CORONERS COURT

NEW SOUTH WALES

Inquest:	**Inquest into the death of Manjit Singh**
Hearing dates:	6-9 July 2015
Date of findings:	17 August 2015
Place of findings:	State Coroner's Court, Glebe
Findings of:	Deputy State Coroner HCB Dillon
Catchwords:	**CORONERS – Cause and manner of death –** Complications following removal of lung destroyed by active tuberculosis – 457 visa holder – Health undertakings by visa holders – Medical screening of immigrants and visa holders with tuberculosis by NSW Health – Care and treatment at Royal North Shore Hospital – Exemplary conduct by clinicians and nurses
File number:	2027/11

Representation:	Dr K Stern SC with Mr I Fraser (Counsel Assisting) instructed by Ms J Geddes (Crown Soliticor's Office) Mr S Barnes instructed by Mr J Kamaras – Avant Law (for Dr P Brady) Mr D Brogan instructed by Ms R Deane -- the Australian Government Solicitor (for Department of Immigration and Border Protection) Ms E Elbourne instructed by Ms Z Officer – Holman Webb (for St Vincent's Hospital) Mr G Gregg instructed by Ms C Hogan -- Curwoods (for NSW Health and the Northern Sydney Local Health District, Dr R Harris, Dr S Tattersall)
Findings:	I find that Manjit Singh died on 26 August 2011 in the Intensive Care Unit of Royal North Shore Hospital, St Leonards, New South Wales due to hypoxic respiratory failure following a right pneumonectomy for the treatment of severe pulmonary tuberculosis with malnutrition being a contributory causal factor in the development of that disease.
Recommendations:	***To the NSW Minister for Health***: I recommend that pre-discharge interviews with patients being screened for TB be undertaken face-to-face and include a physical check for signs of possible active TB or risk factors for activation of TB. In this context, I also recommend that, when considering discharge, physicians reviewing patients' most recent chest x-rays do so with the benefit of the radiologist's report. ***To the Minister for Immigration and the NSW Minister for Health:*** I recommend that their departments confer to find the optimal policy (or policies) for ensuring both that the health and welfare of temporary visa holders who are subject to TB health undertakings (or similar undertakings in respect of other public health risks) are protected, and public health is safeguarded.

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SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

Introduction

1. Manjit Singh died on 26 August 2011 in the Intensive Care Unit (ICU) at Royal North Shore Hospital, from complications following a right pneumonectomy (removal of right lung) on 8 August 2011for tuberculosis at the Royal North Shore Hospital. At the time of his death Mr Singh was 33 years old.

2. That simple outline, however, is but the bare bones of one of the saddest stories that I have encountered in nearly eight years as a coroner.

3. In 1946, George Orwell wrote an autobiographical essay entitled "How the Poor Die".[1] He described his experience as a patient in a French hospital suffering from lung disease, the disgraceful conditions in which the poorest inhabitants of France were medically treated for their chronic and frequently fatal, poverty-induced illnesses and how the pre-welfare state French public hospital system failed them. This case is a 21st century retelling of the story of "How the Poor Die".

4. In contrast with Orwell's scathing account of the public health system of those pre-welfare state societies, the work of doctors and nurses in caring for and treating Mr Singh was kind, caring and highly professional.

5. But, despite that care of the clinicians and the excellence of the medical services that treated him, Mr Singh, an Indian national who came to Australia as 457 visa worker, died as one of the poorest and most vulnerable members of our society. This inquest has heard a story redeemed only by the humanity of Good Samaritans, the nurses and doctors at the Royal North Shore Hospital who cared for and befriended him.

The coroner's functions and the nature of the inquest

6. In our society, if a person dies suddenly or unexpected, or if that person's death may have been caused by some unnatural event, or if the cause and circumstances of the death raise questions of public health or safety, a coroner will investigate the case.

7. Manjit Singh's case was reported to the Coroners Court because his treating doctors and nurses were so concerned that his deterioration and death had been caused largely the conditions in which he was forced to live and work. I commend those clinicians for

[1] Orwell, George *The Collected Essays, Journalism and Letters of George Orwell Vol 4*. London, Penguin 1968 pp 261-272.

ensuring that his case was brought to the attention of law enforcement authorities before he died and, after his death, to this court.

8. As provided by s. 81 of the *Coroners Act 2009,* it is my responsibility to make findings at the conclusion of the inquest as to:

- The identity of the deceased;
- The date and place of the person's death;
- The manner and cause of the person's death.

9. The identity of the deceased, and the place and date of his death are clear. There are, however, a number of issues that arise as to the manner and cause of Mr Singh's death. I will identify those and discuss them further in this report. (See paragraph [104] and following).

10. Coroners also have jurisdiction under s. 82 of the Act to make such recommendations as they consider necessary or desirable in relation to any matter connected with the death.

11. It is important to emphasise that an inquest, by definition, is an inquiry not a trial. It is not a forum for determining any civil liability, or for the guilt or innocence of involved people. It is an opportunity to expose the facts of the matter, with a focus on considering any steps that might be taken to prevent similar deaths occurring in the future.

Manjit Singh

12. Mr Singh arrived in Australia on a 457 visa on 19 February 2006 to work as a chef in an Indian restaurant. At that time he had been identified as having latent tuberculosis. This is a non-infectious form of the disease. A diagnosis of "latent TB" indicates that the person has suffered undiagnosed TB in the past that has healed naturally without treatment. It is usually discovered by screening with a chest x-ray which shows scarring of the lungs. So it was with Manjit Singh who was screened in India before he came to Australia.

13. During his time in Australia his tuberculosis reactivated, and for some years prior to his death he suffered from severe tuberculosis for lengthy periods. For this he received treatment at Royal North Shore Hospital both as an inpatient and as an outpatient.

14. Unusually for an inquest, the brief of evidence tendered in the inquest contains two statements of Mr Singh. These statements were taken by the Australian Federal Police as part of an investigation into possible criminal offences relating to aspects of Mr Singh's employment in Australia. I should emphasise that it was never considered that Mr Singh himself had committed any offence, rather that he may have been the victim of human trafficking.

15. Manjit was born in a small village named Sangowar, a short distance from the city of Jalandhar in the Punjab, in Northern India. Manjit's father (Jaswinder Singh) is a farmer and his mother (Surinder Kaur Singh) a housewife. His father tended a small 10 acre farm on which he grows wheat, rice and maize. Manjit was one of four children, having two brothers and a sister. Manjit's only relative in Australia was Satpal Khinda, who was

present at the inquest and who gave evidence regarding what he knew of Manjit's life whilst here in Australia.

16. Manjit attended school in his village until he finished the equivalent of year 12. In his 2010 statement to police, Manjit said that he had learnt some English at school, but that he was not confident. He also spoke and wrote Punjabi and Hindi, although he described being more confident in the latter.

17. After finishing school, Manjit moved to Jalandhar where he undertook a diploma in food and beverage service before commencing an apprenticeship at the International Hotel in Jalandhar. It was whilst working at the International Hotel that Manjit was introduced to Gurjit Singh, who was to sponsor his Australian visa application..

18. People who knew Manjit liked him very much. It was clear when they gave evidence, his treating physician, Dr Susan Tattersall and two of the nurses who cared for him, Deborah Correll and Amy Lim, were deeply affected by his death. He was a quiet, unassuming man. Amy Lim called him "a lovely boy". Deborah Correll described him as a "gentleman" who was always very polite and undemanding, a man who showed real appreciation for the care he was receiving. They were very distressed by the fact that he was so vulnerable and apparently so badly exploited by his employers.

The background

19. Manjit told the AFP that Gurjit Singh had told him that in Australia he would be paid $800 per week, get one day off a week, and that after two years he would be guaranteed permanent residency. He was told that he only needed to work 38 hours per week and that he would be given accommodation at Gurjit Singh's house.

20. Manjit's 457 visa application was sponsored by Anmol Holdings P/L trading as North Indian Flavour in Darlinghurst. The application was signed by Gurjit Singh, who described himself as the manager. The application stated that the company had an urgent need for suitably qualified cooking staff to conduct training at the restaurant, and that the visa applicant would be paid $43,000 per year.[2]

21. Whether this was a deliberate falsehood has not been proven but there is no evidence that Manjit was ever paid anything like that sum, even on a pro rata basis. His statements to police and the objective evidence of his circumstances suggest that he was never paid the wages that were indicated to the Department of Immigration and that he had been promised.

22. The application was approved for a two-year period. Prior to Mr Singh being granted a visa he was required to undergo a medical examination in India which included a chest x-ray. This was reported as showing lung changes which were abnormal in the right upper lobe and in the right apex, which were indicative of TB. A laboratory report showed no growth of mycobacterium tuberculosis which is consistent with latent, rather

[2] Approximately $825 per week.

than active, TB. A Mantoux test[3] was positive with induration[4] at 21 mm . A CT scan was reported as showing signs of old healed granulomatous disease. Dr Mahajan examined Mr Singh and noted that he denied any history of present illness and denied any history suggestive of pulmonary tuberculosis. Dr Mahajan described Manjit as a well-built young man. The doctor concluded that Mr Singh had evidence of old healed granulomatous disease.

Tuberculosis

23. Tuberculosis (commonly known as TB, and previously commonly referred to as "consumption") is an infection caused by certain bacteria, the most common of which is *Mycobacterium tuberculosis.* TB most commonly infects the lungs, but can infect other parts of the body. A large proportion of people who become infected with TB bacteria are asymptomatic, and do not have the TB disease. Such people are described as having latent TB. Approximately 10% of those with latent TB go on to develop active TB. Similar to many diseases, TB can be by transmitted by an infected person spreading airborne droplet infection when they cough, laugh, shout, sing or sneeze.

24. Active tuberculosis can usually be treated with a combination of drugs, taken daily over a period over at least six months. A small proportion of TB strains have become resistant to medication (multi-drug resistant TB). Such strains are difficult to treat. There is nothing to suggest that Manjit had a drug-resistant strain, as the bacteria were noted on various occasions to be "fully sensitive" to the drugs.

25. The incidence of TB is significantly higher in poor countries. It is estimated that approximately one third of the world's population has latent TB, most of them living in poorer countries. The World Health Organization has estimated that in 2013 there were 9 million new active cases and 1.5 million TB-related deaths.

26. Australia has a very low incidence of TB and this has been achieved since the introduction of antibacterial drug therapy in the 1950s. Mass miniature radiological chest screening and effective bacteriological examination of World War II army recruits resulted in reliable diagnosis. The Australian Tuberculosis Campaign 1948-76 utilized the army experience for detection, and the use of specific treatment virtually eliminated the disease.[5] The success of the anti-TB campaigns was due to a mixture of factors such as improved living and hygiene standards, and TB prevention programs. Failure to maintain strict screening of high-risk groups, especially immigrants, led for a time to a resurgence of tuberculosis as shown by an increase in notifications in adults and prevalence rates in secondary school children. Public health authorities, however, responded and measures were introduced to ensure that the incidence remains low. India on the other hand has one of the highest rates of TB. In 2013, the rate of new cases in Australia was 5.5. cases per 100,000 population; in India it is approaching 500 cases per 100,000.

[3] A Mantoux test is a simple and safe test. A small amount of tuberculin is injected under the skin. The reaction indicates whether a person has been exposed to TB.
[4] Hardening of normally soft tissue.
[5] Williams, HE & Phelan, PD "The epidemiology, mortality and morbidity of tuberculosis in Australia: 1850-1994" *J Paediatr Child Health*. 1995 Dec;31(6):495-8.

27. Testing for TB, and its diagnosis, involves a number of aspects. A Mantoux test is one indicator; symptoms such as fevers, night sweats and weight loss are also indicators. A chest x-ray can show abnormalities in the lungs. Those abnormalities may be static over time, thereby being consistent with latent TB, or they may change over time, being more suggestive of active TB. The examination of sputum or phlegm samples is seen as a more reliable indicator. Such a sample can be stained and examined for any of the TB bacteria (referred to as acid fast bacilli). Samples are also cultured. Those samples in which live bacteria are grown following being cultured indicate active tuberculosis, and are referred to as "culture positive".

Mr Singh's health undertaking and screening

28. One of the conditions for granting a 457 Visa is known as a public interest health criterion. It requires that the applicant must be free from tuberculosis. A medical officer of the Commonwealth may request a health undertaking as a pre-requisite for an applicant satisfying this criterion.

29. The policy of the Department of Immigration and Border Protection is to interpret the health criterion relating to "tuberculosis" as meaning "active tuberculosis". Active tuberculosis will delay the grant of a visa until the TB is treated and is no longer active. Visa applicants who have a history of treatment for diagnosed or suspected TB may be granted a visa (if it is currently inactive) but are required to sign a health undertaking to accept regularly screening for a period of (usually) two years.

30. As a condition of his visa, Mr Singh was required to sign a health undertaking. This directed that, within four weeks of arriving in Australia, he place himself under the supervision of a State health authority and undergo any necessary treatment for his chest condition. The purpose of the health undertaking is to ensure that persons at greater risk of developing active TB receive appropriate follow up. The health undertaking also stated that the Australian Government provided free health checks to minimize the risk of the spread of tuberculosis. Mr Singh signed the health undertaking on 10 February 2006 before leaving India for Australia.

31. Health undertakings within Australia are administered by a body called the Health Undertaking Service. The functions of the Health Undertaking Service are in fact outsourced to Bupa Visa Services. Information collected by Bupa Visa Services is then accessible to both Bupa and to the Department through an information portal.

32. Two steps are required pursuant to the health undertaking. The first of these two steps is that the visa holder must contact the Health Undertaking Service to notify arrival in Australia so that the relevant medical information can be provided to the State health authority. The second stage is for the visa holder to attend a clinic to which they have been referred.

33. Once the first appointment is attended, Bupa and the Department no longer pay a role in monitoring the visa holder unless the visa holder fails to comply with the chest clinic's directions concerning attendances for screening. If the visa holder fails to comply with either of these two requirements under the health undertaking, this is noted on the

Department and Bupa's computer systems. The visa holder will be notified that this can be taken into account in relation to any further visa applications. The Department may also raise what is called a movement alert record.

34. Once a health undertaking is complied with, it has no further significance from DIBP's perspective because the purpose is to ensure that the visa holder is screened and, if necessary, treated. After the visa holder attends the nominated clinic, in practice there appears to be no further step taken by DIBP to monitor or note non-compliance with further treatment required by the nominated clinic. Curiously, this seems inconsistent with that is said on the face of the health undertaking, namely that there are obligations to comply with treatment required and to notify of changes of address. These requirements are also noted on the department's procedure manuals.

35. The public interest health criterion is not applied in relation to bridging or criminal justice visas. Thus, although Mr Singh applied for, and was granted those further visas, his health status was not investigated at those times.

36. It is state and territory departments of health that manage the screening and treatment of visa holders with a history of TB. For a person who has not previously been treated for TB, NSW Health's policy is that the recommended routine follow-up is that if they have abnormal chest x-rays, or a positive Mantoux reaction, they should be seen by a clinician to be considered for preventative treatment or chemotherapy. If, on the other hand, they have stable minor chest x-ray abnormalities, indicating that the TB is inactive, and no other risk factors, they should be discharged after 24 months. On discharge the patient should be advised to seek medical attention immediately at the nearest Chest Clinic if they develop any symptoms.

37. Cancellation of a visa is not an option on the sole basis that the visa holder does not comply with a health undertaking. However, according to the current Department of Immigration and Border Protection procedure manual, a visa may be cancelled on health grounds. This could be because the visa holder no longer meets the public interest health criterion or because the visa holder's presence in Australia is or would be a risk to the health, safety or good order of the Australian community (s 116).

38. This requires medical evidence that the applicant has active tuberculosis and cannot be based on mere suspicion of tuberculosis. A visa can also be cancelled on the basis that a fact upon which the decision to grant the visa was based is no longer the case. The Department of Immigration and Border Protection says on its website in relation to the health undertaking that "*the visa is not at risk, once in Australia, no matter what status of tuberculosis is diagnosed as a result of the monitoring*."

39. NSW Health statistics show that about 50 per cent of overseas-born TB patients in NSW were diagnosed within the first five to six years of arrival in Australia. People are at increased risk of TB if they have latent tuberculosis, and if they have certain conditions that increase their risk of developing active disease, including fibrotic changes consistent with TB on chest radiograph without a history of previous treatment, and malnutrition. Loss of some body weight may not be dangerous in itself but, if caused by malnutrition and loss of condition, it raises the risk of activation of TB. For this reason,

NSW Health policy notes that one clinical sign of increased risk of TB developing from latent to active status is weight than 90% of the patient's ideal body weight.

40. Under NSW Health policies, treatment for TB was between 2008 and 2013 free for everyone in NSW except 457 visa holders Tuberculosis Related Services. Nevertheles, in practice, however, for public health reasons, no distinction was made between holders of Medicare cards and others. Manjit was never charged for treatment by NSW Health.

41. The Communicable Diseases Network Australia (CDNA) has published national guidelines for the public health management of TB. These provide that the most important priorities for TB control are the timely identification and treatment of persons with active TB, the detection of new infection in persons in contact with TB cases, and targeted screening of high risk groups.

Manjit Singh's initial period in Australia

42. On 19 February 2006, just over a week after being granted his 457 visa, Manjit arrived in Sydney. In his statements to police, he said that, before he came to Australia, he was told by Gurjit Singh that he would have to bring $12,000 with him as he had not passed the medical. He said that Gurjit Singh told him that that money would be returned to him if he did not get sick in Australia. This was untrue. There was no such requirement imposed by the Department of Immigration and Border Protection.

43. Before Manjit left India, his father took out a loan for $12,000 and Mr Singh brought the money with him to Australia. After Manjit's arrival in Australia, this money was deposited into an account which Gurjit Singh arranged. Manjit believed it was a joint account in his name with Gurjit Singh. Gurjit Singh was also a signatory. Manjit Singh was unable to give the police the details of the bank or the account number because the account was operated by Gurjit Singh.

44. Manjit went to work at Gurjit Singh's restaurant North Indian Flavour on Oxford Street, Darlinghurst. In his statements to the AFP, Manjit described his conditions there. According to his statement, Manjit was required to work from 8am until midnight seven days a week. He told police that he was required to sleep in the storeroom of the restaurant and was locked in overnight. He did not have a key to the front door. He describes having only limited food available to eat, and getting little in the way of breaks throughout the day. He had no shower or bath, and was required to bathe using a jug and the tap in the public toilet. He had no mobile phone, no computer, and no email access. He was anxious to work so that he could repay his father the $12,000.

45. The bank provided an ATM card for the bank account that he been opened with Gurjit Singh. He gave the card to Gurjit Singh together with the pin number. It was later given back to him but when he tried to withdraw money he found that the $12,000 that had been deposited was gone. He told police that Gurjit Singh told him that the money had gone to the Department of Immigration. This was not true.

46. He decided to stay working for Gurjit Singh to try to get permanent residency as promised after two years. He was given $10 a month to buy a phone card and he said that he was also given three lots of $300 whilst working at the restaurant.

47. Manjit did not make any complaint as he was concerned about what Gurjit Singh might do to him and, as Gurjit Singh was his sponsor, he was fearful that if he said anything to DIBP it would jeopardise his ability to get a permanent visa in Australia. He said that he was scared and helpless and had no one he could trust in Australia. In around July 2007 he moved out of the restaurant into accommodation in Surry Hills, but kept working or Gurjit Singh in the restaurant. He was given $50 a week by Gurjit Singh's mother for rent.

48. When interviewed by Police, Gurjit Singh denied that Manjit had accurately described his living and working conditions. He claimed that he had paid Manjit but had no records of payment. Gurjit Singh also said that Manjit was always telling him that he was feeling unwell. Before the inquest, Gurjit Singh provided an email to the Crown Solicitor's Office in which he said that he recalled Manjit receiving medication from his father in India whilst he was working for him "to control his illness". He also claimed that since 2008 both his wife and son have been diagnosed with active tuberculosis. He complained that he was excluded from health screening.

49. These claims appear to be untrue. No one is excluded from TB screening in NSW. Letters from Associate Professor Vitali Sintchenko of the Centre for Infectious Diseases demonstrate, however, that it is unlikely that Gurjit Singh's family were infected by Manjit as no other patients have been identified by the New South Wales Mycobacterium Reference Laboratory with the same tuberculosis profile as Manjit Singh. Manjit Singh does not appear to have been the source of infection of any other person with active tuberculosis who has had tuberculosis confirmed by culture in NSW.

Review at St Vincent's Hospital (March 2006 - February 2008)

50. Despite the restrictions on his movements described above, Manjit complied with his health undertaking. He registered with the Health Undertaking Service, and was referred to St Vincent's Hospital where he attended the chest clinic on 29 March 2006. The records relating to Manjit's medical examinations in India were forwarded to the clinic, and reviewed by Dr Marshall Plit, a senior staff specialist in thoracic medicine. Dr Plit recommended clinical review. The protocol at St Vincent's is for two years of monitoring with scheduled appointments every six months. This is standard procedure around Australia. This period may be extended if thought necessary by the clinicians assessing the patient.

51. An initial nursing assessment, with medical review, was carried out on 15 March 2006 before Manjit attended St Vincent's Hospital. This recorded his weight as being around 63 kg. It appears that his weight was not taken again during the period of his review at St Vincent's Hospital.

52. Manjit was first assessed in the clinic on 29 March 2006 by Dr Adrian Havryk. Manjit had no symptoms of active tuberculosis and reported that he felt well. Dr Havryk

observed the abnormalities in X-ray and the positive Mantoux test of 21 mm. He formed the view that Manjit had latent tuberculosis, and no clinical signs of current activity. He recommended further chest x-rays in three months, one and two2 years.

53. Dr Havryk gave evidence that it is generally recognized that the stress of significant life changes, such as emigration, increases the likelihood of tuberculosis reactivation for a period of approximately two years, and that malnutrition further contributes to this risk. The medical notes record that Manjit was planning to return to India after two years (although that is not consistent with Manjit's statement that he was planning on seeking permanent residence. It should be noted that Manjit did not take steps to return to India at the expiry of his two year visa.)

54. Manjit was further reviewed by Dr Havryk on 19 July 2006, and was reviewed by Dr Simone Barry on 12 March 2007. Her notes record that he was "due to return to India in February 2008" although again that is not consistent with what Manjit said in his statement. He was reviewed by Dr Rebecca Pearson on 3 October 2007. She recorded that there should be a repeated x-ray in six months then discharged.

55. On each occasion Manjit was observed to be well with no cough or fever. On 19 July 2006, his chest ex-ray was observed to have minor changes in the right upper lobe that were viewed as "radiologically stable"; the x-rays of March 2007 and October 2007 were both reported as unchanged.

56. On 26 February 2008 Manjit attended St Vincent's for what would be his last appointment there. He underwent a chest x-ray, and Sister Isabelle Huynh noted in the clinical records that he was "generally well". Sr Huynh spoke to Manjit by phone on that occasion. I should observe at this point that while Sr Huynh speaks English well, and she is obviously intelligent, she speaks with quite strong Vietnamese accent. Manjit's English was poor and he often needed assistance of others in translation. It seems that she spoke to Manjit with the help of an intermediary who assisted Manjit with translations. It is therefore difficult to know how reliable the information Sr Huynh obtained actually was, particularly as Manjit had a tendency to be shy and unassertive, was concerned about his immigration status, and as Sr Hunyh did not assess him visually.

57. The following day Dr Plit reviewed the x-ray. In Dr Plit's view the right upper lobe scarring was essentially unchanged. Dr Plit recommended that Manjit be discharged. According to Sr Huynh, who had spoken to Manjit on 26 February, she provided Manjit with tuberculosis education. It seems that this mainly consisted in advice that if he developed any symptoms, he should immediately seek medical attention. Again, it is difficult to know how well Manjit was able to understand the advice he was given.

58. On 29 February 2008 Dr Jan Laguna, a consultant radiologist at St Vincent's reported on the chest x-ray which had been performed on 26 February. In relation to the right lung, her report noted "tenting" which had increased since the previous x-ray, and showing signs that had not been previously present. Dr Laguna reported peripheral shadowing present over the right costophrenic angle extending along the lower part of the lateral chest wall. She expressed the opinion that this could represent an "effusion" and

recommended that a decubitus study (a series of x-rays taken whilst the patient is lying down) be carried out. The left lung was observed to remain clear.

59. Dr Plit did not see Dr Laguna's report as it was not available when he reviewed the x-ray. In a statement made on 22 June 2015, and in his oral evidence, he expressed the view that the radiological changes in the 26 February 2008 x-ray are unlikely to have been an effusion. In reaching that opinion he relied in part upon his understanding that Mr Singh was asymptomatic, which understanding was based in turn upon what he understood Mr Singh to have said to Sister Huynh. His position was that there was no reason to follow up Mr Singh beyond February 2008, because Manjit was asymptomatic, there was no radiological evidence of TB reactivation, and because the clinic had information that Manjit planned to return to India after his two years in Australia. He said that even if Dr Laguna's report had been known to him, the absence of symptoms would not have justified any further tests. As he did not himself examine Manjit, and neither did Sr Huynh, Dr Plit was only able to *assume* that Manjit was asymptomatic. But for the reasons already discussed, the reliability of that assumption must be doubted.

60. It is possible that Manjit was was asymptomatic at the time of his discharge from St Vincent's Hospital, but if Manjit's account of his treatment at North India Flavour is true, he may well have been developing malnutrition at the time of discharge. If so, it is likely that a physical check would have picked this up. Moreover, Dr Plit would have had a more complete clinical picture with which to assess Manjit's condition. And if there were signs of malnutrition observed, because of the risk of reactivation of his TB, this would have been a factor that had to be addressed before Manjit could have been discharged under the protocol.

61. On 5 March 2008, a standard discharge letter was sent to Mr Singh's address telling him to seek medical attention in the event that he suffered from any of the symptoms of tuberculosis (which were listed on the letter). It is not known whether or not Manjit saw or read the letter, although it was sent to his last address known to the hospital.

62. In his statement to the AFP, Manjit said that he stopped working at Gurjit Singh's restaurant in January 2008. He also said that while working for Gurjit Singh he was very run down and got a flu which would not go away. That information does not appear to have been conveyed to Sister Huynh. Manjit may not have wished to be forthcoming with Sister Huynh given his uncertain immigration status at that time.

63. By the time that Manjit presented to his GP, then to Westmead and Royal North Shore Hospital in May 2009 he was malnourished, folate deficient and had severe vitamin D deficiency. The medical evidence suggests that these are unlikely to be attributable to his tuberculosis. They were almost certainly the result of his living conditions and lack of adequate nutrition. Both malnutrition and vitamin D deficiency lead to an increased risk of tuberculosis.

March 2008 - May 2009

64. Manjit's 457 visa expired on 10 February 2008. On 4 February 2008 an application for a further 457 visa was lodged, and Manjit was granted a bridging visa pending

determination of the new application. In his statement to the AFP he said that he did not make this application and did not know about it. It may thus have been that when he attended St Vincent's Hospital in February 2008 he did not know it had been lodged, or that he had a bridging visa. Indeed, he said that at around this time he visited St Vincent's Hospital to find out whether he would be getting his $12,000 back and only then was told that this was not a bond and realized that his money had been taken. At about this time he went consulted a migration lawyer and applied for a bridging visa. What followed over the following 18 months or so was a series of appeals and further applications. At times Manjit held temporary bridging visas without work rights. He held no visa and was therefore an unlawful non-citizen, during the following periods:

- 5 May 2008 to 24 June 2008
- 30 October 2008 to 7 May 2009
- 23 July 2009 to 22 July 2010.

First admission to hospital (May 2009) and subsequent treatment (May 2009 - March 2010)

65. On 1 October 2008 Manjit was notified that the application that had been made on 4 February 2008 for a further 457 visa had been rejected. The Migration Review Tribunal had determined that it had no jurisdiction to review the refusal of that application. At that time he had a bridging visa, pending the outcome of the review proceedings, but it was a condition of that visa that he not work. That visa expired on 30 October 2008.

66. On 27 March 2009 he applied for a protection visa. On 31 March, he was notified that the application was not valid. On 6 May 2009 he made a further application for a protection visa (subclass 866). In connection with this, on 7 May 2009, he was granted a further bridging visa, again with a restriction on working.

67. Two days later, on 9 May 2009, he attended the West Ryde Medical Centre for the first and only time complaining of a cough. It appears that he did not mention any history of tuberculosis. The GP noted "rhonci +", meaning that there were rattling respiratory sounds, and obtained a chest x-ray. This showed patchy consolidation in the right upper lobe with volume loss leading to elevation of the horizontal fissure. There was also patchy consolidation in the right lower zone medially and in the left mid-upper zone – raising the possibility of tuberculosis. He was referred to Westmead Hospital, where he was admitted on 11 May 2011. The letter of referral from the West Ryde Medical Centre did not identify that he had tuberculosis, but did identify that he had been coughing for "1+ months".

68. Triage at Westmead recorded that he had only had symptoms for one month, and said that he had had fever at onset but did not have further fever. The notes at Westmead recorded two (or perhaps two-and-a-half months of symptoms, malaise and weakness, and 10 kg of weight loss over the past 21 months. Past medical history was recorded as "nil". The inaccuracy of this history further throws into doubt the reliability of the history obtained by Sr Huynh before Manjit's discharge at St Vincent's Hospital. This is

not to criticise either her or the triage nurse at Westmead Hospital but to underline the potential risks in taking histories from patients like Manjit.

69. The following day he was transferred to Royal North Shore Hospital with a preliminary diagnosis of possible TB. Manjit was diagnosed with severe pulmonary tuberculosis and also with malnutrition and anaemia. His weight on admission was recorded as 52kg (in contrast with a weight of 63kg recorded at St Vincent's chest clinic in March 2006).[6] He reported unintentional weight loss and loss of appetite. His weight was described as having dropped from 70 to 54 kg.[7] At that time he was working in an Indian restaurant in Crows Nest. The progress notes recorded that he had had a screening chest x-ray in India for TB but no further radiology, and that he was on a working visa planning on applying for permanent residency. It is not clear how this incorrect information came to be recorded. It may have been that Manjit concealed information, offered misleading information or there may have been misunderstandings in taking the history.

70. Precisely when Manjit had become unwell, and what his living conditions were during this time, are somewhat unclear. Manjit told police that he had moved out of the room above the restaurant in June or July 2007, and moved into accommodation in Surry Hills. In January 2008 he stopped working at the restaurant. He also told them that he had become ill in January 2009 but linked this time to his admission to Royal North Shore Hospital. During this period, Manjit continued to work at different Indian restaurants, although the precise details are unclear. By May 2009 he was working part-time at a restaurant in West Ryde, and also at another in Crow's Nest, above which he lived. One of the nurses from Royal North Shore Hospital who later visited this residence described it as small and without much furniture, but clean. His financial situation is not precisely known but it is evident that he had little money and his circumstances appeared to the nurses who cared for him to be impoverished.

71. Manjit was severely unwell on presentation to Westmead Hospital and his subsequent admission to Royal North Shore Hospital, and had been for some time. At Royal North Shore Hospital, Manjit was recorded by one member of staff as having experienced fevers, cough and shortness of breath for two months. Dr SusanTattersall, an experienced respiratory physician at Royal North Shore Hospital, described him on his admission as having advanced pulmonary tuberculosis and as "perilously ill" and emaciated. Her impression was that he had had worrying symptoms for several months prior to coming to medical attention, including fever, cough and significant weight loss. Her view was that his working and living conditions over the previous couple of years preceding his first attendance at Royal North Shore Hospital led to deprivation and malnutrition which in turn led to the advanced state of his disease at presentation. In Dr Tattersall's opinion, because of the severity of his illness, it is very likely that Manjit knew that he had active TB and there must have been a long delay between the onset of symptoms and his presentation for medical attention.

72. Fortunately his TB was sensitive to all standard drugs. Manjit was treated at Royal North Shore Hospital with a combination of four drugs until the end of August 2008. He was

[6] A weight loss of about 17.5%.
[7] A weight loss of approximately 23%.

discharged as an inpatient on 3 July 2009, and remained an outpatient under Dr Tattersall's care. As well as attending the chest clinic for consultations with Dr Tattersall, he was required to attend to take his medication, as TB medication is routinely administered on a directly observed basis to ensure compliance. Manjit was a compliant patient.

73. Two nurses, Deborah Correll and Amy Lim, had regular contact with Manjit over this time. They observed that he had major difficulties in his living and working conditions during the period of his first admission and the period of outpatient attendances. In particular, they had serious concerns about his lack of heating, warm clothing, nutrition and money. He appeared to be under stress relating to his living and working conditions in Crows Nest. They made attempts to obtain assistance from charities but these were largely unsuccessful due to the fact that Mr Singh was not an Australian citizen. He was described in the outpatient notes as having no money and not being able to feed himself or pay for housing. His situation was so dire that the nursing staff collected money for him, cooked him food and gave him warm clothing.

74. Manjit's TB responded slowly to the drug regimen. In September 2009 his sputum was culture negative for the first time since his admission, and on 5 March 2010 Dr Tattersall ceased the drug therapy. Manjit continued to see Dr Tattersall, and also his GP. He continued over the following months to report feeling feverish, short of breath and having a cough. By June 2010 he was living in Surry Hills and going to a GP in the city. His weight had increased to 60kgs.

Second admission to Royal North Shore Hospital and subsequent treatment

75. In July 2010, only four months after ceasing drug therapy, Manjit's sputum tested positive. On 12 July 2010 he was readmitted to Royal North Shore Hospital and diagnosed with active TB. Subsequent testing confirmed that Manjit was infected with the same strain of TB. He had not been re-infected but had suffered a relapse.

76. Around this time, Amy Lin got in touch with the DIBP about Manjit's case. As a result, the AFP and the Australian Red Cross became involved, investigating possible trafficking of Mr Singh. Both the AFP and Red Cross provided very real assistance to Manjit. The AFP also prepared a number of statements of evidence, and a statement of facts. No criminal prosecution, however, was commenced by the Commonwealth DPP.

77. Manjit was again treated with a daily four-drug therapy. On 17 August 2010 he was discharged from hospital. He continued daily drug therapy (directly observed) at Royal North Shore's chest clinic until 14 January 2011, when it was reduced to two drugs, three times per week. The drug therapy continued until his death, although for a period he attended Parramatta chest clinic for that purpose. The disease again responded to the drug therapy. Although a number of subsequent tests were "scant positive" (showing the presence of organisms in the sputum, although not necessarily alive), Manjit's last positive culture sputum sample was collected on 21 September 2010,

78. By October 2010, Dr Tattersall had spoken to Dr Peter Brady, a thoracic surgeon at Royal North Shore Hospital, concerning Manjit's case. Dr Brady agreed that a lobectomy would be an appropriate course once Manjit had completed further drug therapy.

79. From 14 February 2011 until 15 March 2011 Manjit travelled to India. Because Manjit had been identified as a suspected victim of human trafficking, and was providing the Australian Federal Police with assistance in their investigations, in October 2010 he had been granted a criminal justice visa and was able to re-enter Australia at the end of his trip.

80. Dr Tattersall formally referred Manjit to Dr Brady on 29 April 2011. Dr Tattersall's view was that Manjit's right upper lobe was "totally destroyed" and that this was a sump for residual infection. Whilst she had not yet carried out formal lung function tests, Dr Tattersall indicated that her view was that the right upper lobe was totally non-functional, and that its removal would not worsen Manjit's condition.

81. On 1 June 2011 the sputum culture from 18 April 2011 was reported as being negative.

82. Dr Brady saw Manjit on 1 June 2011. Manjit was accompanied by two workers from the Red Cross. Dr Brady explained the rationale for surgery and the risks. Dr Brady's view was that Manjit would require at least a lobectomy[8] and possibly a pneumonectomy[9].

83. Further sputum cultures were performed in May, June and July but showed no pathogens after 48 hours incubation.

84. Dr Brady arranged for Manjit to undergo lung function tests. Dr Tattersall noted in a letter to Dr Brady dated 27 July 2011 that the results of the tests were "a little disappointing", but noted that people of Indian origin usually have lower lung volumes that Europeans, and that a six minute walk test was "more reassuring". Although he was significantly guided by Dr Tattersall's assessment, Dr Brady's view was that the results were acceptable. The lung function results indicated that Manjit had a substantial impairment in lung function, not surprisingly, given the impairment in his right lung capacity.

85. A chest x-ray in July 2010 was reported as showing no change from June 2010. A chest CT from July 2010 had also been reported as showing patchy parynchmal change within the right lower lobe and left upper lobe laterally. This showed extensive nodular opacity in the left lower lobe.

Surgery and post-operative treatment

86. Dr Brady operated surgery proceeded on 8 August 2011 at Royal North Shore Hospital. As had been anticipated, the right upper lobe was found to be severely diseased or, as Dr Brady put it, "destroyed". Dr Brady was also surprised to discover how diseased the right lower lobe was. It was described in his operation report as "non-salvageable" and "destroyed". Dr Brady says that having performed the lobectomy, he could not suture or

[8] A removal of a lobe of the lung.
[9] A removal of the whole lung.

staple the surgical site closed due to the residual severe disease in the lobe, and he therefore had to proceed to a lower lobe resection.

87. The poor condition of the lower right lung was not apparent on pre-operative radiology. There was no pre-operative CT scan performed in August 2011. The earliest x-ray reported in August 2011 was taken after the surgery on 8 August 2011. This x-ray refers to an earlier x-ray of 26 June 2011. Dr Brady, it seems, operated on the basis of the June x-ray. The first post-operative x-ray report indicated that the left lung remained unchanged since June.

88. Tissue resected during the operation on 8 August 2011 was examined by Dr Kaufman, a consultant pathologist at the hospital. He reported that there was prominent chronic inflammation including nodules of caseous granulomatous inflammation[10] and numerous acid-fast bacilli. As in his experience patients with latent TB would not display the degree of histopathological changed demonstrated in the specimen, he was suspicious of active tuberculosis. Nevertheless, he was unable to make a definite diagnosis of active TB because this requires correlation with clinical findings and radiological changes. Cultures alone are not always accurate and, in any event, must be taken from infected tissue to demonstrate viability.

89. Following the operation, Manjit's recovery was initially assessed as satisfactory. He was discharged from the ICU on 10 August 2011, readmitted briefly on 15 August due to respiratory issues and pain, and returned to the ward later that day.

90. Chest x-rays and CT scans over the days following his operation began to show significant abnormalities in Manjit's left lung, which according to Dr Brady were not apparent on pre-operative radiology. On 12 August 2011 the radiological appearances of the left lung were noted to be slightly altered. By 19 August 2011, there had been significant further deterioration.

91. On 22 August 2011 Manjit was readmitted to the ICU. The admission summary noted increased "confluent opacification of the left lung" and "difficult ventilation". Manjit was intubated and a bronchoscopy administered. From the bronchoscopy it appeared that the bronchial stump where the right lung had been removed was intact. On 23 August Manjit was extubated and given high flow oxygen. On 24 August 2011, Dr Roger Harris of the ICU recorded that Manjit appeared exhausted, and he was given a trial of "non-invasive ventilatory support (BiPAP)"[11] to assist with his breathing.

92. At 9.30am on 25 August Dr Harris recorded that Manjit was suffering from continuing hypoxic and hyperbaric respiratory failure. He noted that Manjit did not tolerate the BiPAP but remained on high-flow oxygen. Attempts were made to reduce pulmonary arterial pressure.

[10] "Caseous granulomatous inflammation" is a description of tissue which has elements of chronic inflammation and which looks soft, easily breakable, and whitish-gray resembling clumped cheese. Such a condition is most often seen in tuberculosis and tuberculosis-like diseases.

[11] Bilevel Positive Airway Pressure. BiPAP Bilevel positive airway pressure is used when positive airway pressure is needed, usually for patients with breathing difficulties.

93. Later that day and into 26 August Dr Harris spoke with Dr Brady, Dr Tattersall and other ICU specialists. Dr Harris recorded that Manjit's left lung had deteriorated following the removal of the right lung and that, despite various therapies, Manjit's respiratory condition had deteriorated. Dr Harris recorded in his notes that "all avenues had been exhausted". Treatment was changed to a palliative approach.

94. At midday on 26 August Dr Harris spoke with Manjit's father by telephone. He explained that Manjit's condition had deteriorated and that it was expected that he would die that day. Manjit's father dropped the phone and the connection was lost. Manjit was declared life extinct at 1.55pm.

95. Dr Harris's opinion is that, following the surgery on 8 August, Manjit developed a progressive pulmonary infiltrate[12] in his left lung with increasing respiratory distress complicated by his extreme malnutrition. The possible diagnoses of the infiltrate are discussed further below.

Issues

96. An issues list was circulated to interested parties before the inquest.

97. The first issue relates to the cause of death, and in particular (a) whether Manjit had active tuberculosis in his left lung in the period immediately preceding his death, and/or (b) the extent of the impairment of his left lung prior to the surgery on 8 August 2011.

98. The second question is whether or not the health undertaking provided an adequate precaution against Manjit suffering a recurrence of TB which may not be promptly diagnosed or treated.

99. The third issue relates to Manjit's discharge from chest clinic at St Vincent's Hospital, and specifically whether (a) he had evidence suggestive of active TB and/or a potential recurrence of TB at the time of his discharge, and (b) where or not Manjit should have been subject to medical review or further review or follow up at that time.

100. The fourth issue raises the question of whether or not the Department of Immigration and Border Protection took adequate steps to safeguard Manjit's welfare and to protect public health in the period up to 11 May 2009, and whether, after Manjit's 457 visa expired, it would have been desirable that steps be taken by the Department (or at its instigation) to review his health status and welfare with a view to both protecting him and to safeguarding public health.

101. The fifth issue relates to the pre-operative investigations prior to the pneumonectomy were adequate, and the appropriateness of the decision to operate.

102. The final *factual* issue raises the question of the adequacy of the post-operative care following the pneumonectomy.

[12] A localized, ill-defined opacity seen in the lung on a chest x-ray or CT scan.

103. Lastly, it is necessary to consider whether recommendations pursuant to s81 of the Coroners Act should be made.

The cause of Manjit's death

104. It is not possible to identify precisely the cause of Manjit's deterioration following his operation and his death. An autopsy was not conducted, so his lungs were not examined by a forensic pathologist. We have only his history (including the x-rays and CT scans taken), and the clinical observations and investigations undertaken at the Royal North Shore Hospital. The pathology investigations at the Royal North Shore Hospital were inconclusive.

105. A number of possible diagnoses have been suggested by clinicians who have considered Manjit's case. Dr Harris gave evidence that a pneumonectomy has unpredictable results. Sometimes the remaining lung does not function well afterwards and the patient dies. He was unsure why Manjit's left lung became stiffer and less functional over time but thought that it may have been due to an inflammatory reaction to pulmonary TB. Nevertheless, he said that the infiltrate could have indicated a number of possible problems. He thought that pneumonia was less likely than TB. He said that as the body struggles to recover post-operatively, TB may be reactivated. On the other hand, Manjit may have acquired an infection or suffered from aspiration damage to his left lung.

106. Dr Tattersall also found it difficult to identify the precise cause of Manjit's death. While she was sure that he died due to complications of surgery, what they were was difficult to say. She thought that it was possible that he became infected as a result of a diaphragm leak and possibly a leak at the site of the right bronchial stump. She noted that the operation had been difficult because of adhesions on the diseased lung[13]. The more difficult the surgery, the more chance of complications.

107. Dr Brady thought that the most likely cause of Manjit's deterioration was a hospital-acquired infection that, due to his weakened state, he was unable to overcome even with intensive care treatment. He dismissed the possibility of the bronchial stump having been the source of infection because it had been examined by bronchoscopy and no sign of leakage had been detected.

108. Professor Guy Marks, a respiratory physician who provided an independent expert report, was also uncertain as to the exact nature of the complications that followed surgery. In his opinion, pneumonia or an acute lung injury superimposed on a previously damaged left lung were the most likely possibilities. Because no proof of active TB was found, he was not persuaded that Manjit had died of active TB which had been reactivated in his left lung. He also thought that, absent evidence of a leak from the bronchial stump, it was unlikely to have been a source of infection.

109. Finally, Dr Michael Dally, a thoracic physician, who provided a report on behalf of NSW Health and the hospital, thought that the post-operative CT scans suggested lung

[13] Adhesions are bands of scar tissue that joins two internal body surfaces that are not usually connected. TB causes scarring of lung tissue. To remove the destroyed lung, Dr Brady had to separate the lung from the adhesions that had joined the lung to the chest wall.

infection. In his view, the fact that Manjit seemed to be recovering initially and was quite stable for some days suggested that the operation was not the direct cause of Manjit's deterioration.

110. Although the immediate cause of Manjit's deterioration has not been identified, all clinicians involved in examining his case were agreed that the primary cause of Manjit's death was that he had become very ill with active TB in the period before his surgery. It was unusual for active TB not to be cured by a course of treatment. Dr Tattersall considered that Manjit's poor living conditions were directly implicated in the relapse of his condition and, indeed, were a key factor in the reactivation of his TB. Her view was that the upper lobe of his right lung had become a sump of infection. She thought that the scar tissue that is caused by TB had probably sealed off a section of the lung from the antibiotics with which he was being treated. Once the course of treatment finished, this enabled the TB bacteria to flourish once again and to spread from the sump.

111. In an expert report prepared by Dr Tattersall for the inquest, she stated:

> [Manjit] clearly had worrying symptoms for several months prior to coming to medical attention including fever, cough and significant weight loss. This would normally have led to medical consultation… He was emaciated and clearly very unwell on presentation… The delay in in diagnosis and starting treatment resulted eventually in his death because his disease was incurable with medical treatment alone and this led to the attempt to cure him with surgery.

112. In summary, Manjit died as a result of complications following surgery to remove his diseased right lung. The surgery had been undertaken because he had severe active TB which was not curable by medical treatment alone.

The health undertaking

113. I was surprised to learn during the inquest that performance of the health undertaking required of visa applicants is neither enforceable nor directly monitored by the Department of Immigration and Border Protection. At first blush, the fact that a visa holder, or, indeed, an unlawful non-citizen, with untreated active tuberculosis might be working in Australia seemed to me to suggest a significant flaw in the system.

114. On closer examination, however, for the following reasons, the problem appears to be both less dire and more complex than it had first appeared to me to be.

115. First, as was demonstrated in Manjit's case, he was checked in India before he arrived in Australia and his TB was discovered.

116. Second, he complied with his health undertaking. Most visa holders in his position, being hopeful of extending their 457 visas or of obtaining permanent residence, have an incentive to comply with the health undertaking.

117. Third, the chest clinics that screen people like Manjit have excellent clinicians and their protocols, if adhered to, are effective in protecting the visa holders and public health generally.

118. Fourth, the system is largely in the hands of public health clinicians who understand the importance of building therapeutic relationships of trust with their patients.

119. Fifth, the system as it operates is designed to encourage TB sufferers to come forward for treatment. The emphasis at the clinics treatment of the patient for his or her own good and for the public good, rather than on a punitive approach which is likely to be counter-productive. The DIBP website also seeks to provide reassurance to visa holders that their visas are not at risk if they become ill.

120. Sixth, if a visa holder fails to comply with a health undertaking to undergo regularly screening, clinics report this fact to DIBP through Bupa. Although a failure to comply with the health undertaking does not, in itself, result in cancellation of visas, it is taken into account by DIBP when assessing their immigration status generally and further applications by the visa holder.

121. Finally, although TB is a serious condition and is contagious, it is not as contagious as some other diseases are and is able to be cured in most cases with one course of treatment.

122. Manjit's case raises the question whether the two-year screening program is long enough. The expert evidence was that experience and research has found that there is very little extra benefit to be gained from extending the period to, say, three years but the added costs would be very considerable. From a risk-management perspective, all the experts (including NSW Health policy experts) agree that the "sweet spot" is two years. And, of course, if individual patients need longer that can be accommodated.

123. The real issue that Manjit's case raises, therefore, is not whether the health undertaking system failed but the protection of the welfare of 457 visa holders once they arrive in Australia.

Manjit's discharge from St Vincent's Hospital

124. As we have seen, Manjit was discharged from the screening program in March 2008 after being cleared by Dr Marshall Plit, a staff specialist in thoracic medicine and lung transplantation at St Vincent's Hospital. Dr Plit has been a doctor for about 35 years and is an expert in the diagnosis and treatment of TB. He was head of TB services at the time Manjit was discharged.

125. He reviewed the chest x-ray that had been taken when Manjit attended the clinic on 26 February 2008 and the notes concerning Manjit's history. At the time of his review, however, he did not have the radiologist's report. Dr Laguna's report raised the possibility of a pleural effusion and therefore of an infection and recommended that further x-rays be taken to investigate this. For reasons that are not entirely transparent, the report was never read by Dr Plit.

126. The most likely explanation was that given by Dr Plit himself at the inquest. He has enormous experience in the diagnosis of tuberculosis. He argued at the inquest that he is more capable than a general radiologist of interpreting chest x-rays. He vigorously

asserted that the feature referred to by Dr Laguna as a possible pleural effusion was in fact not that but part of Manjit's rib structure showing up as opacity on the film. If that is so, it seems a surprising error for a consultant radiologist to make.

127. Whether or not Dr Plit is correct, I do not have the expertise to say. I do not doubt Dr Plit's expertise or his bona fides but it is troubling that other eminent and skilled thoracic physicians – Professor Marks and Dr Tattersall -- were much more cautious about the interpretation of the x-ray.

128. If it is his general practice – and I do not suggest that it is -- to ignore radiologist's reports and to rely solely on his own interpretations of chest x-rays, his self-confidence may be misplaced. If, on the other hand, Dr Plit's practice *is* to review the reports but he overlooked doing so on this occasion, he would have made a better impression as a witness and a medical practitioner by admitting this. The defensive posture he adopted at the inquest had the counter-productive effect of strengthening the doubts that the evidence of the more cautious experts had raised. At the very least, before he discharged Manjit, it could have done no harm for Dr Plit to have reviewed the radiology report and discussed the case with Dr Laguna.

129. This is not to say that Dr Plit acted negligently or incompetently, much less that Dr Plit bears any responsibility for Manjit's death three years later. Nevertheless, if in February 2008 he had considered the possibility suggested by Dr Laguna's report that there may have been changes in Manjit's condition, it might have thrown Manjit's assurances that he was well and asymptomatic into doubt and required closer investigation of his circumstances.

130. This case suggests that some 457 and other temporary visa holders may not provide all the necessary history or information for clinicians to make appropriate assessments. Some may simply be ignorant of matters that are significant. Others may deliberately conceal symptoms due to anxiety about losing their visas.

131. A latent flaw in the system, at least as it operated at St Vincent's Hospital in 2008, was that the interview with the patient took place over the telephone rather than face-to-face. This prevented Sr Hunyh from making her own visual assessment of Manjit's condition. Dr Plit relied on the information he had received from Sr Hunyh that Manjit was well and asymptomatic. And further complicating this information-gathering exercise was the fact that it was conducted in part through an intermediary, one of Manjit's friends or colleagues who spoke better English than he did. This was not the ideal process. In my view, before a TB patient is discharged from the screening process, he or she should be *seen* by a clinician, whether a nurse or a doctor, whichever is more appropriate, and physically checked.

132. A face-to-face interview would have the additional benefit of enabling the clinic to ensure that the patient fully comprehends the advice he or she is being given about tuberculosis and the need to return to the chest clinic or see a doctor if symptoms develop following discharge. Just sending a letter, in English, to a person in Manjit's situation perhaps "ticks a box" but is a weak safeguard of his welfare and public health more generally.

133. If investigations of the chest x-ray had, as recommended by Dr Laguna, been carried out, and if he had been interviewed face-to-face, the process may have revealed how dire Manjit's circumstances were, and raised the question whether he was at risk of developing active TB. We cannot now be sure, but perhaps an opportunity to improve Manjit's current life, and his life chances, was lost at that point.

The operation

134. Manjit was very sick and the upper lobe of his right lung was, as Dr Brady described it, "destroyed". In his independent report, Professor Marks conceded that the decision to operate was a reasonable one but raised the question whether it would have been preferable to continue to treat Manjit medically rather than surgically.

135. Professor Marks stated that Manjit's case was "a complex one. He was in a serious and unusual situation". He outlined the pros and cons of surgery in his report.

136. The factors in favour of surgery were:

- Relapse of TB patients with drug-susceptible TB is very uncommon when full adherence to therapy has been assured by direct observation, as it was in Manjit's case. There are few options other than surgery if the drug therapy does not work.
- Manjit had an extensively destroyed right upper lobe which may have been a site of chronic infection.

137. Against surgery he listed the following factors:

- Radiology showed that Manjit had disease in both lungs. It was therefore not certain that removal of the right upper lobe would eliminate the problem.
- As Manjit had disease in both lungs, his residual lung function after the operation would probably be more impaired than it would otherwise be if the left was undamaged.
- Manjit had responded to drug treatment previously.
- The surgery would be expected to be difficult and complex due to the likely presence of adhesions surrounding his extensively destroyed right upper lobe.

Although the decision was clearly a very difficult one, Professor Marks's preference would have been not to operate because he thought that there was still a chance that drug therapy could work and there was a risk that surgery might result in the effective loss of both lungs.

138. If Manjit's history is any guide, and Dr Tattersall's diagnosis that the upper right lobe was a sump of infection is correct, the disadvantage of this approach was that his tuberculosis was incurable by medical treatment alone. Manjit would probably have continued on a roller-coaster of chronic illness, getting better as he was treated, then relapsing when the treatment finished, without any end in sight. Dr Tattersall knew

Manjit and had the advantage over Professor Marks of being able to clinically assess him, as did Dr Brady.

139. In Dr Tattersall's view, Manjit had deteriorated to the point that, to give him a chance of long-term recovery, sooner rather than later the diseased right upper lobe would have to be removed. Dr Tattersall's compassion for Manjit was very evident, as is her expertise. This was not a decision she took lightly. Both she and Dr Brady, and Manjit himself, understood that the outcome was unpredictable because he was very sick and the surgery was difficult and that an even more risky possibility – pneumonectomy – lay ahead of Manjit. Their carefully considered judgment was that the operation gave him his best chance. I accept this.

140. Professor Marks does not cavil with this decision. He did, however, suggest that, with the benefit of hindsight, it may have been useful to have performed a CT scan shortly before the operation to gain a better image of the left lung. He noted that the pre-operative chest x-ray showed the left lung to be "relatively clear" but that there was some sign of disease in it.

The post-operative care

141. All the medical evidence demonstrates that Manjit received excellent post-operative care at Royal North Shore Hospital. The doctors who cared for Manjit tried everything they reasonably could to help him survive. Unfortunately, his illness had so weakened him that he was overwhelmed despite their best efforts. It was evident at the inquest that those who cared for Manjit after his operation, particularly Drs Tattersall and Harris and Nurses Correll and Lim, still felt upset by his death and the circumstances that had led to it.

The role of the Department of Immigration and Border Protection

142. This inquest has not been a general inquiry into the operations of DIBP. A number of features of the case that must, however, cause concern to the department.

143. First, Manjit was sponsored to come to Australia on certain conditions but those conditions appear not to have been met by the sponsor. Of course, once Nurse Lim got in touch with DIBP on Manjit's behalf, action was taken and the AFP began an investigation. But for Nurse Lim, his story may never have come to the attention of DIBP. Certainly, unscrupulous employers of 457 visa holders are in a position of dominance in relation to their employees. Employees like Manjit are extremely vulnerable to exploitation and intimidation.

144. Second, unless there is scrutiny by DIBP of the bona fides of employers making 457 visa applications by, for example, auditing them after the arrival of 457 workers, it appears likely that cases like Manjit's are and will remain the tip of the iceberg.

145. Third, if so, that is dangerous for the 457 visa holders and may pose a threat to public health more generally.

146. Fourth, there is cogent evidence that Manjit was brought to Australia on false pretences; that he was never paid what he was promised and what DIBP was told he would be; that his money disappeared without his knowledge and may have been taken by his employer; and that subsequently, even while he was living in Australia on a criminal justice visa as a suspected *victim* of people trafficking while the Australian Federal Police conducted their investigations, Manjit had no right to work and therefore lived hand-to-mouth, relying on charity, but suffering from malnutrition and deteriorating physically so much that he became vulnerable to reactivation of his tuberculosis.

147. As we did not delve deeply into the 457 visa system, and it would therefore be unfair to make recommendations that may imply criticisms of the Australian Government or DIBP, I do not propose to make any formal recommendations to them. Nevertheless, I propose to write to the Minister for Immigration, drawing his attention to the case and my findings. Given that the department was represented at the inquest, I am confident that these matters have been recognised and will be even more closely considered following this inquest.

Can more be done?

148. I propose to make two formal recommendations pursuant to s81 of the Coroners Act.

149. First, for reasons outline above, I will recommend to the NSW Minister for Health that pre-discharge interviews with patients being screened for TB be undertaken face-to-face and include a physical check for signs of possible active TB. In this context, I also recommend that, when considering discharge, physicians reviewing patients' most recent chest x-rays do so with the benefit of the radiologist's report.

150. It was put to me by counsel for DIBP that the current system is "not broken, so there is no need to fix it." I do not suggest that the system is broken. I hope, however, that DIBP is not so complacent that it thinks that Manjit Singh's case is unimportant for what it reveals about the potential threats to the welfare of 457 visa holders, and for public health to be jeopardised if they become seriously ill but are diverted from the health system by direct intimidation or by more amorphous anxieties about their immigration status. And I hope that DIBP is not so complacent that it believes its systems cannot be improved.

151. Therefore, I will also recommend to the NSW Minister for Health and the Minister for Immigration that their departments work together to find the optimal policy (or policies) for both ensuring that the health and welfare of temporary visa holders who are subject to TB health undertakings (or similar undertakings in respect of other public health risks) are protected, and public health safeguarded.

Conclusion

152. Shortly before his death, Manjit spoke to Deborah Correll. He had realised that he was dying. It is difficult to imagine what must have gone through his mind at that time. He was lying in a hospital bed thousands of kilometres from home and his loving parents. His hopes of providing for his family in India and of perhaps establishing a new life in

Australia had turned to dust. He was only 33 and had no close relatives with him, no wife or children to carry on after him. The hardship of Manjit Singh's life, and the loneliness of his death, in one of the richest countries in the world is desolating.

153. For any parent, the loss of a child is almost unbearably distressing. But Jaswinder and Surinder Kaur Singh have suffered the loss of a treasured son who went to Australia and never came back. Their sorrow and sadness must be almost without limit. I hope that this inquest will at least enable them to learn how much Manjit was liked, respected and cared for by the good doctors and nurses who knew him at the Royal North Shore Hospital. And I also hope that they will accept the very sincere respects and condolences of the coronial team and me, and the staff of the Coroners Court in Sydney.

Findings s 81 Coroners Act 2009

154. I find that Manjit Singh died on 26 August 2011 in the Intensive Care Unit of Royal North Shore Hospital, St Leonards, New South Wales due to hypoxic respiratory failure following a right pneumonectomy for the treatment of severe pulmonary tuberculosis with malnutrition being a contributory causal factor in the development of that disease.

Recommendations s 82 Coroners Act 2009

155. To the NSW Minister for Health:

I recommend that pre-discharge interviews with patients being screened for TB be undertaken face-to-face and include a physical check for signs of possible active TB or risk factors for activation of TB. In this context, I also recommend that, when considering discharge, physicians reviewing patients' most recent chest x-rays do so with the benefit of the radiologist's report.

156. To the Minister for Immigration and the NSW Minister for Health

I recommend that their departments confer to find the optimal policy (or policies) for ensuring both that the health and welfare of temporary visa holders who are subject to TB health undertakings (or similar undertakings in respect of other public health risks) are protected, and public health is safeguarded.

Magistrate Hugh Dillon
Deputy State Coroner