Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 15/16

I, Barry Paul King, Coroner, having investigated the death of ***Sajidu Rahman*** *with an inquest held at the* ***Perth Coroner's Court*** *on* ***3 May 2016****, find that the identity of the deceased person was* ***Sajidu Rahman*** *and that death occurred on 1 June 2013 at* ***Phosphate Hill Detention Centre on Christmas Island*** *from* ***ischaemic heart disease, with myocarditis*** in *the following circumstances:*

Counsel Appearing:

Sergeant L Housiaux assisting the Coroner

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INTRODUCTION

1. Sajidu Rahman (**the deceased**) died suddenly and unexpectedly from ischaemic heart disease with myocarditis at the Phosphate Hill Immigration Detention Centre (**the detention centre**) on Christmas Island. He had arrived at Christmas Island on an Australian Navy vessel only hours earlier after being transferred from an Indonesian boat that had entered Australian territorial waters.

2. I infer from the evidence available to me that, at the time of his death,[1] the deceased was in immigration detention on Christmas Island because he was reasonably suspected by officers of the Department of Immigration and Border Protection to be an unauthorised maritime arrival and an unlawful non-citizen under the *Migration Act 1958* (Cth).[2]

3. Under section 5 and 6 of the *Christmas Island Act 1958* (Cth), Christmas Island is a territory of the Commonwealth of Australia and all property, rights and powers in or in connection with Christmas Island are deemed to be held or enjoyed by or on behalf of the Commonwealth.

4. Under sections 8A and 14B of the *Christmas Island Act 1958* (Cth), the laws of Western Australia are in force in Christmas Island and the Coroners Court of Western Australia has jurisdiction in Christmas Island as if it were part of Western Australia.[3]

5. Under s 19 of the *Coroners Act 1996* (***the Act***), a coroner has jurisdiction to investigate a death if it appears that the death is or may be a reportable death. As the deceased died unexpectedly, his death was a reportable death as defined in section 3 of the Act. I therefore had jurisdiction to investigate his death.

6. Under section 22(1)(a) of the Act, a coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and the

[1] Or 'immediately before death' as provided in s 22(a) *Coroners Act 1996*.
[2] Sections 5, 5AA, 14, and 189
[3] Note also the *Coroners Act 1996(WA)(CI)* (Cth)

deceased was immediately before death 'a person held in care'. A person held in care is defined to mean, effectively, a person involuntarily detained under certain Western Australian legislation, including the *Prisons Act 1981*, the *Young Offenders Act 1994* and the *Mental Health Act 1996*, or by a member of the Police Force.

7. A person held in immigration detention under the *Migration Act 1958* does not come within the definition of a person held in care, so there was no requirement for me to hold an inquest. However, given that the deceased was, nonetheless, involuntarily detained, it was desirable that an inquest be held.

8. I held an inquest into the deceased's death on 3 May 2016. The focus of the inquiry was the medical care provided to the deceased while in immigration detention.

9. The documentary evidence adduced at the inquest comprised a report prepared by the Australian Federal Police, the Western Australian Police and the Department of Immigration and Border Protection.[4] Oral evidence was provided by Senior Constable Tay Yeow of the Australian Federal Police.[5] Following the hearing of the inquest, further documentary evidence was obtained at my request from the Department of Immigration and Border Protection.[6]

10. Under s 25(2) of the Act, where the death is of a person held in care, the coroner investigating the death must comment on the quality of the supervision, treatment and care of the person while in that care. That obligation does not apply in relation to the deceased's case, but it is desirable that I make such comments. I have found that the treatment and care provided to the deceased was appropriate in the relevant circumstances.

[4] Exhibit 1
[5] ts 4 – 20 per Yeow, T
[6] Letter with attachments, E Upcroft to Sergeant Housiaux, 23 May 2016

THE DECEASED

11. The deceased was a Rohingya man born in Maungdaw in Myanmar on 22 June 1961. He married in 1990 and had one daughter and three sons with his wife. He was a businessman with two shops in which he sold clothing and shoes.[7]

12. Until about eight years before his death, the deceased had been quite healthy, but at that time he was diagnosed with diabetes, high blood pressure and a heart condition. He was prescribed medication for these problems. He took tablets every day for the diabetes and the high blood pressure and had heart medication to use when needed.[8]

13. On 20 April 2013 the deceased and his wife and children left Myanmar and travelled to Indonesia where agents had arranged for their passage by a boat to Australia. On about 27 May 2013 they left Indonesia for Christmas Island on a boat containing scores of passengers and crew. Also on the boat were the deceased's brother and, it seems, his brother's wife and son.[9]

THE BOAT JOURNEY

14. On the first day of the boat journey, the seas were calm and the deceased appeared to be well. He ate and drank normally but could not take his medication as it was stored in luggage which could not be found on the crowded boat. His brother asked him about the medication, and the deceased said that he would survive.[10]

15. On the second day, the conditions became rough and it rained heavily. The deceased and his family got wet, and the deceased appeared to suffer from seasickness. He ate very little.[11]

[7] Exhibit 1, Tab 17
[8] Exhibit 1, Tab 15
[9] Exhibit 1, Tabs 15 and 16
[10] Exhibit 1, Tabs 15 and 16
[11] Exhibit 1, Tabs 17 and 18

16. On the third day the deceased appeared jaundiced and ate nothing. He was sleepy but was unable to sleep. The boat's engine stopped and the conditions were bad, with water entering the boat. The deceased cried and told his wife to pray.[12]

17. On the fourth day the deceased's face became increasingly yellow and his wife became worried. He was very cold but could not eat. He was again crying and asked his wife to forgive him. That night at about 6.00 pm the boat was intercepted by a Royal Navy vessel and the deceased and his family were taken on board over a five hour period.[13] The deceased was relieved, but he could still not find his medications and he was still cold and shivering during the night.[14]

18. The next morning the deceased and his family were taken to Christmas Island where they disembarked at the jetty.[15]

ARRIVAL AT CHRISTMAS ISLAND

19. The system at Christmas Island for processing people who were suspected unauthorised maritime arrivals involved officials moving them as quickly as possible from the jetty by bus to the detention centre where they could be fed and treated for any medical conditions. The situation at the jetty when groups of people arrived could be quite hectic.[16]

20. Nurses would board the buses and, with the help of interpreters, would ask whether anyone was unwell or required medical attention. The nurses would give a coloured card to each person needing medical treatment. The card would have clinical details for prioritisation of treatment upon arrival at the detention centre. It seems that no record in the form of a triage assessment was kept.[17]

21. Upon disembarkation at the jetty on Christmas Island, the deceased and his family were placed on a bus to be

[12] Exhibit 1, Tabs 17 and 18
[13] Exhibit 1, Tabs 15 and 16
[14] Exhibit 1, Tabs 17 and 18
[15] Exhibit 1, Tabs 15 and 16
[16] ts 10 and 11 per Yeow, T
[17] Letter with attachments, E Upcroft to Sergeant Housiaux, 23 May 2016

transferred to the detention centre in accordance with the usual procedure.[18]

22. In the bus, a nurse inquired through an interpreter whether the deceased was unwell or had a medical condition. The deceased told the nurse that he had diabetes and a heart condition. The nurse gave the deceased a yellow card to indicate to staff at the detention centre that he should be seen and assessed quickly by medical staff.[19] There is no direct evidence to indicate that the nurse had written anything on the card about the deceased's heart condition.

23. When the deceased and his family arrived at the detention centre, the deceased was separated from his family and taken to see a doctor. The doctor was not immediately available, so the deceased was told to have lunch while he waited.[20] About 20 minutes after he had lunch, he saw Dr Vincent Keane.[21]

24. It appears from Dr Keane's notes that he conducted a standard examination of the deceased with the help of an interpreter and found no indication of any acute problem. No cardiac history or chest pain is mentioned in his notes, but a history of diabetes requiring metformin was noted. Dr Keane recorded that the deceased was healthy looking and that his observations were satisfactory. Dr Keane proposed a plan of monitoring the deceased's glucose levels and following up as required. [22]

EVENTS LEADING UP TO DEATH

25. After seeing Dr Keane, the deceased re-joined his family and told them that the check-up with the doctor went very well. He had something more to eat and drank some tea. He and his family then sat and relaxed while they watched people.[23]

[18] Exhibit 1, Tabs 15 and 16
[19] Exhibit 1, Tabs 15 and 16
[20] Exhibit 1, Tabs 15 and 16
[21] Exhibit 1, Tab 13C
[22] Exhibit 1, Tabs 13C and 19
[23] Exhibit 1, Tab 16

26. About 15 minutes after he had finished eating, the deceased told his brother that he was not feeling well and was feeling sleepy. He got up and left his family and told them that he was going to the toilet. When he did not return after 10 or 15 minutes, his children went to look for him but could not find him.[24]

27. It seems that the deceased had made his way to a covered communal area at the detention centre known as Bravo Compound. At about 2.40 pm that afternoon the deceased was sitting at a table in Bravo Compound when he slumped forward and lowered himself to the concrete floor where he collapsed onto his left side.[25]

28. People sitting nearby alerted a nurse attached to the detention centre, Nicole Cantrill RN, of the deceased's collapse. Ms Cantrill immediately attended the deceased, who at that time was breathing spontaneously but rapidly.[26]

29. One or two minutes later, more nurses arrived to assist her. Dr Keane arrived and requested urgent assistance from Christmas Island medical staff.[27]

30. The deceased became unresponsive and his heart stopped. A Christmas Island medical officer arrived with an AED defibrillator and an ECG monitor. No shock could be given. The ECG showed various evolving cardiac rhythms. An ambulance from Christmas Island Hospital was called and cardiopulmonary resuscitation was administered.[28]

31. The deceased was transferred by ambulance to Christmas Island hospital while Dr Keane and other staff administered cardiopulmonary resuscitation and advanced life support. On arrival at the hospital, the deceased had fixed dilated pupils and no evidence of cardiac output. The ECG showed that he was asystole. One of the Christmas Island doctors, Dr Julie Graham, declared the deceased to be life extinct at 4.30 pm.[29]

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[24] Exhibit 1, Tabs 17 and 18
[25] Exhibit 1, Tab 2
[26] Exhibit 1, Tab 13C
[27] Exhibit 1, Tab 12
[28] Exhibit 1, Tab 12
[29] Exhibit 1, Tab 8

CAUSE OF DEATH AND HOW DEATH OCCURRED

32. Chief Forensic Pathologist Dr C T Cooke conducted a post mortem examination of the deceased on 5 and 6 June 2013 and found severe ischaemic heart disease with widespread scarring of the heart muscle associated with arteriosclerotic hardening and narrowing of the arteries on the surface of the heart. There was congestion of the lungs as can be seen with heart disease.[30]

33. Microscopic examination of tissues on 1 July 2013 confirmed significant past ischaemia and showed a recent healing heart attack and inflammation of the heart muscle.[31]

34. Dr Cooke formed the opinion, which I adopt as my finding, that the cause of death was ischaemic heart disease, with myocarditis.[32]

35. I find that death occurred by way of natural causes.

COMMENT ON THE SUPERVISON, TREATMENT AND CARE OF THE DECEASED WHILE IN CUSTODY

36. It appears from the evidence available to me that the deceased told the nurse who spoke to him on the bus on the morning of the day he died that he had a cardiac history as well as diabetes. That evidence includes notes of interviews with the deceased's family[33] and a report of the deceased's collapse made by Ms Cantrill.[34] However, Dr Keane's notes indicate that he was not made aware of the deceased's heart condition by either the nurse or by the deceased himself.[35]

37. Dr Karen McKenna, an emergency medicine consultant and a senior clinical advisor in the Patient Safety Surveillance Unit of the Office of Patient Safety & Clinical Quality in the

[30] Exhibit 1, Tab 5
[31] Exhibit 1, Tab 5
[32] Exhibit 1, Tab 5
[33] Exhibit 1, Tabs 15 and 18
[34] Exhibit 1, Tab 13C
[35] Exhibit 1, Tab 13C

Department of Health, reviewed the records of the deceased's care and provided an opinion of whether the care was reasonable.[36]

38. Dr McKenna stated that, in relation to the emergency care provided, the care was reasonable. There was an immediate and well-escalated response with good quality CPR provided in the absence of a shockable rhythm.[37]

39. As to the question of whether treating medical staff could have predicted the deceased's fatal cardiac event, Dr McKenna stated that there was no apparent mention of a pressing need for care when the nurse first spoke to the deceased, so he was seen by Dr Keane in the afternoon instead of being transferred to the hospital for immediate attention.

40. Dr McKenna noted that no cardiac history or chest pain is mentioned in Dr Keane's initial assessment and the physical examination appears to be unremarkable. She said that the plan for monitoring blood sugar levels and follow up seemed adequate, if not consistent with expected standards for chronic disease in the Australian community.[38]

41. Dr McKenna stated that it would have been impossible to have predicted that the deceased would have a fatal cardiac event at any particular time, only that his diabetes increased his lifetime risk of heart disease, including myocardial infarction and sudden cardiac death.[39]

42. It appears to me that, while it would have been preferable if Dr Keane had been made aware of the deceased's cardiac history by way of a system of relaying information obtained during the fairly informal triage process of the nurse on the bus, it would have been reasonable to expect the deceased to have told Dr Keane of that history himself. In any event, it is clear that, at the time Dr Keane assessed the deceased, there was no reason for him to believe that the deceased needed urgent medical care for a heart condition.

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[36] Exhibit 1, Tab 19
[37] Exhibit 1, Tab 19
[38] Exhibit 1, Tab 19
[39] Exhibit 1, Tab 19

43. In these circumstances, I find that the medical treatment and care of the deceased was of a satisfactory standard.

CONCLUSION

44. My internet research revealed that thousands of Rohingya people have become refugees from persecution in Myanmar.

45. The deceased risked his life and the lives of his family members to come to Australia, no doubt to provide his family with a future that he did not see as possible in Myanmar.

46. While it is perhaps ironic that the deceased died after surviving the dangers of the sea journey, it appears that his medical condition was such that he was at risk of a sudden death from a cardiac arrest at any time.

B P King
Coroner
9 September 2016