Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 46/16

I, Sarah Helen Linton, Coroner, having investigated the death of ***Maung PU*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***1 and 2 December 2016*** *find that the identity of the deceased person was* ***Maung PU*** *and that death occurred on* ***30 September 2012*** *on board the* ***M.V. Equator Prosper about 30 nautical miles north of Port Hedland*** *in circumstances* ***consistent with bronchopneumonia****:*

Counsel Appearing:

Ms K Ellson assisting the Coroner.
Ms R Roach (Corrs Chambers Westgarth) appearing on behalf of John Finch.

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INTRODUCTION

1. Maung Pu (the deceased) was a seaman on board a vessel travelling between China and Western Australia when he died on 30 September 2012. His body was flown to the nearest port, being Port Hedland, where his death was certified at 1.56 pm that day by Dr Daniel Saplontai at the South Hedland Health Campus.[1]

2. Without exploring further the question of my jurisdiction in relation to the death, which the known facts suggest occurred approximately 30 nautical miles from the Western Australian coastline, I note that as the body of the deceased was brought to Western Australia, it comes within the definition of a "Western Australian death" under s 3 of the *Coroners Act 1996* (WA) (the Act). Further, it is a reportable death under the Act as it is a Western Australian death and the cause of death was certified by Dr Saplontai, who examined the deceased's body. A coroner has jurisdiction to investigate a reportable death.[2]

3. On 15 July 2013 the then State Coroner concluded that it was desirable, as part of the coronial investigation, that an inquest be held into the death. On 1 and 2 December 2016 I held an inquest at the Perth Coroner's Court.[3]

4. Expert evidence was given by Associate Professor David Mountain, an Emergency Medicine Specialist and Dr Glenn McKay, a Specialist in Retrieval Medicine, as well as Mr John Finch, the General Manager of Operations and Harbour Master of the Pilbara Ports Authority, and some witnesses of fact.

BACKGROUND

5. The deceased was born on 27 February 1963 in Myanmar. He was married and identified as a Buddhist. His home residence was in Yangon, Myanmar.[4]

6. The deceased underwent a pre-employment medical examination in Yangon on 11 June 2012 and was found to be physically and mentally fit for sea-going duties. The deceased had filled out a questionnaire prior to the examination and indicated that he had not been admitted to hospital in the past and had no known medical conditions.[5]

7. The deceased was employed on board the Iron Ore Carrier MV Equator Prosper from June 2012. He was the Second Engineer, which meant that he was the second in charge of the engine room on the ship. A total of nine people worked in the engine room.[6] The ship was operating between Western

[1] Exhibit 1, Tab 4.
[2] Section 3 *Coroners Act 1996* (WA) and s 44 *Births, Deaths and Marriages Registration Act 1998* (WA).
[3] Section 22(2) *Coroners Act 1996* (WA).
[4] Exhibit 1, Tab 23.
[5] Exhibit 1, Tab 23.
[6] Exhibit 1, Tab 7.

Australian and China, transporting iron ore. Like the deceased, most of the crew were from Myanmar, apart from the Captain and one other crewman.[7]

8. Crew members describe the deceased as a hard worker and a kind man. He did not drink and did not take illicit drugs. At the time of his death he was not known to be on any regular medication.[8]

9. On 29 August 2012 the ship was berthed at Port Hedland Harbour. At that time the deceased complained of a fever. He presented at the Port Hedland Medical Clinic and was seen by Dr Tan Heng. He had a fever and reported feeling unwell. The deceased was diagnosed with a virus and was advised to rest until the following day. He was provided with a prescription for the antibiotic Keflex to take if his symptoms had not resolved in three days. He was also given panadeine and voltaren for his symptoms. It appears that the deceased had the prescription filled, as boxes of the medication were found in his cabin after his death.[9] The Equator Prosper returned to China after the deceased's doctor's visit.

10. The Equator Prosper set sail again on 17 September 2012 from Xingang, China and was heading for Port Hedland to collect iron ore. The ship was due to reach the port on the morning of 30 September 2012. The Captain of the vessel was Mr Viresh Singh and the Chief Officer was Mr Htay Aung. Captain Singh had only been the Captain on the Equator Prosper ship for approximately two months, but had been a ship captain for 15 to 20 years [10]

ONSET AND PROGRESSION OF THE DECEASED'S ILLNESS TAKEN FROM ACCOUNTS OF THE CREW

11. On 29 September 2012 the deceased ate a traditional breakfast of rice noodles, salad and chicken and seemed well. Sometime later he reported to Mr Win Khaing, another crewman who worked with the deceased in the engine room, that he was having back pain and feeling sick. However, despite feeling unwell the deceased continued to work in the engine room. Mr Hla Oo, who was the Fourth Engineer, later rubbed some traditional medicine into the deceased's back, to try to relieve his back pain.[11]

12. At about 10.00 am the deceased had a tea break. He was seen to drink a black coffee but only drank half the coffee as he was still not feeling well.[12]

13. Sometime around 10.30 am a safety meeting was held in the crew mess room. At that time the ship was drifting and the Chief Officer approximates it was 30 nautical miles off Port Hedland Harbour, and within the reporting area.[13]

[7] Exhibit 1, Tab 2, p. 1 and Tab 20 [9].
[8] Exhibit 1, Tab 8 and Tab 11.
[9] Exhibit 1, Tab 26, Photos 18 and 23.
[10] Exhibit 1, Tab 13.
[11] Exhibit 1, Tab 5 and Tab 6.
[12] Exhibit 1, Tab 6.
[13] Exhibit 1, Tab 9 [10].

14. The deceased initially attended the safety meeting but was excused from the meeting after about 15 minutes. He went out of the room and was immediately heard vomiting loudly in the toilet. The Chief Officer went outside to check on him and found the deceased was doubled over and visibly in pain. The Chief Officer checked the vomit and found there was not much food and it was mainly a white liquid. Two members of the deceased's engine crew assisted the deceased back to his cabin as he was unable to stand and was crouched over.[14] The deceased told one of the crewmen that he was experiencing very serious pain in his stomach, which felt like gas but was all over his stomach and in his back.[15]

15. The Captain, the Chief Officer, the Second Officer and the Chief Engineer went to the deceased's cabin after the safety meeting to check on him. The deceased was doubled over and in pain and was saying in his own language that he was suffering and in "too much pain."[16] The Chief Officer, Mr Aung, translated this for the Captain. The Captain asked where the pain was located and the deceased said it was in his back between his shoulder blades. He wouldn't let Mr Aung touch his back as the lightest pressure caused him pain, but did let him touch his stomach as the pain was not as bad there. Mr Aung noticed that the deceased's extremities were very cold to the touch but his middle was sweating.[17]

16. Mr Ha recalls that the deceased was asking to see a physician and the Captain was asking the deceased what happened and "telling him not to be a child."[18] Mr Ha got the impression that the Captain thought that the deceased was trying to get home.[19] The Second Officer, Mr Bo Bo Kyaw, was the medical officer on board by virtue of his rank. His medical training consisted of a two week course, which was the same as all the other officers on board apart from the Captain, Chief Engineer, Chief Officer and Second Engineer (who all had advanced medical training, having completed a 4 week course).[20]

17. The Captain ordered the Second Officer to take the deceased's blood pressure, recorded about 124/82, which was a normal reading. The Captain decided that the deceased needed antacid for a 'hyper acid stomach' so the Second Officer went and obtained some antacid from the medical room and gave it to the Captain, who gave it to the deceased.[21] According to the Chief Engineer, it was not uncommon for crew to experience 'gas troubles' on ship, which is why that appears to have been their focus in the context of the deceased's symptoms.[22]

18. The deceased stayed in his cabin the rest of the day. He continued to have gas like symptoms, a distended stomach, abdominal pains and back pain.

[14] Exhibit 1, Tab 5 and Tab 7 and Tab 9.
[15] Exhibit 1, Tab 7.
[16] Exhibit 1, Tab 9 [19] – [20].
[17] Exhibit 1, Tab 9.
[18] Exhibit 1, Tab 7 [21].
[19] Exhibit 1, Tab 7.
[20] Exhibit 1, Tab 10 [4].
[21] Exhibit 1, Tab 10.
[22] Exhibit 1, Tab 12.

He was noted to be having difficulties standing, was unable to go to the toilet and could only drink small amounts of water.

19. At about noon Mr Oo saw the deceased lying down in his cabin. He spoke to the deceased, who replied that he wasn't feeling very well. Mr Oo thought the deceased looked worse than he had in the morning and noticed there was a bucket beside the deceased's bed.[23] Mr Aung checked on the deceased after lunch and was told the deceased had had a little bit of milk but nothing else.[24] The Second Officer checked on the deceased several times and noted the deceased was mainly complaining of stomach pains.[25]

20. At 3.30 pm the deceased was still in pain so the Second Officer spoke to the Captain. The Captain told him he could be given pain medication, so the deceased was given two tablets of codeine phosphate. The Second Officer also gave the deceased more antacid at about 6.00 pm.[26]

21. At about this time another crewman, the Third Engineer, recalls being in the deceased's cabin when the deceased asked the Fourth Engineer, Mr Oo, to call a doctor for him to find out what was wrong with him. The deceased gave them a phone number for a doctor in his country. The Fourth Engineer went to the bridge and tried to call the doctor but the connection was poor due to their distance out to sea and although he could hear the doctor, the doctor could not hear him. He told the deceased who then asked the Fourth Engineer to contact his monk to pray for him, which he did.[27]

22. The Chief Officer, Mr Aung, checked on the deceased several times during the day and noted his condition was not improving and he was still in pain but he was lying down and quiet.[28]

23. At around 6.30 pm Mr Oo went to the deceased's cabin to check on him again and the deceased told him that he had pain in his front and back. The deceased was crying due to the pain and said that "he didn't think he could stand anymore."[29] Mr Oo states he went and told the Chief Officer, Mr Aung, that the deceased wasn't very well. Mr Aung said that he would tell the Captain. Mr Oo then went to the engine room to be on watch.[30]

24. Mr Aung agrees that he did go and see the Captain, but recalls it was after he had checked on the deceased at about 8.00 pm. He states he asked the Captain if he could give the deceased some pain medication and the deceased had also asked for sleeping tablets. The Captain agreed he could give the deceased pain medication but not sleeping tablets.[31]

25. Mr Ha went to the deceased's cabin at about 9.30 pm to relieve the Electrician, Mr Myint Tun Kyaw, who had been watching the deceased.

[23] Exhibit 1, Tab 6.
[24] Exhibit 1, Tab 9.
[25] Exhibit 1, Tab 10.
[26] Exhibit 1, Tab 10.
[27] Exhibit 1, Tab 11.
[28] Exhibit 1, Tab 9.
[29] Exhibit 1, Tab 6.
[30] Exhibit 1, Tab 6.
[31] Exhibit 1, Tab 9.

Mr Kyaw left to have dinner and a shower and then returned.[32] Together they gave the deceased some Airex (gastro medicine) but it didn't work to relieve his symptoms and he was unable to pass wind, although he wanted to. They tried to help him walk to see if that would help, but it also didn't assist. The deceased was unable to sleep and complained that his stomach was getting bigger and bigger. Mr Kyaw also recalls the deceased's vision was not normal.[33]

26. Mr Khaing, who had been working with the deceased in the engine room in the morning, went to see the deceased again after he finished his shift in the engine room, at about 10.00 pm. In his cabin he found Mr Kyaw and Mr Ha with the deceased. All three men noticed the deceased's hands and feet were very cold so they tried massaging them to get some blood flow. Mr Khaing later watched as the deceased tried to make himself vomit by sticking his fingers in his throat, but nothing came out.[34]

27. According to Mr Khaing's statement he overheard the Electrician, Mr Kyaw, ask Mr Aung for a doctor. He then overheard Mr Aung ask the Captain for a doctor and the Captain said that he would get an ambulance when they reached port the next day.[35]

28. Mr Ha and Mr Kyaw stayed with the deceased overnight. Mr Ha called the bridge three or four times during the night, on behalf of the deceased, to ask for a doctor. He spoke with the second and third officer on these occasions. By the morning the deceased could barely talk.[36] Both Mr Ha and Mr Kyaw believed the deceased was seriously ill. Mr Kyaw described the deceased as "a very good worker,"[37] and someone who was usually very fit and strong, so he genuinely believed that the deceased was suffering and not malingering.[38]

29. Mr Ha remembers that the Captain and the Second Officer, Bo Bo Kway, came to check on the deceased in the early hours of the morning. He recalls the deceased saying that he was very drowsy and the Captain took his blood pressure, which was low. The Captain told the deceased to take some salts and minerals and again told him "not to be so childish."[39] The deceased continued to ask to see a doctor and even told the Captain that he would pay the cost of a helicopter, but the Captain did not agree to do so.[40] The Second Officer recalls checking on the deceased at about 4.00 am, but indicated he was not with the Captain and the deceased was sleeping so he did not disturb him. Mr Kway did take the deceased's blood pressure again, but not until about 11.30 am.[41]

30. Mr Aung checked on the deceased at about 4.00 am on 30 September 2012 and found the deceased was no better. The deceased was lying in his bed

[32] Exhibit 1, Tab 7.
[33] Exhibit 1, Tab 8.
[34] Exhibit 1, Tab 5 and Tab 7.
[35] Exhibit 1, Tab 5.
[36] Exhibit 1, Tab 7.
[37] Exhibit 1, Tab 8 [13].
[38] Exhibit 1, Tab 8.
[39] Exhibit 1, Tab 7 [41].
[40] Exhibit 1, Tab 7 [43].
[41] Exhibit 1, Tab 10.

and was quiet so he left. Shortly afterwards Mr Aung was called back by the deceased, who repeatedly pleaded with Mr Aung to arrange a helicopter or boat urgently so he could go to hospital. The deceased offered to pay any amount of money to have it arranged. Mr Aung stated he knew the deceased was "serious and in a critical state"[42] at this stage. Mr Aung tried to calm the deceased and told him he would speak to the Captain. Mr Aung went to the bridge but the Captain was sleeping.[43]

31. At 5.30 am Mr Aung called the Captain and the Captain came up to the bridge at 6.00 am. Mr Aung asked the Captain to arrange a helicopter and told him the deceased said he would pay the money. The Captain responded that the pilot would be on board at 1.00 pm and arrangements had been made for the deceased to go to hospital after berthing. Mr Aung understood from the conversation that the Captain had made up his mind and it was not to be discussed further.[44]

32. Other crew members relieved Mr Ha and Mr Kway at about 5.30 am from watching the deceased, so they could get some sleep.[45]

33. At about 6.30 am Mr Oo came up from the engine room to check on the deceased. The deceased was lying on his bed and in a lot of pain but he was able to speak to Mr Oo. The deceased asked for some help to sit up and at some stage said to Mr Oo that if he died, he wanted Mr Oo to pass on a message to the deceased's family. Mr Oo tried to reassure him that he would be alright.[46]

34. At about 7.00 am Mr Oo went and spoke to the Chief Officer, Mr Aung, and told him that the deceased was in a lot of pain. The deceased also called Mr Aung and asked what arrangements had been made to get him to hospital. At this time the deceased told Mr Aung that "he thought he would die if he didn't get help."[47] Mr Aung told the deceased he had already spoken to the Captain, who was arranging it. He said this in the hope of calming the deceased, although he knew the helicopter was still some time away.[48]

35. After finishing his duty at about 8.10 am Mr Aung went to the Captain's cabin and told the Captain the deceased was suffering too much and his respiration was compromised. He asked the Captain to please arrange a helicopter. The Captain told Mr Aung that the ship's agent has already arranged for them to berth in two hours and the agent had told him the hospital had been arranged so they didn't need to arrange for a helicopter. Mr Aung again told the Captain that the deceased had indicated he was willing to pay money for the transfer to shore but the Captain told Mr Aung not to worry and everything had been arranged.[49]

[42] Exhibit 1, Tab 9 [48].
[43] Exhibit 1, Tab 9.
[44] Exhibit 1, Tab 9.
[45] Exhibit 1, Tab 7.
[46] Exhibit 1, Tab 6.
[47] Exhibit 1, Tab 9 [58].
[48] Exhibit 1, Tab 6 and Tab 9.
[49] Exhibit 1, Tab 9.

36. Mr Ha and Mr Kyaw both checked on the deceased at around 8.30 am and noted the deceased was having a lot of trouble breathing and looked worse.[50] The deceased was unable to have breakfast so Mr Ha went to the galley and asked the cook for some boiled rice, which he put extra garlic in with the hope it would help with the gas.[51]

37. Mr Aung spoke to another crewman at about 9.00 am, who relayed a conversation with the Captain where the Captain had queried how the deceased could afford to pay so much money from his wages. This angered Mr Aung, who responded that he would personally arrange payment.[52]

38. Mr Aung reviewed the deceased again at 10.00 am. The deceased had vomited again at this time and Mr Aung suggested he take some medication but the deceased threw it up. Mr Aung noted the deceased's feet and arms were cold despite the room being very warm. The deceased again asked Mr Aung when he could get help and Mr Aung tried to calm him and told him not to worry as it had been arranged. The deceased indicated he would need to be moved on a stretcher as he couldn't move anything.[53]

39. At 10.30 am Mr Aung went back again and noticed the deceased's breathing was very hard and shallow and the 2nd Officer brought a manual inhaler to assist his breathing. Mr Aung informed the Captain, who came to check on the deceased himself. Mr Aung told the Captain that he felt the deceased was almost in shock and close to unconscious.

40. It appears that after this time the Captain again attended the deceased's cabin. Mr Oo heard the deceased say to the Captain, "Captain please call a helicopter, I'm in lots of pain."[54] Mr Oo recalls that the Captain responded "If I call [sic] helicopter, helicopter come, medic come, small problem become big problem."[55] The Captain then said that at 1.00 pm the pilot would come in and bring the ship alongside and after that the deceased could go to hospital.[56]

41. The Captain attempted to touch the deceased's stomach but the deceased stopped him as he said he was in too much pain. Mr Oo recalled the deceased then told the Captain he would pay for a helicopter[57] but the Captain responded, "After a second you will be ok,"[58] and then left the deceased's cabin. Another crew member then came in to assist and Mr Oo left to work in the engine room.

42. At 11.18 am the Captain made the ship's first communication with Port Hedland Harbour Tower (PHH Tower). However, he did not report about the deceased's medical condition during this communication.

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[50] Exhibit 1, Tab 8.
[51] Exhibit 1, Tab 7.
[52] Exhibit 1, Tab 9.
[53] Exhibit 1, Tab 9.
[54] Exhibit 1, Tab 6 [30].
[55] Exhibit 1, Tab 6 [31].
[56] Exhibit 1, Tab 6.
[57] Exhibit 1, Tab 6 and Tab 7.
[58] Exhibit 1, Tab 6 [35].

43. At 11.30 am the Second Officer was woken from sleep by a call from the Captain. He was ordered to take the deceased's blood pressure before commencing duty, which he did. He reported the blood pressure reading to the Captain, who said it was 'normal'.[59]

44. At 12.17 pm the ship communicated with the PHH Tower again and, once again, there was no request for medical assistance for the deceased.

45. Mr Khaing reported that after lunch he went to check on the deceased and the deceased told him that he was having trouble breathing. The Second Officer came down with oxygen and a manual breathing mask, which the Captain had authorised, and Mr Khaing helped the deceased breathe with the mask.[60] After a while the deceased pushed the mask away and rolled over a few times. About 10 to 15 minutes later Mr Khaing observed orange coloured fluid on the pillow next to the deceased's mouth and found the deceased was unresponsive and showing no signs of life. Mr Khaing tried shaking him to wake him up but the deceased did not respond. Mr Ha had returned at this stage with some food for the deceased. He called the bridge and told the Third Officer of the situation and also called the Engine Room. The Captain, the Chief Officer and the Chief Engineer all attended and Mr Ha recalls that "[e]veryone was panicking at that time."[61] Mr Ha recalls that this was the first time that the Captain said he was going to call for a helicopter.[62]

46. At 1.05 pm the Captain reported to the PHH Tower for the first time that he needed a medical evacuation as there was a crew member unconscious on the deck. It would appear from the other evidence that at this stage the deceased was near death.

47. The deceased's condition deteriorated further and Mr Khaing and Mr Aung attempted cardiopulmonary resuscitation. Mr Aung recalls at this time that the deceased was unconscious and not breathing but after doing some chest compressions for about a minute he thought he felt a weak heartbeat. He started compressions again for about a minute and then stopped. He could not discern a heartbeat so he did not continue as he believed the deceased had died. Mr Khaing also recalls they stopped CPR after 2 to 3 minutes as he and Mr Aung formed the opinion that the deceased had died. Mr Ha, who had previous experience with death, also thought he was dead.[63] Around this time the Captain advised that the helicopter was about ten minutes away.[64]

THE MEDICAL EVACUATION

48. Mr Robert Townsend was a Port Marine Office (PMO) working for the Port Authority at Port Hedland in September 2012. On 30 September 2012

[59] Exhibit 1, Tab 10.
[60] Exhibit 1, Tab 10.
[61] Exhibit 1, Tab 7 [52].
[62] Exhibit 1, Tab 7 [53].
[63] Exhibit 1, Tab 5 and Tab 7 and Tab 9.
[64] Exhibit 1, Tab 7.

Mr Townsend was working an eight hour shift, which commenced at 7.00 am. Mr Townsend had a limited recollection of events as he was not asked to provide a statement until a few years after the event, although he indicated at the inquest that he still had a memory of the general sequence of events.[65]

49. Mr Townsend indicated that the usual practice was for a PMO to contact a ship at anchorage 12 to 24 hours prior to berthing to give them their 'berthing schedule," which included the time they were to be at the Pilot Boarding Station (a nominal point in the ocean approximately 9 nautical miles from the harbour) to receive the pilot, who would then guide the ship into port for berthing. The PMO would usually contact the ship again two hours prior to their intended arrival at the Pilot Boarding Station, to ensure that the vessel was weighing anchor and proceeding from the anchorage to arrive at the scheduled time. The pilot would usually be brought to the vessel at the Pilot Boarding Station by helicopter. The PMO would call the ship one last time approximately 15 minutes prior to the pilot's arrival, to give the ship notice the pilot was leaving the port in the helicopter to head to the ship. This would give the crew time to prepare to receive the pilot and helicopter on board.[66]

50. Mr Townsend recalls that just prior to the 15 minute call he was contacted on the radio by the ship and told for the first time that there was a very sick crew member on board, who had very low blood pressure. Mr Townsend believed he spoke to the Master or Captain of the ship, which was later confirmed in an email.[67] Mr Townsend recalled that there was no mention that the crew member was deceased or even dying, just that they were unwell and had low blood pressure.[68] An email Mr Townsend sent to the Deputy Harbour Master later that day also mentioned that he was told the patient was "in grave condition…unconscious, shallow breathing and faint pulse."[69] Mr Townsend's memory was prompted by the email and he agreed the information was probably correct as to what he was told at that time.[70]

51. Mr Townsend noted that they had experienced no problems with communications or reception, so the crew of the ship could have easily contacted the Port Authority and provided this information earlier.[71] Indeed, the ship had been in communication with the Port Authority a number of times that morning to advise of their estimated time of arrival at the pilot station, so the Captain and crew had opportunity to raise the matter if they had wished to do so.[72]

52. Mr Townsend explained that there are a number of options to provide someone with medical attention whilst a ship is at anchorage, if required, depending on the severity of the case. Options include evacuation by helicopter or pilot boat, or a doctor or paramedic can be sent out to the boat

[65] T 23; Exhibit 1, Tab 14.
[66] T 24; Exhibit 1, Tab 14.
[67] T 23 – 24, 27; Exhibit 1, Tab 14 [11].
[68] Exhibit 1, Tab 14.
[69] T 27.
[70] T 27.
[71] Exhibit 1, Tab 14.
[72] T 37.

to provide treatment. In his statement Mr Townsend said that "[c]ost is not a factor and the method depends on the circumstances."[73] It was Mr Townsend's understanding that no cost was borne by the shipping company for provision of such a service by the Port Authority, although the Harbour Master later gave evidence indicating that some costs might be borne by the shipping company, depending on the arrangements made.[74] Mr Townsend also suggested that the Captain could have contacted the Australian Maritime Safety Authority, either directly or through their shipping agent, and they would have organised a medivac. Mr Townsend thought there might be no cost to the ship for this service, but the Pilbara Ports Authority Harbour Master later confirmed that the ship's owner would bear any cost involved as per their obligations relating to seafarer welfare and access to medical treatment.[75]

53. Mr Townsend's evidence was that usually in these situations he would contact the Harbour Master and then the ship's agent for arrangements to be made. However, in this case, given the pilot was about to leave in the helicopter, Mr Townsend thought the fastest option was to send someone with medical training to the ship in the helicopter. He spoke to the Deputy Harbour Master, who agreed with the plan, and then Mr Townsend called around to see if he could get a medic onto the helicopter before it left with the pilot. Mr Townsend believed they always had a paramedic working on the front gate of the port. The helicopter delayed its departure by a few minutes while Mr Townsend tried to find someone suitable.[76]

54. Graeme Eudey was employed by a security company as a supervisor and was working on 30 September 2012 as a security officer at the Port Hedland Port Authority. He received a call at around midday from Harbour Control and was told that one of the ships had an unconscious male who needed medical assistance. The person on the telephone asked Mr Eudey if they had anyone with medical experience who could assist. To the best of Mr Eudey's knowledge, this was the first time such a request had been made of the security staff, although they did attend emergency situations at the port itself.[77] Mr Eudey replied that they were trained in first aid, but that was about it. After a quick discussion with his colleagues, Mr Eudey established that he was as qualified as the others, having completed an Occupational First Aid Course (a three day course run by St John Ambulance) twice and he had also been a royal lifesaver for eight years. Mr Eudey's supervisor then gave Mr Eudey approval to go with the helicopter.[78]

55. It was arranged that Mr Eudey would attend the helipad and fly out with the pilot. Mr Eudey had only been told that the crewman was unconscious, but he took kit bags of equipment including an oxygen bottle, a defribrillator and a first aid kit with him, just to be safe. He was aware that the helicopter that they travelled in was not equipped for medical evacuation.[79] Mr Eudey estimates it took him two minutes from grabbing his gear to reach the

[73] Exhibit 1, Tab 14 [15].
[74] T 39; Exhibit 1, Tab 14 [16] and Tab 30..
[75] Exhibit 1, Tab 14 and Tab 30.
[76] T 25 – 27.
[77] T 57.
[78] T 57; Exhibit 1, Tab 15.
[79] Exhibit 1, Tab 15.

helicopter and the helicopter left almost immediately.[80] There is a record that the helicopter left the port at 1.00 pm to fly to the ship.[81]

56. In the meantime, Mr Townsend telephoned the Port Hedland Hospital so that they knew to expect the ill crew member and would be ready when the helicopter arrived. Mr Townsend estimated the flight to the ship would take approximately 15 minutes, and then the flight from the ship to the hospital would take 20 to 25 minutes. There was no quicker method available to convey the deceased to hospital.[82]

57. On the Equator Prosper, Mr Oo had been called in to the engine room after lunch and told to go to the deceased's cabin. He went straight to the deceased's cabin as he was worried for the deceased. When he got to the deceased's cabin he found the Chief Officer, Mr Aung, Mr Khaing and Mr Soe with the deceased. He observed the deceased was lying down on the bed and did not appear to be breathing. He also saw a stretcher next to the bed.

58. While Mr Oo was watching Mr Aung checked the deceased's neck and declared that there was no heartbeat. He then checked the deceased's wrists and again indicated there was no heartbeat. At this time Mr Oo could hear a helicopter approaching the ship. They lifted the deceased onto the stretcher. When Mr Oo lifted the deceased's legs he observed that the deceased's body felt very cold and he was very white and he did not feel alive. The crewmen then carried the deceased on the stretcher up to the main deck.[83]

59. Mr Ha recalls that once they had carried the deceased to the main deck all the crew stood there not doing anything. He estimates they waited about 8 minutes for the helicopter to arrive.[84]

60. When the helicopter landed on the ship Mr Eudey recalls being surprised that "there was just no urgency at all"[85] amongst the crew although he could see a group of men standing around the stretcher. Mr Eudey saw that the deceased was strapped to the stretcher and there was an oxygen bottle next to him, but not in use. He was guided by the crew to the stretcher but they didn't say anything to him. Mr Eudey tried to question the crew, but much to his frustration none of them would answer him. Mr Eudey made the assumption from their lack of response that the crewmen did not speak much English. Mr Eudey was not introduced to the Captain or anyone purporting to be in charge at any stage. After many requests of the crew someone finally told Mr Eudey after three or four minutes had passed that the deceased had become sick the day before.[86]

61. When Mr Eudey examined the deceased he immediately realised that he was not responsive to touch and sound and when he opened the deceased's eyes he was very surprised by the size of his pupils. The deceased felt warm to the touch, but Mr Eudey also noted that he was lying out on the deck

[80] T 61.
[81] T 29.
[82] T 28; Exhibit 1, Tab 14.
[83] Exhibit 1, Tab 6.
[84] Exhibit 1, Tab 7.
[85] T 57.
[86] T 57 – 58, 62; Exhibit 1, Tab 15.

underneath an open hatch. Mr Eudey checked for a pulse and thought that he found a pulse, albeit it was a very weak pulse felt with his fingers on the deceased's neck.[87]

62. Mr Eudey frankly admitted he was quite shocked at the state that the deceased was in and the lack of reaction from the crew. He was expecting to find someone in the recovery position and being tended to, not a situation where the crew members were sitting nearby and no one seemed distraught or upset or hurried. Mr Eudey described the situation as bizarre and indicated his personal feeling was that "it seemed like they had been hushed, to be perfectly honest, because no one wanted to say anything at all."[88]

63. Mr Eudey was reluctant to use the defibrillator given they were on a steel ship and there were crew members sitting nearby. Instead, given he thought he felt a pulse he believed it was best to get the deceased off the ship as quickly as possible.[89]

64. As there was already oxygen present, Mr Eudey commenced giving the deceased oxygen. Given the helicopter was not equipped for a medivac the deceased could not be put into the helicopter on the stretcher. With the crew's assistance they removed the deceased from the stretcher and put him in the back of the helicopter, in a sort of squatting position on his back. The deceased remained non-responsive throughout this process. The helicopter then flew straight to the hospital. Mr Eudey kept the oxygen on the deceased throughout the flight. He estimated the flight took 5 to 10 minutes.[90]

65. When the helicopter landed at the hospital helicopter pad at 1.29 pm there was a medical team waiting. A doctor quickly examined the deceased and announced that he was dead. They asked Mr Eudey if he had been like that when he arrived at the ship, and Mr Eudey indicated that he had thought the deceased had a pulse. The medical team took the deceased out of the helicopter and commenced doing full CPR but he could not be resuscitated and he was declared deceased at 1.56 pm. He was noted on the hospital documentation to have been "dead on arrival."[91]

66. Mr Eudey was shocked and distressed by the events. He spoke to one of the nurses later who suggested to Mr Eudey that what he may have felt was a "wish pulse," where you feel a pulse because you want to believe there is a pulse. Mr Eudey acknowledged that was possible, but at the time he spoke to police he still felt certain he had felt a pulse.[92] However, by the time Mr Eudey gave evidence at the inquest he indicated that he had looked back at the events and acknowledged that the deceased may well have been dead at the time he examined him on the ship's deck and he was mistaken about feeling a pulse.[93]

[87] T 57 – 58, 62; Exhibit 1, Tab 15.
[88] T 59.
[89] T 57, 60.
[90] Exhibit 1, Tab 15.
[91] Exhibit 1, Tab 25.
[92] Exhibit 1, Tab 15.
[93] T 59.

CAUSE AND MANNER OF DEATH

67. On 5 October 2012 Dr D.M. Moss, a Forensic Pathologist, conducted a post-mortem examination on the body of the deceased. The post mortem examination showed early post mortem changes. The lungs appeared congested and somewhat heavy. During the initial examination there was no evidence of significant injury or natural disease that would account for the death. Further testing was then undertaken to assist in determining a cause of death.[94]

68. Microscopic examination of the tissues showed widespread post mortem changes. Despite the presence of these post mortem changes, there was evidence of patchy bronchopneumonia within the lungs. There was no evidence of significant abnormality in sections from the gastrointestinal tract. Microbiology and virology testing was non-contributory. Toxicology analysis showed a low therapeutic level of paracetamol and a therapeutic level of codeine. A very low level of morphine was detected, There was evidence of alcohol in the bile but alcohol was not detected in the blood. There was no evidence of other common drugs within the blood.[95]

69. In the absence of evidence of significant injury, other natural disease or toxicological abnormality, Dr Moss felt that the most likely cause of death in this case was the bronchopneumonia. Accordingly, he formed the opinion that the cause of death was consistent with bronchopneumonia.[96]

70. Dr David Mountain is an emergency physician and an Associate Professor in the field of emergency medicine. Dr Mountain was asked to review the circumstances of the deceased's death and provide an expert opinion to the court. Based upon the known history, Dr Mountain believed the deceased was unlikely to have had a lingering viral illness from late August, when he had seen a doctor in Port Hedland. Rather, Dr Mountain believed that the deceased developed a rapid onset infection in the days prior to his death.[97]

71. Dr Mountain also expressed the view that the deceased probably had significant pericarditis or a pericardial effusion at the time he died, which was most likely a secondary complication from the bronchial pneumonia and contributed to his death. Dr Mountain explained that the pericarditis meant the deceased's heart would have found it hard to open up wide enough to regain fluid. The pericarditis, when combined with the fact that the deceased was clearly dehydrated by the time he died due to his persistent vomiting and inability to keep solids or fluids down, meant his body could not maintain his circulation and he developed shock.[98]

72. Dr Mountain expressed the opinion that the deceased died from cardiovascular collapse secondary to sepsis due to a rapidly progressive bilateral basal bronchopneumonia. Dr Mountain advised that it is not unusual to see patients with severe infective diseases in other systems also

[94] Exhibit 1, Tab 27.
[95] Exhibit 1, Tab 27 and Tab 28.
[96] Exhibit 1, Tab 27.
[97] T 8.
[98] T 7; Exhibit 1, Tab 32.

presenting with non-specific abdominal issues and he concluded the bronchopneumonia caused the deceased's gastrointestinal symptoms: namely the vomiting, the distension, the pain.[99]

73. Relying upon the expert evidence of Dr Moss and Dr Mountain, I find the cause of death was bronchopneumonia, noting that the pericarditis and dehydration referred to by Dr Mountain were seen by him to be complications of the bronchopneumonia.

74. It follows from this finding that I find that the manner of death was by way of natural causes.

WAS THE DEATH PREVENTABLE?

75. Dr Mountain was asked whether he believed the deceased's death was preventable. Dr Mountain replied that the death was "clearly preventable."[100] He explained that at any stage in the previous two or three days if the deceased had had treatment, including intravenous fluids, antibiotics and supportive care, he would have had a very good opportunity to survive.[101] Dr Mountain indicated that the deceased was a patient who would have been taken very seriously if he presented to an emergency department, and would be getting very rapid diagnostics, interventions and treatment.[102]

76. Dr Mountain noted that even at 6.30 am in the morning on 30 September 2012 the deceased was still talking and was able to have a sensible and rational conversation, which indicated the deceased was still maintaining enough blood pressure to be able to profuse his brain. Dr Mountain expressed the opinion that if the deceased had received treatment almost immediately, he might have survived.

77. By about 8.30 to 9.00 am events had progressed and the deceased had very rapidly deteriorated. Nevertheless, even at that time Dr Mountain expressed the opinion that if treatment had been timely and aggressive, a survival rate of 40 – 50% could be expected.[103]

78. At the time when Captain Singh finally recognised the need for evacuation and spoke to Mr Townsend at the Port Authority, Dr Mountain indicated the description of the deceased was of a patient showing signs of arrest and at near death. They would need high level medical attention as they would be "very close to succumbing."[104] Dr Mountain indicated his view that, if the deceased had not actually died prior to the helicopter's arrival, he was "beyond the point of survivability."[105]

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[99] T 7.
[100] T 8.
[101] T 8.
[102] T 12.
[103] T 11; Exhibit 1, Tab 32.
[104] T 10.
[105] Exhibit 1, Tab 32, p. 3.

79. In terms of what would be required for a medical evacuation of such a person, Dr Mountain indicated a team would be taking full armamentarium, which would basically be a 'mini ICU' in the hope of supporting the patient to try and get them back to the hospital. The patient would most likely need to be intubated for safe transfer, as they would not manage their airway properly while unconscious and they would need ventilation as they would probably be hypoxic.[106] It is obvious that a person who had done only a short St John's Ambulance course, such as Mr Eudey, would not be in a position to provide this kind of high level medical care.[107]

80. Dr Mountain was also asked his opinion as to whether it would have made a difference if the crew had still been performing active CPR on the deceased when the helicopter arrived and if CPR had then been continued on the helicopter journey (if it had been practicable to do so, which it was not). Dr Mountain explained that, given the deceased's serious dehydration, it would have been very difficult to get a good output as he had lost the ability to keep his blood vessels up. Dr Mountain indicated he was "pretty sure by the time [the deceased] got on the helicopter he was in an irretrievable state of shock."[108] He also noted that it was difficult to be sure that the deceased even had a pulse at that time, as there was only the evidence of Mr Eudey to that effect. Dr Mountain observed that in such a stressful situation people have been known to feel their own pulse in those situations. Without monitors or equipment to measure a pulse, there was no guarantee that Mr Eudey was actually feeling a real pulse when he examined the deceased on the ship.[109]

CAPTAIN SINGH'S ACCOUNT OF EVENTS

81. Police officers from Port Hedland Police Station, including the Acting Officer in Charge Senior Constable Daniel Allen, boarded the Equator Prosper at 5.00 pm on 30 September 2012 in company with officers from Customs and Quarantine and from the Shipping Agent Wilhelmsen. Senior Constable Allen was taken to the Chief Officer's office where he spoke with Captain Viresh Singh.

82. Captain Singh provided a brief statement to the investigating police. The statement was signed in Port Hedland on 1 October 2012, so the day after the death. Captain Singh did not outline in the statement any occasions that he personally visited the deceased and assessed him, but he did acknowledge in his statement that he spoke to the deceased on the evening of 29 September 2012 and told the deceased that they were reaching the port the next day and he would send him to the hospital then.[110]

83. Captain Singh indicated in the statement that he was aware the deceased was vomiting during the safety meeting and was told that the deceased was complaining of back and stomach pain later on 29 September 2012. He

[106] T 10.
[107] T 10.
[108] T 10 – 11.
[109] T 11.
[110] Exhibit 1, Tab 13 [15].

stated that at about 12.00 pm the following day the Second Officer told him that the deceased's blood pressure was fine but his pulse was 55. Then at 12.35 pm he was told the deceased was pale and having trouble breathing and he states he then called for an emergency to the tower in Port Hedland and was told that the helicopter was coming out with one medic on board.[111]

84. Captain Singh claims he was informed by the pilot the deceased was breathing and had a pulse when he was taken on the helicopter shortly after 1.15 pm.[112]

85. In the final paragraph of his statement Captain Singh stated that the deceased "always was complaining of pain in his stomach and back. It was just the severity that changed."[113]

86. At the time of the inquest Captain Singh was no longer employed by the shipping company that owned the Equator Prosper. A letter was sent to the lawyers for the shipping company advising an adverse finding might be made against Captain Singh and the brief was made available for viewing by a solicitor from the firm to allow some consideration to be given as to whether Captain Singh should be represented. After the viewing was arranged no further indication was given that Captain Singh would be represented at the inquest. Attempts were made to contact Captain Singh personally and police investigations established an internet social media profile and an address in Mumbai, India. Communication was attempted via the internet and correspondence was sent to Captain Singh at the Mumbai address advising of the possibility of an adverse finding pursuant to s 44 of the Act. No communication was received from Captain Singh in response and no appearance was made at the inquest by him or on his behalf.

87. Accordingly, no further evidence was able to be obtained personally from Captain Singh as to his version of events. The only additional information was able to be obtained from an 'incident alert' forwarded by Captain Singh to the Australian Maritime Safety Authority (AMSA) within hours of the incident. The alert indicated that the deceased had become unwell during the safety meeting at approximately 10.35 am and was heard vomiting. It was noted he also complained of stomach ache all over his back and was given medicine as per the medicinal guide for stomach ache and gas. It was noted that "all thru [sic] the day his appearance was normal but his pain eased only a little. As we were making the port the next day we told him that we will send him to a doctor on arrival."[114] The alert then records that the following morning the deceased still complained of stomach pain but could talk normally. He was told again he would get to see a doctor on berthing. At midday his blood pressure was checked and was normal. At 12.40 pm the Captain was told the deceased had a breathing problem and he was given oxygen and the Captain called up the Port Hedland Harbour for assistance, which resulted in the helicopter bringing a medical person at 1.15 pm.[115] The information in the incident alert largely matches what Captain Singh

[111] Exhibit 1, Tab 13.
[112] Exhibit 1, Tab 13.
[113] Exhibit 1, Tab 13 [26].
[114] Exhibit 2.
[115] Exhibit 2.

provided in his statement to police, which is unsurprising as they were given around the same time.

THE SHIPS AGENT & THE SHIPPING COMPANY

88. A ship's agent is responsible for the safe and efficient port call for a vessel. In September 2012 Wilhelmsen Ships Service Pty Ltd (Wilhelmsen Ships) acted as the Ship's Agent for the Equator Prosper and organised port services for the ship's visits to port.[116] These included services such as transport, accommodation and even airport transfers home for the crew, as required.[117]

89. The ship's agent, as the ship owner's representative, is also responsible for authorising expenses and making payments for costs incurred. This includes the cost of any medical evacuation necessary for the health and safety of a seafarer on board a ship.[118]

90. Mr Robert Gilchrist works for Wilhelmsen Ships and is currently the acting agency finance manager. In September 2012 he also worked for Wilhelmsen Ships and was working as a ship's agency operator, which was mainly an administrative role.[119]

91. Mr Gilchrist was on duty on 30 September 2012 and was the only staff member in the Wilhelmsen Ships office that day.[120]

92. On the morning of 30 September 2012 Mr Gilchrist received an email sent to the group office email address by Captain Singh at 9.30 am on 30 September 2012. The email referred to a telephone conversation the previous day with one of Mr Gilchrist's co-workers, Mr Steven, and confirmed that the ship's second engineer was sick. In the email Captain Singh asked Wilhelmsen Ships staff to arrange for the second engineer to visit a doctor "this noon itself [sic]."[121] Mr Gilchrist responded to the email at 11.40 am confirming that he would arrange to take the crew member to the doctor as soon as the vessel berthed. Mr Gilchrist did not try to make a doctor's appointment as he was aware there was no GP available that weekend. Instead, he planned to meet the vessel when it came alongside and take the crew member to hospital.[122]

93. Mr Gilchrist was not aware at that stage what was wrong with the crew member. He agreed that if he had been told that the crew member was unconscious and had a weak pulse it would have changed his plans and led him to contact the Port Authority, who were in direct contact with the vessel by radio, and asked them to make a radio communication with the vessel and find out what was really happening. He then expected the Port Authority would act on the information if it was an emergency.[123] In his oral evidence

[116] Exhibit 1, Tab 17.
[117] T 48.
[118] Exhibit 1, Tab 30.
[119] T 49.
[120] T 51.
[121] Exhibit 1, Tab 16 [2].
[122] T 50 – 51.
[123] T 51 – 52.

Mr Gilchrist did not appear to know about the role played by AMSA's Joint Rescue Coordination Centre in such an emergency situation.[124]

94. Mr Gilchrist gave evidence at the inquest that he recalled receiving a phone call from the Port Authority stating that there was an emergency on board the vessel while it was coming through the Port Hedland channel. Mr Gilchrist's statement indicates that he received the call at 1.15 pm and was made aware by the Port Hedland Port Authority that a crew member would be transported from the vessel to hospital by the same helicopter that was being used to deliver the marine pilot.

95. Mr Gilchrist drove to the Port Hedland Hospital a short time later to check on the status of the crew member. He was informed by hospital staff that the crew member was deceased. Mr Gilchrist then informed Australian Customs by telephone of the death.

96. Mr Gilchrist returned to the Wilhelmsen Ships office to inform various relevant parties and complete necessary arrangements for the boarding of the vessel by Customs, the police, etc. He also received a telephone call from someone overseas asking for information on the deceased and had to explain that he had died. Mr Gilchrist found delivering this news upsetting so he rang a colleague with experience in delivering this sort of news to ask for advice on how to do such a task. Mr Gilchrist was unable to recall any discussions with any other Wilhelmsen Ships staff about this matter. He was also unable to say whether Wilhelmsen Ships reviewed its processes after this event. However, he did not think the company implemented any changes to its procedures as a result of the events surrounding the death of the deceased. Mr Gilchrist expressed the view that then, as now, they rely upon the Captain to provide them with relevant information and they simply act on the information they are given at the time.[125]

97. In his written statement Mr Gilchrist advised that at the time he corresponded with Captain Singh prior to the death of the deceased, the seriousness of the deceased's condition was not conveyed to him. Mr Gilchrist indicated that if the ship's agent had been informed of the seriousness of the deceased's condition, they would have contacted emergency services through the Port Authority and or AMSA to arrange medical assistance and evacuation of the deceased.[126]

COMMENTS ON THE CONDUCT OF CAPTAIN SINGH

98. The evidence reveals a stark contrast between the Captain's behaviour and the other crew members towards the deceased. The crew members' statements reveal they were all extremely concerned for the deceased and very caring in their behaviour towards him while he was ill.

[124] T 52 – 53.
[125] T 54 – 55.
[126] Exhibit 1, Tab 17.

99. On the day of the deceased's death 19 of the deceased's crewmen (out of a possible 20)[127] co-signed a letter addressed to "To whom it may concern" setting out their concerns about the decisions made by the Captain (whom they refer to as the Master). They gave the letter to Senior Constable Allen when he boarded the ship that afternoon.[128] I have set out the contents in full below:

Dear Sir.

This is M.V Equator Prosper. We joined this ship since delivery time. We would like you to know about our second engineer who joined this ship on 16-06-2012. Yesterday about 10:30 hours while we are having safety meeting and drills in the crew mess room all together, he requested to the Master to relieve him from meeting because he was vomiting. Then he went to the nearest toilet and vomited. Then straightly go to his cabin and take rest. He reported to Master about his status that he needs to meet the physician as soon as possible. At night about 21:20 pm 29-09-2012 he requested to Master that he need immediate medical assistant from ashore. Also requested to Master to get the Helicopter to pick him up to Hospital. At that time we are near with the Port Headland Port about 100 miles. But Master only replied him to wait until berthing. During the whole night, he was getting worse and worse. He also told to Master that he will pay all the charges for the Helicopter from his account. But the Master gave the answer the same as before. We continuously are reporting to Master about his situation. Master only gave some pain killer drugs which is from our board. Those medicines didn't make to release his pain. This morning he requested to Master that he can't breathe well, he need immediate medical assistant by picking up with helicopter urgently. At that time we were drifting near the port about 30 nautical miles. But the Master gave the same answer which is until to wait berthing. When the second engineer was unconscious at 13:15 pm, at that time only, Master tried to call helicopter. Fortunately, we can send him by pilot helicopter which brought the pilot for our ship.

We all of the rest crews, feel don't safe under the command of this Master. Who will be sure, it will not be happened again in future like our second engineer due to Master's wrong and delay decisions. It is really make us frighten to all crews onboard to sail together with that kind of Master.

We all are agree and acknowledge.

C/O	2/O	3/O	3/E	4/E	E/O
Htay Aung	Bo Bo Kyaw	Aung Zaw Lat	Aung Kyaw Swar Oo	Hla Myat Oo	Kyaw Myint Tun
E/C	D/C	E/FIT	D/FIT	O/S	
Soe Thi Ha	Khant Zaw Wynn Htoon	Kyaw Kyaw Soe	Htay Maung	Hein Min Ko Ko	
BOSUN	AB/2	AB/3	MTM/1	MTM/2	
J.Tatiyan@ Subba Rao	Nyi Nyi Tun	Min Po Myint	Bo Bo Thwin	Ye Hla	
MTM/3	G/S	C/COOK			
Win Min Khaing	Aung Khine	Khin Maung Zaw			

Exhibit 3 – Letter and signatories of the crew on board the M.V Equator Prosper dated 30 September 2012

[127] Exhibit 1, Tab 20 [9].
[128] Exhibit 1, Tab 20 [20].

100. As is indicated in this letter, and in their individual statements provided to the police, the crew of the Equator Prosper were very upset and angry that the Captain had not arranged for the deceased to see a doctor.[129] They had all done their best to convey to the Captain the seriousness of the situation, without success.

101. Detective Sergeant Fergus Mackinnon, who was the Officer in Charge of the South Hedland Detectives at the time, observed that on a vessel such as the Equator Prosper "there is a strong regimented rank structure which either cannot or will not be compromised."[130] Therefore, "the Captain of the vessel has sole authority to make decisions and is not challenged by others if his decision-making is errant."[131] Given the hierarchy on board the ultimate responsibility and power to arrange an urgent transfer rested in the Captain's hands, and he chose not to do so until it was too late.

102. Without the opportunity to question Captain Singh at the inquest, it was not possible to hear his reasons as to why he made that decision. However, other evidence on the brief suggested that he did not believe the deceased was as ill as he said and there was also a concern about the cost involved. According to Mr Townsend from the Port Authority, the cost may not have been only for the medivac, but also costs arising from the ship's berthing being delayed, which apparently can be very expensive.[132]

103. The second Officer on board, Bo Bo Kway, was the medical officer on board but by his own admission this was by virtue of his rank rather than any significant medical training. He had only completed a 14 day first aid course. The Captain had only completed a four week first aid course. Detective Sergeant Mackinnon suggested the evidence supported the conclusion that the Captain had erroneously formed the belief that the deceased's illness was not of a serious nature, due to his lack of knowledge and medical experience, rather than having any criminal intent.[133] I accept that this was the case.

104. However, as Dr Mountain expressed in his oral evidence, "people who are in positions of authority who take on the responsibility of looking after other people need to err on the side of caution, not on the side of ignoring things and hoping it will all get better."[134]

105. Dr Mountain explained that once the deceased could not manage fluids, there was an urgency to get him treatment "and you would want to at least get some advice from somewhere else."[135] As Dr Mountain explained, one of the biggest killers in the world is gastroenteritis, which causes millions of children to die every year of dehydration in countries where they do not have the same access to medical care as we do in Australia.[136] Emergency departments in Australia treat many patients for severe gastroenteritis who

[129] Exhibit 1, Tab 5 [44] – [45].
[130] Exhibit 1, Tab 2.
[131] Exhibit 1, Tab 2.
[132] Exhibit 1, Tab 14 [22].
[133] Exhibit 1, Tab 2.
[134] T 13.
[135] T 13.
[136] T 13.

cannot keep up with their fluids. They are treated and given support for four to six hours to make sure that their vomiting is brought under control and that their fluid levels are back up to a reasonable level and it is clear that their system can manage.[137] Dr Mountain expressed the view that "[o]ne would expect if medical training provided to lay people with responsibility for others, that the rule should be to err on the side of caution and that red flags such as poor fluid intake, severe abdominal pain and respiratory distress should be acted on urgently."[138]

106. Although the Captain had medical training, he appears to have believed that the relatively normal observations taken were sufficiently reassuring to ignore the other symptoms. In hindsight, it is clear that he was wrong, which had fatal consequences for the deceased.

107. The MV Equator Prosper was owned by an international shipping company, Synergy Marine Pty Ltd in September 2012. The company and its insurers were represented by Ausship P&I/Ausship Lawyers for the purposes of answering enquiries in relation to the coronial investigation, although they did not seek leave to appear at the inquest hearing.

108. Information was provided on behalf of the shipping company acknowledging that, as per the employment contract, the deceased was entitled to immediate medical attention when required and the employer was to pay all medical expenses for any illness contracted or injury suffered during service on the vessel, provided it was not self-inflicted or due to the seafarer's fault or negligence. As per the International Convention of Standards of Training, Certification and Watchkeeping for Seafarers ('the STCW') identified by Mr Finch (set out later below), Captain Singh had training as a qualified Master Mariner to assess the vital signs and provide medical care to the seafarers on the ship and was required to immediately inform the office and company's doctor when any illness was reported on board so that medical advice could be obtained from the company doctor. The Captain could also seek radio medical advice and seek assistance for emergency evacuation if there was danger to life.[139]

109. The Court was advised that the shipping company had conducted an investigation to find out if there were any lapses in providing medical care to the deceased. The Court was advised that the investigation found Captain Singh provided first aid as per the Ship Captain medical guide on board when first notified that the deceased was sick on 29 September 2012, including forwarding a report to the company's doctor that evening (although the advice was not received until after the deceased was evacuated from the ship). The investigation also found the Captain made arrangements with the agent for medical assistance the following day. It was suggested that the deceased was complaining of pain but speaking normally and his vital signs were normal until noon when the deceased suddenly developed a breathing problem, and it was only then the Captain found a serious condition.[140] The investigation does not appear to have taken into account the accounts of the

[137] T 13.
[138] Exhibit 1, Tab 32, p. 3.
[139] Exhibit 1, Tab 31.
[140] Exhibit 1, Tab 31.

crew, or at least no reference was made to the concerns they had raised about the Captain's conduct. It was not indicated in the response provided on behalf of the company what was the conclusion of the investigation. The company did indicate that there had been no changes to company procedures for providing seafarer's with medical treatment and the right to medical care remains the same as was applicable to the deceased at the time of his death.[141] The company also advised that Captain Singh was no longer employed with Synergy Group as at May 2015.[142]

110. Counsel assisting wrote to Ausship again after the inquest and queried what the conclusion of the investigation had been, and whether the views of the crew had been taken into account in the investigation. They advised that unfortunately they had not received any instructions from their client since 2016 and were unable to assist further.

111. Taking into account all of the evidence before me, including the accounts of all of the crew members provided to police as well as the information provided by Captain Singh and the shipping company, I am satisfied that the Captain failed to appreciate the seriousness of the deceased's medical condition despite clear evidence before him from both the deceased and other crew members that he was gravely ill. He ignored their requests for an urgent medical transfer to be arranged, apparently in the mistaken belief that the deceased was exaggerating the severity of his symptoms and that treatment could wait until they had reached the port, which would obviously have been far more convenient from the Captain's point of view. Sadly, the Captain only realised his error, and took appropriate action, when it was too late to save the deceased. Given the ultimate responsibility for the health of the deceased rested in the Captain's hands, he should have erred on the side of caution and taking action at a much earlier time, given the information that was before him.

COMMENTS ON PUBLIC SAFETY

112. Under s 25(1) of the *Coroners Act*, where a death is investigated by a coroner, a coroner may comment on any matter connected with the death, including public safety. This inquest raised some issues of public safety in relation to the availability of medical evacuation services from ships to the harbour, which I address below.

Medical Evacuation Services by Helicopter in Port Hedland

113. In July 2014 the Port Hedland Port Authority was amalgamated with the Dampier Port Authority and together now form the Pilbara Ports Authority. Mr John Finch is the Harbour Master of Port Hedland and also the General Manager of Operations for the Pilbara Ports Authority. In this role Mr Finch is responsible for the safe and efficient operations of shipping in the port. Mr

[141] Exhibit 1, Tab 31.
[142] Exhibit 1, Tab 31.

Finch was on leave at the time of the incident and his authorities were delegated to his deputy.[143]

114. Mr Finch was asked about the general procedure at the port in the event of a medical incident on a ship. Mr Finch indicated that they are notified of quite a few medical incidents as they have up to 50 or 60 vessels in and around Port Hedland anchorage and at berths at any given day, which equates to somewhere between 1000 and 1200 personnel on ships in and around the port.[144]

115. Mr Finch's understanding is that the Captain of the ship is responsible for the safety of the vessel and the crew and the Captain is required under the SCTW to be proficient in diagnosing and responding to injury and illness. The Captain, on the ship owner's behalf, is responsible for assessing the severity of an injury or illness and arranging for the seafarer to have access to appropriate medical care.[145] This accords with the information provided by the shipping company.

116. Mr Finch explained that, depending on the nature of the incident, the medical evacuation will take one of two forms. If it is something of a minor nature, the ship's Master will organise a response through the shipping agent. In such a case, the ship's agent will organise a means of transport to get the crew member off the ship and arrange for them to be seen for medical advice locally in Port Hedland.[146]

117. If the medical issue is of a more significant nature, then the Master will advise the port marine officer or vessel traffic service officers (employees of the port authority such as Mr Townsend) who will advise the Joint Rescue Coordination Centre, which is part of the Search and Rescue Division of AMSA in Canberra.[147]

118. Mr Finch also expressed the opinion that if the information given was that a crew member was unconscious, breathing shallowly and had a faint pulse this would normally classify it as a significant event and result in the matter being referred to the Rescue Coordination Centre.[148]

119. The Pilbara Ports Authority is not obliged to provide a medivac or rescue capability. However, Mr Finch acknowledged that Port Hedland is located in a remote part of the Pilbara Region in North Western Australia and there are limited resources in the region to assist those injured at sea. Therefore, the Pilbara Ports Authority assists where it can by allowing the helicopters contracted for the provision of marine pilot transfers to be used to transfer injured or sick seafarers to shore where their condition is stable and they can sit upright without assistance. This would not include critically ill or seriously injured patients. If the transfer can be incorporated into the normal shipping schedule, there may be no cost to the ship in relation to the

[143] T 33; Exhibit 1, Tab 30.
[144] T 34.
[145] Exhibit 1, Tab 30.
[146] T 34 – 35.
[147] T 34; Exhibit 1, Tab 30.
[148] T 34.

helicopter. However, if it requires an additional flight, then the cost of the flight would be invoiced to the ships agent.[149]

120. Mr Finch was also asked about the particular circumstances of this case, which he was informed of after he returned from leave. Mr Finch explained that in the event of a Master of a ship calling an emergency then under the Safety of Life at Sea convention, anybody in the vicinity has an obligation to respond to the best of their abilities. Mr Finch considered what was done by Mr Townsend, in utilising the helicopter already taking the pilot to also take someone with first aid training, was done in this context. As Mr Finch outlined above, he has regularly taken advantage of a similar opportunity if it has presented itself for transfer of seafarers who are stable and can fly unassisted but not for a critically injured patient as such a situation is rare.[150] Nevertheless, Mr Finch emphasised the importance of considering what was done in this case in the context of the need to respond to the emergency "to the best of their abilities."[151]

121. Mr Finch was referred to an aide-memoire that he had attached to his statement. The particular aide-memoire was designed to assist port marine officers with procedures in the event of an incident such as a fire on a ship or a vessel collision or a medical evacuation, to assist them to know what to do and to make sure that they don't miss anything.[152]

122. Mr Finch advised at the inquest that this process has changed since 2012, and again more recently. In 2012 St John Ambulance officers were not trained to go out in a helicopter as they had not completed helicopter underwater escape training. This meant that they were unlikely to participate in a significant medical evacuation at the time of the deceased's death, even if one had been available to go on the marine pilot helicopter.[153]

123. In 2013, various members of industry in the region got together and providing funding to put seven St John Ambulance officers through the appropriate training. From that time until 2015, St John Ambulance officers were then able to go on a helicopter out to ships to assist with a medical evacuation. They were generally sent out, by arrangement through the ship's agent, on the usual marine pilot helicopters on a semi-regular basis where the medical condition was of a minor nature. As the helicopters are not primarily designed for medical evacuation and not 'stretcher capable', even with the assistance of ambulance officers they could not provide patient transfers for critically ill patients. The patient would have to be capable of being seated in a seat and wearing the appropriate safety harness and belt.[154] The cost of this service was generally borne by the shipping company.[155]

124. However, at the end of 2015 the situation changed again and reverted to the position that ambulance officers could not accompany the helicopter.

[149] Exhibit 1, Tab 30.
[150] T 35.
[151] T 40.
[152] T 35 – 36.
[153] T 36.
[154] T 38 – 39.
[155] T 39.

Mr Finch advised that as of December 2016, that remained the case. Mr Finch understood the reason for the reversion to a position where ambulance officers were not permitted to go on a helicopter was due to a policy decision by St John Ambulance. The Port Authority was advised that St John Ambulance had done a review that had led to this decision.[156] No formal reason has been provided for the decision, although informally it was suggested that there might be a jurisdictional issue as to whether it was appropriate for St John Ambulance officers to go out to vessels when their priority is land based services.[157]

125. In his evidence at the inquest Mr Finch indicated that the Port Authority was still contacting St John Ambulance and advising them of an incident and requesting their assistance, but generally they are advised that the ambulance officers will no longer participate.[158] Therefore, if it is a relatively minor matter, where the person does not require someone medically trained to accompany them, the port may be able to facilitate a medivac. However, if it is a more serious matter then the only recourse is to the Rescue Coordination Centre.[159]

126. Mr Finch's evidence was that in his seven years at the Port Authority they have been involved in very few significant medical evacuations, as generally the ships will divert under direction of the Rescue Coordination Centre to a suitable point, such as near Broome or Karratha, where there are offshore equipped helicopters. Hence it is unlikely to occur off Port Hedland unless the ship is already in that location. Further, in Mr Finch's time at the port, no similar situation had arisen as occurred in this particular case.[160]

127. However, if it was to occur again, Mr Finch acknowledged that as far as he is aware there are very few options available, even to the Rescue Coordination Centre. Jayrow Helicopters Pty Ltd is a private company contracted to provide marine pilot transfers for the Port Hedland Port Authority. It was a Jayrow helicopter that was used to transport the deceased. The Jayrow helicopters are not stretcher suitable and, therefore, would not be ordinarily be tasked to fulfil an evacuation for a significantly injured or infirm seaman. The nearest other guaranteed available helicopters to the port are based in Karratha, which is at least a three to four hour journey away.[161] There is a rescue helicopter run by Heliwest that is based in the East Pilbara and is contracted to mining companies. It sometimes sits in Port Hedland, but it moves around depending upon the mining companies and their requirements, so it's location in Port Hedland is not guaranteed.[162] Accordingly, as Mr Finch explained, for serious incidents where someone is seriously ill, sourcing a suitable asset may be very difficult or result in quite a prolonged response time.[163]

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[156] T 36.
[157] T 36.
[158] T 36.
[159] T 41.
[160] T 40.
[161] T 37.
[162] T 38, 41.
[163] T 41.

128. Mr Finch has some experience working in ports in Queensland and he agreed with the view of Dr McKay that there is a different system in that jurisdiction as there are a whole series of rescue helicopters located down the coast that do offshore evacuations and are trained for that purpose. He noted that there is "no comparable system in WA."[164] In terms of the need for something similar to be put into place, Mr Finch expressed the opinion that, whilst major medical emergencies are a rare event, minor issues arise regularly and the regime that was in place from 2013 to 2015, involving the cooperation of ambulance officers, was a much better system than what is currently available. Mr Finch acknowledged that "we're certainly in a bit of a hole at the moment,"[165] and I infer that the 'we' encompasses the entire shipping industry in Port Hedland rather than just the Port Authority.

129. Mr Finch summed up his evidence by saying,

> As a port authority we're not responsible for the medical evacuation of seafarers but we do it under the Safety of Life at Sea convention to … the best of our ability, and noting that we're in a very remote locality and there is not much in the way of dedicated assets and resources."[166]

130. Following an enquiry by counsel assisting St John Ambulance has advised that the arrangement entered into between the Pilbara Ports Authority and St John Ambulance between 2013 and 2015 was entered into locally on an informal basis only. On St John Ambulance management becoming aware of the practice in 2016 it was ceased for clinical and occupational safety and health reasons. St John Ambulance has indicated that it must remain ceased until "an acceptable arrangement with robust process and procedure is put in place."[167] As at January 2017, St John Ambulance had not been involved in any consultation with any WA government agencies to develop systems to provide paramedical services to rotary wing air services offshore from the Pilbara, but the Chief Executive Officer indicated that St John would welcome the opportunity for further communication on this issue.[168] St John Ambulance are currently contracted as the tasking agency in relation to the two Rescue 65 helicopters based at Jandakot and Bunbury, so they already have some experience in this area in the south west of WA.[169]

131. Moving then to the role played by AMSA, it is noted that AMSA is the national coordinator for search and rescue services in Australia. AMSA does not have any dedicated rotary air wing assets under its control, but tasks a variety of assets as required. In 2012 AMSA tasked a variety of rotary wing assets in response to incidents within the coastal Pilbara region, primarily involving the extraction of sick/injured people from vessels for transportation to a suitable medical facility.[170] All the helicopters were obtained through cooperative commercial arrangements with various

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[164] T 42.
[165] T 42.
[166] T 44.
[167] Letter to counsel assisting from Mr Tony Ahern, Chief Executive Officer of St John Ambulance Western Australia dated 5 January 2017.
[168] Ibid.
[169] Ibid.
[170] Letter to counsel assisting from Mr Alan Lloyd, A/General Manager, Response, AMSA dated 6 January 2017.

helicopter companies who are primarily in place to service the oil and gas industry, with an 'ad hoc' approach to the operators to ascertain the availability of an asset when the need arises.[171] AMSA confirmed that the coordination of such extraction activities is undertaken by the Joint Rescue Coordination Centre, with each incident allocated to a Senior Mission Coordinator, who determines the need for an asset and coordinates its response. In the event that the incident involves a medical evacuation, attempts are made to ensure that medical personnel are sourced to travel on the asset.[172]

132. For a medivac from a vessel at sea, it was confirmed that it is usually initiated by the Master of the vessel and the Rescue Coordination Centre staff will seek medical advice from a contracted medical authority with an on call doctor, who will consult with the Master and confirm if medical evacuation is required. In terms of response time, it is dependent upon the sourcing of a suitable rotary wing asset and the location of the incident.[173]

133. Mr Lloyd, who wrote to the Court on behalf of AMSA acknowledged that the Rescue Coordination Centre "continues to face challenges in the North West region of WA (including the Pilbara region) when sourcing suitable rotary wing assets to assist with SAR responses including (but not limited to) medevacs."[174] With no dedicated multi role "Emergency Medical Service" helicopter bases in the North West of WA, rescue efforts are entirely reliant on commercial operators to assist, although contractual requirements may often preclude these assets.[175] The Rescue Coordination Centre also often faces difficulties obtaining the services of medical personnel to place on board commercial assets.[176]

134. In a response from the Director General of Health (WA), Dr Russell-Weisz, it was noted that "the issues surrounding aeromedical retrieval are complex and can involve many stakeholders, depending upon the presenting scenario. This is particularly the case in Western Australia which, due to its size, has unique challenges and requirements in comparison to other jurisdictions." However, Dr Russell-Weisz also indicated that WA Health are supportive of a review of State rotary wing services limited to offshore aeoromedical retrievals, noting that such a review would need to be inclusive of relevant Commonwealth and State agencies and non-government organisations currently involved in offshore retrievals. Dr Russell-Weisz very helpfully suggested that WA Health is well-placed to take a lead role in such a review.[177]

135. Mr Wayne Gregson, the Commission of the Department of Fire & Emergency Services (DFES) advised the court on 19 December 2016 that DFES is not aware of any completed or planned whole of government independent strategic review of Western Australia's rotary wing services. However, Mr Gregson advised that an internal review had recently been commenced of

[171] Letter to counsel assisting from Mr Alan Lloyd, A/General Manager, Response, AMSA dated 6 January 2017.
[172] Letter to counsel assisting from Mr Alan Lloyd, A/General Manager, Response, AMSA dated 6 January 2017.
[173] Letter to counsel assisting from Mr Alan Lloyd, A/General Manager, Response, AMSA dated 6 January 2017.
[174] Letter to counsel assisting from Mr Alan Lloyd, A/General Manager, Response, AMSA dated 6 January 2017, p. 3.
[175] Letter to counsel assisting from Mr Alan Lloyd, A/General Manager, Response, AMSA dated 6 January 2017, p. 3.
[176] Letter to counsel assisting from Mr Alan Lloyd, A/General Manager, Response, AMSA dated 6 January 2017, p. 3.
[177] Letter to counsel assisting from Dr Russell-Weisz dated 6 December 2016.

the State's Emergency Rescue Helicopter Service, which was due to be completed by the middle of this year. Mr Gregson suggested the outcomes of that internal review might provide insights that would inform any independent strategic review.[178]

136. There currently exists in WA a State Search and Rescue Advisory Group, which has representatives from many government agencies including the WA Police, DFES, AMSA, St John Ambulance and the Royal Flying Doctor Service, as well as others. The meetings are held three times a year and the objectives of the group include identifying major risks and issues for SAR incidents within WA. Further, in 2014 AMSA proposed a working group between AMSA, WA Police, WA Health and St John Ambulance and RFDS to better understand the roles, responsibilities, resources and limitations of the WA Government health-related agencies. I understand this group continues to meet.[179] Nevertheless, despite these working groups, it seems to be acknowledged generally by the relevant parties involved that there is a lack of coordinated and well-resourced rotary wing services for medical evacuations in the north west of this state, particularly in the Pilbara. For the safety of the community, this needs to be addressed.

137. Dr Glenn McKay, who is an emergency medicine retrieval specialist, made a similar submission to the court when giving evidence in this matter. Dr McKay has specialised qualifications in Aero-Medical Retrieval and Transport and practices in the area of coordination of retrieval medicine.[180] Dr McKay is also an assistant professor in retrieval medicine at Bond University Retrieval medicine is part of emergency medicine, but involves medical evacuations, usually from a remote location or where there is limited access (such as a ski field, for example).[181]

138. Dr McKay spent three years working in and out of Karratha on one of the private aeromedical evacuation jets.[182] He is currently the managing director for Medical Rescue Air Ambulance operating international air ambulances out of Brisbane and Perth. This company also provides the medical teams to the new 'all weather search and rescue' (AWSAR) helicopter funded by Shell and based in Broome.[183]

139. Dr McKay indicated that in his experience it is a fairly common occurrence for people on board vessels to become unwell and to require evacuation to shore.[184] Dr McKay gave evidence that the best practice for transporting a patient in an aero-medical helicopter is for a stretcher to be secured to the floor in compliance with the Civil Aviation Safety Authority (CASA) standards. In addition, Dr McKay indicated that most states require there to be oxygen, suction, a power supply and a crew of two medical personnel, with a minimum of two paramedics or preferably a doctor and a paramedic.[185]

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[178] Letter to counsel assisting from Commissioner Gregson dated 19 December 2016.
[179] Letter to counsel assisting from Mr Alan Lloyd, A/General Manager, Response, AMSA dated 6 January 2017.
[180] T 14.
[181] T 14 – 15; Exhibit 1, Tab 29.1.
[182] Exhibit 1, Tab 29.1.
[183] Exhibit 1, Tab 29.1.
[184] T 18.
[185] T 16 – 17.

140. Dr McKay became involved in this particular coronial investigation as he had heard about the events involving the deceased from a District Medical Officer at Port Hedland Hospital and was concerned by what he had been told.[186] Dr McKay gave evidence that to the best of his knowledge Western Australia does not have an aero-medical standard and the Department of Health do not regulate in any way how a patient should be transported by helicopter. The State also makes no funding contribution to rotary wing evacuation services. As a result, the standards of the evacuation services provided are determined independently by the various private companies requiring this capability, and are not necessarily equivalent to what is provided in other states.[187] Dr McKay was particularly concerned that in this case the lack of a proper medical evacuation service may have contributed to the death of the deceased.

141. Dr McKay was made aware of the factual circumstances of the deceased's evacuation and the role played by the Port Hedland Port Authority. He acknowledged that it was a difficult call for someone in the Port Authority to make and agreed it was not their fault. However, he noted there was a hospital close by and it might have been better to try to source someone from there as a person with a first aid qualification would have insufficient skills to tend to an unconscious patient with breathing difficulties.[188] The time factor was put forward as a reason for making use of someone from the port, but Dr McKay expressed his view that a "lot more than just the departure time should be taken into account when transferring a patient."[189] He explained that in retrieval medicine, "it's often said you never run to the helicopter. You plan and you make sure that everything is on board before you depart."[190]

142. Dr McKay went on further to explain that "it's referred to as scoop and run versus stay and play. You can come and you can pick somebody up with no equipment and run as fast as you can to the hospital, however if that patient is so unwell that sitting them upright in a seat or not doing basic interventions would lead to their demise then it would be better to take longer, leave them lying flat with oxygen on the ship, and have the right people arrive to actually manage that case."[191] Without knowing the full details of the case, when Dr McKay had first heard of this death he had been concerned that very basic airway management may have helped to save the deceased.[192] The evidence of Dr Mountain, who had reviewed the full details of the case, that the deceased was most likely already dead, or nearly so, at the time the marine pilot helicopter arrived, addressed this concern.

143. Nevertheless, as Dr McKay eloquently stated, "this is somebody being transported. They had called for help, being transported in Australian borders, to an Australian hospital but not to the standard that we would expect as Australians and I think that we fail a lot of people in, particularly,

[186] T 18; Exhibit 1, Tab 29.1.
[187] T 17.
[188] T 19 – 20.
[189] T 19.
[190] T 19.
[191] T 20.
[192] T 20.

the north west of WA where there's not an established rescue helicopter network, like there is in Victoria, New South Wales, Queensland."[193] Dr McKay acknowledged that the vastness of the area covered in Western Australia might make it difficult to have the same system as in other states with larger populations, but he also noted that we have a lot of activity offshore and the Royal Flying Doctors Service cannot assist in those cases, which means there needs to be some kind of rotary wing medical evacuation and search and rescue network established. Currently, that has been left to private companies to determine, which leads to varying standards.[194]

144. Dr McKay provided the Court with a copy of the New South Wales government's health reform plan for areo-medical rotary wing retrieval services to demonstrate that other states have been looking at this issue via independent reviews. Dr McKay suggested that, given the reviews in other jurisdictions, it might not even be necessary for Western Australia to conduct its own review. Rather, it might be possible to simply look at the recommendations made in other reviews to see if some common ground can be found and from there mandate a minimum standard for private companies that wish to establish a rescue capability for their offshore activities.[195]

RECOMMENDATION

I recommend the Government of Western Australia initiate an independent strategic review of the aeromedical (rotary wing) retrieval services in Western Australia. The review should include consultation with AMSA, WA Health, St John Ambulance, the Royal Flying Doctor Service, WA Police, DFES and the Harbour Masters of the various ports. A primary concern should be to ensure that there are appropriate assets that are stretcher capable, with properly trained medical staff, readily available. With that aim in mind, the review should consider whether it is practical to establish an emergency medical service involving rotary wing helicopters and staffed with trained medical personnel, in the State's North West.

CONCLUSION

145. The deceased was a 49 year old man who by all accounts was generally fit and well. He was working as the second engineer on board the Equator Prosper when he became acutely unwell with abdominal pain and vomiting on the morning of 29 September 2012. His condition deteriorated over the next 24 hours and he repeatedly, and increasingly desperately, requested to be transferred to hospital. This request was supported by other crew

[193] T 21.
[194] T 21.
[195] T 21 – 22.

members on board the vessel, however the request was denied by the Ship's Captain.

146. By the time the Captain finally contacted the Port Hedland Harbour Tower and requested a medical evacuation, the deceased was either moribund or dead. A staff member of the Port Hedland Port Authority acted promptly and tried to provide some assistance by sending a security officer with first aid training in a helicopter that was about to fly to the ship. However, by the time the helicopter arrived at the ship, it would seem they were faced with the situation of transporting a body, rather than a patient. The security officer did the best he could do in the circumstances, by giving him oxygen and transporting the deceased immediately to Port Hedland Hospital, but on arrival it was confirmed that he had already died.

147. Whilst there has been some criticism of the response by the Port Hedland Port Authority in sending a first aid officer on a non-stretcher capable helicopter to a critical patient, I accept that what was done by the Port Hedland Port Authority staff was done in an emergency situation and with the knowledge that there were limited other services available and any other help would probably be hours away. The death was preventable only if appropriate action had been taken by the Captain at a much earlier stage.

148. The inquest has highlighted the limitations in the services available for medical evacuations from ships in the Pilbara. It is to be hoped that the evidence will prompt a review of those services, for the benefit of the community.

S H Linton
Coroner
14 July 2017