However, he had completed a mission from 11:30am to 1:30am on 26 April 2016. Therefore, he was required to have 15 hours of rest from 1:30am, before commencing his next duty period. Effectively, this meant that the earliest the third pilot could commence his next flight duty on 27 April 2016 was 4:30pm.[242]

190. At 4:43pm a conference call took place between International SOS personnel (at head office at Sydney and Nauru), the RBWH and Dr MacKillop. The purpose of this call was a formal briefing to share all the medical information and details pertaining to Omid that were available.[243]

191. During the inquest, it was clarified that in the period between the formal approval being made, and the conference call at 4:43pm, other matters such as visas were taken care of, as required for an international departure.[244] However, those matters had no impact on when the medical retrieval team departed. Dr MacKillop explained the situation on Nauru was unique. The unreliability of navigational services meant that aircraft operations in or out of Nauru were restricted to daylight hours.[245]

192. I am satisfied that because of the aircraft capability, flight duty restrictions, and absence of night landing capability in Nauru the earliest that the LifeFlight aircraft could have arrived there was first light on 28 April 2016. This was as soon as possible in the circumstances.

193. Meanwhile, Omid had been intubated and was being ventilated on an anaesthetic machine. The cannula in his foot had 'tissued', and Dr McGregor suggested inserting a central line to improve intravenous access.[246] No adult lines were available - only paediatric. The paediatric lines were noted by Dr Eunice to be insufficient.[247] Femoral Vascath lines were used, but as Dr Eunice was concerned about hitting the femoral

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[238] Lifeflight had an exemption under the Civil Aviation Order 48 where they were able to extend the flight duty period to 14 hours if they went 'crew heavy' – refer Exhibit F9 paragraph 15, Annexure B.
[239] Per the Civil Aviation Order 48 Exemption – refer Exhibit F9 paragraph 6, Annexure B.
[240] Exhibit F10 paragraph 29.
[241] Both Lear 45 assets were in Brisbane – refer Transcript, day 4, page 49 from line 40.
[242] Exhibit F9 paragraphs 16-17.
[243] Exhibit F2.1 paragraph 30 & 32.
[244] See Exhibit F7 from page 3.
[245] Transcript, day 4, page 7 from line 14.
[246] Exhibit C2 paragraph 42.
[247] Exhibit G2 page 120.

artery, Dr McGregor performed the procedure. The procedure was uneventful, and fluid reportedly ran well afterwards.[248]

194. Throughout the day, advice was received from Dr Jason Miller, who is a General Surgeon and Senior Staff Specialist at the Stuart Pegg Adult Burn Centre at the RBWH.[249] Dr McGregor's first contact with Dr Miller was at around 2:00pm (Nauru time) by telephone. By that stage, Omid was on his sixth litre of fluid.[250] Although Dr Miller could not recall the precise detail of these conversations, Dr McGregor recalled that there was agreement as to the management plan.

195. Based on photographs that had been sent to the RBWH, Dr Miller thought that the patient had approximately 80% total surface body area burns. Dr Miller made the following suggestions:

- Continue IV fluids via the Parkland Formula,
- Elevate arms,
- Keep warm (avoid hypothermia),
- Keep the patient's "head up",
- Aim for a urine output of >40-50 ml/hr.[251]

196. Dr Miller suggested that escharotomies[252] be performed to the right arm, right chest and right lateral thigh where the skin was white, and anywhere else it was clinically indicated. He invited the RNH surgeon, Dr Oten, to call him if any advice was needed.[253] Dr McGregor conveyed Dr Miller's advice to Dr Oten.[254]

197. Dr McGregor wrote a summary of the recommendations for treatment in the hospital notes before leaving the RNH at approximately 4:30pm (Nauru time) as he needed to return to the IHMS clinic.[255] These were:

- Check electrolytes 4-6 hourly- to check electrolyte imbalance,
- 2nd hourly BSLs, aiming for a BSL of 6-9- as per standard ICU care regime,
- IV fluids as charted - IV fluids written up on chart as per Parkland Formula,
- Regular antibiotics- already in place,
- Escharotomies with Dr Oten- awaiting his review at that time,
- Urine output >=50 ml/hr- indication of kidney function,

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[248] Exhibit C2 paragraphs 42 – 45; Exhibit G2 page 120.
[249] Exhibit G6.
[250] Exhibit C145.1
[251] Exhibit C2 paragraph 47; Exhibit C145.1; the plan is also reflected in the RNH notes Exhibit G2 at page 121.
[252] Escharotomy is a surgical procedure used to treat full-thickness (third-degree) circumferential burns. It involves a full thickness incision of the circumferential burn down to the subcutaneous fat.
[253] Exhibit C145.1.
[254] Exhibit C2 paragraphs 49-50.
[255] Exhibit C2.5 paragraph 12; Exhibit G2 page 123.

- Aim SBP >=110. May need IV fluid boluses or Noradrenaline- for end organ perfusion,
- Bite block as reinforced tube inserted- patient may accidentally bite down on tube and become impossible to ventilate,
- CXR for ETT position - already organised by RONH staff,
- Minimal oxygen via the ventilator to reduce oxygen free radicals- also mindful of limited oxygen supply,
- Warm patient to 36.5-37.5C -staff already organising a Bair Hugger from OT. No fluid warmers available,
- Hourly observations- staff already performing.[256]

198. Despite not being present at the RNH, Dr McGregor remained in contact with the hospital to provide clinical updates to IHMS and the medical retrieval team.[257]

199. The escharotomies were subsequently performed by Dr Oten.[258] In the entry where this is noted, it was also noted that there had been no urine output for one hour. There is a further entry at 19:00 hours (Nauru time) confirming again that there was no urine output.[259] This was noted again in an entry at 20:30 hours.[260] Omid's blood pressure was also dropping, and he was noted generally to be deteriorating.

200. At about 20:30 hours, Dr Eunice was called back to the RNH to review Omid. It seems this call was made by a GP who was covering the emergency department that evening.[261] At 21:00 hours, Dr Eunice arrived at the RNH.[262] By 23:00 hours Omid's condition was noted as critical and unstable, and he had still achieved no urine output.[263] It was at around this time that Dr Eunice called Dr McGregor.

201. Dr McGregor's recollection of this conversation was generally consistent with Dr Eunice's notes:

    - Omid had become anuric about 3 hours ago, so they were giving IV fluid boluses with the aim of increasing his urine output to 50-100 mls per hour;
    - She had been called by the GP who covers the Emergency Department concerned with Omid's low systolic blood pressure. When she arrived at the RNH the systolic blood pressure was 40 to 50;
    - His potassium was found to be 7.8 and he started to develop cardiac arrhythmia. He was given calcium chloride and two rounds of insulin and dextrose. The potassium dropped to 7.2 or 7.4;

[256] Exhibit C2 paragraph 51; Exhibit C2.4 page 8 & G2 page 123.
[257] Exhibit C2 paragraph 55; Exhibit C143 from page 53 upwards.
[258] Exhibit G2 page 124 notes these were done in an entry time stamped 18:00 hours.
[259] Exhibit G2 page 124.
[260] Exhibit G2 page 125.
[261] Exhibit C2 paragraph 56(b).
[262] Exhibit G2 page 125.
[263] Exhibit G2 page 125.

- Noradrenaline was started with a concentration of 6mg of Noradrenaline and 100ml of Dextrose which was running at 15 mls per hour.[264]

202. Dr Eunice's notes also recorded 'abdominal compartment syndrome', and that Dr Oten needed to urgently review Omid for 'urgent fasciotomy @ surgeon's discretion.'[265] Dr McGregor was concerned that Omid had acute renal failure, possibly secondary to hypovolaemia and hypotension. He promptly drove to the RNH, and updated IHMS and International SOS in Sydney on the way. It was approximately 9:00pm AEST at this stage.[266]

203. When Dr McGregor arrived at the hospital, he noticed that Omid's abdomen was significantly more swollen than earlier in the day and the skin was white. The abdomen was very tense to palpation. A veinous blood gas sample was collected by RNH staff and this showed a marked metabolic acidosis with raised lactate. The pH was 6.5.[267] Regular blood gas monitoring had not been possible during Omid's admission due to limited 'cassettes' available to collect the sample.[268]

204. Dr McGregor and Dr Eunice felt that Omid was suffering from abdominal compartment syndrome ('ACS'). This was impairing the flow of veinous blood and the IV fluids to the heart, leading to haemodynamic instability while also affecting end organ perfusion. ACS would also impair the arterial blood flow and would explain the worsening renal function.[269]

205. Dr McGregor noted at this stage that ventilation was effective with good oxygen saturations. His heart rate was stable at 100 bpm and he was well sedated. A potassium test came back as 7.4. With respect to the ventilation of Omid, Dr McGregor's evidence was that during the 25 hours he was at the RNH he asked Dr Eunice on several occasions whether there were any problems with the ventilation, including via the ventilator or bagging. She did not raise any concerns with ventilation.[270]

206. Dr Oten was called to attend. After Omid went into cardiac arrest it took three cycles of CPR to return cardiac rhythm. Dr McGregor recalled that this occurred around midnight.[271] The RNH notes record it occurring at around 23:30 hours.[272] IHMS and International SOS were updated about the clinical situation at that point.[273]

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[264] Exhibit C2 paragraph 56; Exhibit G2 pages 126-127.
[265] Exhibit G2 pages 126-127 – refers to fasciotomy however Dr McGregor refers to laparotomy.
[266] Exhibit C2 paragraphs 58-59; Exhibit C143 page 52.
[267] Exhibit C2 paragraph 61.
[268] Exhibit C2.5 paragraph 11.
[269] Exhibit C2, paragraph 62.
[270] Transcript, day 3, page 59 from line 14.
[271] Exhibit C2.5 paragraph 16.
[272] Exhibit G2 page 128.
[273] Exhibit C143 at page 49 – time of the entry is just before 11pm AEST (1:00am Nauru time).

207. Dr Oten subsequently performed a laparotomy, which was uneventful.[274] Dr McGregor observed part of the surgery, after which he noted that Omid's haemodynamics began to normalise. Once again, IHMS and International SOS were updated by Dr McGregor when the laparotomy was 'almost complete'. This was just before 11:30pm AEST (1:30am Nauru time).[275] Dr McGregor left the RNH at approximately 2:30am (Nauru time).

208. The RNH notes record entries at 2:30am, 4:00am, 4:25am and 6:00am.[276] These entries suggest that Omid's condition was dire, and that he was kept stable until the medical retrieval team arrived. This is consistent with Dr McGregor's evidence. He said that he suggested to Dr Eunice that they speak again the RBWH, and her response was that she believed "they had done everything they could for Omid at that time."[277]

209. The LifeFlight medical retrieval team was comprised of Angus McDonell and Tracey Griffiths. Dr McDonell was employed by LifeFlight as a fixed wing retrieval physician, and Ms Griffiths was employed as an equipment nurse. They had been informed of the mission to retrieve Omid at 2:02pm AEST on 27 April 2016, and that the anticipated departure time was 10:45pm AEST that evening. There was a slight delay, and the aircraft departed Brisbane airport at approximately 11:33pm AEST on 27 April 2016.[278]

210. Ms Griffiths and Dr McDonell were met by Dr McGregor at the airport and arrived at the RNH at 5:39am AEST on 28 April 2016. The RNH had run out of noradrenaline and had to transfer Omid to adrenaline. Ms Griffiths said that though the ventilator was an old machine of a type she had not seen before, it was providing Omid with the right amount of oxygen. She came to this conclusion due to an arterial gas reading that was done when they arrived.[279]

211. Dr McDonell noted that Omid was unconscious and unresponsive to touch, voice or pain stimuli. As noted by Dr McDonell, Omid's femoral pulse rate was 130 bpm (normal rate 60-100), his blood pressure was 84mmHg (normal 60 – 90mmHg). He was not taking any spontaneous breaths. His pupils were unreactive. His temperature was 34˚C (normal 36 – 37.5) and he was cold to touch. He was very swollen.[280]

[274] Exhibit G2 page 130.
[275] Exhibit C143 at page 48; Exhibit C2.5 at paragraph 17.
[276] Exhibit G2 at pages 131-133.
[277] Exhibit C2.5 paragraph 18.
[278] Exhibit F3 paragraph 2; Exhibit F7 page 5.
[279] Transcript, day 3, page 81 from line 14.
[280] Exhibit F3 paragraph 3; Exhibit F8; Exhibit F1.

212. Dr McDonell identified the ventilator as a bellows ventilator and that Omid's chest had a rhythmic rise and fall of a rate of approximately 15 ventilations per minute. Dr McDonell spent about three hours at the RNH attending to Omid and preparing him for retrieval back to Australia.[281]

213. A chest X-ray showed that the ETT was not placed far enough down into the trachea, or had become dislodged.[282] This was replaced successfully. Dr McDonell formed the opinion that Omid's clinical issues were:

- Extensive partial thickness burns;
- Hypovolaemic shock with evidence of significant poor perfusion to his vital organs particularly Omid's kidneys and gut;
- Hypothermia;
- Either abdominal compartment syndrome or ischaemic bowel from another cause; and
- High positioning of the breathing (endotracheal) tube.[283]

214. Dr McDonell believed there had been a significant period of poor perfusion (the passage of fluid through the circulatory system or lymphatic system to an organ) of Omid's vital organs. This resulted in acute renal failure and possibly ischaemic gut. Dr McDonell instituted the following treatment:

- Maintenance of induced coma and mechanical ventilation of Omid's lungs;
- Exchange of the endotracheal (breathing) tube within his windpipe (trachea);
- Insertion of an intra-arterial catheter into his right femoral artery to enable continuous monitoring of blood pressure;
- Application of chemical heating blankets to raise Omid's core body temperature.[284]

215. Both Dr McDonell and Ms Griffiths gave evidence relating to the facilities at RNH, noticing that they were not sterile and generally not well kept.[285]

216. Dr McDonell's evidence was that the building and the rooms were tired. He said they could have done with a fresh coat of paint. There was no wash basin in the high-dependency intensive care area. The handwashing area out of the room and down a corridor was more like a sloosh - somewhere that you would empty drainage into rather than a hand basin for washing. There was no soap. When he asked for soap someone provided him with dishwashing liquid.

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[281] Transcript, day 4, page 29 at line 16.
[282] Exhibit F1 paragraph 26; Transcript, day 4, page 27 from line 3; Exhibit F3 paragraph 6.
[283] Exhibit F3 paragraph 5.
[284] Exhibit F3 paragraph 6.
[285] Transcript, day 3, page 78 from line 45; day 4, page 29 from line 25; Exhibit F3 paragraph 9.

217. Dr McDonell said that it was not a closed building and there was a reasonable amount of dust in the air that day. Dust was coming through the breezeway into the emergency department. There was dust on the floor and perhaps grime on the walls. He said the equipment was old. The bed was old, and the life support equipment was not stand alone.

218. Part of an anaesthetic machine was the only breathing device. Dr McDonell said he was informed that it was from the operating theatre and had been brought into the room that Omid was in to enable him to be placed in an induced coma and his breathing supported. The machine was like a bellows. You could see a rubber bellows inside a vacuum bell chamber. Instead of having the sophistication of modern mechanical ventilators that have a variety of sensors to inform the operator how effective each breath is, it was simply a matter of eyeballing it. While the anaesthetist who used that machine may have an inherent knowledge of how much gas passed each time, someone who was not familiar with this machine would be concerned.[286]

219. Dr McDonell said it was "not the level of care we would accept in Australia. There is no doubt about that".[287]

220. At 8:52am AEST Omid was on board the LifeFlight plane and it was being prepared for departure. At 8:56am, the plane had departed for Honiara. Prognosis at that stage was poor, and it was thought that Omid may die mid-flight.[288] At 11:14am, the plane departed Honiara and had an expected time of arrival into Brisbane of 1400 hours.

Admission to the RBWH Burns Unit – 28 April 2016 to 29 April 2016

221. Omid arrived at the RBWH and was admitted to the ICU at 15:17 hours on 28 April 2016.[289]

222. The main clinicians involved in Omid's care at the RBWH were Dr Miller, Dr Jason Brown (burns surgeon) and Professor Michael Muller (consultant on call and burns surgeon). Statements from each of these clinicians were tendered at the inquest and Dr Miller and Professor Muller gave evidence.[290]

223. Omid was assessed to have burns covering 57% of his total surface body area. His blood pressure remained low despite being on inotropic drugs (95/50). He was severely acidotic with a pH of 6.87 and his lactate level was very high at 9.9. He was oozing from all his wounds. The escharotomies to the lower limbs were observed to be partial. His lower limb calf compartments were rock hard. He would require lower limb

[286] Transcript, day 4, page 29 from line 25.
[287] Transcript, day 4, page 21 from line 6.
[288] Exhibit F7 page 6.
[289] Exhibit G2 page 2.
[290] Exhibit G3 – G3.2; G6 – G6.3; G7 – G7.1.

amputations. He was hyperkalemic (high potassium). Hypoxic brain injury was also possible given the dislodgement of the ETT and the history of cardiac arrest, however this could not be confirmed.[291]

224. It was considered that Omid was not sufficiently robust to survive an operative procedure. Professor Muller considered his situation was dire and he would be unlikely to survive. Despite this, it was decided to provide Omid with maximum support and intervention in the hope that he would improve sufficiently to undergo surgery.[292] This intervention was subsequently performed in the early hours of 29 April 2016.[293]

225. Professor Muller reviewed Omid just after 9:30am on 29 April 2016 and concluded that he had no chance of survival without extensive surgery, including four limb amputations, but he had no chance of surviving extensive surgery. He concluded that treatment was futile.[294]

226. Later that day, supportive care measures were withdrawn, and Omid died.

Medical Cause of Death

227. On 3 May 2016, a full internal autopsy examination with associated toxicology, CT scans and a review of the medical records was conducted by senior forensic pathologist Dr Nathan Milne. A copy of Dr Milne's autopsy report was tendered at the inquest.[295] Dr Milne's findings were peer reviewed by senior forensic pathologist Dr Rebecca Williams.

228. Internal examination showed no obvious respiratory burns and no evidence of pre-existing natural disease. There was evidence of change, possibly due to ischaemia, to the small bowel and large bowel, the heart, the kidneys, liver and muscles.[296]

229. External examination confirmed burns to approximately 57% of the total surface body area. There was generalised swelling of tissue. Incisions from the escharotomy and laparotomy were evident.[297] CT scans confirmed, among other things, swelling in the brain and areas of lung collapse. Toxicology revealed nothing of significance.[298]

230. Dr Milne structured the formal cause of death as follows:

> 1(a). Multiple organ failure, *due to or as a consequence of*;
> 1(b). Burns"[299]

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[291] Exhibit G7; Exhibit G2 pages 23-25.
[292] Exhibit G7 paragraphs 27 – 30.
[293] Exhibit G2 pages 29-30.
[294] Exhibit G2 page 33.
[295] Exhibit A2.
[296] Exhibit A2 page 12.
[297] Ibid.
[298] Ibid.
[299] Exhibit A2 page 13.

231. Dr Milne explained that multiple organ failure is a common cause of death in people with significant burns.[300]

EXPERT EVIDENCE – MENTAL HEALTH CARE

232. The inquest was assisted by a court-appointed expert, Dr Jill Reddan, and two experts who were briefed by those representing Omid's family, Dr Michael Dudley and Professor Jon Jureidini. Reports from each of the psychiatrists were tendered.[301] The psychiatrists each had extensive clinical experience. They confirmed that they had had regard to the potential impact of hindsight bias in the preparation of their reports.[302]

233. The psychiatrists agreed that the triage process in relation to the self-referral form was not appropriately documented.[303] Dr Reddan said that she would have liked more documentation, such as a written record of the case conference. She said her impression was that staff knew more about people than they wrote down and there was a lot of informal networking, which was also not uncommon in health services in metropolitan areas.[304]

234. Given that none of the triage team had any knowledge of Omid, Dr Reddan said that contact should have been made with him to clarify the basis of his request. She described this as a "curious mindset"[305], to which Professor Jureidini also made reference in his evidence.[306] Dr Dudley and Professor Jureidini agreed that contact should have been made with Omid.[307] As Professor Jureidini said:

> *"The triage process should be, does this person have a problem, let's find out more about it and see if we've got anything to offer."*[308]

235. Dr Reddan's evidence was that contact should have been made with Omid within 12 to 24 hours of the request to see a psychologist being received.[309] However, this did not need to be on the day of the referral if there was no other information that indicated it was something that should be reacted to more urgently.[310]

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[300] Ibid.

[301] Exhibit H3 (Dr Dudley); Exhibit H4 – H4.1 (Professor Jureidini); Exhibit H5 (Dr Reddan).

[302] Transcript, (02.09.2020), page 76 from line 18; day 2 (03.09.2020), page 4, from line 30; day 2 (03.09.2020), page 19 from line 26.

[303] Transcript, (03.09.2020), pages 5-6, from line 46 (Dr Dudley); page 20, from line 11 (Professor Jureidini).

[304] Transcript, (02.09.2020), page 80, from line 4.

[305] Transcript, (02.09.2020), page 89, from line 1.

[306] Transcript, (03.09.2020), page 19, from line 44.

[307] Transcript, (03.09.2020), page 7, from line 21 (Dr Dudley); page 20 from line 19 & page 22 from line 14 (Professor Jureidini).

[308] Transcript, (03.09.2020), page 23, from line 1.

[309] Transcript, (02.09.2020), page 82, from line 7.

[310] Transcript, (02.09.2020), page 82, from line 30.

236. Dr Reddan thought the timing of the appointment with the psychologist for 2 May 2016, six days from when the form was triaged, was reasonable when compared to the general community.

237. However, given it had been some time since Omid had such an appointment, Dr Reddan would have preferred there to have been some contact with Omid about why he needed the appointment. [311]

238. Dr Dudley considered that the difficulty with Nauru when comparing it to the general community, was that people on Nauru generally have:

> "*moderate to severe level of mental disturbance or mental disorder. The vast majority of those who are indefinitely detained on Nauru as refugees or asylum seekers are in that situation*…"[312]

239. Dr Dudley had not been to Nauru and based his view on several sources, one which held its data from evacuees of Nauru.[313] That data was not necessarily representative of the entire Nauruan refugee population, although Dr Dudley did not think there would be much difference.[314] This evidence contrasts with that of Ms Cleary, who said that it was not correct to suggest that all refugees were in a constant state of despair.

240. Dr Reddan had no major criticisms of the adequacy of the template for the self-referral form. Her evidence was that a template should be kept simple, particularly in situations where users of the form are from non-English speaking backgrounds.[315] She said that forms with 'tick boxes' can actually 'put people off'. When responding to the idea that the self-referral form might be more effective if it included some sort of prompting questions for whomever is completing the form, Dr Reddan said that would have to be done carefully. A form that enabled the client to write what they want to write was better – "*The problem with tick boxes is that it starts to lessen the amount of useful information you might get"*.[316]

241. Dr Reddan explained that the form should be left open-ended and be followed up with a phone call to elicit further information about matters such as thoughts of self-harm or suicide.[317]

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311 Transcript, (02.09.2020), pages 82-83, from line 45.
312 Transcript, (03.09.2020), pages 7 – 8, from line 44.
313 Transcript, (03.09.2020), page 8, from line 5.
314 Transcript, (03.09.2020), page 8, from line 11.
315 Transcript, (02.09.2020), page 83, from line 12.
316 Transcript, (02.09.2020), page 84, from line 4.
317 Transcript, (02.09.2020), pages 92-93, from line 42.

242. Dr Dudley's evidence was that the form was not adequate. He said that while Dr Reddan's view highlighted something that can be an issue with questionnaires that are presented with too much detail, he thought some form of structured documentation was important.[318] His evidence was that it was important to "get the story", and that could be elicited by the clinician writing down what they are being told.[319]

243. Professor Jureidini agreed with Dr Reddan that the form should be left open ended. His evidence was that the template of the form itself was not the issue. More important was the reaction to the form:

> *--- I don't think the way around this problem is to provide a better form when you're talking about people with potentially little or no skill in written English. It's more the reaction to the form that's the problem*.[320]

244. Professor Jureidini's opinion was that "in assessing the adequacy of the triage process, it is essential to note that the Nauru refugee population has very high levels of severe psychiatric disturbance, so that the baseline level of risk for any unknown individual is high."[321]

245. Dr Dudley agreed with Professor Jureidini's opinion. His evidence in explaining what is meant by 'high risk' was that the population have established mental health problems because of being indefinitely detained and their predicament being very uncertain, and the circumstances of the environment of immigration detention, which is disempowering and dehumanising.

> *it's hard to be absolutely certain about this, but when people are depressed – and many people – large numbers of people in this population would be depressed – there's – depression is certainly associated with suicidal ideas and suicidal actions. It doesn't mean that everyone who's depressed necessarily does that, but I guess when it's associated with a sense of hopelessness, it's more likely to be the case. And so, people are going to have much higher levels of despair, basically, of a sense of hopelessness and a sense of despair*.[322]

246. Professor Jureidini's evidence was that it would not have to be a very high number to be considered high in this context. He said that if there was a chance of a few percent that somebody might kill themselves, he would regard that as a high risk situation, because in the general population there is a 1/10000 chance that a person will kill themselves.[323]

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318 Transcript, (03.09.2020), pages 8- 9, from line 39.
319 Transcript, (03.09.2020), page 8, from line 41.
320 Transcript, (03.09.2020), pages 20-21, from line 47.
321 Exhibit H4, page 2.
322 Transcript, (03.09.2020), page 8, from line 41.
323 Transcript, (03.09.2020), page 21, from line 42.

247. Dr Reddan's evidence was that it was dependent on what was meant by 'high'. In her opinion, there are high levels of distress in refugee populations and that distress will vary at various times. She said that the problem with assuming that it was always high makes it very difficult to triage.[324]

248. Dr Dudley agreed that high levels of distress in refugee populations may vary at different times, depending on the context in which people find themselves.[325] Professor Jureidini also agreed that the levels of distress may vary, but said it was more a matter of visibility of the distress that would vary, clarifying that sometimes people can suffer quietly and make their suffering unknown.[326]

249. In the context of Omid's actions in setting fire to himself being an act of protest that were not intended to end his life, each of the psychiatrists was asked whether this led to the possible conclusion that there was no "mental health element" to his death.

250. Dr Reddan explained that there may not have been a formal mental health diagnosis, however,

> *"---It doesn't mean there wasn't frustration and strong emotion because even a protest involves strong emotion, and – but it doesn't necessarily mean that he had an illness..."*[327]

251. Dr Dudley's evidence was that protest does not disqualify despair or depression. He said that the two things can coexist as people are in intolerable situations and that was why they protested.

> *Sometimes, in the media and in, you know, commentary by certain politicians, protest is read as manipulation, and it may be an attempt to obtain an outcome, but it's always – almost always based in, you know, the underlying, you know, depression, hopelessness, despair of this context."*[328]

252. He described the action of burning yourself in protest as "an extreme action to take", and in combination with his background, thought it very likely that Omid was suffering from psychiatric symptoms at the time.[329]

253. Professor Jureidini considered it was extremely likely that Omid would have met criteria for at least one and probably more than one psychiatric diagnosis at the time.[330]

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324 Transcript, (02.09.2020), page 84, from line 43.
325 Transcript, (03.09.2020), page 11, from line 14.
326 Transcript, (03.09.2020), page 22, from line 3.
327 Transcript, (02.09.2020), page 86, from line 7.
328 Transcript, (03.09.2020), page 12, from line 14.
329 Transcript, (03.09.2020), page 13, from line 30.
330 Transcript, (03.09.2020), page 24, from line 17.

--- I think the important thing is that if somebody was contemplating setting fire to themselves as a form of protest, then that represents some fairly disturbed thinking. Whether it represents some kind of formal mental illness or not is – feels less important to me. And there's a missed opportunity here. It's entirely possible that he could have been sought out by the triage service, they could have had a conversation with him, and nothing may have come up about the setting himself alight, and he might have gone ahead and done it anyway. But the fact remains that there was also the possibility that having made contact with the mental health service, he might have opened up about this stuff and it might have been preventable, whether or not you attribute it to mental illness or protest or some combination of that.[331]

254. Dr Reddan said that self-immolation, in some cultures, can be very much associated with protest. When it was associated with mental illness, it has generally been either severe melancholic depressions or psychotic illnesses, with the melancholic depressions also associated with significant anger.[332] If a person is experiencing melancholic depression, they usually exhibit signs as follows:

Where I've seen it in those circumstances… it's been very noticeable to other people that there was something not just wrong, not just distress, but very wrong. They've been, for example, with a melancholic depression, you often seen profound psychomotor retardation, statements of profound hopelessness and despair, or, really more often, nihilism such as, "I'm dead and we're all dead," or something like that. And the psychosis is usually manifest to other people if they're actually psychotic. So, it's usually not something that's subtle.[333]

255. Dr Reddan could not find any evidence of Omid having been in a sustained state of despair, or nihilism, in the lead up to his death. In her review of Pari's statements, she could also find no indication that Omid was in such a state.[334] As Professor Jureidini said in his evidence, it is possible that Omid made the decision to protest on the morning of 27 April 2016.[335]

256. When giving evidence about thoughts of suicide or self-harm, as opposed to committing suicide or self-harming, Dr Reddan commented on the difficulty in predicting the latter.

– it's very much more common for people to be thinking of self-harm or thinking of suicide than actually suiciding, so it makes your assessment of it and how you respond to it always fraught with enormous uncertainty.[336]

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331 Transcript, (03.09.2020), page 22, from line 35.
332 Transcript, (02.09.2020), pages 96-97, from line 35.
333 Transcript, (02.09.2020), page 97, from line 15.
334 Transcript, (02.09.2020), page 101, from line 4.
335 Transcript, (03.09.2020), page 28, from line 21.
336 Transcript, (02.09.2020), page 96, from line 9.

257. There was no evidence from the information available that Omid had a significant mental health diagnosis.[337] However, as Dr Reddan explained one of the problems in psychiatry was "*knowing what's the boundary between, for example, distress, psychological suffering, psychological pain, and a diagnosis*."[338] Dr Reddan also agreed that a decision to commit suicide is a decision that can be made by a person who is not suffering a diagnosable illness. She said many people who suicide are not out of contact with reality.[339]

258. Dr Dudley's evidence was that, at a minimum, one would have to describe Omid's actions as "reckless indifference."[340]

EXPERT EVIDENCE – EMERGENCY MEDICAL CARE

259. The inquest was assisted by two court-appointed experts, Dr Mark Little and Dr Drew Wenck. In addition to Drs Little and Wenck, Professor Muller and Dr Miller also provided assistance to the inquest in an expert capacity, despite their involvement as clinicians who dealt with Omid at the RBWH.

260. In terms of the timeliness of Omid's retrieval from Nauru, I was also assisted by Mr Guthrie from LifeFlight, and Mr Gillard from International SOS. Both brought their relevant experience to the inquest to assist in understanding how the timeframes for retrieval in this matter compared to the rural context within Australia.

261. Dr Little is a Consultant Clinical Toxicologist and Emergency Physician who is employed as a Senior Staff Specialist at the Cairns Hospital. In addition to his qualifications and experience in emergency medicine, he has experience in humanitarian aid and medical assistance outside a tertiary hospital environment. He is a member of the Australian Medical Assistance Team, health professionals who deploy at short notice to crisis situations within Australia and overseas (e.g., earthquake events, flood events and typhoon events).[341]

262. Dr Wenck is an Anaesthetist and Intensive Care Specialist, who is employed as the Director of Intensive Care at the Cairns Hospital. While having been in this role for the last 20 years, he also has seven years' experience in the management of very large burns in a tertiary referral burns centre.

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337 Transcript, (02.09.2020), page 86, from line 7.
338 Transcript, (02.09.2020), page 77, from line 9; Exhibit H5, page 3.
339 Transcript, (02.09.2020), page 98, from line 20.
340 Transcript, (03.09.2020), page 15, from line 36.
341 Exhibit H2.

263. No evidence was produced at the inquest by any other party to contradict the opinions expressed by Dr Little or Dr Wenck. They were impressive witnesses, as were Professor Muller and Dr Miller, and their high level expertise greatly assisted the inquest in understanding what occurred and what would normally occur in the treatment of serious burns.

264. Dr Little confirmed that Nauru is a resource poor country compared to Australia, and the health care is not of the same standard. He demonstrated this by providing the following data:[342]

	Nauru	Australia
Life expectancy	60.2 yrs	82.4 yrs
Neonatal mortality rate/1000 live births	21.7	2.3
Under 5 mortality rate/1000 live births	35	3.8
Immunisation coverage	DPT1: 98% DPT3: 79% Polio: 79%	DPT1: 92% DPT3: 92% Polio: 92%
Number of Hospitals with intensive care units (level 3)	0	81

265. Dr Little believed the RNH clinicians worked "tirelessly to care for a critically injured Omid with limited resources." He believed that "the care was of a reasonable standard for a resource poor country like Nauru."[343]

266. Dr Little's opinion was shared by Dr Miller. He said that he would expect a major burn of the nature suffered by Omid on a Pacific Island "to be lethal 100 per cent of the time", and "the only chance he had was to have more effective care at an earlier timeframe and, unfortunately, that couldn't be provided".[344]

267. Dr Little's opinion in terms of the limited resources was also touched on by other clinicians in their evidence to the inquest. Ms Robinson agreed that the facilities at the Republic of Nauru Hospital were not suitable or adequate for dealing with severe burns patients.[345]

268. Dr McGregor also detailed the shortcomings in terms of the facilities available. He observed the medical staff at the hospital appeared to have worked tirelessly over a 24 hour period to try to save Omid's life. In relation to ventilation the emergency department had a typical, transport ventilator, common within emergency departments in Australia. Unfortunately, that was unserviceable at that time. He said that the anaesthetist, Dr Eunice,

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342 Exhibit H2 page 3, 'Table 1: Health data comparison Nauru and Australia' - Data from WHO (www.who.int) UNICEF (www.unicef.org), Australian Institute of Health & Welfare(www.aihw.gov.au) and Nauru Bureau of Statistics (www.nauru.prism.spc.int).

343 Exhibit H2 page 8.

344 Transcript, day 3, page 6 from line 4.

345 Transcript, day 3, page 74 from line 38.

brought the theatre ventilator into the emergency department and used that for the ventilation of Omid. He acknowledged that although it is not a "*ventilator you would commonly see in that environment, it should certainly have done the right job*".

269. Dr McGregor said that there was other equipment that was not available. For example, no adult central lines were available, and they had to make do with Vascath dialysis catheters that he managed to find. They worked well. There was also limited pathology available on Nauru. While they used machines like the i-STAT machine, which is commonly used in remote and rural parts of Australia for running simple blood tests, he was made aware that they only had limited cartridges in certain areas, particularly regarding blood gases.

270. However, running blood gases in Nauru was not a common test that needed to be run, as it was unusual to have a critically unwell patient such as Omid.[346]

271. Professor Muller also touched on the importance of adequate facilities, making the point that chances of survival should not be measured in terms of distance and time. He noted that in the Middle East, where people are looked after by high care specialists there was no difference in mortality figures compared to Germany. He said it was not the distance and the time that were important. It was the "equipment and the training of the personnel that gives you the changes in outcome".[347]

272. Professor Muller agreed "that everyone did their very best with limited resources and limited training."[348]

273. Dr Miller's evidence as to whether the ACS might have been picked up earlier is relevant to the issue of facilities. He said that there would have been some delay to the identification of abdominal compartment syndrome "without the full gamut of monitoring equipment available at a major trauma centre". He said that ultimately, you also need access to an emergency operating theatre in a very timely fashion and unless you had that resource available on the back of monitoring, it was not going to make a difference.

274. The monitoring equipment Dr Miller referred to was equipment to monitor arterial blood pressure with an arterial line, and monitoring central venous pressures with a central line to check fluid levels. In addition, bladder pressure should be monitored. Bladder pressure monitoring requires specific equipment and training, and an intensive care nurse is trained to be able to measure that. This is often done to confirm the suspicion of abdominal compartment syndrome. None of that equipment was available on Nauru.[349]

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[346] Transcript, day 3, pages 57-58 from line 23.
[347] Transcript, day 5, page 18 from line 36.
[348] Transcript, day 5, page 3 from line 29.
[349] Transcript, day 3, page 8 from line 5.

275. There were several shortcomings in the medical care of Omid at the RNH established on the evidence. The critical aspects of treatment of a burns patient were explained by Professor Muller during his evidence, as follows:

> *So in a burn patient, there are two things going on. One is commonly – so it's called restriction. The dead burned tissue we call the eschar –… and it doesn't move. It doesn't, you know, shift. And that's why we – people will get compartment problems in their limbs and in their belly… so that there are a number of things that go on that cause restriction of ventilation*.[350]

…

> *the eschar, the dead burned tissue, does not have the same distensibility as normal skin. And if – you have a circumferential burn, particularly around the chest and or around the abdomen, which is particularly important for children because they breathe with their abdomen, there is a restriction and it is called a restrictive lung disorder that doesn't allow the chest wall, or the diaphragm in Omid's case, to move properly and therefore create negative pressure therefore sucking – or if there's positive pressure ventilation, there is – it's fighting against that restriction. If you think of a cuirass … the breast plate by worn by conquistadors, it isn't going to move and that's the sort of thing that we see*.[351]

276. Dr Muller said that the RBWH provided nutrition within hours and ventilatory support to treat significant burns to over 50 percent of the body Within 24 hours, the patient is taken to the operating room and the burn wound is removed and covered with a skin graft or depending on the burn size, donated skin or a sterile nylon fabric. Patients are also kept warm, and they are monitored with blood tests, and with "invasive monitoring on complex machines".[352]

277. In terms of the ventilation of Omid while at the RNH via the anaesthetic machine, there was some conjecture during the inquest about whether this was working adequately or not.[353] The evidence of Dr McDonell about the type of ventilator used at the RNH was:

> *"You wouldn't use a machine like that. The only places you'd find them now are in museums*."[354]

278. Professor Muller agreed that if Omid had had the benefit of receiving ventilation via a modern ventilator rather than the bellows ventilator that would have improved the standard of treatment he received at RNH.[355]

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[350] Transcript, day 5, page 14 from line 30.
[351] Transcript, day 5, pages 23-24 from line 45.
[352] Transcript, day 5, page 10 from line 10.
[353] Transcript, day 5, page 23 from line 25.
[354] Transcript, day 4, page 34 from line 21.
[355] Transcript, day 5, page 27 from line 23.

279. Dr Wenck's evidence about the type of ventilator used in the context of a rural or remote area hospital was that a lot of small hospitals have transport ventilators, which are "quite a bit more sophisticated than an anaesthetic ventilator". He said several Pacific Islands have second-hand anaesthetic machines from Australia, which usually have Campbell ventilators on them. The Campbell ventilator is inadequate for this task:

> "*It would be able to ventilate the patient if there was no other complication, but once the patient became complicated, then it wouldn't be up to it."*

280. Dr Wenck said that most anaesthetic machines have ventilators which are not anywhere near the level of sophistication required to look after a complex burns patient beyond the first six hours or so.[356]

281. Dr Little's evidence was that respiratory acidosis in Omid was contributed to by poor ventilation.[357] This may have been due to the ventilator or its settings, lack of neuromuscular paralysis and/or the burns injury preventing adequate ventilation. While he was not able to be definitive; he said the LifeFlight doctor was able to reduce the CO2 level, and the pH improved. This led him to conclude that Omid's acidosis was due to the inadequate ventilation. However, he accepted the burns injury would limit chest movement so that they would have difficulty ventilating from the compartment syndrome.[358]

282. It was clear that Omid developed ACS while at the RNH, and this was responded to by Dr Oten performing the laparotomy in the early hours of 28 April 2016.

283. In explaining how ACS develops and its link to fluid administration, Dr Miller said that the presence of increasing abdominal pressure would have resulted in the fluid not going where it needed to. The increased abdominal pressure caused reduced renal blood flow, and that led to renal failure.[359] Dr Miller also said that the absence of fluid administration charts created a critical gap in being able to determine exactly how effective the fluid administration was.

284. With respect to how ACS is generally detected whether it should have been detected earlier, Professor Muller said this deterioration is often seen in non-burns centres. His view was that this was the "critical point"[360], and "fluid wasn't getting in and past the tight abdomen from the groin – started at that point and deterioration continued from there."[361]

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[356] Transcript, day 5, page 33 from line 18.
[357] Exhibit H2 page 5.
[358] Transcript, day 5, page 48 from line 1.
[359] Transcript, day 3, page 7 from line 29.
[360] Transcript, day 5, page 3 from line 42.
[361] Transcript, day 5, pages 3-4 from line 35.

285. Professor Muller's evidence was that the ACS was caused by fluid resuscitation[362], and the ACS contributed to renal failure. In this regard, his evidence was that the most sensitive, or important aspect is the urine output.[363] The evidence in this case has established that Omid had no urine output in the hours before the ACS was recognised.

286. Dr Wenck's evidence was that the lack of urinary output in a major burns patient could indicate many things. First, the patient may have other injuries from the burn itself. Second, the lack of urine output may reflect not enough fluid. It may reflect heart disease in the patient and blood pressure for many reasons. It may indicate that the patient has early sepsis, but it might also indicate other problems like in Omid's case, where he developed an abdominal compartment syndrome.

287. Dr Wenck said that one of the early features of abdominal compartment syndrome, in areas where diagnostic sophistication would not be present was a drop in urine output.[364] Anuria or zero urine output is one of the classic features of abdominal compartment syndrome.[365]

288. Dr Wenck also mentioned that in a burns patient, if the escharotomies are not completed early enough, not performed deeply enough and in the correct anatomical position, this can also prevent the abdomen constricting and cause raised intra-abdominal pressure.[366] Dr Wenck said that the incisions needed to be "really very, very deep, long cuts into the patient and they must be down to bleeding tissue when you do that. You have to cut to bleeding tissue."

289. Dr Wenck said these are very large wounds and you must then control the bleeding. While they injected some adrenalin into the wounds to try and stop the bleeding, in Australia diathermy would control the bleeding. He said that in addition, these patients almost invariably have a coagulopathy that needs to be supported with blood, plasma and platelets to try and control the bleeding. These were not available in Nauru.[367]

290. While Dr Wenck's view was that the escharotomies were inadequate in this case[368], Dr Miller held the opposite view.[369] The review at the RBWH noted that the escharotomies were partial.[370]

291. Following Dr Wenck's evidence that adrenaline was used for the escharotomies, the RNH ran out of noradrenaline in its care of Omid, and adrenaline had to be administered in its place.[371]

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[362] Transcript, day 5, page 28 from line 30.
[363] Transcript, day 5, page 6 from line 21.
[364] In Australia, this would be measured using intra-abdominal pressure
[365] Transcript, day 5, page 32 from line 31.
[366] Transcript, day 5, pages 32-33 from line 45.
[367] Transcript, day 5, pages 35 from line 30.
[368] Exhibit H1 page 2.
[369] Transcript, day 3, page 9 from line 4.
[370] Exhibit G2 pages 24 – 25.
[371] Exhibit F3 paragraph 5.

292. Dr McDonell explained that inotropes increase the strength of contraction of the heart. In the care of a critically ill person, the preference would be to use noradrenaline because you do not need to deal with the range of side effects that adrenaline brings. In rural and remote settings where there may not be a supply of noradrenaline, adrenaline is a reasonable substitute for up to 24 hours.[372]

293. Dr McDonell's evidence was that noradrenaline is an "expensive drug."[373] Professor Muller explained the importance of noradrenaline, and more importantly the availability of it in the Australian context. He said that it was vital to have a sufficient supply of noradrenaline to keep burn patients alive. He said that he would not expect a sufficient supply of noradrenaline to be available in any hospital in Australia. He said that a rural hospital in Queensland would have "an amount", but they would be resupplied by the retrieval staff.[374]

294. I also heard that while the initial estimate of the extent of the burns suffered was 75-80% of the total surface body area, this was later assessed as 57% at the RBWH and at autopsy. Dr Miller said that there is no machine available to provide an exact assessment, and any assessment is therefore made based on clinical experience.[375] Similarly, Professor Muller said was that issues with diagnosing the size of burns is commonplace, and occurs "almost always."[376]

295. While there were no doubt shortcomings in the medical care provided to Omid, the experts in this matter consistently indicated that this needed to be considered in the context of the serious nature of the injuries Omid had sustained.

296. Dr Miller established how important specialist burns care is for this type of injury:

> *…your opinion would be that the predicted percentage of chance for Omid to die from his injuries is five to 10 per cent? ---That's correct.*
> *So he had, essentially, a 90 to 95 per cent chance of surviving those injuries? ---That's correct.*
>
> *Okay. And is it correct to understand that that 90 to 95 per cent chance of survival would be on the assumption that he is receiving care in an Australian accredited tertiary hospital - - -? ---Absolutely.*
>
> *- - - with burns specialists? ---It would be fully dependent on the care that he received in a timely fashion.*[377]

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[372] Transcript, day 4, page 35 from line 24.
[373] Transcript, day 4, page 35 at line 46.
[374] Transcript, day 5, pages 8-9 from line 46.
[375] Transcript, day 3, pages 17-18 from line 38.
[376] Transcript, day 5, page 3 from line 32.
[377] Transcript, day 3, page 5 from line 35.

297. Dr Little's evidence was that burns patients are very difficult to manage, and require "meticulous attention and the use of appropriate investigations and observations to monitor the progress of the patient."[378]

298. Professor Muller agreed that patients such as Omid are difficult to manage and that regional centres in Queensland find them extremely challenging.[379] He also agreed that someone who has received burns to approximately 50 per cent of their body is in a very serious medical condition.

299. Asked whether effective treatment for someone with burns to a significant part of their body is very challenging from a medical perspective, Dr Muller said such care was routine at the RBWH but was challenging for many. The treatment of such burns requires significant experience in relation to dealing with such issues and the type of equipment that is available at an Australian tertiary hospital. He said, "they deteriorate the longer it takes to get to a tertiary institution". [380]

300. Dr Muller also said that people "with big burns and the ones that get our attention are over 50 per cent burnt …their wheels start falling off, around about hour 8 to 10. And so, we want our burn patients to get to us absolutely as quickly as possible".[381]

301. Professor Muller considered that the "die was cast"[382] from the time of Omid's cardiac arrest at the RNH. He said he was not able to remember a case where a severe burns patient had a cardiac arrest, and "actually making it through".[383]

302. With respect to whether he would expect a rural hospital in Australia to be able to deal with Omid's case, Dr Wenck said that in rural Australia the doctors usually have a great deal of further training in rural and isolated medicine. Their resuscitation and anaesthetic skills are of a high calibre. The equipment is well maintained and comprehensive. End tidal carbon dioxide monitoring is available with blood gas analysis. Concentrated fibrinogen is available to treat coagulopathies. Telemedicine links are easily established to liaise with consultants in the bigger centres. The nursing staff would have meticulously recorded the observations of the patient. The doctors would have been communicating intensely particularly when the patient started to deteriorate.[384]

[378] Transcript, day 5, page 46 from line 14.
[379] Transcript, day 5, page 3 from line 16.
[380] Transcript, day 5, pages 17-18 from line 28.
[381] Transcript, day 5, page 5 from line 7.
[382] Exhibit G7 paragraph 58(d).
[383] Transcript, day 5, page 4 from line 7.
[384] Exhibit H1 pages 2-3.

303. In relation to blood gas monitoring, Dr Wenck said that was that hospitals at Mareeba and Thursday Island would be "able to cope with this."[385] Professor Muller also gave evidence about his expectations of a regional hospital in Australia being able to deal with a burns patient. He said that in towns such as Dalby, Emerald, Charters Towers and Proserpine he would agree with Dr Wenck. However, the training is patchy around burns patients because big burns are quite uncommon.[386]

304. Professor Muller agreed that in his 25 plus years of treating burn injuries, he was aware of other people who received burns like Omid in rural or remote Queensland or other parts of Australia, who did not ultimately survive.[387]

305. Evidence was also heard regarding the timeliness of the retrieval of Omid, and whether it was comparable to retrievals in other parts of rural Australia to major tertiary facilities. The total time from when Omid sustained his injuries, to when he was delivered to the RBWH was some 31 hours.

306. In his evidence, Mr Guthrie explained that international retrievals are very different to domestic retrievals in terms of the immigration requirements. He said that "generally, domestically, a task would take lesser time overall."[388] However, with respect domestic retrievals, he clarified this by pointing out that sometimes they can be quite like international retrievals because "distance is really what dictates the timeframe for us. Our planes don't travel at different speeds or things like that, depending on international or domestic, so really, it's down to distance."[389]

307. With reference to Omid's case, Mr Guthrie explained that the retrieval would be like what was done regularly from the Northern Territory through to South Australia based on distance. They have the same or similar rest periods that are incurred based on flight and duty period.[390]

308. Mr Gillard also gave some evidence about Omid's timeframes for retrieval compared to that experienced in rural parts of Australia. He said that where there is very little infrastructure, then certainly that could take an extended period. However, 31 hours was "quite a long time, and I would be surprised if it took that long. However, it's not outside the realms of possibility".[391]

[385] Transcript, day 5, page 37 from line 5.
[386] Transcript, day 5, page 27 from line 7.
[387] Transcript, day 5, page 19 from line 9.
[388] Transcript, day 4, page 45 from line 5.
[389] Transcript, day 4, page 45 from line 30.
[390] Transcript, day 4, page 45 from line 35.
[391] Transcript, day 4, page 75 from line 2.

Conclusions on Inquest Issues

Issue 1 – The findings required by s 45(2) of the Coroners Act 2003

309. The focus of an inquest is to make the findings required by 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 the material contained in the exhibits and the evidence given by the witnesses, I make the following findings in relation to the death:

Findings required by s. 45

Identity of the deceased

Omid Masoumali

How he died

In September 2013, Mr Masoumali and his partner were transferred from Christmas Island to the Nauru Regional Processing Centre where he was detained under an agreement between the Australian and Nauruan governments. After they were given refugee status in December 2014, they were released from the RPC and permitted to live at the Nibok settlement on Nauru.

They were effectively unable to leave Nauru in the absence of resettlement arrangements or a temporary transfer to another country for medical treatment.

On 26 April 2016, Mr Masoumali asked to see a psychologist employed by IHMS at the Settlement Clinic which was collocated with the Republic of Nauru Hospital. He was scheduled to see the psychologist on 2 May 2016.

On the morning of 27 April 2016, representatives of the UNHCR went to the Nibok settlement to interview refugees. Mr Masoumali's partner was seen by a UNHCR employee and was very unhappy after that meeting.

After leaving with his partner, Mr Masoumali returned to the area where the meetings with refugees were being held and set himself alight after fuel was applied to his clothing. It is not clear who applied the fuel.

Before igniting the fuel, Mr Masoumali spoke of his frustration with his situation. He said that he was tired, miserable and exhausted.

Mr Masoumali suffered severe burns to over 50% of his body. He was taken to the Republic of Nauru Hospital where attempts were made to treat his burns with the guidance of IHMS clinical staff. He went into cardiac arrest but was stabilised.

Mr Masoumali was airlifted by LifeFlight Australia from Nauru to the Royal Brisbane and Women's Hospital on 28 April 2016. He arrived 31 hours after sustaining his burns. By that time his condition was irretrievable. After palliative treatment he died the following day.

The level of care he required could not be provided at the Republic of Nauru Hospital. He could not be transferred to a hospital with the necessary equipment and clinical skills in time to treat his burns.

Place of death

Royal Brisbane and Women's Hospital, Brisbane.

Date of death

29 April 2016

Cause of death

Multiple organ failure, due to, or as a consequence of, burns.

Issue 2 - The factors, circumstances and events giving rise to and surrounding the incident on 27 April 2016 at the Nibok Settlement in the Republic of Nauru whereby the deceased was seen to set fire to his own clothing and, in particular, the factors, circumstances and events giving rise to his decision to take that action.

310. Omid and Pari were detained in the RPC on Nauru for over a year up until December 2014. After their refugee status was recognised by the Government of Nauru, they were transferred to the Nibok settlement where they lived for over a year. At the time of Omid's death, they had been in the position of not knowing what would happen to them (apart from not being able to settle in Australia) for 959 days.

311. Although a transitory person could be removed from Nauru by the Commonwealth for a temporary purpose, the clear policy position was that such persons would only be brought to Australia or other countries in exceptional circumstances. Medical transfers from Nauru to Australia were significantly restricted.

312. On 26 April 2016, the PNG Supreme Court held that the detention of asylum seekers on Manus Island was illegal. However, there was no clear end to the time that Omid and Pari would be required to remain on Nauru as refugees.

313. The evidence indicated that the visit by the UNHCR to the Nibok settlement on 27 April 2016 was viewed with suspicion by refugees. Pari perceived that the purpose of the visit was to limit their capacity to leave Nauru for an indeterminate period, and to certify that living conditions on Nauru were acceptable.

314. On 27 April 2016, these events created a catalyst for a public display of frustration and anger by Omid and other refugees at the site of the visit to the Nibok settlement by UNHCR officials.

315. I accept counsel assisting's submission that there is no evidence that indicates that Omid's actions were anticipated by the UNHCR officials, CSS staff, or Wilson security staff.

316. Counsel assisting also submitted there was no evidence of any measures, such as additional security, rescheduling the UNHCR visit, or other protective measures that might have been implemented to contain or preventing such an event on that day. Although the precise level of risk relating to Omid was not identified, I do not accept the submission that more general risk mitigation was not feasible.

317. There was evidence that in the six weeks before 27 April 2016 there had been "protests every night at 6:00pm as they are wanting their voices heard."[392] Relevantly, the meeting of the Emergency Control Organisation ('ECO') on 26 April 2016 was in relation to a "continuation of the ECO for the regular daily protests, to discuss what to do over the next few days of the UNHCR visit."[393] The ECO minutes record that the threat level was regarded as low, even though there had been other attempts at suicide by self-immolation.

318. I accept the submission on behalf of Pari that in the lead up to Omid's death, the Department had knowledge that refugees were expressing the same feelings of hopelessness, helplessness and uncertainty about progress that Omid expressed immediately before setting himself alight. The risk level was not low.

319. The February 2014 report of the Physical and Mental Health Subcommittee of the Joint Advisory Committee noted with respect to mental health that:

> *The main issues seen relate to a lack of certainty about when processing and RSD decisions will be handed down. Mental distress and uncertainty contribute to feelings of hopelessness and mental illness. Intrusive anxiety symptoms are prevalent – including constant worrying about the future, and anxiety about current living conditions, and how people are being treated - reinforcing a sense of insecurity, powerlessness and helplessness in everyday life.*[394]

320. The IHMS response and clarification to that report agreed with "the assessment that these are the predominant stress factors that negatively impact on the mental health of transferees".

321. The Wilson Security assessment of the security issues following Omid's incident noted that most asylum seekers had been on Nauru for over 1000 days. The assessment stated that "increasing length of time in processing is the single greatest contributing factor to an increase in adverse behaviour; including non-compliance and self-harm activity, aggressive behaviour, violence and demonstration."

322. I also consider that having regard to the information that was known about the likelihood of protests at the site of the UNHCR visit, steps should have been taken the mitigate against the risk of public protests, including those involving self-harm. Those measures might have included additional security staff or the rescheduling or relocating the UNHCR visit to a closed environment, as was recommended by Mr Soubjaki.

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[392] Exhibit E1 page 118.
[393] Ibid.
[394] ExhibitB15, p 22

323. Omid's partner and family described him as someone who was generally optimistic and resilient. There was no evidence that he suffered from a mental illness before he was transferred to Nauru from Christmas Island as a 22 year old. He and Pari had left Iran with the hope that a better life might be found in Australia. The extent to which the lack of any certainty about the future affected Omid's emotional well-being over the following 959 days should not be understated.

324. On this background, I am satisfied that the conversation with UNHCR officials on the morning of 27 April 2016, as recounted by Pari, was a triggering event for Omid. The conversation resulted in Omid becoming extremely angry, upset and distressed. His words just before he set fire to himself confirmed those emotions. Omid felt miserable, hopeless, tired and exhausted.

325. Those feelings were expanded upon by Pari in her statement and oral evidence about the living circumstances in the RPC and at the Nibok settlement and the impact that ongoing uncertainty about the future, and the inability to leave Nauru, had on their mental health.

326. I am also satisfied that Omid's actions in setting himself on fire were deliberate. While I accept that it is likely that Omid had discussions with Pari and others in the community about self-immolation in the lead up to his death, there is insufficient evidence to establish to the requisite standard that his specific actions on the morning of 27 April 2016 were planned with Pari or with other refugees.[395]

327. There was no evidence that anyone saw how the fuel was applied to Omid or by whom. It is also unclear whether Omid intended to only set fire to a part of his body and limit the spread of the fire to that part, or whether he intended the fire to spread as it did. As someone who was familiar with the operation of vehicles, he would have known of the risks involved in setting fuel alight.

328. The statements by Omid indicating his intention to kill himself were made after his injuries were sustained, when he was in severe pain. At that time, he might have wished to die from his injuries. However, his intent at the time of igniting the fuel may have differed.

329. On the balance of probabilities and in the absence of any clear evidence to the contrary, I find that there is insufficient evidence that Omid had an intention to die at the time of setting himself on fire.

[395] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-3.

330. The evidence points to the conclusion that it is more likely than not that Omid was indifferent to whether he lived or died. While it is possible that Omid only made the decision to set himself on fire on the morning of 27 April 2016, I consider that his actions were those of someone who had given up hope and felt powerless as a result his prolonged placement on Nauru.

331. In the context of a finding that Omid did not care whether he lived or died, it is possible that Omid did not anticipate that the fire would spread as rapidly as it did. As Dr Dudley said in his evidence, at the minimum, Omid's actions could be regarded as those of someone with 'reckless indifference'. This does not lead to the conclusion that there existed an intent to die.

332. Dr Reddan described nihilism, and statements of profound hopelessness and despair as indicators of melancholic depression. While he may not have met the formal criteria for this diagnosis, everything Omid said just before he set himself alight reflected a sense of hopelessness and despair.

333. As Professor Juireidini said, whether Omid had a diagnosable mental illness at the time of his death is less important. It follows that Omid's baseline level of risk was also less important. I am satisfied that his actions in setting himself alight demonstrated disturbed thinking, and showed the level of significant anger, frustration and despair felt by Omid at that time. I do not accept the submission from IHMS that his actions were simply a form of protest or public demonstration.

334. There is no evidence that supports a finding that Omid's actions in setting himself alight could have been anticipated. It is possible that Omid formed the plan to set his clothes alight on the morning of 27 April 2016. Notwithstanding, there was a limited opportunity to intervene with Omid by making contact with him after he lodged his self-referral form on 26 April 2016 to assess how he was coping. That opportunity was missed.

2.1 Whether Mr. Masoumali was in fact triaged in the period after he submitted the self-referral (but before the appointment was made) or whether there was a missed opportunity to intervene in his case.

335. In the context of the specific circumstances on Nauru leading up to his death, I accept that while Omid had not displayed overt signs of depression, he should have been regarded as having a higher baseline level of risk on 26 April 2016. The fact that he had sought mental health assistance was an indicator that his risk was not low.

336. Accordingly, the triaging clinicians should have telephoned him to clarify the basis for the self-referral.[396] Dr Reddan agreed that the triage staff made no attempt to find out why Omid was seeking help. They did not contact him via any means or call for the records from RPC1. I agree with her opinion that these factors demonstrated a lack of action with respect to the self-referral form.[397] This view was shared by Dr Dudley and Professor Jureidini.

337. The evidence demonstrates that the triage undertaken was limited to a discussion between the triage team that was not recorded. Omid was then booked for an appointment with the psychologist, Ms Cleary, on 2 May 2016. The triage team determined that Omid's request to see a psychologist was a standard, non-urgent request, and treated it as such. It is relevant that Pari lodged a request form at the same time.

338. The IHMS treating team could have contacted RPC1 to ask about Omid's mental health history and relevant medical history. This was not done. The treating team proceeded on the basis that Omid was unknown to the Settlement Clinic, and did not consider they needed to inquire whether he had been known to RPC1. Irrespective of how long it had been since Omid had sought assistance for his mental health, this was not an appropriate response in the circumstances.

339. While it might not have altered the outcome, having access to the RPC1 mental health records would have provided the triage team with a range of collateral information which may have assisted in engaging with Omid.

340. Omid tried to book an appointment with a psychologist on 26 April 2016, the day before the events that led to his death. While he did not give any detail of the reasons for this in the self-referral form, the fact that he was not contacted to clarify why he wanted the appointment was an inadequate response in the circumstances. There was a missed opportunity to speak with Omid and obtain more information. This is supported by the expert opinion. While the result of that contact, if it had occurred, will never be known, there is a possibility the contact might have assisted Omid and his partner in a positive way.

341. The evidence supports the conclusion that the triage team did not have the 'necessary curiosity' in dealing with Omid's self-referral form, and this resulted in the form being classified as non-urgent. Given the pending visit by the UNHCR officials, and the evidence of Ms Smith in this regard, the treating team should have had regard to this when triaging Omid's form.

396 Transcript, (02.09.2020), page 85, from line 7.
397 Transcript, (02.09.2020), page 85, from line 31.

2.2 Whether the triage (if undertaken) was properly documented, and records of the triage process were made and properly stored.

342. The only evidence produced in relation to the triage process was the self-referral form, and the evidence from the triage team about what occurred during the triage.

343. No notes were taken of the triage discussion. No other documentation was produced to the inquest in relation to the triage. No policy or protocol documents were produced to the inquest setting out how triage of self-referral forms was expected to be conducted at the Settlement Clinic at the relevant time.

2.3 Whether IHMS see patients quickly enough after an initial request is made to IHMS.

344. The expert evidence supported a conclusion that, when comparing with the general community, the fact that an appointment was booked for Omid to see a psychologist within six days of the request was adequate.

345. However, the detail contained on the self-referral form was not sufficient to inform the triage team about the nature of the request. Contact should have been attempted with Omid at the earliest opportunity to obtain more information.

346. There is no evidence to suggest that this attempt could not reasonably have been made by the triage team at the time they were discussing the self-referral form.

2.4 Whether the form of the self-referral request is adequate to record all pertinent details, such as the date of the request by the refugee/asylum seeker, the date of triage, range of possible actions in response to the triage, the outcome of the triage, etc.

347. Each of the psychiatrists who gave evidence provided an opinion on this issue. Dr Reddan preferred an 'open ended' approach to the form, while Dr Dudley preferred a structured form. I also heard that a person in distress may not have the capacity to complete the form.

348. The evidence heard at the second phase of the inquest supports the conclusion that the adequacy of the template of the self-referral form was not really the issue.

349. The primary issue was the response to the information that was included by Omid on the form. The form in this case acted as a request to speak with a psychologist by Omid, which should have been sufficient for follow up contact to have been made with him to obtain further information.

Issue 3 - The adequacy and appropriateness of the health and medical evacuation services provided to the deceased from the time of the incident until the time of his death on 29 April 2016, including whether those services were the best available in the circumstances and broadly comparable with health and medical evacuation services available within the Australian community.

350. As Omid was a refugee, there was no contractual obligation on the RNH or IHMS to provide health and medical evacuation services broadly comparable with that available within the Australian community.

351. Without a specific request from DHA, there was also no specific contractual basis for IHMS to provide care to Omid while he was a patient at the RNH. IHMS were required to cooperate with the emergency department at the RNH, to which all emergencies had to be referred; and to facilitate the timely transfer of refugees for urgent medical care not available in Nauru, to be agreed by the Department.

352. Dr McGregor and Ms Robinson assisted appropriately in the circumstances, within the scope of the contractual obligations of their employer, and out of professional respect to the RNH clinicians who were caring for Omid. Their support ensured that Omid was kept alive while he was awaiting medical evacuation

353. I accept that the IHMS clinic at RPC1 did not have the required facilities and appropriately skilled staff to take over Omid's care even on a Good Samaritan basis. A transfer to this facility would not necessarily have resulted in a better outcome for Omid.

354. Omid had serious and life threatening major burns that required prompt, specialised care, that was not available anywhere on Nauru. His best chance of survival was early evacuation to a tertiary hospital.

355. The IHMS recommendation for medical retrieval was undertaken and approved without delay. The actions of International SOS in sourcing the timeliest and most medically capable service provider were appropriate, taking into account all the circumstances of the case and the limitations of the airport at Nauru. The evidence indicated that a medical retrieval from the most isolated parts of Australia would have occurred in less than 31 hours.

356. The actions by the LifeFlight retrieval team were appropriate in all the circumstances and were of a standard that would be expected in the Australian community. There was nothing else the retrieval team could have done to prevent Omid's death. The care they provided kept Omid alive until he reached Brisbane.

357. It was clear on the evidence that the clinicians at the RNH did not have the necessary clinical skills, equipment, or facilities to deal with Omid's injuries.

358. The deficiencies in terms of the facilities available at RNH to care for a critically ill patient were made known to the Australian Government in the February 2014 report of the Physical and Mental Health Subcommittee of the Joint Advisory Committee. These included the lack of a blood bank and a functioning ventilator and the lack of staff skilled in the operation of a ventilator.

359. Professor Sundram is a Consultant Psychiatrist who gave evidence to the inquest referencing his experience as a member of the Health Sub-Committee of the Joint Advisory Committee for the Commonwealth of Australia and the Government of Nauru on Nauruan regional processing of asylum seekers and refugees from mid-2013. He confirmed that emergency, resuscitation and life support services at the RNH were still limited at the time of the incident in April 2016.

360. The shortcomings were also recognised by Associate Professor Rebecca Kimble and Dr John Brayley during a site visit to RNH in February 2016. A report prepared by Associate Professor Kimble following that visit contained the following observation:

> *Adult resuscitation equipment is limited to one very old defibrillator, and no intensive care unit. The High Dependency Unit for adults is ill-equipped by Australian standards in all aspects, and could not be assessed in any detail.*

361. Omid was not monitored and observed appropriately, and his deterioration and development of ACS was not identified in a timely manner. When the expert evidence is considered in the context of the serious and specialised nature of Omid's injuries, I accept that the RNH clinicians did their best with the limited resources available. This was supported by the evidence of Dr Wenck and Dr Little.

362. Professor Muller, one of Australia's most senior burns specialists, said that Omid's condition was effectively irretrievable after he suffered a cardiac arrest at RNH on 27 April 2016 at around 11:00pm.

363. I accept Dr Little's opinion was that it was likely that "severe acidemia, elevated potassium, and hypotension contributed to this cardiac arrest." The likely cause of the acidemia was identified as inadequate ventilation using a bellows ventilator.

364. As explained by Professor Muller even if a functioning ventilator was available it would have been difficult to ventilate and hydrate Omid because he had developed ACS.

365. I accept Dr Wenck's evidence that the doctors from Nauru made "heroic efforts to save Omid". However, they were hampered by a lack of training in burns, a lack of equipment and a lack of infrastructure such as comprehensive laboratory and blood services:

If ventilator observations were made it would have been apparent that airway pressures were rising. If end tidal carbon dioxide monitoring was available and frequent blood gases were performed it would have been obvious that ventilation was dangerously inadequate. If frozen plasma and platelets were available, the surgeon would have been able to perform extensive escharotomies required and have been able to control bleeding. My opinion therefore is that his care was the best available in the circumstances.

366. The specific issue that this inquest was required to consider was whether the health and medical evacuation services provided to the deceased from the time of the incident until the time of his death on 29 April 2016 were the "best available in the circumstances and broadly comparable with health and medical evacuation services available within the Australian community".

367. I accept the evidence of Dr Wenck and Dr Little that Omid's care before retrieval by LifeFlight was inferior to that he would have received in a rural setting in Australia. As Dr Little noted, "the hospital infrastructure, clinical equipment and consumables, and critical care training of the senior medical staff would have been of a higher level" in Australia.

368. Dr Little indicated that the level of care available on Nauru was inferior to that which could be provided on Thursday Island in Queensland's Torres Strait. He referred to the November 2016 Report of Professor Grantham in relation to the *Assessment of Emergency Medical Capability and Capacity Nauru.* In that report Dr Grantham indicated that

"a level of care meeting a Pacific Island standard as found in Fiji seems an appropriate base level. The RON hospital currently falls a long way short of this standard. The medical director suggested as an estimate they might be at 30% of this standard. This is a reasonable estimate."

369. It is important to note that the Australian Government's policy, as required under the Heads of Agreement[398] was that the emergency care was a matter for the RNH, and that the standard of care for refugees on Nauru should be broadly comparable to that available in the Nauruan community.

370. The standard of emergency medical care available in Nauru was well below that which would be expected in rural Australia.

371. Counsel assisting submitted that it is possible that even if Omid had been provided with appropriate care from the outset, he may not have survived his injuries. However, the evidence of Dr Miller and Dr Muller was that a patient with 50% burns would almost certainly survive if treated in a major burns unit. If Omid had received appropriate monitoring and ventilation before he was transferred by Life Flight his chances of survival, while not assured, would have been greatly increased.

[398] Exhibit D1.2.

372. I accept that the team at the RBWH had no other medical options available to them to salvage Omid's condition or otherwise prevent his death after he was received into their care.

373. The outcome in Omid's case was inevitable considering the serious injuries he had sustained, the skills of those treating him on Nauru, the facilities available at RNH and the lengthy delay before he could be provided with a higher level of care.

Issue 4 – Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003.

374. The purpose of this inquest was not to examine Government policy relating to offshore processing of asylum seekers or the offshore treatment of refugees. It is now over five years since Omid's death. I accept the submission from the Commonwealth that circumstances on Nauru have changed significantly since April 2016.

375. On 31 March 2016 there were 1178 asylum seekers and refugees on Nauru. The most recent statistics available on the DHA website indicate that in July 2021 there were 107, including 78 refugees and 16 awaiting a refugee status determination.[399] The remainder were identified as non-refugees. As of 31 July 2021, the resettlement arrangement with the Unites States has led to 398 individuals from Nauru being resettled in the United States.[400]

376. Over the past five years arrangements for medical and other transfers of refugees from Nauru have been the subject of ongoing public scrutiny, including the passage and repeal of medevac legislation by the Parliament of Australia. Hospitals in PNG and Taiwan have also been engaged to take more medical transfers from regional processing countries.

377. At the same time, offshore processing on Nauru has recently been recognised as a continuing and core component of Australian immigration policy. On 24 September 2021, the Australian and Nauruan Governments signed a memorandum of understanding "to establish an enduring regional processing capability in Nauru".[401] DFAT's Nauru country brief recognises that "revenue associated with the presence of the regional processing centre and its ancillary service providers represents Nauru's most significant revenue stream".[402] The interdependency is obvious.

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399 https://www.homeaffairs.gov.au/about-us-subsite/files/population-and-number-of-people-resettled.pdf

400 https://www.homeaffairs.gov.au/about-us/what-we-do/border-protection/regional-processing-and-resettlement

401 https://minister.homeaffairs.gov.au/KarenAndrews/Pages/maritime-people-smuggling.aspx

402 https://www.dfat.gov.au/geo/nauru/nauru-country-brief

378. Professor Sundram's evidence about the absence of a memorandum of understanding between the RNH and the IHMC clinic at RPC1 was that it would be very sensible for such an arrangement to be put in place to clarify when services could move, for example, from RPC1 to the RNH, both in terms of equipment and staff.

379. RPC1 had highly qualified and experienced staff who were very capable, but there was no MOU to protect them if they were called to the hospital or other types of medical interventions. Professor Sundram said that one of the issues that could arise was whether staff would be indemnified through their insurance, for example, in relation to treatment at the RNH.

380. A recommendation was made by the subcommittee that a formalised memorandum of understanding or heads of agreement arrangement be made to better facilitate that type of movement of patients, staff and equipment.[403] Mr Nockels said that this recommendation had not been implemented, and the broader Memorandum of Understanding was relied upon to manage activities on Nauru.[404]

381. Counsel assisting and Omid's family submitted that it was open for me to recommend that DHA and IHMS consider working with the Government of Nauru to put in place an MOU as recommended by the JAC in 2014.

382. However, the Commonwealth's submissions indicated that cooperation between IHMS and the RNH had significantly improved since 2016, with regular meetings with the Nauru Overseas Medical Referral Committee and weekly rounds at the hospital with Nauruan staff. The submission indicated that DHA would endeavour to ensure that IHMS (as the ongoing contractor) would reach an understanding with the Nauruan Government regarding medical support and cooperation with the RNH.

383. Omid's family submitted that I should make recommendations on a range of other matters, some of which had been the subject of recommendations at previous inquests but had not been implemented. These included recommendations from the Inquest into the Death of Hamid Khazaei and the Inquest into the death of Fazel Chegeni Nejad. The Commonwealth has previously indicated that it does not propose to implement the recommendations arising from the Khazaei inquest, some of which were focused on the circumstances of detainees on Manus Island. I also accept that Mr Khazaei's circumstances as a detainee on Manus Island were different in some respects to those of Omid as a refugee.

[403] Transcript, day 2, page 51 from line 39. This was before refugees were placed in the Nauru community.
[404] Transcript, day 2, page 99 from line 22.

384. The family's suggested recommendations fell within the following topics:

- the Department should work together with IHMS to ensure more mental health staff on Nauru including at least one on-shore psychiatrist and patients are seen promptly by mental health staff on self-referring or requesting assistance;
- training supervision and peer support for mental health staff;
- faster refugee status determination processing times with viable resettlement options for those assessed as genuine refugees and communication in a timely manner;
- end tidal monitoring equipment be stocked at the RONH and RPC facilities;
- reform the mental health triage process;
- prior clinical records needed to be accessible and acted upon;
- mandated psychiatric action plans for significant events;
- education, accountability and training, including re culturally appropriate care.

385. IHMS submitted that mental health personnel were not scarce at the time of Omid's death. There was an experienced psychologist and two mental health nurses working at the clinic. Further specialist input could be arranged if required.

386. The Commonwealth indicated in its submissions that in October 2020 there was a psychiatrist, two mental health team leaders, and three mental health nurses in Nauru with mental health outreach to the transferees in the community. At that time there was one mental health practitioner to every 24 transferees.

387. The Commonwealth also submitted that the Nauruan Department of Health is responsible for the governance and operation of the Republic of Nauru Hospital, including the management of staffing profile and health equipment. The Government of Nauru has reported to Australian officials that since 2016 it had acquired additional ventilators.

388. At the inquest, I received evidence from DHA about changes implemented in relation to the allocation of medical resources, facilities, staff and treatment to refugees on Nauru following Omid's death.[405] Mr Nockels confirmed:[406]

- In 2016, mental health awareness training sessions were provided to the Government of Nauru staff working with refugees and transferees;
- In May 2016, gastroscopy-colonoscopy equipment was provided for use at the hospital;
- In July 2016, a Community Resource Centre was constructed to provide a shared office space for refugee settlement staff and

[405] Exhibit D3.
[406] Exhibit D1.5 paragraph 28.

communal rooms for classes, community meetings (including refugee meetings), functions and training;
- In September 2016, the Department, in conjunction with DFAT, funded several new wards, new pathology and paediatrics buildings, and a new services compound containing a back-up power supply a wastewater treatment plant and water supply tanks. This work was completed in February 2017.

389. Mr Nockels also referred to the actions taken by the DHA in response to the *'Physical and Mental Health Subcommittee of the Joint Advisory Committee for Nauru Regional Processing Arrangements Nauru Site Visit Report 16-19 February 2014'*.[407] He confirmed that the DHA considered the recommendations from that report, and following the receipt of the report the DHA took steps, most relevant to this inquest, as follows:[408]

- In March 2014, the Department, working with IHMS, coordinated and funded the establishment of a blood bank at the RNH;
- On 31 December 2015, a computed tomography scanner was installed at the RNH along with temporary imaging facilities;
- On 31 January 2016, construction of a temporary dental clinic, pathology, ambulance bay, inpatients ward and surgical unit was completed. A purpose built surgical facility was also constructed along with a six-bed inpatient ward, primary mental health nurse consultation rooms and a new x-ray building and temporary clinic;
- Throughout 2016, mental health awareness training sessions were provided to the Government of Nauru staff working with refugees and transferees.

390. Mr Nockels was also asked about a finding in a report prepared on behalf of Dr John Brayley, dated 27 February 2016, by Associate Professor Kimble. It was a report which looked at the staffing, consumables, equipment and facilities available at the RNH with respect to obstetrics at the time of a visit in February 2016.[409] This report was directed to the RNH maternity and neonatal services, rather than intensive care or high dependency care services.

391. Mr Nockels' evidence about this report was that a tour of infrastructure relevant to the services during the visit revealed major deficiencies in availability of basic medical equipment at RNH to the extent that resuscitation and life support equipment for neonates and children was not available at the time.

[407] Exhibit B15; Exhibit D1.5 from paragraph 29.
[408] Exhibit D1.5 paragraph 31.
[409] Annexure A to Exhibit D1.5.

392. Adult resuscitation equipment was limited to one very old defibrillator and no intensive care unit. The high dependency unit for adults was ill-equipped by Australian standards in all aspects and could not be assessed in any detail. These significant deficiencies could be rectified in the immediate term with provision of relevant equipment to support services. Training of personnel and the use of this equipment will be dependent on the varied experiences of the current staff in use of this equipment.

393. Mr Nockels said that Commonwealth provided a significant amount of support to the Nauruan healthcare system during and after Associate Professor Kimble's report. A lot of that support focused on improving the infrastructure at the hospital. There were two stages of work involved in replacing a significant portion of the hospital that was destroyed by a fire. That was focused on the physical infrastructure in terms of rebuilding, which also included an eight bed suite.

394. Mr Nockels said that there were several other things that were being done after this incident and prior in terms of support for the Nauruan healthcare system. The Department of Foreign Affairs and Trade also had a strong focus to aid programs around improving the healthcare system in Nauru. A lot of work has been done in and around that, but he was not sure if it was specific to the February 2016 report.[410]

395. Mr Nockels confirmed that, immediately after the event involving Omid, the DHA organised for the deployment of a surgical team from Aspen Medical to Nauru.[411] Counsel assisting submitted that it was open to me to recommend that DHA continue this work as it appeared to have ceased in December 2016.

396. Mr Nockels' evidence at the inquest was that deployment of the Aspen team was a direct response to Omid's death. The first of the Aspen team members arrived a day or so after the incident, and the rest of the team arrived on-island within days. That was a surgical team, an emergency doctor, a trauma surgeon and a range of other professionals such as an anaesthetist, paramedic, intensive care paramedic and intensive care nurses. Aspen subsequently deployed a variety of staff, including an orthopaedic surgical team from 29 July 2018 to 1 August 2018.

397. The intention was to put onto Nauru and into the hospital a team of people who could assist the RNH if there were similar emergencies. The Aspen team were there to provide an immediate medical response to the potential incident, but also to provide some assistance to the RNH, particularly around training and building capacity as it related generally to trauma and specifically to burns.

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[410] Transcript, day 2, page 91 from line 21.
[411] Exhibit D3.

398. Mr Nockels said that changes were also implemented by IHMS in response to Omid's death. There was a range of ongoing training focused on medical staff managing burns. There were several other things that were put in place, including fire extinguishers and fire retardant blankets at key points around settlement sites and at the RPC environment.[412]

399. In terms of the changes implemented by IHMS, the evidence was:
    - All IHMS staff had refresher training about burns injury and management, and this training remains on-going;
    - IHMS staff implemented burns injury and management training to the RNH Emergency staff, with this training conducted by the IHMS Emergency Medical Officer;
    - All service providers were briefed in initial management of burns and each organisation was provided with burns blankets;
    - Fire extinguishers and burn blankets were placed at the entrance to each Regional Processing Centre and at IHMS clinics, with regular training regarding use of this equipment undertaken – with this training remaining on-going;
    - IHMS in conjunction with Aspen assessed the capability at the RNH, and Aspen conducted training with medical practitioners at RNH during the time they were in situ at the RNH;
    - IHMS conducted Mass Casualty training with all service providers including the Government of Nauru Emergency Services and the RNH, to assist with preparedness and appropriate responses in the event of a significant injury;
    - IHMS practitioners were required to follow standard guidelines for initial burns injuries, and would work in conjunction with the International SOS Assistance Centre in the event of a serious injury;
    - All patients threatening acts of self-harm were required to be assessed and managed in line with Mental Health protocols.[413]

400. IHMS also submitted that there were several safeguards available to refugees in the Nibok community that would not be available other clinical settings. These included the Settlement Clinic's open door policy, outreach in the form of welfare checks where concerns were expressed about a person's wellbeing and the availability of interpreters to assist in the completion of self-referral forms. Additional services were provided by Connect Settlement Services, Broadspectrum and Torture and Trauma Services.

[412] Transcript, day 2, pages 117-118 from line 38.
[413] Exhibit D3 page 2.

401. The IHMS submission, based on Ms Cleary's evidence, endeavoured to suggest that Omid's circumstances were greatly improved in the Nibok community because he had moved from a tent to an air-conditioned demountable where he had some privacy, and was free to live, work and engage in the Nauruan community. I do not agree with the suggestion that a move to the Nibok community would on its own result in enhanced mental wellbeing.

402. Evidence was also heard about potential recommendations to upgrade the Nauru airport to allow for aircraft to land after dark.[414] However, that would ultimately be a matter for the Republic of Nauru.

Timely Refugee Status Determination and Settlement

403. The JAC's first recommendation in the February 2014 report was "*provide clear information on the timing of the Refugee Status Determination process and plans for settlement to ameliorate the mental health impact of ongoing uncertainty and reduce the risk of destabilisation*." A similar recommendation was proposed by Omid's family.

404. This recommendation was not addressed in Mr Nockels' evidence. The Commonwealth's submission was that there was no evidence in relation to "a range of diplomatic, legal, economic and other issues that would bear upon how feasible and appropriate it would be to achieve this".

405. Notwithstanding, Nauru is now the only regional processing country for the assessment of the asylum claims of persons who arrive in Australia by boat. It may also be the destination for persons subject to regional processing arrangements in PNG who are willing to voluntarily transfer to Nauru as the arrangements with PNG cease at the end of 2021.

406. I acknowledge that the negotiation of resettlement arrangements for refugees involves matters of "high policy". However, having regard to the circumstances of Mr Masoumali's death and the statements made by him about the impact of delay on his wellbeing, I consider that there is a need to provide more certainty to refugees to ensure those who are successful in their asylum applications are resettled in third countries expeditiously, and that refugees are given some assurance that will be achieved.

407. I recommend that the Commonwealth work with the Government of Nauru to achieve that outcome. This would not undermine the objective of Operation Sovereign Borders and would likely see fewer requests for medical transfers off Nauru on mental health grounds.

408. Acknowledging the changed circumstances in Nauru since 2016 in terms of the reduced number of refugees and asylum seekers, together with the improvements to hospital facilities and training identified by the Commonwealth and IHMS, I make no other recommendations.

[414] Transcript, day 4, page 90 from line 27.

409. I extend my condolences to Omid's partner and to the rest of his family and friends. His family in Iran and elsewhere were unable to visit him once he was transferred to Nauru and given refugee status. Sadly, Omid's hopes for a better life with his partner were never realised. Perhaps this inquest will assist in explaining the challenges they faced as refugees. The evidence indicates that Omid started his journey in 2013 as an optimistic and perhaps naïve 22 year old. Within three years he had died a painful death in a Brisbane hospital after struggling to come to terms with the reality of an indefinite period on Nauru.

410. I close the inquest.

Terry Ryan
State Coroner
BRISBANE