IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 0200

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Nilofer Nezami
Date of birth:	4 April 1980
Date of death:	7 January 2019
Cause of death:	1(a) Unascertained
Place of death:	Mashhad, Iran

INTRODUCTION

1. On 7 January 2019, Nilofer Nezami was 38 years old when she died after undergoing multiple surgeries performed in Iran. At the time of her death, Mrs Nezami lived at Lynbrook with her husband and their three children.

THE CORONIAL INVESTIGATION

2. Mrs Nezami's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. While Mrs Nezami died overseas, she ordinarily resided in Victoria at the time of her death and her death appeared to have occurred following a medical procedure, namely cosmetic surgery.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. The Victoria Police Coronial Support Unit assigned an officer, Leading Senior Constable Kelly Ramsey, to be the Coroner's Investigator for the investigation of Mrs Nezami's death. Leading Senior Constable Ramsey conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. I note the investigation was limited by the difficulties Leading Senior Constable Ramsey had in obtaining information from Iran, as the Coroners Court's jurisdiction only applies in Victoria.

6. This finding draws on the totality of the coronial investigation into Mrs Nezami's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I

will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

7. On 30 January 2019, Nilofer Nezami born 4 April 1980, was visually identified by her husband, Zabihullah Nezami.

8. Identity is not in dispute and requires no further investigation.

Medical cause of death

9. Mrs Nezami's body was returned from Iran and transported to Coronial Admissions and Enquiries. Detective Senior Sergeant Mark Colbert from the Homicide Squad made an application for an immediate autopsy on grounds including that family members alleged the Mrs Nezami's husband had caused her death. An immediate autopsy was directed by the then Deputy State Coroner Iain West on 29 January 2019.

10. Professor Noel Woodford, Director of the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 29 January 2019 and provided a written report of his findings dated 27 May 2019.

11. By the time Mrs Nezami's body was received in Victoria, an autopsy had already taken place overseas and she had been embalmed. Professor Woodford's post-mortem examination revealed the following:

    (a) evidence of recent skin and subcutaneous tissue surgery (bilateral eyelids, bilateral breasts, upper arms, and lower abdomen/torso);

    (b) patchy haemorrhage right side of larynx (larynx intact);

    (c) minor oedema of lungs;

    (d) possible zonal steatosis and parenchymal collapse in liver; and

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

(e) no evident pulmonary thromboembolism or coronary artery atherosclerosis.

12. Professor Woodford noted that interpretation of the findings in this case had been significantly compromised by the significant post-mortem delay (with tissue autolysis), a previously conducted post-mortem examination, and embalming procedures.

13. However, the findings on external examination were in keeping with the history that Mrs Nezami had undergone a number of cosmetic/plastic surgery procedures prior to her death. These procedures appear to have been conducted in the region of the eyes, face, breasts, arms, and abdomen.

14. Whilst there was some degree of haemorrhage into the soft tissues of the abdomen consistent with recent surgery, no large collections were identified of a type likely to have caused or contributed to death. Nor was there evidence of an infective complication of the surgery.

15. Professor Woodford did not identify any natural disease of a type likely to have caused death. In particular there was no evidence of significant coronary artery atherosclerosis, pulmonary thromboembolism, or fat embolism. Areas suggestive of parenchymal collapse in the liver raised the possibility of ischaemic hepatitis about the time of death, but due to the extent of post-mortem changes, the significance of this finding could not be determined.

16. Professor Woodford did not identify any injuries of a type likely to have caused death. A bruise noted to the side of the larynx was a non-specific finding, particularly given the absence of observable conjunctival/mucosal petechiae or strap muscle bruising.

17. Professor Woodford noted that although the cause and mechanism of death had not been identified, possible factors (given the context of the case and the absence of definitive post-mortem findings) included cardiac rhythm disturbance or significant biochemical and metabolic derangements in the setting of recent surgery. Other possible factors including sepsis could not be excluded due to the inability to perform appropriate microbiological testing or serology for inflammatory markers such as C-Reactive Protein.

18. Toxicological analysis of post-mortem samples identified the presence of morphine, codeine, midazolam,[2] paracetamol, atropine,[3] ondansetron,[4] and lignocaine.[5] Professor Woodford noted these were consistent with administration in a healthcare setting.

19. Professor Woodford provided an opinion that the medical cause of death was *"1(a) Unascertained"*.

20. I later received some medical records from Mrs Nezami's surgeries in Iran. As part of the coronial investigation, they were translated into English and were provided to Professor Woodford for comment.

21. Following consideration of the materials, and noting them to be incomplete, Professor Woodford noted they confirmed Mrs Nezami:[6]

> *… underwent a general anaesthetic (**GA**) for a surgical procedure on 7th January (with recorded date of admission on the 6th). Given the dates on other documents, I think the date of this surgery was actually the 6th of January. The procedure lasted 4.5 hrs (finishing at 1915 hrs) and the deceased was reportedly awake 'at recovery' (presumably by the time she arrived at the recovery ward). Vital signs were essentially normal prior to the GA …*
>
> *According to the Operation Report Sheet, thrombo-prophylaxis was attended to prior to the procedure with the administration of low molecular weight heparin (enoxaparin) although the dose as recorded appears excessive (?translation error). There is a variably detailed description of procedures to the arms, breasts and abdominal wall. There is no mention of complications …*
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> *According to the Recovery Room Record the BP [blood pressure] was initially lowish (100 systolic) but normal by the time of discharge at 2100 hrs. Fluid loss estimated at 600 ml.*

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[2] Midazolam is clinically used as a preoperative medication, antiepileptic, sedative-hypnotic and anaesthetic induction agent.
[3] Atropine is a competitive reversible antagonist at all muscarinic receptors. It is indicated for paralysis of accommodation and pupil dilation for eye examinations, urinary incontinence, irritable bowel syndrome, cardiac slowing and may be used as an antidote for anticholinesterase poisoning.
[4] Ondansetron is used clinically to control nausea and vomiting in post-operative patients and in those receiving cytotoxic chemotherapy and radiotherapy.
[5] Lignocaine (or Lidocaine) is a local anaesthetic often administered to patients prior to surgery or during resuscitation attempts. Lignocaine may also be used as an anti-arrhythmic drug to return the heart to a more regular beat (rhythm).
[6] Email from Professor Noel Woodford to Deputy State Coroner English dated 1 November 2021.

According to the Progress Notes sheet at 05.?? Hrs on the 7th January the deceased was transferred to the 'Women's ward' from ICU [intensive care unit] following what appears to have been bradycardic arrest. CPR [cardiopulmonary resuscitation] and administration of (?) adrenaline and atropine occurred. She was declared dead at 0545 hrs that morning …

According to information from the University of Medical Sciences Medical Centre Resuscitation Report Form, the deceased was admitted there on 7th January at 10.15 hrs. Cardiac rhythm described as asystole-chest compressions were performed but no defibrillation. CPR for 45 minutes. Final diagnosis was given as pulmonary embolism, but I cannot determine on what basis this diagnosis was made.

There are no records relating to autopsy procedure.

22. He concluded:

From the information provided, it is not possible to determine the cause of the bradycardic arrest and death. An autopsy report would obviously be helpful if available, especially if it confirmed the clinical suspicion of pulmonary (thrombo) embolism. Given the recent long-haul flight, and despite thromboprophylaxis, pulmonary thromboembolism remains a possibility although there were no findings at the time of my autopsy to indicate this. There are no operative notes relating to the periorbital surgery but I wonder if two general anaesthetics in close proximity could have increased the risk of cardiac rhythm disturbance, particularly given the likely considerable fluid shifts as a consequence of a second prolonged procedure.

23. I accept that following a physical examination and review of the available medical records, Professor Woodford was unable to formulate an opinion regarding the cause of death. However, he stated there were a number of medical procedure-related possible causes, such as cardiac rhythm disturbance or significant biochemical and metabolic derangements in the setting of recent surgery. He also noted two general anaesthetics in close proximity may have increased the risk of cardiac rhythm disturbance.

24. The available evidence suggests Mrs Nezami's cause of death appears likely to be surgery related. I otherwise accept Professor Woodford's opinion that the cause of death is unable to be ascertained.

Circumstances in which the death occurred

25. Mrs Nezami was born in Afghanistan and migrated to Australia with her parents, sister, and three brothers in 1996. They settled in Auburn, an outer suburb of Sydney, and she went on to complete secondary school and a thereafter studied travel and tourism.

26. In approximately 2001, she commenced a relationship with Zabihullah Nezami, and they married in 2002 and settled in Melbourne in 2004.[7] The couple welcomed three children.

27. In 2008, Mrs Nezami was involved in a motor vehicle accident. She sustained injuries, which caused ongoing pain and was subsequently prescribed medication to assist with the pain. The combination of the ongoing effects of the injury and medication appears to have caused Mrs Nezami to gain weight, which caused her further distress. Her concerns about her weight gain led her to consult her general practitioner, Dr Xiuli Susan Wang, in 2016 about the possibility of cosmetic surgery. It appears that Mrs Nezami did not have the financial means to proceed with surgery at that time.[8]

28. According to her husband, in 2018, Mrs Nezami began making enquiries about having the surgery overseas, noting that she had received advice from friends. She eventually decided on a medical facility in Mashhad, Iran.[9]

29. Mrs Nezami disclosed her surgery plans to her doctor in December 2018. Dr Wang noted that Mrs Nezami was excited but very nervous, noting that Mrs Nezami had assured her that she had organised a proper hospital and that two of her friends or relatives had had liposuction and had very good results.[10] The statement from Dr Wang notes she was close to Mrs Nezami, and saw her for appointments once or twice a month for the last eight years. Dr Wang described Mrs Nezami as "*one of my early and favourite patients*."[11]

30. On 8 December 2018, Mrs Nezami travelled to Sydney with her children, leaving the eldest two in the care of her parents. She returned to Melbourne on or about 23 December 2018 with her youngest child.[12]

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[7] Affidavit by Zabihullah Nezami, dated 3 February 2019, 2.
[8] Coronial brief (**CB**) 39.
[9] Affidavit by Zabihullah Nezami, dated 3 February 2019, 3.
[10] CB 39.
[11] CB 39.
[12] Affidavit by Zabihullah Nezami, dated 3 February 2019, 3.

31. On 28 December 2018, Mrs Nezami consulted another general practitioner, Dr Nayani Jayakody, regarding post-operative pain relief in preparation for her upcoming cosmetic surgery.[13]

32. On 29 December 2018, Mrs Nezami travelled to Iran with her husband, their youngest child, and her sister-in-law, Zara Bashira (Mr Nezami's sister).

33. Ms Bashira stated that they visited a clinic called the ATER Clinic in Mashhad town.[14] However, Mrs Nezami's brother, Ahad Aboss, noted the hospital was known as the Shams-O-Shamos Artash Hospital.[15] Conversely, Mr Nezami identified the clinic as the Arthur Beauty Clinic.[16] Subsequent enquiries made by Leading Senior Constable Ramsey to the Australian Department of Foreign Affairs and Trade confirmed that officials from the 505 Artesh Hospital in Mashhad later reported Mrs Nezami's death to the Australian Embassy in Tehran.[17]

34. The exact surgical procedures Mrs Nezami underwent in Iran and the hospital and medical clinicians who provided treatment and care remain unclear, although evidence of the surgeries is detailed in Professor Woodford's report.

35. According to Ms Bashira, on 5 January 2019, Mrs Nezami had surgery to her chin and eyes, which was performed by a Dr Sangrey. On 7 January 2019, Mrs Nezami had surgery on her stomach, which was performed by a Dr Rasol Kamal Poor.[18]

36. Mr Nezami stated that his wife had a consultation with the surgeon on 3 January 2019 and was advised to undergo a blood test and endoscopy to obtain clearance for surgery. She underwent these procedures on 6 January 2019 and was subsequently cleared for surgery, which was booked for 7 January 2019.[19] Mr Nezami's affidavit does not refer to the procedures apparently performed on 5 January but describes the surgery performed on 7 January 2019 as *"liposuction"*.[20]

37. According to Ms Bashira, she tended to Mrs Nezami after her surgery during the evening of 7 January 2019. She stated that Mrs Nezami was alert after the surgery and able to engage in

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[13] CB 45.
[14] CB 36.
[15] CB 47.
[16] Affidavit by Zabihullah Nezami, dated 3 February 2019, 3.
[17] CB 122.
[18] CB 36-37.
[19] Affidavit by Zabihullah Nezami, dated 3 February 2019, 3-4.
[20] Affidavit by Zabihullah Nezami, dated 3 February 2019, 4.

conversation. Mrs Nezami subsequently complained of pain in her left upper arm and shoulder area and said she was cold. A nurse fetched a blanket and administered an injection to assist with the pain. Ms Bashira remained with Mrs Nezami who again complained of pain. Ms Bashira noted that her sister-in-law's hands were very cold. The nurse subsequently felt Mrs Nezami's hands, which apparently elicited a panicked look, and caused her to activate an alarm. Medical clinicians then entered Mrs Nezami's room and Ms Bashira was asked to leave.[21]

38. Ms Bashira stated she immediately contacted her brother, Mr Nezami, who subsequently attended the hospital with his youngest child.[22]

39. In his affidavit, Mr Nezami stated that his sister telephoned him at approximately 4.00am asking him to attend the hospital as his wife was feeling unwell. Upon his arrival, he was informed that his wife had slipped into a coma.[23] I note the timing of this telephone call, which appears to have been made during the morning of 8 January 2019, is inconsistent with Ms Bashira's statement and the date of death as it appears on the death certificate.[24]

40. After some time, a doctor or nurse advised Mr Nezami that his wife had passed away due to *"a piece of fat went to her heart and she had a heart attack"*.[25]

LIMITATIONS IN OBTAINING INFORMATION

41. According to Leading Senior Constable Ramsey, efforts to obtain further information from the hospital or Mrs Nezami's treating clinicians in Iran have been fruitless.[26]

Information from Iran

42. As part of my investigation, I requested Leading Senior Constable Ramsey to obtain the autopsy report, the details of where the cosmetic surgery was conducted, as well as any information about a police investigation and statements and medical records form surgeons and hospital staff who cared for Mrs Nezami.

[21] CB 37.
[22] CB 37.
[23] Affidavit by Zabihullah Nezami, dated 3 February 2019, 4.
[24] CB 116.
[25] CB 37; Affidavit by Zabihullah Nezami, dated 3 February 2019, 4.
[26] CB 123, 125.

43. On 27 June 2019, Leading Senior Constable Ramsey requested the Consular Operations Branch of the Department of Foreign Affairs and Trade for assistance obtaining documentation in relation to Mrs Nezami's death.

44. On 2 July 2019, Rob Vlazlovski, Executive Officer at the Consular Operations Branch of the Department of Foreign Affairs and Trade, advised Leading Senior Constable Ramsey that he confirmed the Australian Embassy in Teheran, Iran, had been advised by 505 Artesh Hospital in Mashhad, Iran, that Australian citizen named Nilofer Aboss (Mrs Nezami's maiden name) had passed away at their establishment in January 2019.

45. Under Iranian law, they would only advise that she had died from 'embolism' and would only provide further information to Mrs Nezami's direct relatives.[27]

46. Mr Vlazlovski advised that Mr Nezami had made brief contact with the Embassy and that Mrs Nezami's brother and uncles had contacted the Embassy raising concerns her death was suspicious. They were directed to lawyers to take those concerns further. The Australian Embassy was not able to request any further information or documentation. Leading Senior Constable Ramsey detailed in her statement her efforts to contact the hospital through internet searches and trying to contact organisations such as the General Department of Legal Medicine of Teheran Province that completed the death certificate, without success.[28]

47. Leading Senior Constable Ramsey also obtained a statement from Mrs Nezami's sister-in-law, Ms Zara Ghezal Bashira, who travelled to Iran with her. She provided the names of the two doctors who were involved with the procedures as well as another hospital, the ATER Clinic. Leading Senior Constable Ramsey has not been able to find this hospital or the two doctors from internet searches.

48. Although Mrs Nezami's brother submitted some medical documentation from the hospital, Professor Woodford was unable to provide advice regarding the exact cause of Mrs Nezami's death.

49. Given the lack of fulsome medical documentation from the hospital or her treating clinicians, I have been unable to determine the exact cause of Mrs Nezami's death nor the time of her death.

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[27] CB 122.
[28] CB 123.

50. And, in light of Leading Senior Constable Ramsey's unsuccessful efforts to obtain information, I am not of the view I am able to make any further inquiries to obtain further information that may shed further light of Mrs Nezami's cause of death.

Information from family

51. I also note the Court's efforts to obtain documentation that had been provided to Mrs Nezami's family from officials in Iran were also unsuccessful.

52. On 27 November 2019, I issued a *Form 4 Document or prepared statement required to be given to the coroner* pursuant to section 42 of the Act to Mr Nezami. The Form 4 required Mr Nezami to produce the following documents:

    (a) a detailed statement outlining:

        (i) any known medical history of Mrs Nilofer Nezami including the name(s) and details of any treating medical practitioners in Australia;

        (ii) the reasons and circumstances regarding her travel to Iran prior to her death;

        (iii) details of the events in Iran leading up to her death;

        (iv) details of the nature of the surgery/ surgeries performed;

        (v) details and addresses of the hospital(s) where the surgery/ surgeries took place as well as the details of any medical practitioners involved;

        (vi) any other details which would assist the coroner in determining the circumstances and cause of death; and

    (b) a copy of any documents (whether translated or not) regarding the circumstances of Mrs Nezami's death which had been provided to him from Iran. This includes but is not limited to medical materials, autopsy results, etc.

53. Mr Nezami failed to comply within the required period of 21 days. My solicitor followed up with Mr Nezami's solicitor on multiple occasions and, on 19 August 2020, I received a copy of an affidavit prepared for the purpose of family law proceedings[29] and an unsigned

[29] Affidavit by Zabihullah Nezami, dated 3 February 2019.

statement. No explanation has been provided regarding Mr Nezami's failure to co-operate with the coronial investigation.

Conclusion regarding limited information

54. Coronial investigations regarding deaths occurring overseas are particularly difficult because coroners do not have any jurisdiction outside of Victoria. The Court therefore relies on the *goodwill* of governments, medical facilities/practitioners, and family members to provide information that is relevant to the coronial investigation. While I have received many pieces of written correspondence from Mrs Nezami's family members, the information that would be most helpful to my investigation has not been forthcoming, including:

    (a) a statement from Mr Nezami in the terms stated above;

    (b) a final death certificate recording the cause of death. I have only been provided a copy of a death certificate dated 23 January 2019, which records the cause of death as *"under investigation"*;[30]

    (c) a report from the coroner in Iran, which the Australian Embassy could not obtain as official documents would only be released to Mrs Nezami's family;[31] and

    (d) medical records from the hospital(s) where the surgeries were performed or statements from the clinicians involved in Mrs Nezami's treatment and care.

FAMILY CONCERNS

55. During my investigation, I received statements and written correspondence from members of Mrs Nezami's family, which contained allegations about:

    (a) family violence (psychological and physical) perpetuated by Mr Nezami against Mrs Nezami and their children;

    (b) that Mr Nezami had forced or coerced his wife to undergo cosmetic surgery; and

    (c) that Mr Nezami had caused his wife's death or took action to bring about her death.

56. These allegations were also made to Detective Senior Sergeant Mark Colbert from the Victoria Police Homicide Squad. It was noted that the allegations were broad and uncorroborated and

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[30] CB 116.
[31] CB 122-123.

not able to be readily confirmed or dismissed, particularly given that Mrs Nezami's death had occurred in Iran, which was outside of Victoria Police's jurisdiction. The Homicide Squad therefore was unable to proceed with a criminal investigation.[32]

57. It is clear that there is significant animosity between Mrs Nezami's family and her husband and tensions remain within the family.

58. I accept that Mrs Nezami's family are devastated by her death and their devastation is further heightened by historical and ongoing family tension and acrimony, including Family Court proceedings. I accept the voluminous evidence provided by Mrs Nezami's family supports the contention that family violence occurred in the course of Mr and Mrs Nezami's marriage in the presence of their children.

59. However, my jurisdiction is limited to the medical cause of death and surrounding circumstances contributing to the death. And, as explained above, my investigation has been curtailed due to the lack of information from the hospital(s) and clinicians who performed the procedure(s). I am therefore unable to be satisfied as to the medical cause of her death, including whether the surgical procedures indeed contributed to her death. Upon the evidence before me, I cannot be satisfied as to the reasons why Mrs Nezami chose to have cosmetic surgery in Iran rather than Australia.

60. Mrs Nezami's family contend that Mr Nezami encouraged his wife to undergo cosmetic procedures[33] in Iran. I note the evidence from Mrs Nezami's doctor, Dr Wang, who described Mrs Nezami as follows:

> *She was excited at the same time very nervous. She had bought return tickets, she told me she organised a proper hospital and accommodations etc. She told me two of her friends or relatives had some liposuction* [and] *got very good results*.[34]

61. Dr Wang's statement appears to suggest that Mrs Nezami willingly made plans to undergo cosmetic surgery. The statement from Dr Jayakody also notes Mrs Nezami's intended plans for overseas surgery.[35] Neither doctor refer to coercion or note her reluctance to proceed with the surgery.

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[32] CB 121.
[33] I note that in his affidavit, Mr Nezami was initially against his wife undergoing cosmetic surgery.
[34] CB 39.
[35] CB 45.

62. Therefore, the only circumstances I can be satisfied about are:

(a) Mrs Nezami travelled with her husband, sister-in-law, and son to Iran for the purposes of cosmetic surgery; and

(b) she died following surgery in Iran.

63. While officials from the hospital reported to the Australian Embassy in Tehran that Mrs Nezami had died from an *"embolism"*,[36] I have no official record of this. A post-mortem examination conducted at the VIFM failed to ascertain the cause of death.

64. There were also no injuries of a type likely to have caused death identified during the post-mortem examination. I am able to be satisfied there is no evidence from Professor Woodford or in the coronial brief supporting the suggestion there are suspicious circumstances surrounding Mrs Nezami's death.

FINDINGS AND CONCLUSION

65. Pursuant to section 67(1) of the Act I make the following findings:

(a) the identity of the deceased was Nilofer Nezami, born 4 April 1980;

(b) the death occurred on 7 January 2019 at Mashhad, Iran, from an unascertained cause of death; and

(c) the death occurred in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

66. I have made a finding that I am satisfied Mrs Nezami underwent cosmetic surgery in Iran and died following surgery. I have conducted previous coronial investigations where I have found 'medical tourism' is an inherently dangerous risk.

67. In my *Finding into Death Without Inquest into the death of Leigh Thomas Aiple*,[37] I examined the circumstances of a gentleman who had travelled to Malaysia for the purpose of cosmetic

[36] CB 122.
[37] Published 4 December 2017.

surgery. Two days after returning to Australia, Mr Aiple died of pulmonary thromboembolism.

68. In that investigation, I was able to obtain medical records from the hospital where the surgery was performed and a statement from Mr Aiple's treating surgeon, which was helpful in determining the circumstances that led to his death.

69. In that finding, I noted clinical standards differ between Australia and other countries. For example, while multiple cosmetic surgeries are routinely performed on the same day in many countries, in Australia that practice may be deemed to be below the standard of care or exceed usual protocol. Similarly, post-surgery and discharge standards of care may also differ.

70. I also noted that the Australian Society of Plastic Surgeons had been gravely concerned about the risks associated with medical tourism, believing them to be significant and under-estimated by the Australian population. While standards of medical practice in Australia are amongst the highest in the world, Australians who seek medical services overseas may not be aware that there is often a difference in standards of medical practice and management of patient care.

71. I went on to refer to the Commonwealth Department of Health's warning about medical tourism. I note the Commonwealth Government currently has the following advice on its Smart Traveller website:

> *Many hospitals overseas operate at a similar standard to Australian facilities. However, quality and standards in some countries can be poor. Some may have low training standards for doctors and nurses. Others may have high rates of infection and complications.*
>
> *The quality of care you receive may not be of the same standard you would expect in Australia.*
>
> *Minimum health standards in some countries can be very low, even in economically developed nations.*
>
> *Standards can differ greatly within countries. Standards vary between regions, hospitals and medical professionals.*

Your health is your responsibility. It's up to you to research the risks and determine if a hospital or surgeon meets an acceptable minimum standard.[38]

72. I subsequently made a recommendation that the Victorian Chief Health Officer consider the merits of taking a similar approach to the Department of Health and Department of Foreign Affairs and Trade to publish a health advisory along the same lines. This would increase the breadth of material available to advise Victorian consumers of medical services overseas to be aware that the quality of medical care provided in other countries may not be of the same standard as that provided in Australia.

73. In January 2018, the then Victorian Chief Health Officer, Professor Charles Guest, advised that my recommendation would be implemented through a notification to the Victorian public providing advice about potential dangers of seeking elective medical treatment in another country and that standards of medical care may not be as high as for treatment provided within Victoria.

74. While I note that the Chief Health Officer's Health alerts and advisories website[39] does not currently contain a warning about medical tourism, the Department's Better Health Channel[40] provides quite detailed advice. The Better Health Channel describes the concerns held by the Royal Australasian College of Surgeons and lists a number of risks as identified by the Australian Medical Association, including:

    (a) lower quality surgical skills and practices that can lead to infection or disfigurement;

    (b) antibiotic resistant bacteria that can cause complications after surgery and may not be treatable;

    (c) lack of discussion before the operation about whether the procedure is necessary;

    (d) lack of follow-up after the operation to ensure the results are satisfactory and safe; and

    (e) poor regulatory systems in some other countries.

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[38] Australian Government, Department of Foreign Affairs and Trade, Smartraveller, Going overseas for a medical procedure (medical tourism), https://www.smartraveller.gov.au/before-you-go/health/medical-tourism, accessed 18 March 2022.

[39] Department of Health, Health alerts and advisories, https://www.health.vic.gov.au/news-and-events/healthalerts, accessed 18 March 2022.

[40] Department of Health, Better Health Channel, Medical tourism and insurance, https://www.betterhealth.vic.gov.au/health/HealthyLiving/medical-tourism, accessed 18 March 2022.

75. Both organisations point out that the quality of care Australians may receive overseas may not be as high as what they would expect in Australia.

76. The Victorian Department of Health appears to be an obvious starting point for Victorians searching for advice about medical tourism. Given the Chief Health Officer does not currently have an alert on the Health alert and advisory page, I will repeat the recommendation I made in the *Finding into Death Without Inquest into the death of Leigh Thomas Aiple.*

77. While Mrs Nezami's cause of death remains unascertained, her death occurred shortly after a surgery. Given the surgery was conducted overseas, I have been unable to determine the specific cause of her death or review the standard of medical care and treatment she received. This is also a risk that must be considered in medical tourism.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation:

1. I recommend that the Victorian Chief Health Officer publish an alert/advisory regarding the risks of medical tourism, including but not limited to advice that the standard and quality of medical care provided in other countries may not be of the same standard as that provided in Australia.

Pursuant to section 73(1A)(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I convey my sincere condolences to Mrs Nezami's family for their loss.

I direct that a copy of this finding be provided to the following:

Zabidullah Nezami, senior next of kin (care of Starke Westwood Lawyers)

Alistair Aboss (copy to Adviceline Injury Lawyers)

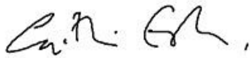
Abdul Ahad Aboss

Chief Health Officer, Professor Brett Sutton, Department of Health

Detective Senior Sergeant Mark Colbert, Victoria Police, reporting member

Leading Senior Constable Kelly Ramsey, Victoria Police, Coroner's Investigator

Signature:



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Caitlin English, Deputy State Coroner

Date: 21 March 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.