Coroners Act, 1996

[Section 26(1)]

Western Australia

RECORD OF INVESTIGATION OF DEATH

Ref No: 36/10

I, ***Evelyn Felicia VICKER, Deputy State Coroner,*** *having investigated the deaths of* ***Sandra McCarty, Pia Bosso, Sandra Kokalis, Deborah Gruber & Carmelo Vinciullo,*** *with an Inquest held at the* ***Perth Coroners Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***1 November 2010 – 19 November 2010 & 29 August 2011 – 5 October 2011*** *find the identities of the deceased persons were* ***Sandra McCarty, Pia Bosso, Sandra Kokalis, Deborah Gruber and Carmelo Vinciullo,*** *and that death occurred:*

in the case of ***Sandra McCarty*** *on* ***25 May 2005*** *at* ***Fremantle Hospital*** *as the result of* ***Gastro Intestinal Haemorrhage & Metabolic Derangement arising out of the administration of a treatment including Caesium in a woman with widespread Metastatic Breast Carcinoma;*** *and*

in the case of ***Pia Bosso*** *on* ***26 May 2005*** *at* ***Fremantle Hospital*** *as the result of a* ***Caesium Induced Arrhythmia in a Woman with Metastatic Thyroid Carcinoma;*** *and*

in the case of ***Sandra Kokalis on 27 May 2005*** *at* ***Sir Charles Gardiner Hospital*** *as the result of* ***Gastro Intestinal Haemorrhage & Metabolic Derangement arising out of the administration of a treatment including Caesium in a woman with Metastatic Colonic Carcinoma;*** *and*

in the case of ***Deborah Gruber*** *on* ***28 May 2005*** *at* ***Fremantle Hospital*** *as the result of* ***Sepsis arising out of the***

administration of a treatment including Caesium in a woman with Metastatic Breast Carcinoma; *and*

in the case of ***Carmel Vinciullo*** *on* ***1 July 2005*** *at* ***Royal Perth Hospital*** *as the result of* ***Metastatic Ewing's Carcinoma;***

in the following circumstances:

Counsel Appearing:
Dr Celia Kemp assisted the Deputy State Coroner
Mr RH Lawson appeared on behalf of Dr A Boyd
Mr GA Ryan appeared on behalf of Mr K Preston
Ms BE Burke appeared on behalf of Ms De Wilt & RN Baker
Mr AP Hershowitz appeared on behalf of Ms S Phasey

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I would like to thank:

Mrs Felicity Zempilas, who was part-time, sole, Counsel Assisting at WA State Coroners Office when these deaths occurred and compiled a comprehensive, detailed time line which was invaluable to this investigation.

Dr Celia Kemp, who continued Mrs Zempilas' work, and without whom this matter could not have been heard. She worked relentlessly to provide coherence and format to a very arduous set of circumstances.

Dr Suzanne Redknapp, who provided assistance whenever I asked for help in trying to express myself in a comprehensive manner.

Det.Sgt Terry Rakich and Det.Const. Darren Bethell of WAPOL, Major Crime Squad, who conducted the police investigations on behalf of this office.

The South Australian State Coroner's Office for their help with access to information relevant to their State.

The Northern Territory Coroner's Office for their help with access to large amounts of information with respect to the operation of KPMHC in Darwin.

All the experts who provided unstinting support in trying to understand what had happened at KPMHC/Perth

And last but not least my JSO/Secretary Janet Roy, who un-reservedly supported me at all times.

Without all those people this would never have been completed.

SUMMARY OF FINDING

In May 2005 the Kathi Preston Memorial Health Centre (KPMHC) began operating *"a clinic"* out of the home of a General Practitioner (GP), Dr Alexandra Boyd, at 16 Beagle Street, Mosman Park, Perth. The alleged purpose of KPMHC/Perth was to cure patients of their cancer by administration of an IV High pH Cancer Therapy devised by Dr Helfried Sartori (Sartori). The treatment used a range of substances including caesium, DMSO (an industrial solvent) and Laetrile (also called B17 although it is not a vitamin, or Amygdalin), all of which are potentially toxic.

Seven people were administered the IV therapy by KPMHC/Perth, some of whom had prior oral treatments containing caesium, and one of whom had received prior IV Laetrile in Mexico. The treatment offered in May was for a course of 12 days.

Sandra McCarty, Pia Bosso, Sandra Kokalis, Deborah Gruber and **Antonio Ranieri** all commenced IV therapy on 14 May 2005.

Carmelo Vinciullo and **Daryl Green** commenced IV therapy on 20 May 2005.

Carmelo Vinciullo ceased treatment on 25 May 2005 because he was in so much pain he could not continue. He died on 1 July 2005 of his cancer. It had not been cured.

Sandra McCarty died on 25 May 2005.
Pia Bosso died on 26 May 2005.
Sandra Kokalis died on 27 May 2005.
Deborah Gruber died on 28 May 2005.

On 26 May 2005 the WA Police were alerted to the operation of the clinic as a result of concerns raised through Fremantle Hospital after the death of Sandra McCarty and admission of Pia Bosso. When the police attended to execute a search warrant at 16 Beagle Street, midday on 26 May 2005, none of the people who had been treated were present.

Daryl Green returned to South Australia and then continued with his treatment, but died on 20 July 2005 of his cancer. It had not been cured. This is a South Australian death.

Antonio Ranieri completed the treatment on 25 May 2006. He died in November 2009 with his cancer still present. It had not been cured. In the interval since his treatment in May 2005 he had undergone IV caesium treatment in Mexico which did not make him sick, and chemotherapy in Sir Charles Gairdner Hospital (SCGH).

This inquest was conducted to examine the circumstances of the five deaths in Western Australian in 2005.

We were provided with files from the State of South Australia and Northern Territory to assist in the inquest as the death of Daryl Green in July 2005 in South Australia, and preceding

deaths in the Northern Territory involving Sartori's treatments, were investigated by police from those jurisdictions and considered to be of a matrix which warranted inclusion in the overall pattern of operation of KPMHC in Australia, under the tutelage of Sartori.

In addition to the assistance received from other states and territories, the WA police recovered files, documents and records from a car they searched on 26 May 2005 which had been at 16 Beagle Street, Mosman Park. This allowed expert evidence to be provided to the inquest by senior clinicians informed as to the individual treatment of the people treated at KPMHC/Perth as far as those records go. While the record keeping may be deemed inadequate due to the circumstances in which the nurses found themselves, in conjunction with computer records seized by police from other jurisdictions, it does provide a basis upon which this particular treatment can be assessed for its efficacy. The clinical conditions in which the treatment was provided, as evidenced by the carers and families, is also a matter for consideration.

'The treatment' as referred to in the following finding refers to the substances given, the clinical conditions and manner in which it was undertaken.

Of the seven people treated in Perth in May 2005 KPMHC, four became unwell and died before they had completed 12 full days of treatment; two died of their cancer by the end of July 2005, both of whom had an interrupted treatment, and Mr

Ranieri died from progressive lung disease with complications from asbestosis and his cancer in November 2009. His lymphoma had not been cured.

No one treated in KPMHC/Perth was cured of their cancer.

While it is accepted all six cancer patients who died in 2005 had serious, end stage cancer, one of the issues of concern was whether the treatment accelerated any of their deaths. And, of some significance, whether or not they had been misled into expecting a cure for their cancer which ultimately caused them to die in very distressing circumstances, rather than prolonging either their quantity and/or quality of life.

I have formed the view the KPMHC/Perth did accelerate the deaths of the four women who died over the four days 25-28 May 2005; and I speculate Carmelo Vinciullo would have died during treatment had he not withdrawn from any further treatment by the clinic on 25 May 2005.

While I unreservedly support the proposition patients have a right to choose their treatment, that choice must be appropriately informed. The four women who died, and those who had families involved with the treatment, were given serious misinformation about the risks involved with the treatment itself. As a result they were not prepared for imminent death, and did not have the opportunity to say and do the things they may have done had they been able to

accept they might die. In the case of Pia Bosso this meant she died far away from the support of a loving family.

I consider one of the most important outcomes from this inquest is to attempt to provide independent information to the public so those considering Sartori's High pH therapy in the future can be properly informed about its danger. There is no evidence this particular treatment had any real benefit at all to patients. There is considerable evidence it is dangerous and has a serious risk of accelerating death.

It also caused serious suffering, which was exacerbated by the setting in which it was provided and instructions given to participants. Sartori lacked clinical skills and was unable to provide proper medical care while the treatment was occurring. Patients are at risk of suffering serious harm or dying due to the questionable clinical care received under his instruction. Those promoting the treatment claim it is *"natural"* and *"safe"*. Sartori's form of this treatment is neither. It requires high doses of industrially manufactured substances and is manifestly unsafe, as are a number of other purportedly 'natural' products.

BACKGROUND

The history of the WA deaths in May 2005 really starts in Darwin with Kathleen and Keith Preston. However, their involvement with Sartori and his high pH cancer therapy means some history of Sartori and his treatment of Kathleen Preston in Thailand is essential to an appreciation of the fundamentals of the May 2005 KPMHC/Perth.

One of the problems in attempting to understand how those administering the treatment under Sartori's direction could continue with a situation which was so obviously, potentially disastrous, has its genesis in the history of KPMHC and the fact Keith Preston, and those he then came into contact with, was a *"true believer"* in the treatment.

There is no doubt the main Australian practitioners in the KPMHC/Perth were caring, compassionate people. It is my view Sartori needed people like Simone Phasey, Merrilee Baker and Alexandra Boyd because they empathised with people, and it showed. It is doubtful Sartori could have engendered such sympathy without their support. These individuals' desire to *"help"* those suffering the ravages of cancer appears to have clouded their professional integrity to do no harm. By relying on a wishful philosophy of the ends justifies the means, they unwittingly created much harm. Hope is a wondrous achiever, but representing a clinical manifestation of bodily harm as a "*healing crisis"* is unrealistic and evidences a mind set of denial. It proved to be very destructive.

KEITH PRESTON

Bernard Keith Preston (Keith) and Kathleen Preston lived in Darwin. Keith is a mechanic by trade and ran a repair business. Kathleen had been diagnosed with ovarian cancer in 1997. She had chemotherapy, but also researched and tried many alternative cancer treatments. It is clear the Prestons were a devoted couple and spent a considerable amount of time and money trying to extend Kathleen's life. She, like many patients, found chemotherapy extremely taxing.

In the course of their research they came across Paul Rana (Rana) who was advertising a *"Cancer Attack Pack"*. In November 2003 the Prestons paid and signed up with Rana for his treatment.

In April 2004 Rana emailed the Prestons some information about a caesium and high pH therapy. Kathleen Preston then emailed Sartori with information about her cancer, and treatment to date, and on 26 April 2004 received a response from Sartori in which he claimed his treatments were *"empirically proven highly effective treatment protocols for the treatment of cancer"* and *"by far the most consistently effective therapy for fast-growing cancers no matter what stage or type or extent".*[1]

Sartori suggested they could have access to the treatment in Thailand, with the assistance of a Thai doctor to oversee the

[1] Vol 14, Tab 5, pgs 55-56) wherever a volume is referred to in the foot notes it depicts one of the Exhibit/Volumes 1-23.

treatment and ensure general medical needs were met. The treatment was to cost $16,000 (US) of which $5000 was to be paid in advance.

Keith and Kathleen Preston travelled to Thailand in July 2004 for the treatment. It included intravenous (IV) ozone and IV caesium chloride. Kathleen Preston originally did well, but then became very unwell during treatment and was admitted to Chang Mai Hospital on 26 July 2004, with a high potassium level. The high potassium led to rhythm disturbances of her heart which necessitated surgery to insert a pace maker. During surgery an artery was damaged which caused bleeding and collapse. She died.

Caesium can cause an alteration in potassium levels and the resulting arrhythmias are one of the reported toxicities of caesium. Sartori reluctantly agreed in evidence it is likely the reason Kathleen Preston experienced high potassium levels was as a result of his high pH therapy.[2]

An autopsy conducted in Thailand [3] also indicated Kathleen's metastatic ovarian cancer was active and had not disintegrated as Keith Preston was led to believe. Sartori disputed this in evidence despite being confronted with the report.[4]

[2] Transcript 19.11.10, pg 946 -47.
[3] Volume 10, Tab 6
[4] Transcript 19.11.10, pgs 947-8

Keith Preston gave evidence[5] he believed Sartori's treatment of his wife had effectively cured her of her cancer and the only reason she died was because of the accidental event during surgery. He did not appreciate the cardiac disturbance was probably a direct result of the treatment or that the autopsy indicated her cancer was widespread and active. He did seem to understand the relationship between potassium levels and the administration of caesium, however.[6]

The outcome of those events in Thailand and Sartori's explanation for his wife's death evoked in Keith Preston great faith in Sartori. He believed Sartori had cured his wife's cancer, and had there not been the intervening cardiac event she would have been cured and survived.

It was Keith Preston's memorial to his wife to promote Sartori's treatment for those suffering terminal cancer in Australia who were seeking an alternative cancer cure. There is no doubt Keith Preston believed the IV caesium high pH cancer had cured his wife and her death was just a bi-product of an accident in the conventional medical arena. The clinic was a tribute to his wife and her very tragic premature death, evolving out of her metastatic ovarian cancer.

This then was the origin of the KPMHC in Australia. Keith Preston remained convinced Sartori's high pH cancer therapy was effective in prolonging life, if not curing cancer.[7]

[5] Transcript 30.08.11, pgs 1133-1135
[6] Transcript 30.08.11, pg 1133
[7] Transcript 30.8.11, pgs 1151, 1232

Documents seized from personal computers indicate that for a brief period there were hopes the treatment would provide a lucrative business, which would also serve to provide people with a genuine alternative treatment to conventional chemotherapy. However, I accept it was never Keith Preston's ultimate goal to make money. I am satisfied Keith Preston in 2004 and 2005 was more concerned to provide terminal cancer patients with the treatment he felt would have saved his wife, if not for the intervention of conventional medicine.

Keith Preston did not press patients for payment when it became obvious there were difficulties involved for families. He fell out with proponents of the treatment who seemed to be only concerned with financial gain. Keith Preston researched and refined adjuncts to the treatment by way of natural therapies and nutrition, but remained basically at the mercy of professionals with respect to the actual biochemistry and biology of the treatment he so passionately believed in. He accepted Sartori's explanation for all apparently adverse outcomes and because he believed in the treatment he accepted all other explanations as conspiracy theories perpetuated by conventional medical practitioners to promote drug corporations.[8] This led to him being less than forth coming with the facts with respect to the treatment of some patients in Darwin prior to May 2005.[9]

[8] Transcript 30.8.11, Pg 1123
[9] Death of Lesley Bramston 24.11.2004 in Darwin Papers provided by NT Coroner Volume 10

Keith Preston lodged and received registration for the business name the *"Kathi Preston Memorial Health Centre"* (KPMHC) on 29 October 2004. He set up his property in Darwin to provide the treatment and was in charge of the financial aspect of KPMHC. He procured, with Simone Phasey, most of the equipment required for the treatment, and most of the substances. This took considerable effort and negotiation through legislation because many of them were not legally able to be purchased in Australia, or imported into Australia to supply to others, due to the Therapeutics Goods Administration (TGA).

There are large amounts of documents indicating Keith Preston ordered and paid for substances which he had to access from all over the world. With respect to Laetrile large quantities were found on his property in June 2005 which he claimed were left over from the treatment of his wife.[10]

It was clear from the evidence[11] most of the patients treated in May 2005 understood some of the substances were restricted in Australia, and they or their carers apparently undertook the physical administration of those substances to avoid legislation in place to protect Australian citizens. [12]

[10] Transcript 31.8.11, pgs 1236-7
[11] Transcript 1.11.10. pg 52, 2.11.10, pgs 129, 160-161, 3.11.10, pg 270
[12] Transcript 5.9.11, pg 1326 & 27.9.11, pgs 1936-1939

SARTORI

Sartori was born Helfried E Sartori but changed his name in 2003 to Abdul-Haqq Sartori.

He graduated as a medical doctor from the University of Graz in Austria in 1963. He was admitted to work as a general practitioner by the Austrian Chamber of Medical Doctors in 1969, however he has not appeared on that list since 1 January 1974.

He worked in the USA from 1976 to 1998. He was initially in the navy and came to the attention of authorities on multiple occasions.

In 1982 he was arrested in Baltimore on a charge of distributing caesium chloride to three cancer patients with intent to defraud. This case resulted in a mistrial for reasons not connected to the strength of the evidence.

In 1984 a Commission on Medical Discipline in Maryland found Sartori had acted medically inappropriately by relying on *"unvalidated techniques"*, that his record keeping practices were deficient and he was seriously deficient in medical knowledge and clinical judgment and in their opinion *"no remedial education program could correct this deficit"*. The Commission concluded Sartori was professionally incompetent and revoked his licence to practise medicine in Maryland. This information is available on the internet.

Following the revocation of his licence in Maryland a chain of licence revocations in other states in the USA followed.

In 1996 Sartori was found guilty of two counts of practising medicine without a licence and one count of unauthorized possession of a hypodermic needle in New York. He was sentenced to imprisonment in the Westchester County Jail.

In 1998 he was convicted and sentenced in Virginia to five years in jail for a number of charges including practicing medicine without a licence. The charges arose out of complaints made by two patients who were injected with ozone. One suffered a heart attack and another suffered a stroke.

Sartori also faced charges of mail fraud and bad cheques during his time in the USA.

He was released from jail in 2003 and travelled to Thailand. This was a breach of his USA parole.[13]

Once in Thailand Sartori placed material for promoting his treatment on the internet and patients from other countries flew to Thailand for treatment by him. It was as a result of that promotion the Prestons flew to Thailand for treatment of Kathleen.

[13] Transcript 19.11.10 pg 990

Sartori flew to Darwin once Keith Preston had established the KPMHC in Darwin to promote his treatment in Australia.

Sartori then attempted to become registered in Australia as a doctor in February 2005 but there were inaccuracies on his application, including stating he had never had his licence to practise suspended or cancelled in any country. He indicated he had never been the subject of any disciplinary action by a professional body and that he had never been convicted of any offences. Not surprisingly his application was not successful. It was purported to be as a result of his denial of a visa to enter Australia that the KPMHC moved from Darwin to Perth in May 2005.

In support of his application to become registered as a doctor in Australia Sartori provided some General Medical Council (UK) documents which indicate he became registered to practice medicine in the UK in January 1995. There is no evidence to indicate he did practice there and his General Medical Council (GMC) registration was suspended on 22 June 2006.

The Northern Territory Police sent documents provided by Sartori to the GMC and the information returned from the GMC was that one of the documents alleged to have originated from GMC was a fabrication.[14]

[14] Volume 10

While Sartori was awaiting registration in Australia as a doctor he remained in Thailand and it was from Thailand he provided advice to KPMHC Darwin/Perth with respect to the treatment of patients.

At the time of the inquest Sartori indicted he was registered to practice in Austria. However, inquiries in Graz failed to reveal any evidence he was registered to practice in Austria. He was not at the time registered to practice in Austria and had not been since 1970's. Promotion of his treatment can still be found on-line and there is some indication he may be participating in treatments in South America.

At the time Sartori gave evidence at the inquest in 2010 following the deaths in Perth, he had completed a term of imprisonment in Thailand in 2006, in relation to charges arising out of the death of a patient in Thailand who had travelled there for Sartori's treatment.

Obviously this could not have been known to the Prestons in 2004/5 because it had not then occurred. However, there was evidence of Sartori's lack of credentials to practice medicine and previous convictions available on the internet, and Keith Preston was certainly aware of the circumstances of the death of Lesley Bramston in Darwin in November 2004.[15]

Sartori appeared voluntarily in the 2010 portion of the inquest. He claimed he wished to support Dr Boyd's position

[15] Volume 10 the treatment in Darwin included Ozone, not used in Perth due to Dr Sartori's absence

she had not been physically involved in any administration of the treatment at the May 2005 clinic.

This may not have been his only motive in attending. It became apparent any publicity of his treatment is utilized by Sartori as an opportunity to promote it, regardless of the circumstances and reality of the outcomes for patients.

PAUL RANA

It is appropriate I cover a little of Paul Rana's involvement because a number of family members of patients referred to their original involvement or contact with Paul Rana. Certainly some of the treatment undertaken in Perth was as a result of his promotion. He did respond to communication briefly during preparation for the inquest but became uncontactable when attempts were made to serve him with a Summons for the 2011 portion of the inquest. He could not be located and did not attend the inquest. There is some evidence he may be in South America.

Paul Rana operated out of Melbourne originally, and ran businesses involved with alternative cancer therapies. He called his alternative treatments *"The Rana System"*. He had no medical qualifications.

Paul Rana and Sartori made contact sometime in 2003. Sartori spent time in Victoria in mid 2004, and Paul Rana also travelled to Thailand and observed Sartori treating a patient there.

Paul Rana decided to start recommending Sartori's treatment and his plan was to refer patients to Sartori. The treatment was recommended in materials he was distributing in 2004/5. It is clear Sartori and Paul Rana collaborated in the treatment of patients throughout Australia in 2004/5. There is also evidence they continued collaboration and the pursuit of funds after May 2005.

Following its registration in Darwin in October 2004, KPMHC started treating patients in Darwin in November 2004. At this time there seemed to be a close relationship between Paul Rana, Sartori and Keith Preston to provide alternative cancer treatment.

There is evidence in documents located in Darwin that Keith Preston and Paul Rana collaborated with both pre-treatment and post-treatment therapies for patients intending to undertake, or having completed, the 12 day High pH therapy.[16]

In evidence Keith Preston even suggested some patients died because they were no longer able to access products from KPMHC once the police had intervened in the distribution of substances.[17]

Paul Rana referred patients to the KPMHC and charged a fee for doing so. He was involved in the referrals of Lesley

[16] Vol 13, Tab 6, pg 1
[17] Transcript 30.8.11, pg 1150

Bramston, Mr Green and Mr Vinciullo and he was also a visitor during the operation of the May 2005 KPMHC/Perth. Following that visit Keith Preston and Paul Rana fell out because Paul Rana was clearly more interested in the money than the outcome. Keith Preston became aware he was seeking and charging more money from patients than KPMHC.

In events after 2005 Paul Rana was pursued by the ACCC in the Federal Court of Australia for breaches of the Trade Practices Act by representing to people with terminal illness, (including cancer) and to their families, that the RANA system could cure cancer, reverse, stop or slow its progress or prolong the life of persons suffering from cancer.

In May 2007 the Federal Court found Paul Rana's companies had engaged in misleading and deceptive conduct and ordered he be permanently restrained from conducting this type of business. The Federal Court stated the RANA system did not cure cancer, stop or reverse, or slow its progress and did not prolong life, that Paul Rana knew such claims were false and there were no reasonable grounds for making them. The RANA system included the promotion of coffee enemas, diets described as eating according to blood type, Vitamin C, Vitamin B17 (Laetrile), ozone therapy and caesium.

The Court also found Paul Rana had behaved *"unconscionably"* towards five named people, one of whom was Lesley Bramston. The conduct complained of included pressuring people in financially difficult circumstances to pay

unreasonable fees for products he knew didn't do what was promised with statements such as *"money should be no problem where someone's life is concerned"* and *"you cannot put a value on life and you should borrow the money required for the treatments from any source you can".*

Judge Ryan stated the case revealed a *"consistently cynical and heartless exploitation of cancer victims and their relatives when they were at their most vulnerable. This conduct was not like that which is sometimes encountered in the context of a well-meaning but misguided administration of a single cure or treatment which the promoter genuinely believes, in the face of a body of opposing scientific opinion, to offer a prospect of arresting or delaying the progress of the disease. In this case, the evidence reveals that Mr Paul Rana…. has personally taken the leading role in promoting and administering the so called 'treatments' and extorting from the patients, or their relatives, substantial upfront fees."*[18]

During the inquest in 2011 Simone Phasey and Keith Preston both gave evidence of their, now poor, opinion of Paul Rana, although there is no doubt he was significant in the early development of KPMHC.

During the operation of KPMHC/Perth one of the difficulties Keith Preston and Simone Phasey complained of was the arrival of patients seeking treatment, referred by Paul Rana, of

[18] [2007] FCA 695 para 7 of Reasons for Judgement

whom they had no prior warning. This was a considerable strain on their ability to care for patients.

Sartori gave similar evidence in 2010 saying he no longer had anything to do with Paul Rana, however, police investigations revealed continued contact between Sartori and Paul Rana in 2006[19] with both Sartori and Paul Rana charging a patient for treatment. In addition Sartori alleged he had received information with respect to the inquest through an email address he claimed Paul Rana was using in Columbia. [20]

The website attached to this email address was still operating in August 2011 and contained a lot of information authored by Sartori. It is a concern people may still be informing themselves of this therapy as promoted by Sartori and Paul Rana.

[19] Volume 15, tab 2, pgs 111-9
[20] Transcript 18.11.10, pg 905

SIMONE PHASEY

Simone Phasey was a Registered Nurse in Darwin. She qualified at the Queen Elizabeth Hospital in South Australia in 1983 and had been working since then with some time away from work having children. She is married and she and her husband run a business. She had a younger brother who had suffered extensively with cancer and conventional treatment.

She presented as an intelligent, caring and capable nurse. She also appears to have largely accepted Sartori's explanation for any apparently adverse effects of the treatment, and relied on his clinical instruction, in preference to that of Registered Australian Consultants.

RN Phasey met Keith Preston in about 1995 when he was the mechanic at her local garage. She knew both Keith and Kathleen Preston and they discussed Kathleen's cancer and complementary/alternative treatments for cancer. Although conventionally trained RN Phasey was certainly interested in, and alert to, alternative cancer therapies, acknowledging as many professionals do, chemotherapy can be extremely difficult for a number of patients.

RN Phasey assisted Kathleen with some of the preparation for her treatment in Thailand.

On Keith Preston's return from Thailand, after the death of his wife, he explained to RN Phasey in detail what had

happened.[21] He apparently showed her a translation of his wife's autopsy report. RN Phasey confirmed Kathleen Preston's death was as a result of the damaged artery, which it was, but she also confirmed it appeared to indicate Kathleen Preston's cancer was severely disrupted. When RN Phasey was shown in evidence the autopsy report obtained from the Chang Mai Hospital, she indicated it was not the document which had been shown to her originally as Kathleen Preston's autopsy. [22] There never was an explanation for the report allegedly seen by RN Phasey and explained to Keith Preston by Sartori.

Once RN Phasey became aware of the details of Kathleen's treatment, Keith Preston approached her to assist him in setting up the KPMHC. The intention was to offer Sartori's treatments to cancer patients. Due to her pre-existing interest in alternative therapies, RN Phasey was prepared to consider this option.

In evidence RN Phasey indicated she did not immediately agree to assist Kieth Preston but instead did some research on the internet to inform her decision. From her research she became impressed with the reported success stories from use of the High pH cancer therapy. RN Phasey indicated she could not believe Sartori was having so much success yet the treatment had not been approved. From her research all the effects of the treatment on cancer patients seemed positive.

[21] Volume 9, Tab 5, pg 21
[22] Transcript 5.9.11, pg 1305

"At the time, what did you think Dr Sartori's treatment could achieve the cancer patients? ... My belief was that it could at least reduce the tumours to make them receptible.

At the time did you think there were any risks involved with this treatment at all?... No; No, there was nothing indicated at all.

In particular, at the time did you know that caesium could cause tachyarrhythmias?... No.

So is it a fair summary to say that back then you thought Dr Sartori's treatment was both effective and safe?...Yes, I wouldn't become involved otherwise".[23]

RN Phasey indicated she believed Sartori's treatment to be a natural treatment and agreed she was involved with KPMHC from about August 2004 through to the end of May 2005, at least.

While Ms Phasey is certainly still in favour of alternative cancer therapies it is clear she was concerned Sartori's attitude, as displayed during his evidence, did not reflect her own motives for being involved in the treatment.[24]

Ms Phasey gave evidence, which I have no reason to doubt, she was paid $100.00 per day, or thereabouts, plus expenses, for her work while in Perth. The conditions in which she was working must have been distressing and I do not believe monetary reward was her motive for being involved in this cancer therapy at that time.

[23] Transcript 5.9.11, pg 1306
[24] Transcript 6.9.11, pg 1424, 7.9.11, pgs 1479-80, 7.9.11, pg 1505 & 1508

Unfortunately, Ms Phasey's belief in Sartori caused her not to question his clinical ability with her own.[25] I accept she did not always follow his instructions where she believed it could cause harm (Carmelo's pain relief), however, on the whole she preferred to accept Sartori's conspiracy theories rather than question why others, with recognised clinical ability, would not subject their own loved ones to IV caesium therapy, or why it is Therapeutic Goods Administration (TGA) had any restrictions on Laetrile used in the treatment.

This caused her, while under Sartori's influence, to be selectively forthcoming with details of the treatment with other practitioners once conventional medical input became necessary, or the authorities become involved.

I accept during the latter stages of the KPMHC/Perth at 16 Beagle Street the situation was chaotic due to the sickness of the patients. It is likely Ms Phasey was not in a position to sit back and question her involvement. Belief in Sartori caused her to consider finishing the treatment was in the best interests of the patients. Following his instructions at that time may have seemed the better option, rather than discontinuing the treatment.[26] She did not appreciate those stopping the treatment had a better chance of surviving the treatment.

[25] Transcript 6.9.11, pg 1444
[26] Transcript 7.9.11, pg 1517 & 1535

It is significant all those patients who had years to live with their cancer without treatment,[27] or those who voluntarily stopped treatment after a few days, survived the treatment.[28]

At the time of the deaths Simone Phasey was registered in NT, but not WA and in 2005 registration in one State or Territory did not cover registration in other States or Territories (as is now the case). I have referred to her as RN Phasey in Darwin, but Simone or Ms Phasey in WA.

[27] Ranieri - Transcript 4.11.10, pg 337
[28] Martin - Volume 12, tab 28

KPMHC/DARWIN

Sartori went to Darwin and trained RN Phasey and Keith Preston. They treated their first batch of patients with Sartori's therapy in Darwin in November 2004.

THE TREATMENT IN DARWIN

There was a standard treatment given by KPMHC which varied only slightly between patients.

1. A registered Australian doctor (usually a GP) was asked to order a PICC line be inserted (a PICC line enables substances to be given intravenously over a period of time, it is inserted into a more central vein so it does not need replacing as often as a peripheral intravenous line, provided care is taken to maintain sterile conditions) so that IV treatments could be given. The registered Australian doctor was supposed to provide a baseline review to which later results could be compared.

2. Baseline blood tests were ordered.

3. Blood type specific nutrition with a specific diet given according to the blood type (to be given by nasogastric tube if a patient is unable to eat).

4. The 'pre-treatment pack' was given which is three weeks of a large number of substances to be taken orally (including oral amygdalin and caesium)

5. 12 consecutive days of the intravenous program:

    a. IV ozone (which was not used in Perth as Sartori was not present with the machine which produced it);
    b. Mineral drip (typical drip contained caesium, magnesium, potassium chloride and trace minerals);
    c. Vitamin drip (typical drip contained vitamin C, vitamin concentrate, B12, folic acid and DMSO);

d. Vitamin A and Laetrile (Amygdalin) IV. The patient's carer was asked to give the Laetrile to avoid breaking the law.

6. Coffee enemas were also administered in some cases.

7. Repeat blood tests at intervals throughout the treatment as part of ongoing review of patient health.

8. The 'post treatment pack' which is a large number of substances to be taken orally (including oral amygdalin and caesium) recommended to be taken indefinitely.

Each patient was asked to bring a carer with them to assist.

Patients were expected to cease taking their regular medications in most cases as Sartori believed regular medications to be incompatible with his treatment. Patients were told they could not receive intravenous saline or glucose because those two substances were incompatible with his treatment. Sartori was most emphatic morphine was a particular problem.

In evidence Sartori confirmed the main principles of the treatment as outlined above. In addition he explained it was essential there be a qualified registered doctor supervising the treatment to ensure any clinical signs or symptoms associated with either the patients originating cancer or their responses to the treatment could be dealt with appropriately. This was supposed to be according to general medical principles in conjunction with the requirements of his treatment concerning for example, no morphine, glucose or saline.[29]

[29] Transcript 18.11.10, pg 865-872

Sartori was not registered in Australia and it was for that reason there were associated GPs in Darwin. Their function was to assist with the general medical side of the treatment where Sartori was not in a position to prescribe treatments such as PICC lines, or certain drugs.

Sartori was present to supervise the treatment in Darwin but relied on GPs with sympathies to alternative therapies to perform those procedures required of a registered doctor.

One aspect which was of particular importance to the treatment was the requirement all those involved in the treatment, whether they be patients, carers, family, or staff implementing the treatment, must have a totally positive frame of mind towards the benefits of the treatment.

To ensure patients fully understood how important the philosophy was to their cure there was a form of *"consent material"* provided to patients which also contained an indemnity for named persons and was generally required to be signed by them.

Throughout the documents collected, both in Darwin and the Perth patients, there are a number of versions of the *"consent material"* which have varied slightly over time due to the inclusion of different staff in the indemnity format. However, the substance of the consent materials is the same and the inquest used that provided by Mr McCarty as the main

example for the purposes of the inquest. This was given to Mr McCarty to sign, which he declined, but retained his copy.

It is a good example of how philosophically patients and their carers were taught to believe in the treatment, and that any adverse outcome from the treatment was their *"fault"* because they had not believed strongly enough in the treatment.[30]

CONSENT MATERIALS OF SANDRA McCARTY[31] – See Appendix 1

In evidence[32] Sartori agreed the wording of the principles and philosophy for the treatment were his. In summary, the materials claim a five year survival rate for patients with terminal cancer with wide spread metastases, who had exhausted conventional treatment, at 40-50% if they survived the first three weeks after treatment, and up to 60% if they survived three months after treatment. It said their chances of surviving longer were increased if the patients faithfully followed a three week pre-and three month post-treatment program provided they:

> *" (i) Closely followed the program;*
> *(ii) Live to achieve their purpose in life;*
> *(iii) Do not return to your old destructive habits, false friends, unhealthy diet and lifestyle; and*
> *(iv) You Let go of all losses you may have suffered and all of which co-caused your cancer or other degenerative disease, to begin with. The success of our treatment is entirely up to you and may approach 100% barring late complications of chemotherapy etc."*

[30] Exhibit 36
[31] Volume 1, Tab 13
[32] *Transcript 18.11.10, pg 819*

It would be fair to say some of the families of those who have died still believe much of the *"evidence"* quoted by Sartori as supporting his claims for the success of his treatment and are perplexed when provided with information which would seem to dispute his claimed success rate. These people clearly *"believed"* to the requisite standard, but still did not survive.[33]

The material refers to the program as *'by far the most effective acute and long-term health care available to all of humanity'* and says *'even the most dying terminal patients may be restored to permanent wellness, to the degree to and for as long as they are willing to follow the program'*. It claims *'if you completely (and as long as you) follow our program you have an excellent chance of permanent recovery no matter what kind or stage of cancer you have'*.

Overall the material gives the impression the treatment has a very high success rate in curing cancer and that this claim is backed up by substantial scientific studies. It implies the treatment will be delivered in a professional setting by professional people and that the treatment has minimal side effects and risks.

In many forms of the documentation a success rate for cure is given as 95-98% provided the patient truly believes in (and pays for) the treatment.[34]

[33] Transcript 10.11.10, pg 567 & pg 579
[34] Transcript 30.8.11, pgs 1162-1166

On the basis of these materials five patients were treated in Darwin by KPMHC in November/December 2004, two in January 2005, two February 2005 and two in March 2005. An additional patient was treated by Sartori, Keith Preston and Sheena Sindholt (cook) in Thailand in March 2005.

None of these patients were cured of their cancer, all suffered serious side effects and a number became very unwell and had to be hospitalised during the course of their treatment. These were explained by Sartori to be usual responses, healing crises, the body freeing itself of cancer, or of no concern.

Mention has been made of Lesley Bramston, a Victorian patient who died in Darwin in November 2004. Police became involved at the time of her death but were informed she had not received any treatment. As a result her doctor in Victoria wrote a death certificate, on the grounds she had not commenced the alternative treatment. Later, when other deaths were reported the matter was re-investigated and it would appear she had been given some of the treatment at least, at the time she died. The treatment was in Darwin and involved ozone which was not used in the Perth clinic.

Of more relevance to the Perth May 2005 KPMHC was a Perth patient, Genevive Bond. Mrs Bond was treated in Darwin by KPMHC in March 2005. She had been a patient of Dr Alexandra Boyd in Perth.[35]

[35] Transcript 4.11.10, pg 344

Genevive Bond was diagnosed with breast cancer in Perth in 1992 and had elected not to have conventional medical intervention. Her surgeon believed it had been present for some years at the time he diagnosed it. She survived with her cancer for a long-time.

She had a visible external cancer mass. On commencing treatment in Darwin, Genevive Bond's mass was rubbed daily with DMSO and at a later point fell off. Genevive Bond and the KPMHC staff saw this as evidence the treatment had *"killed"* her cancer.

When Genevive Bond returned to Perth she returned to see Dr Boyd and told her about the treatment and the external tumour mass falling away. Dr Boyd was very impressed with the treatment, however, in evidence indicated she did not see the external mass falling away as having cured Mrs Bond's cancer. Indeed Dr Boyd ordered tests from the tumour site in June 2005 and those tests revealed Mrs Bond's tumour was still present and active.

Mrs Bond was very active in May 2005 in promoting the treatment. This is entirely understandable.

In a statement taken from Mrs Bond in June 2005 she had this to say about her wish to try Sartori's treatment –

> "*Heard Dr Sartori was travelling to Darwin to administer a treatment program involving the use of caesium in March*

2005. I was interested in trying the caesium treatment and I preferred that it was administered under supervision. I knew that Dr Sartori was an expert in this area so I made the decision to travel to Darwin to undergo the treatment. I had about 50-60 pages of information in relation to this treatment. I was provided with more information by Dr Sartori and I was required to sign an indemnity form prior to staring the treatment. I also provided Dr Sartori with all of my recent medical tests. The cost of this program in Darwin was $30,000."[36]

The information provided by Sartori about the benefits of the caesium treatment was significant in Mrs Bond's mind. Her husband described how unwell his wife was when he reached Darwin a day later. He described her as vomiting with diarrhoea, that she had lost a lot of weight and become very weak. She was having difficulty keeping any food down and it got to the stage where she had to be fed by way of a feeding tube to ensure she was retaining some nutrition.

Mr Bond confirmed the expectation there would be diarrhoea and vomiting; in Keith Preston's words the treatment was *"harsh",* however, all patients and carers were advised the vomiting and diarrhoea experienced as a result of the intravenous caesium was an expected side effect of the treatment. Mr Bond confirmed that while they were not convinced his wife's cancer had been *"cured"* they were certainly very happy with the progress of the treatment and its result when the tumour fell away.

[36] Transcript 4.11.10, pgs 344-345

Mrs Bond died in Mexico in 2008 as a result of complications from her breast metastases.

It was Genevive Bond's treatment in Darwin which first made Dr Boyd aware of KPMHC.

Sartori returned to Thailand in March 2005 to treat a patient and was due to return to Australia in April 2005 because more patients were arranged for the Darwin clinic, many through the relationship with Paul Rana.

Sartori was refused entry into Australia on 27 April 2005 and returned to Thailand. However, his computer was seized at the time which revealed he had been present in Darwin at the time of Lesley Bramston's death. It was at this stage the Lesley Bramston matter was again referred to the Northern Territory Organised Crime Unit for investigation.

Gerald and Sandra McCarty arrived in Darwin with their daughter Renee for Sandra McCarty to commence treatment on 29 April 2005.

The McCartys met up with Keith Preston and Simone Phasey at the Boomerang Motel to discuss Mrs McCarty's treatment and at the same time Paul Rana called their other daughter, Natalie, angry because Mrs McCarty had already travelled to Darwin, without his input.

KPMHC then commenced Mrs McCarty on the pre-treatment pack by giving her oral caesium at the motel, and blood samples were taken for the initial blood work to be prepared. The McCartys were told Sartori had gone on holiday and was having difficulty with his visa. It was while KPMHC were trying to commence pre-arranged treatments they were also involved with trying to organise a suitable venue where there would be an Australian registered doctor willing to supervise the treatment.

In Darwin the two GPs who had been monitoring the conventional medical health of patients during treatment were not prepared to continue in the absence of Sartori on site for the administration of the treatment. As a result KPMHC needed a replacement for Sartori, as well as a registered Australian doctor, to treat patients already started on the treatment pre-packs.

I have to assume Dr Boyd was necessary, and therefore the move from Darwin to Perth was necessary, because Dr Boyd was prepared to have more input with the day to day supervision of the patients receiving treatment in Sartori's absence, than were the GPs already involved in Darwin.

Sartori agreed it was part of the treatment that, where necessary, conventional medical care is available to care for individual patients. [37]

[37] Transcript 18.11.10, pg 869 & pg 872

To enable that to happen the locally registered GP would need to know the treatment involved substances such as caesium, and should understand some of the symptoms associated with caesium treatment, which may need conventional medical input.[38] Satori understood caesium could cause seizures but no-one else involved with the treatment was prepared to acknowledge that a *"healing crisis"* may well be a toxic side effect of the treatment.

Contact was made with Dr Boyd who agreed to assist with the High pH treatment in Sartori's absence.

It is not clear whether or not negotiations were had directly with Dr Boyd or her Practice Manager, Jo Firth.

Once those arrangements were finalised between KPMHC, Dr Boyd, and her Practice Manager, Jo Firth, arrangements had to be made for patients in Perth. Dr Boyd, and her business, were to receive approximately $35,000.

Patients had already been arranged to travel to Darwin for the treatment by Paul Rana. KPMHC was faced with the prospect of having to move those patients who were already in Darwin to Perth, as well as advising any expected patients to travel to Perth, instead of Darwin.

[38] Transcript 18.11.10, pgs 865 – 867

KPMHC/PERTH

There were seven patients accompanied by carers as follows:

Interstate/overseas patients.

1. Sandra McCarty with Gerard McCarty (husband) and Natalie Squire (daughter). Her mother was also present;

2. Deborah Gruber with Philip Gruber (husband);

3. Pia Bosso with Sandra Hoffman (niece);

4. Daryl Green with Marjan DeWilt (friend, registered nurse);

Local patients

5. Sandra Kokalis with Nikolaos Couanis (husband) and Ramoh Kokalis (son);

6. Carmelo Vinciullo with Vincenza Vinciullo (mother);

7. Antonio Ranieri with Assunta Ranieri (wife);

The KPMHC arranged for the interstate/overseas patients, carers and staff to stay at the Mosman Beach Apartments at 3 Fairlight St, Mosman Park. Local patients stayed at their own homes, other than Carmelo Vinciullo, who commenced treatment while staying at the apartments.

Every day the patients and carers would go to Dr Boyd's house to receive the IV treatment.

The people who had input with KPMHC in Perth were:

1. Sartori was communicating by e-mail /web-cam /phone;

2. Keith Preston (founder of KPMHC);

3. Simone Phasey (RN registered in NT but not in WA at the time);

4. Dr Alexandra Boyd;

5. Merrilee Baker (RN registered in WA and brought in by Dr Boyd);

6. Joanne Firth (Dr Boyd's practice manager);

7. Sheena Sindholt (cook who assisted Keith by preparing food for the patients);[39]

8. Covianna Young (former distributor for Neways International who worked with Paul Rana and was asked by him to assist with massage for the Perth patients)

There are difficulties knowing exactly what happened during the clinic as there was poor record keeping by Nurses Phasey and Baker, and Dr Boyd did not keep any records at all.

The WA police seized the KPMHC records for the seven patients on 26 May 2005 from a car being driven by RN Baker. They do not contain the detailed information one would expect in records for patients receiving intravenous therapy. However, I accept they are accurate in the details they do record. In evidence are e-mails which passed between Ms Phasey and Sartori during treatment, and were taken from

[39] I have no doubt the nutrition provided to patients by way of pureed fruit, vegetables and proteins was beneficial to those suffering from inadequate nutrition due to a lack of appetite, nausea and vomiting. However the ability to absorb the nutrition provided was largely compromised by the treatment itself.

their computers at a later date by police. These give a large amount of additional information about what was occurring.

Also in evidence are hospital records about patients which record information given to hospital staff by family and, at times, by KPMHC staff. I have before me statements made by patients in some cases, and family members to police at the time and later, and information given by KPMHC staff to the police in interviews at the time. Finally I heard oral evidence from family members and KPMHC staff which had the obvious disadvantage of being taken many years after the deaths occurred.

DR BOYD

Dr Boyd is a GP who qualified as a doctor in approximately 1980. She was registered with the Medical Board and has always been interested in alternative therapies.

Dr Boyd has worked overseas in many commendable organisations attempting to provide some level of medical care for severely disadvantaged populations in third world communities. I have no doubt she was a compassionate and caring person who wanted to help people.

Her interest in alternative therapies included running a thermo-imaging clinic in Mosman Park. This is a very controversial area in the medical world with respect to its relationship with breast cancer. At the time of the move of KPMHC from Darwin to Perth she was extensively involved in

providing conventional locum coverage for GPs in conjunction with her thermo-imagining clinic.

Her clinic had an administrator, Jo Firth, who appears to have been prepared to oversee the business side of Dr Boyd's practice. I am concerned this was a very inadvisable move on Dr Boyd's behalf, in that, she appears to have trusted Ms Firth implicitly by believing Ms Firth's interest would always coincide with her own.

The inquest did manage to summons Ms Firth to provide evidence for the purposes of the inquest. I found Ms Firth to be both an incredible and unreliable witness. I suspect Dr Boyd was very foolish to allow Ms Firth such control over the business aspect of her clinic. Two cheques were paid to Dr Boyd and her business for her participation in KPMHC.[40]

I am of the view, however, Dr Boyd must have known more about the purposes and requirements for KPMHC at the time of the move to Perth than she was able to recall in 2011. I have no doubt, with hindsight, Dr Boyd is extremely stressed over the outcome of the treatments administered at her home by KPMHC.

My biggest concern with Dr Boyd is I simply cannot accept she did not know that part of the treatment involved the

[40] Transcript 31.8.11, pg 1286

administration of caesium and laetrile along with other questionable substances. [41]

The fact she arranged for PICC lines for some patients, was supposed to review medical histories prior to treatment to appraise herself of the status of their illness, (which she denied) and provided referrals for ongoing blood tests satisfies me Dr Boyd knew more about the treatment than she is now willing to accept. [42]

The biggest dilemma when considering the evidence of the nurses and Dr Boyd is reconciling how well meaning human beings and health care practitioners, could allow patients to continue with the treatment, when so obviously confronted with indicators it was making the majority of the patients, under their care, extremely unwell.

Simone Phasey consistently stated she felt she was not getting the support she needed and it was clear she meant this was from Dr Boyd in Sartori's absence. I suspect Dr Boyd's attempt to distance herself from events was because she had understood some of the risks involved but hoped an alternative therapy would succeed in providing a new cure for cancer.

I do not believe Dr Boyd was as involved with conventional medical care during treatment as she should have been from the perspective of appropriate conventional medical input for

[41] Transcript 21.9.11, pg 1750 & 1771
[42] Transcript 20.9.11, pg 1673

people undertaking a risky therapy. Nor do I believe she was as little involved as her memory of events would now indicate.

I accept Dr Boyd was working away from her home for a lot of the time but am satisfied all the families involved in the May 2005 clinic remembered her presence and her assisting, to some extent, with the conventional medical aspects of the treatment. It is not my concern with Dr Boyd administering the treatment that is the problem, it is my concern she did not use her conventional medical knowledge to prevent continuation of treatment with patients who were clearly suffering, and not experiencing *"healing crises"*.

I accept Dr Boyd advised Mr Vinciullo to desist from further treatment, which was the correct conventional medical advice. I do not understand, if she was doing conventional medical review properly, why she allowed him to start in the first place.

As I understand the evidence of the experts Mr Vinciullo's scans differed little before or after the treatment. If Dr Boyd was of the view the position of Mr Vinciullo's tumour was such it was dangerous for him to continue, that must have been the case at his commencement of the treatment.

I am concerned it was the philosophy of *"belief"* in the treatment which prevented Dr Boyd from acting in a patient's best interest, against the treatment, which had the most influence in her care. It seems it was only when she was

directly asked about the treatment (in Mr Vinciullo's case) outside the confines of the May 2005 KPMHC/Perth she was prepared to say she believed it would be dangerous to continue.

MERRILEE BAKER

Merrilee Baker completed hospital-based registered-nurse training at Sir Charles Gairdner Hospital (SCGH) in 1979. She has been registered continuously since then, working as a registered nurse in a wide variety of areas including hospital ward work, community health, home visiting, remote area nursing and child health nursing.

In 2003-4 she had worked on night duty for a year on an acute assessment ward at SCGH. She also wrote curriculums for the AMA component for health training in the areas of occupational safety and first aid, and for the Nurses College of Australia in the areas of chronic lung disease and complementary medicine. She delivered first aid training for the AMA.[43]

In May 2005 she was registered in Western Australia and had experience with giving intravenous treatments.

At the time of the inquest in 2010 – 2011 she was doing honours in nursing looking at Aboriginal Child health, and she had a post graduate diploma in child and family health, a

[43] Transcript 12.11.10 pgs 748-9

post graduate diploma in narrative therapy and community development.

She was working for Child and Family Health which is part of Children's and Women's Health Service in South Australia as a child and family health home-visiting nurse. She was delivering a targeted parenting program to people at risk.

At the time Merrilee became involved with KPMHC she had known Dr Boyd for approximately seven years prior to 2005. She and Dr Boyd went to a gym together and found themselves at a number of conferences in relation to alternative or complementary therapies in which they were both interested. Some of those conferences were about cancer and were often organised by companies involved in selling natural products.

RN Baker had a very high opinion of Dr Boyd's skill, professionalism, empathy and caring. She believed Dr Boyd was passionate about helping people and they had both been presenters at a workshop on ADHD. That was the only time they had actually worked together. RN Baker considered herself and Dr Boyd to be friends.

RN Baker believed she was contacted by Dr Boyd in late April 2005. This would have been before KPMHC moved to Perth but at about the time they were negotiating the move from Darwin to Perth. KPMHC needed a nurse registered in Western Australia which Simone Phasey was not. It was

considered there would be too much work for Simone Phasey to do all the nursing by herself. Originally they were only considering the treatment for 2-3 patients.

RN Baker was told they really needed a nurse and could she assist. She recalled being told about one of Dr Boyd's patients who had the treatment and for whom it had been really successful. RN Baker said she was influenced to become involved in the treatment due to her trust in Dr Boyd's judgement and by the fact a patient had undergone the treatment and had apparently miraculously recovered.

RN Baker flew from South Australia to Perth, at short notice, and was introduced to Simone Phasey who told her it was Sartori's program, and he would be supervising it. RN Baker thought Sartori would still be coming, but later understood Sartori was going to supervise it from overseas. She said to her it was like a *"standing order protocol",* in that, Simone would be in contact with him the whole time and he would be supervising it. She considered it similar to remote area nursing.[44]

RN Baker was not concerned about the integrity of giving medication on orders from someone not in Australia, who may not be registered, because she had no doubts he was an expert in his field, and it was her understanding they were providing the patients with minerals and vitamins. RN Baker

[44] Transcript 11.11.10, pgs 701-2

said she put it in the same category as vitamin C therapy, or maybe collation therapy, and saw no danger in it.

RN Baker said she did not recall doubting anything to do with the treatment and that the atmosphere was of hope, an infectious hope. No-one thought there could be anything dangerous or there were any problems with the treatment. RN Baker indicated she had no regard for her legal liability at the time, and because she felt the substances being given to the patients were safe, and because Sartori was overseeing it, and because Dr Boyd could be called immediately if something was wrong, she had no concerns at all for the welfare of the patients.[45]

As far as RN Baker was concerned she would not have been involved with anything illegal, nor did she believe Dr Boyd would have been involved in anything which was illegal.

RN Baker acknowledged in 2005 she had a very negative view of chemotherapy, radiation therapy and surgery for cancer. She could not recall ever actually administering any treatment. I speculate RN Baker was adversely affected by the outcome of events in Perth, and is largely in a state of denial as to her knowingly being involved with some of the events which took place.

I also believe as conditions at 16 Beagle Street, Mosman Park, deteriorated, RN Baker became increasingly overwhelmed by

[45] Transcript 11.11.10 pg 702

the atmosphere of pioneering an alternative to conventional medicine and did not really have time to question what she was doing.

However, I found her inability to equate the effects of too much potassium, or too little potassium, with the substances she must have been involved in administering, when she had only months earlier been involved in an acute assessment ward at SCGH, baffling.

CREDIBILITY, RELIABILITY AND WEIGHT

It was important to hear evidence from as many of the people concerned with the operation of KPMHC as possible, to try and put the documentary evidence seized by police in all jurisdictions into some sort of context.

Consideration of:-

- the papers promoted by Sartori on the internet, or in the consent documents, as to his alleged successes in curing cancer for those who believed enough;
- in conjunction with the medical files of the treatment given at 16 Beagle Street, Mosman Park;
- along with the hospital records of what actually happened when Sandra McCarty, Pia Bosso, Sandra Kokalis, and Deborah Gruber died;

present a horrifying picture akin to emotional blackmail and torture, for which people paid, if not understood in context. For this it was necessary to hear from those promoting,

administering and involved with the treatment on a daily basis.

It was necessary to hear from as many of those present as possible due to the need to weight the evidence appropriately as to its reliability and credibility.

Witnesses who believe passionately in their perspective of the evidence are usually credible when giving evidence. It is necessary to examine that evidence against other evidence, to understand the reliability of an individual's evidence, no matter how credible they may be.

It was certainly important for the interests of justice, which in an inquest is aimed at discovering the true facts of what happened, I hear the evidence of as many of the participants as possible.

It was only by hearing evidence from Simone Phasey, Merrilee Baker, Keith Preston and Alexandra Boyd I could make any attempt to establish a version of the facts in context with what the families remembered, and the positions Keith Preston, the two nurses and Dr Boyd took by the time police became involved.

I needed to understand the perspective from which they became involved to make any attempt at trying to understand what actually happened. This included how two nurses, who I accept were dedicated, and a doctor, who has worked in

famine ravaged populations, could continue to be party to a therapy from which people were suffering to the extent of dying, without questioning their involvement.

I have come to the conclusion Merrilee Baker came closest when she said, speaking of their faith in Sartori.

> *"His belief in his work is almost like what I've experienced in religion, almost cult like, where your belief, your faith is so strong".*[46]

It was because I needed to try and determine the facts of who knew, and did what, I was prepared to issue Section 47 certificates for those who asked. It was only by hearing all the evidence and understanding the perspective from which it was given I could make any attempt to understand the continued involvement of the two nurses and Dr Boyd in particular.

I stated at the time, I considered it necessary in the interests of justice to hear their evidence and I am still of that view. I also said the issuing of certificates did not mean I accepted their evidence in full. I stand by that position.

It was only by hearing all the evidence I could hope to be in a position to determine where the truth might lie; and why it might be some participants may find it difficult to now acknowledge, and understand, how much harm may have

[46] Transcript 12.11.10, pg 806

been done in reality, when their hopes and aims were so much at odds with what the reality turned out to be.

TREATMENT IN PERTH

Once it had been finalised the treatments would be undertaken in Perth, as opposed to Darwin, the McCartys flew from Darwin to Perth on 8 May 2005 and stayed in a hostel pending arrangements being made for their accommodation with other patients. Sandra McCarty had a PICC line inserted at Hollywood Hospital to enable her IV treatment to commence.

On 9 May 2005 Ms Firth made reservations for the Mosman Beach Apartments at 3 Fairlight Street, Mosman Park, and Sandra Kokalis went to see Dr Boyd at Unit 3/636 Stirling Highway, Mosman Park, as a preliminary for her commencing the treatment and requiring blood tests. Originally it appears treatment was to have been at the Stirling Highway address, however it seemed for some reason a decision was made it would be more appropriately administered at Dr Boyd's home at 16 Beagle Street.

The treatment to be administered at 16 Beagle Street largely conformed to that set out earlier in this finding (pg 26), with the exception of the use of ozone.

Keith Preston and Simone Phasey travelled to Perth with Sheena Sindholt, on 10 May 2005, and were accommodated at Unit 5 at the Fairlight Street apartments. They had further

discussions, apparently with Jo Firth, that Dr Boyd was to oversee the treatments, order tests as she had been already and provide Merrilee Baker to assist.

On 11-12 May 2005, Sandra McCarty went to see Dr Boyd at the Stirling Highway clinic to show her the scans of her cancer. Ms McCarty no longer had her daughter Renae with her, but her other daughter, Natallie Squire, had arrived instead to be with her parents.

Dr Boyd could not recall preliminary reviews with patients and Mr McCarty confirmed that although they had provided scans and medical histories he could not recall anyone actually receiving them on behalf of KPMHC, although they had seen Dr Boyd. As far as they were concerned Dr Boyd was part of KPMHC. She was represented as such, included in the indemnity materials as such, and they relied on her presence as a conventional medical practitioner as an incentive to undertake the treatment.

Pia Bosso also arrived in Perth for treatment on 12 May 2005 and was accommodated at the apartments. There was some concern because Mrs Bosso did not have anyone with her to take the place of a carer. This entailed one of the KPMHC staff administering laetrile. This seems to have been an issue of concern with Mrs Bosso and indicated a consciousness with KPMHC staff as to the protocols in place under Australia legislation

Once the patients and premises were in place the treatment commenced. The following summaries relate to the individual patients and their treatment and have been collated from the documentation seized from a car, the recall and statements of patients, families and carers of the patients during this period of time, the evidence of those representatives of KPMHC interviewed by police at the time and from whom we heard evidence, and patient hospital records.

		SUMMARY TIMELINE
14 May 2005		Commencement of IV caesium treatment in Perth at the home of Dr Boyd, 16 Beagle St, Mosman Park – Sandra McCARTY, Deborah GRUBER, Sandra KOKALIS, Pia BOSSO, Antonio RANIERI
15 May 2005		Daryl GREEN arrived in Perth from SA for commencement of treatment; undergoes CT scan, blood test, blood transfusion and PICC line inserted at request of Dr BOYD
16 May 2005		Daryl GREEN and Carmelo VINCIULLO booked into Fairlight St apartments
19 May 2005		Sandra KOKALIS has seizure, admitted overnight to Joondalup Health Campus for urinary tract infection(?)
20 May 2005		Commencement of IV caesium treatment in Perth - Carmelo VINCIULLO, Daryl GREEN, Vinciullo pays $40,000 to RANA for the treatment (raised by fundraisers) VINCIULLO instructed to cease all pain medication "cold turkey" but does it gradually instead. VINCIULLO referred for blood tests.
24 May 2005		Paul RANA arrives in Perth to observe treatment
	Evening	Sandra McCARTY at apartment – suffering oedema in legs, lymphatic massage suggested. Suffers large rectal bleed, unconsciousness. Dr BOYD called to unit and suggests calling an ambulance straight away.
	2114	Sandra McCARTY admitted to Fremantle Hospital
		PHASEY attends also and tells Gerard McCARTY and Natalie SQUIRE not to tell the hospital she had been receiving caesium or to mention SARTORI. PHASEY tells hospital staff not to administer saline, then speaks to SARTORI and changes her mind. Dr BOYD attends and speaks briefly with doctor, family then leaves
25 May 2005	0555	Sandra McCARTY passes away – death certificate issued
		Sandra KOKALIS weak after treatment – remains at 16 Beagle St, Mosman Park overnight with partner, Nikolaos COUANIS
		RANA attends 16 Beagle St, Mosman Park (says he sees VINCIULLO and persuades him to cease treatment)
		VINCIULLO's treatment ceased after Dr BOYD reviewed CT scan and x-rays.
26 May 2005	0230	Pia BOSSO collapses at apartment and is taken to Fremantle Hospital by ambulance
	0800	Sandra KOKALIS having trouble breathing. Dr BOYD called – thinks she has pneumonia. COUANIS drives her to SCGH
	0859	Sandra KOKALIS admitted to SCGH
	0910	Deborah GRUBER admitted to Fremantle Hospital
		Coroner's Office notifies Major Crime Squad regarding death of Sandra McCARTY and admission of Deborah GRUBER and Pia BOSSO to Fremantle Hospital. Police told later of admission of Sandra KOKALIS to SCGH
	0940	Pia BOSSO passes away
	2355	Police search 16 Beagle St, Mosman Park and the office of Dr BOYD at Unit 3/636 Stirling Highway, Mosman Park. Police seize medical files from Merrilee BAKER at SCGH
27 May 2005	2205	Sandra KOKALIS passes away – death certificate issued citing Sepsis, End Stage Bowel Cancer
28 May2005		Major Crime closes down treatment centre and seizes items from addresses in Mosman Park. Dr BOYD contact Natalie SQUIRE and leaves a message advising her not to speak to detectives but to speak through her lawyer.
	2250	Deborah GRUBER passes away
1 July 2005	0215	Carmelo VINCIULLO passes away

Sandra McCarty

Gerard and Sandra McCarty were from Ballarat, Victoria. Sandra McCarty was, in the words of her husband, a very loving and caring wife and mother, proud and determined, a friend to everyone. Her daughter, Natalie, said she was one of those rare souls about whom no one had a bad word to say and she lived her life with graceful elegance and kindness.

She was diagnosed with breast cancer in 1995 and had surgery, chemotherapy and radiotherapy. She went into remission. However, in 2002 the cancer was found to have returned. She received more chemotherapy which kept it in check, but by 2005 it was evident it was now spreading.

In 2005 she was provided with Keith Preston's telephone number and told people were being successfully treated for cancer at KPMHC in Darwin. The family made contact with Keith Preston, who forwarded Sartori's email address and they e-mailed Sartori, who responded with some information about the treatment[47] At that stage it was apparent conventional medical treatment was not going to cure her cancer. The family also had some contact with Paul Rana at this stage but the extent of that is not clear.

Sandra McCarty decided to have the treatment. Gerard McCarty said they were told by Keith Preston it would be

[47] Exhibit 36

supervised by Sartori and there had been successful experiences with it. He had information from Sartori saying he was registered to practise in Austria, Australia and the UK. The McCartys' knew part of the treatment was *"unauthorised"* and understood it was fairly new treatment and may be authorised at a later date.[48] Sandra McCarty's condition was worsening and the family felt they had to try something. They believed it may be their last hope of curing Mrs McCarty's condition. The family were under the impression the treatment could cure Mrs McCarty's cancer and there would be a conventional doctor overseeing the treatment.

The family ran a fundraiser and paid $32,500 to KPMHC in April 2005.

A letter written by Dr Rodney Bond from Ballarat Oncology and Haematology on 28 April 2005 indicated that when he had reviewed Mrs McCarty that day she looked clinically well. Her weight was reasonably stable, she had a liver edge and ascites as before. She had a right ovarian mass which would need to be investigated on her return from Darwin.

Mr & Mrs McCarty and their daughter, Renae, flew to Darwin on 29 April 2005. While they were in Darwin their other daughter, Natalie Squires, received a telephone call

[48] Transcript 3.11.10, pg 220

from Paul Rana questioning why her parents had flown to Darwin without negotiating through him.

Mrs McCarty had blood tests and was given the pre-treatment pack substances with instructions for her to take them three times a day. For seven days, three times a day, Keith Preston came and mixed up an oral treatment for Mrs McCarty to drink which contained caesium and DMSO. She found this oral treatment difficult, she would dry retch, vomit and belch after the treatments and Keith Preston indicated this was the correct response for effective treatment. After a few days Mrs McCarty could not eat and Keith Preston and Simone Phasey suggested a naso-gastric tube be inserted for the provision of nutrients, it being very important patients were properly fed during the course of the treatment.

In addition, Keith Preston provided Mrs McCarty mixtures of vegetables and proteins which Mr McCarty gave to his wife by syringe. One of Mr McCarty's diary entries recorded Mrs McCarty was having up to 18 syringes a day.

Although Sandra McCarty had terminal cancer, she was quite well at the start of the treatment. She had been able to walk to the plane, carry her own cases, shop and eat what she liked. However, she struggled with the oral treatment and began to deteriorate quite quickly after it began. There is some indication in Keith Preston's evidence he believed the IV treatment to be less stressful

than the oral treatment. Her treatment was still oral at this stage. Mrs McCarty became nauseous and could not keep food down, had trouble swallowing, started to bloat, and had diarrhoea. She was tired and had trouble sleeping. She lost a lot of weight and she was craving food items she was not allowed, although there is some indication Sheena Sindholt did attempt to provide acceptable alternatives.

Mrs McCarty had been taken off all her regular medications by the KPMHC. This included diuretics. She was informed the diuretics and any other regular medication would interfere with the efficacy of the treatment.

While in Darwin the family were told Sartori had been banned from Australia and instead of treatment in Darwin, there was an opportunity to be treated in Perth because there was a general practitioner who would oversee the treatment in Perth. Mr and Mrs McCarty flew to Perth on 8 May 2005 with Natalie Squires' husband who had come to assist them. Renae returned home.

Once in Perth the McCartys stayed in a hostel while arrangements were made for accommodation by KPMHC and Mrs McCarty had a PICC line inserted at Hollywood Hospital. Although they had brought all Mrs McCarty's medical reviews and scans there is nothing in the KPMHC records to indicate they were assessed.

The McCartys transferred to Fairlight Street apartments when KPMHC flew to Perth and were there from 10 May 2005.

On 13 May 2005 Sandra McCarty was seen by Dr Boyd in her surgery and had thermoimaging done. Mr McCarty could not recall anybody from KPMHC reviewing their own scans or history they had brought with them.

On 14 May 2005 the intravenous treatment started at Dr Boyd's house. It lasted for about 4.5 hours a day and she had blood tests done every few days. This was to measure her organ functioning which she was informed initially had been non-existent. She had already been on seven days of the pre-treatment pack.

Mrs McCarty knew the IV treatment would cause vomiting and diarrhoea, which it did. She is recorded as vomiting up bile. Mr McCarty referred to how stressful the treatment was and that his wife was up all night needing to go to the toilet and therefore very sleep deprive.

Mr McCarty commented his wife had started to develop peripheral oedema and ascites, while in Darwin. He said that when in Perth, at the May 2005 clinic, this became a lot worse. It made her extremely uncomfortable and was so bad she began to have difficulty walking.

It is clear the two nurses were aware of this and Ms Phasey conveyed it to Sartori.

On 18 May 2005 there was e-mail correspondence between Nurse Phasey and Sartori as follows:-

> *"Vomiting commenced, 10 minutes into minerals, diarrhoea continues. Both legs are very swollen with lymphoedema. Girth now 93cm. Down by 1cm. Walking is difficult due to lymphoedema. She is very weak and still not sleeping".*

KPMHC treated Mrs McCarty's symptoms with the following:-

1. Acupressure points were energised
2. She was given Passiflora incarnarta
3. The Quantron Resonanz System was used
4. She was given slippery elm
5. Caffeine enemas

Mrs McCarty's repeat blood tests, including liver function tests, were taken by KPMHC as an indication the treatment was working.

Certainly her family indicated that very initially, when the IV treatment commenced for about the first day, Mrs McCarty's skin and face appeared less drawn. However, they did not feel that improvement was sustained despite being told her liver function tests were improving.

Mr McCarty had this to say about his wife's condition:-

> *"After the first day's treatment she was as happy as Larry. She obviously felt a bit better and was excited it might have been working, then from there it was all downhill."* …, *"We got the results of some blood tests and were told that the liver function had improved dramatically, which gave us a great deal of hope, but other than that, it was all we had to go hopeful. It was obvious she was not getting better".* [49]

Mr McCarty described his wife as terribly thin, with diarrhoea and vomiting continuously. He went on to describe how bloated she became and later lost control of her bowels. He noted a little blood loss in her stools at that time.[50] He described her as being in pain and the development of a rash on her thighs. On discussing it with the staff they were made to feel it was all part of the treatment and nothing out of the ordinary.

Mrs McCarty developed blood in her bowel action after a caffeine enema, which is believed to have occurred around 20 May 2005. According to the family, Mrs McCarty's bleeding became progressively worse, and her daughter described her mother's bowel action as being *"like tomatoe soup".*[51] Ms Phasey did not agree there was frank blood in Mrs McCarty's stools. The family disagree.

Towards the end of the course Mr McCarty and his wife discussed stopping the treatment, but felt they were so close to the end they should finish it, because the staff did not seem to think there was anything seriously wrong.

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[49] Transcript 3.11.10, pg 229
[50] Transcript 3.11.10, pg 231
[51] Transcript 3.11.10, pg 27

Mr McCarty and Natalie Squires described how they felt they had to be positive the whole time, it being a requirement of the treatment patients surround themselves with positive thoughts.

In evidence Mrs Ranieri described Natalie as very distressed and crying about her mother. She would then make a tremendous effort to look happy and go back to her mother's side, chatting and smiling and being happy.[52]

Natalie remembered being very concerned about the blood in her mother's stools and continually asking the nurses about that situation.

In evidence Ms Phasey agreed she had examined Mrs McCarty's stools but did not observe any blood and believed the colour was due to the treatment.[53]

On 21 May 2005 Mrs McCarty's blood pressure was recorded as low by KPMHC staff (99/75). There is no record of any repeat blood pressure in the notes, and indeed from 21 May 2005 onward, no further blood pressure is recorded in the notes.

Ms Phasey agreed in evidence that once the treatment was underway for all seven patients, which it was by 21 May

[52] Transcript 4.11.10, pg 344
[53] Transcript 5.9.11, pg 1334

2005, she and Merrilee Baker were having great difficulty keeping up with the volume of work due to the number of patients and the sickness engendered by the treatment.

Ms Phasey stated that although appropriate records may not have been kept the nursing was up to standard. At the times she was able to, Ms Phasey took all files home at night to make them as up to date as possible, pending her discussions with Sartori via e-mail and web-cam.

Ms Phasey was adamant it was clear they needed more staff, and in the absence of additional nurses she and RN Baker worked extremely hard to provide a good quality of care. I accept Ms Phasey was quite exhausted as time progressed through the treatment due to the number and situation of the patients.

I accept blood pressure can fluctuate quite significantly, however, it is of concern Mrs McCarty's blood pressure was so abnormal on 21 May 2005, and there is no record of any observation being made from that time onwards when one considers her later death occurred after serious blood loss.

On 22 May 2005 Mrs McCarty lost control of her bowels.

The McCarty family became increasingly concerned at Mrs McCarty's deteriorating condition and repeatedly raised this with KPMHC staff. They were told the vomiting and diarrhoea was good as they indicated the removal of cancer cells and toxins from her body. The blood in her stools was not blood, but cancer cells being released from her body, which was a good sign the body was getting rid of the cancer.[54]

On 23 May 2005 KPMHC staff tried to organise acupuncture to assist Mrs McCarty.

By 24 May 2005 Mrs McCarty was sick, swollen, in pain and passing more blood with every bowel motion. KPMHC suggested lymphatic massage.[55] KPMHC staff continued to convey to the family their genuine belief there was nothing seriously wrong. Treatment continued throughout. Sartori's evidence was the ascites and bleeding in the bowel are symptoms the patient's getting *"in the healing phase"* and this was reflected in the KPMHC staff attitude to the McCartys.[56]

In evidence Ms Phasey agreed, in hindsight, Mrs McCarty was much sicker than she appreciated from her communications with Sartori. She indicated she had also

[54] Transcript 5.9.11, pg 1334
[55] Transcript 3.11.10, pg 267
[56] Transcript 18.11.10, pg 925

relied on Dr Boyd, who did not offer her any real assistance. She was therefore left with Sartori indicating the symptoms were all normal. There is no doubt Ms Phasey was influenced by this, the issue is whether or not that was reasonable in view of the fact I do deem Ms Phasey to have been an apparently competent nurse.

On the evening of 24 May 2005, the eleventh day of treatment, Mrs McCarty received a lymphatic massage at the apartments. During the lymphatic massage she was passing in and out of consciousness and passed a large amount of blood. Natalie called Ms Phasey, who called Dr Boyd. Dr Boyd arrived and indicated she believed Mrs McCarty needed to go to hospital and called an ambulance. Ms Phasey also called Sartori. Ms Phasey gave Mrs McCarty some potassium and it is likely this was following an order from Sartori.

The ambulance officer's records include the following-

> *"Patient has private nurse who has travelled with her from Victoria, Patient not taking any other meds other than natural remedies".*

The evidence is not clear as to who informed him of this. However, the family had been told not to mention Sartori's name or give any details about the therapy.[57]

[57] Transcript 3.11.10, pg 288

Mr Telford, the ambulance officer, gave evidence Fremantle Hospital had just come off bypass, and in the early stages hospitals can go back on bypass. He was concerned and asked Dr Boyd contact Fremantle Hospital to ensure they would be accepted when they turned up with Mrs McCarty. He could see she was extremely unwell.

Mr Telford said normally a doctor would contact a hospital and his impression was the hospital had not been contacted until he asked Dr Boyd to do it. He felt this was unusual.[58]

Dr Boyd wrote a letter as follows:-

> *"Dear Dr*
> *Thank you for admitting Sandra McCarty 5.11.51, a 54 year old with breast cancer, metastases and ascites. She has been having (word is difficult to read) therapy to improve her quality of life. However today she developed PR bleeding (bright red) and a rash on her L upper thigh/abdomen. Her therapy precludes saline rehydration. Alex Boyd."*

The word that is hard to read could have been natural. In evidence Dr Boyd said she believed it was *"vitamins".*[59] Neither the ambulance officer nor one of the Fremantle doctors knew what it was when asked in court. The letter clearly failed to convey the treatment Mrs McCarty had been receiving from KPMHC.

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[58] Transcript 5.11.10, pg 401
[59] Transcript 20.9.11, pg 1671

In evidence Dr Boyd stated she later went to Fremantle Hospital and explained *"she had been having other treatment but she was not aware what that treatment was"*. She said she had written *"her therapy precludes saline"* because Ms Phasey requested her to do so.[60]

Dr Boyd used an *"Australian Locum Medical Service"* (ALMS) pad and wrote *"No GP"* in the space for the name of the referring GP. All of this would indicate Dr Boyd was distancing herself from the treatment at a stage when conventional medical treatment should have been a primary consideration.

Mrs McCarty was taken to Fremantle Hospital Emergency Department. At presentation she was recorded as having a grossly distended abdomen, distended legs, an un-recordably low blood pressure and a low temperature.

The consultant, Dr Hodge, thought Mrs McCarty was dying.[61]

Dr Cubitt, the registrar, stated *"Mrs McCarty was very unwell, in pain, was bleeding from the rectum and was dehydrated"*.[62]

Treating staff discussed with her family whether she should be resuscitated in the event of an arrest. It is fair

[60] Transcript 20.9.11, pg 1671
[61] Transcript 8.11.10, pg 452
[62] Transcript 8.11.10, pg 436

to say the McCartys had not, up to that point in time, realised how unwell Mrs McCarty was. They were shocked and confused she was at such a severe point after the earlier reassurances the treatment was going well. The family had been attempting to compromise between the information given them by KPMHC staff, which to them included Dr Boyd, and the treatment the hospital wished to administer. There is an extensive nursing note with respect to this.

Ms Phasey spent time in hospital with Mrs McCarty. Dr Boyd came briefly, apparently had a quick word to, we believe, Dr Hodge, and then left.

Ms Phasey told hospital staff Mrs McCarty could not have saline on the advice of a doctor, and that she was on an intensive vitamin and mineral program. There is a note from the nursing staff indicating *"Simone Watson SRN, Nurse Special from Palliative Care from Vic"*.

There is nothing in either the ambulance, or the hospital, notes that indicates the hospital or ambulance staff were fully informed of the treatment Mrs McCarty was receiving, the fact it was intravenous and, in particular, no indication they were informed she had been having IV caesium.

In evidence both Dr Hodge and Dr Cubitt indicated that information was not of immediate concern to them

because Mrs McCarty was so unwell. If she survived her immediate presentation that information would have been important, but her condition was beyond that information being of relevance at that particular point in time.

Natalie Squires gave evidence Ms Phasey told her it would cause *"trouble"* for Sartoria's name or treatment to be mentioned, and she (Ms Phasey) knew the protocols which could, and could not, be administered at the same time as the caesium treatment. Ms Phasey would ensure the hospital only provided Mrs McCarty the appropriate treatment.

Natalie remembered it as being Ms Phasey who told her to give a false name for the international doctor, and say he came from Mexico. Mr McCarty says Ms Phasey told him not to tell staff his wife was receiving caesium.

Ms Phasey admitted in evidence she told Natalie not to mention Sartori's name initially, however, she also said she gave Dr Hodge the treatment Mrs McCarty was undertaking on a piece of paper once she realised how serious the situation was.

Ms Phasey indicated the doctors did not seem interested in that information at that time. This, on the evidence of Dr Hodge, is probably correct because it was not their immediate problem. It certainly was information they needed at some stage and there is no indication in the

hospital notes they were ever given any information to do with caesium, Laetrile, or DMSO.

Ms Phasey denied telling Ms Squires to mention a specific doctor in Mexico, and also said she assumed Dr Boyd had given the doctors the information about the caesium when she came in and talked to one of the doctors.

Dr Hodge indicated he did not recall any of that peripheral information as he was more focused on Mrs McCarty's presentation and dealing with the immediate problem. Dr Hodge also indicated he had requested the Coroners' office be advised, after the death of Mrs McCarty, the admission of Pia Bosso and another patient. He believed a situation was occurring which would require police investigation.

While I accept the progress note written by the attending nurse may have recorded matters of history slightly inaccurately, I do not believe a name would have been accidently recorded for Ms Phasey, which was in fact her maiden name. Consequently I think it likely the information in the progress note does reflect information given to the nurse. The treating nurse made an extensive entry in the ED notes because she was clearly not at all happy with the information provided by the family and *"the private nurse"*.[63]

[63] Transcript 8.11.10, pg 442

Dr Cubitt was asked to negotiate with the family about sodium (saline) and morphine.

Dr Cubitt recalled a discussion with Mrs McCarty about sodium, with reference to saline, because she was so dehydrated. Mrs McCarty had indicated she wanted the doctors to do whatever was necessary to take care of her, however, Mr McCarty intervened, presumably as a result of him being reminded about the treatment protocols, and warned his wife her sodium was too high. Dr Cubitt had to indicate the tests they had done indicated Mrs McCarty's sodium was too low. Dr Cubitt recorded the family being resistant to anything in breach of the previous treatment initially.[64]

Again, Dr Cubitt reflected the immediacy of Mrs McCarty's circumstances. She believed information at that stage about what had been in the treatment was not as relevant as what they could now give her, to save her life. Saline was one of those things.

From the conflicting evidence I think it is very unlikely the hospital or staff were made aware of the IV caesium treatment. I believe the nurses would have recorded it due to their general concern with Mrs McCarty's presentation. I accept it was not of an immediate concern to the treating doctors.

[64] Transcript 6.11.10, pg 440

Whether or not a treating doctor lost a piece of paper upon which Ms Phasey wrote more extensive details of the treatment I do not know. However, the fact of IV caesium not being mentioned would be consistent with the McCartys' recall and the lack of documentation in the hospital notes.

With respect to the dispute between Dr Boyd and Ms Phasey, I think it highly unlikely Dr Boyd would have given details about caesium. She had failed to put that information in her referral note, had not informed the ambulance officers, and I believe she was by now aware of how ill Mrs McCarty was and trying to distance herself from any involvement with the treatment. Hence her denial she knew what was being administered. I cannot accept she did not know in reality what was in the treatment being administered at her home. It was certainly not reasonable conduct of a doctor patients were relying on to provide conventional medical supervision.

While it was reasonable for Ms Phasey to expect Dr Boyd to give that information, I am of the view Dr Boyd was distancing herself from the treatment. This was causing Ms Phasey to rely on Sartori, and follow his protocols without understanding Mrs McCarty was dying.

Factually, I believe Ms Phasey told hospital staff Mrs McCarty was on an intensive vitamin and mineral program which would have been supported by the referral

letter of Dr Boyd, if anyone could have understood it. This was not an adequate description of the treatment on behalf of KPMHC. It did not convey the very large doses of questionable substances and it wrongly implied she was merely being provided with dietary, supplemental, minerals and does not refer to the large IV doses of caesium, Laetrile and DMSO.

I appreciate Drs Hodge and Cubitt did not consider this information to be immediately important, however, neither did Ms Phasey appreciate how close to death Mrs McCarty was. In view of the fact Ms Phasey did not believe Mrs McCarty was at death's door due to Sartori's questionable clinical skills, then information about the treatment should have been seen by staff on behalf of KPMHC as vital to Mrs McCarty's welfare, from the conventional medical treatment perspective.

Ms Phasey indicated she did initially confirm saline was not to be used. She also told nursing staff it was Mrs McCarty's wish not to have too much morphine.

The instruction about saline was reversed after Ms Phasey had spoken to Sartori, and I suspect once she also realised how severely unwell Mrs McCarty was. Initially, Ms Phasey was following the treatment protocols and encouraging the family to refuse consent to the various treatments needed by Mrs McCarty.

Mrs McCarty died in the Emergency Department at 5:55am on 25 May 2005.

She was 53 years of age.

The hospital was prepared to issue a death certificate due to the fact they believed Mrs McCarty to have had a GI bleed as the result of metastatic liver disease arising out of her breast cancer. They mistakenly understood she had only been receiving supplemental vitamins and minerals.

Sartoir's evidence was Fremantle Hospital had killed Mrs McCarty because they had not given her a blood transfusion.[65]

The death was reported to the Coroner on 26 May 2005 when it became clear there was more to the treatment than vitamins and minerals as the result of the presentations of Pia Bosso and Deborah Gruber to Fremantle Hospital. Mr Gruber had been forthcoming about the treatment but still insisted the hospital abide by the treatment protocols. I suspect he did not fully appreciate the implications for Australian registered medical practitioners involved with professionally questionable conduct. Unbeknown to Fremantle Hospital at that time was the fact Sandra Kokalis had also presented to SCGH on the morning of 26 May 2005.

[65] Transcript 18.11.10 pg 874-5

Because Mrs McCarty's death had not been reported to the Coroner immediately, she had been embalmed. This reduced the amount of information available at autopsy. If the hospital staff had been given full and complete information about the treatment the death would have been apparent as a reportable death and would have been referred to the coroner's office immediately. This could have provided more information from post mortem examination.

The post mortem examination was undertaken by Dr Karin Margolius, who unfortunately was no longer in a position to assist the inquest. Dr Margolius was in extensive discussions with Dr Joyce as to the relevance of the caesium in her findings at post mortem examination. Initially there was very little information with which to assess the post mortem results. Dr Margolius noted extremely high blood levels of caesium and potassium, and gave her initial cause of death as *"Wide spread metastatic breast carcinoma in association with the administration of caesium."* [66]

Once the family had returned home to Victoria, Natalie Squires tried to contact Dr Boyd to discuss her mother's death and ask whether or not it could have been prevented. She was unable to contact Dr Boyd, however, she left a message at the Stirling Highway premises.

[66] Volume 1, Tab 13

Dr Boyd rang Natalie Squire's back and left a message on their voice mail as follows:-

> *"Hello, Nat. I understand that you've been approached and I'd like you to be careful. It can be very easy to be caught off-guard. I've hired a lawyer to act on our behalf. Just tell them you're a little bit upset at the moment and you'll contact them once you've spoken to your lawyer. All right, then? Okay, bye".*

This was the last contact the McCarty family had with anyone involved with KPMHC prior to the inquest.

The mechanism of Mrs McCarty's death was hypovolemic shock from gastrointestinal blood loss. How Mrs McCarty's cancer, the treatment she received via KPMHC, and the cause and mechanism of death relate to one another was the subject of expert evidence during the 2011 part of the inquest.

Pia Bosso

Pia Bosso lived in Glenorie, NSW. She was married to Mario Bosso for exactly 49 years. Mr & Mrs Bosso had no children, however, Pia Bosso was part of a close extended family group with siblings, nephews and nieces.

Her niece, Sandra Hoffman, was residing in Perth in May 2005. She did not know her aunt was coming to Western Australia until she was contacted by Pia Bosso a day or two after she arrived. Originally Ms Hoffman was very

reluctant to be involved in the inquest process due to a promise she had made to her aunt to protect KPMHC.

Ms Hoffman remembers her aunt as a strong healthy person, who was a keen gardener and believed in herbs and natural medicines. She spent a lot of time helping people with herbal remedies and was a very creative and talented person. She was a dress maker, a gardener and an exceptional artist who had won an award for her bark paintings in Italy, and was a judge of bark painting at the Royal Easter Show in Sydney.

Mrs Bosso was a warm generous person who was remembered clearly by the other patients and their families for her bright bubbly personality. Ms Hoffman says her aunt wanted to help others with cancer, and one day wanted to open a centre for young women. Her niece believed Mrs Bosso was very anxious there be a cure discovered for cancer for the world in general. She left 2.5 million dollars to the children's cancer foundation in her will.[67]

Mrs Bosso was diagnosed with a medullary cell carcinoma of the thyroid gland in 1997. It was initially treated surgically and she also had chemotherapy. However it eventually spread to her lymph nodes and to her lungs.

[67] Transcript 1.11.10, pg 38

After her diagnosis Pia Bosso spent a lot of time seeking ways of eradicating her cancer. She sought out a variety of alternative treatments, including herbal remedies, vegetable diets, a low protein diet, buckwheat, amygdalin and caffeine enemas. She travelled to China for electro-chemical treatment in 2001, and travelled to Mexico for treatment in 2002. She also travelled to Perth to see Dr Holt for radio- wave therapy in 2004 but was advised his radio wave therapy would not be able to help her.

It is not clear how she became aware of Sartori's treatment but she made contact with the KPMHC. Ms Hoffman understood form her aunt the treatment was initially going to occur in Darwin, but was transferred to Perth under Dr Boyd's guidance.

It is also not clear what happened financially. Ms Hoffman said her aunt told her the treatment was costing her in the order of $20,000 - $30,000 and she had paid some of the money at least. This is consistent with the evidence generally as to the cost of the treatment. Keith Preston's financial records, however, do not show a payment from Mrs Bosso and it may be she did not pay before she passed away.

Mrs Bosso told her niece the treatment was not legal, and she made her niece promise not to talk to anyone if the treatment went wrong. Mrs Bosso did not want the KPMHC to get into trouble as she considered they believed

in what they were doing. She described Dr Boyd as telling her a friend had received very good results from the treatment.

Her niece described what happened as follows:-

> *"She had decided to go ahead with the treatment as she felt that it may extend her life or cure the cancer altogether and that this was probably the last known treatment she was aware of that might work. She said that she was very keen to prove that cancer could be cured. She had bought hundreds of books at home on herbal remedies, cancer treatments, et cetera. In this situation the fact that there were two medical doctors who believed in this particular treatment appeared to seal her decision to doing it"*[68]

Mrs Bosso flew over alone from Sydney and signed an indemnity on 12 May 2005. She did not have a carer with her, as the treatment required, and it is clear Keith Preston and Simone Phasey were concerned about this. They also acknowledged her desire to be treated and probably spent more time with her initially than those accompanied by a carer. Mrs Bosso was staying at the Mosman Beach Apartments along with the other interstate patients.

Mrs Bosso did not tell Ms Hoffman she was in Perth for treatment until 16 May 2005.

[68] Transcript 1.11.10, pg 40

Ms Hoffman described her aunt as appearing well when she first saw her. Her aunt had been able to fly over without assistance and, despite having had cancer for a very long time, still seemed her normal self. She was eating well and was full of energy. Ms Hoffman said the only indicators in more recent times her aunt was suffering any form of illness was a slight change in colour.

Mrs Bosso already had a port-a-cath in place which could be used for the *"serum,"* as she described it, used in the treatment. As well as describing the intravenous treatment as a serum, Mrs Bosso also advised her niece it was being undertaken in a clinic. She was very resistant to her niece visiting her while she was having treatment. Initially Ms Hoffman only met with her aunt at the Mosman Beach Apartments. She was aware other patients were staying there. Her aunt told her she had told her husband, Ms Hoffman's mother, and a friend she was going to Perth for cancer treatment, but did not make herself contactable while she was there.

Treatment for the five patients present, including Mrs Bosso, commenced on 14 May 2005. Ms Hoffman was very adamant her aunt had provided none of the substances which were to be used at the clinic having been advised by her aunt the clinic had organised everything. Presumably this means either Mrs Bosso administered the Laetrile herself, or someone from KPMHC, who must also have procured it.

Following a dose of IV Vitamin A Mrs Bosso became quite unwell and Ms Phasey described it to Sartori in an e-mail as an allergic reaction to vitamin A;

> *"Had tingling immediately on completion of Vitamin A. Tightness across the chest. Itchy oedematous rash to almost entire body. Vaso-vagul. Was caught and gently placed on the floor. Given sub cut adrenaline. BSL 13.4".*

The treatment chart for Mrs Bosso seized by police does not record any treatment of Vitamin A. It was recorded on some of the other patients' observation charts. It is not uncommon through the records for there to be differences between observation charts and treatment charts. The observation charts were not meticulously kept and are usually scant in detail. It would seem to be likely in view of the e-mail, Pia Bosso was given IV Vitamin A which was not documented. It was a standard component of the treatment.[69]

Dr Boyd was either there, or had to be called in, to authorise the adrenaline and it was provided from Dr Boyd's medical bag. There is no contemporaneous record kept of this in Mrs Bosso's chart.

The following day Mrs Bosso was recommenced on the treatment but experienced unbearable pain radiating from her port-a-cath. The infusion was stopped.

[69] pg 25 above

Dr Boyd wrote a referral note for a PICC line to be inserted at Hollywood Private Hospital on 19 May 2005. The records show Mrs Bosso gave her General Practitioner as Dr A Boyd. In the section *"Escort and Discharge Arrangement/Overnight Support"* the names of both Dr Alex Boyd and Keith Preston were listed, with a mobile number next to Keith's name. Under allergies it says *"Vit A- rash"*. This would further seem to support Vitamin A was given to Mrs Bosso but was not recorded on either her treatment or observation charts.

The KPMHC records indicate Mrs Bosso's treatment started again on 20 May 2005 and then continued to 22 May 2005.

Mrs Bosso developed nausea and diarrhoea. She became weak and lethargic. She developed shortness of breath. She started feeling very unwell, had difficulty walking and became afraid she would pass out and have a heart attack.

Her niece recalls becoming frantic at her aunt's condition in the evenings when she saw her and she began asking if she could visit the clinic with her aunt. Ms Hoffman was at that time working during the day.

The KPMHC records indicate Mrs Bosso developed an irregular pulse for periods, with three records of it being

irregular on 20 May 2005 and once on 22 May 2005. She also recorded a low blood pressure on 22 May 2005.

Following her collapse on 14 May 2005, which was believed to be related to a Vitamin A allergy, she continued to have collapses. Mrs Vinciullo remembers Mrs Bosso fainting on the second day of Carmelo's treatment, which would be 21 May 2005. Ms Vinciullo remembered nurses attended to Mrs Bosso, stated that she was okay and then continued her treatment.

On the evening of 22 May 2005 Mrs Bosso is recorded as collapsing twice. An abnormally low BP and pulse rate are recorded, and it says *"vaso-vagal episode"*. There is a record she was given oxygen.

Although it is not recorded it is clear Dr Boyd was called and she ordered an ECG. Others remember this, Dr Boyd gave evidence she did not remember, but it was *"possible"*.[70]

An unidentified ECG, taken at 8:12pm on 22 May 2005, was found by police among a bundle of paperwork. It was taken on the date and at around the time staff recalled Mrs Bosso as having an ECG, and there is no evidence to suggest anyone else had an ECG. It is consistent with Mrs Bosso being given treatment after the ECG, and Ms Phasey in her evidence confirmed the ECG dated

[70] Transcript 20.09.11, pg 1690

22 May 2005 was the ECG of Mrs Bosso ordered by, and read by, Dr Boyd.[71]

Following the ECG both Ms Phasey and RN Baker indicate Dr Boyd told them it was normal. It in fact indicated a dangerous rhythm disturbance and should have required she be urgently hospitalised.

When Dr Boyd was shown the ECG in evidence, she indicated she had not read one for a long time, did not recall this one, but believed there was an irregular beat or *"something"*.

Sartori recognised the ECG as indicating a dangerous rhythm disturbance.[72]

Mrs Bosso is recorded as being given oxygen and an intravenous push of 50mg hydrocortisone, presumably from Dr Boyd's medical bag.

In addition, Mrs Bosso appears to have been *"resuscitated"* on this occasion by pressing on the governing vessel, an acupressure point on the mid upper lip or below the mid lower lip. RN Baker says Dr Boyd showed her how to resuscitate by pressing on this point and that when Dr Boyd pressed on this point Mrs Bosso opened her eyes and responded. As a result RN Baker subsequently used it on Mrs Bosso a couple of times after

[71] Transcript 5.9.11, pg 1355
[72] Transcript 18.11.10, pg 922

she fainted and it brought her around. Ms Phasey indicated KPMHC staff showed Mrs Bosso how to press on the vessel herself, if feeling light headed, and this helped stop her fainting. Dr Boyd indicated this technique had previously been demonstrated to her and that she *"possibly"* passed it on to RN Baker and maybe she had used it on Mrs Bosso.[73]

Ms Phasey's e-mail to Sartori on 23 May 2005 states:-

> *"Didn't get to Debbie with magnesium mix, sorry, too busy with Pia…*
>
> *Had two seizure like episodes. All previous ones were more like vaso-vagul. Gave 10 mls magnesium mix. .5 adrenaline. No more episodes from 2am. N/G tube inserted this am. CT scan of brain booked for this am at 11. No treatment today".*

I have to assume Ms Phasey is competent at distinguishing between different sorts of collapses and therefore it is likely the two *"seizure like episodes"* are a different response from the two collapses recorded as occurring on the evening of 22 May 2005. Her e-mail says no more from 2:00am, and the collapses had both occurred earlier that evening. In addition the collapses are identified as *"vaso-vagal"* episodes in the notes and it is clear in the record the two seizures were not considered to be vaso-vagal episodes. Magnesium is part of Sartori's *"seizure protocol"* and it is likely to have been given in response to something considered to be a seizure.

[73] Transcript 20.09.11, pg 1687/8

The contemporaneous records indicate there had been an obvious deterioration in Mrs Bosso's medical condition which was recognised by staff and resulted in no treatment on 23 May 2005.

A CT scan of Mrs Bosso's head was ordered by Dr Boyd with a query as to whether or not she had metasteses in the brain. In evidence it was indicated by Ms Phasey this was because they had experienced a similar problem with Mrs Gruber. It confirms no one considered there was a relationship between the IV caesium in the treatment, and a possible heart arrhythmia for Mrs Bosso. The consent form for the CT scan states she has shortness of breath, and an allergy to Vitamin A. The CT scan is dated 23 May 2005 at St John of God Hospital, Subiaco. The result was normal. This is not surprising because in fact the difficulty was with her heart.

Ms Hoffman says on 23 May 2005 her aunt was feeling scared, very ill and frightened she would die. She was not sure about having the imaging done at the hospital in case she died while she was there. Ms Hoffman thought this was totally out of character for her aunt, she had never seen her that scared before and normally she was a woman who never complained. Natalie Squires remembers Mrs Bosso as complaining she was fearful she would have a heart attack.

Sandra Hoffman remembered her aunt on 23 May 2005 looking terribly ill, being unable to walk and very weak and being wheeled into the room to have the scan. She had taken time off work to be with her aunt, but Keith Preston had actually taken her to the hospital. Ms Hoffman recalls Keith Preston, Ms Phasey and her aunt having a discussion. Ms Phasey suggested the cancer may have spread to her brain and was very concerned. She suggested an MRI scan.

In a separate conversation that afternoon between Ms Hoffman and Ms Phasey, Ms Hoffman was told it was possible Mrs Bosso was reacting badly to the treatment because she had her thyroid removed, but Ms Phasey was only guessing.

A script written by Dr Boyd and signed on 23 May 2005 for DHEA 100mg, and Thyroxine capsules, has been altered to change the address from that of Dr Boyd's practise to ALMS. Sartori indicated he may have recommended the DHEA and Thyroxine.[74]

Sartori responded to Ms Phasey's e-mail by instructing Ms Phasey to *"get her back on line with CoQ10, NAC, acetyl- L- carnitine, Mg etc".* Sartori indicated he considers these substances support the heart and he suggested them for Mrs Bosso because she needed support because

[74] Transcript 18.11.10, pg 916

seizures are taxing. The substances are all part of the support pack.[75]

While the treatment was written out on 24 May 2005 there was no signature to say it had been given and no observations were recorded. The only entry relates to the evening of 24 May 2005 where a second vaso-vagal episode is recorded along with an irregular pulse. The record-keeping by this stage had become very erratic and unreliable and observations were not being recorded at all for many patients.

Ms Hoffman remembers her aunt returning to the apartments after dark from the clinic, being very tired, and saying the treatment was harsh and she had been vomiting and having diarrhoea all day. I assume from what Pia Bosso told her niece, treatment had been given on 24 May 2005 despite the problems on 22 & 23 May 2005, and the lack of record.

I appreciate conditions at 16 Beagle Street were extremely stressful by this time with the number of patients, and the level of sickness and diarrhoea reported by the carers. All carers and family members described this in different ways, but universally, with the exclusion of Mr Gruber, they were horrified.

[75] Transcript 18.11.10, pg 914

Ms Hoffman remembered her aunt complaining about the severity of the pain of the treatment. Her aunt said she was feeling very sick. She had diarrhoea from the time she had the treatment, throughout the day. Ms Hoffman said the change in her aunt was dramatic from someone who flew over as her normal happy self and looked fine, to becoming tired and in pain. She remembers her aunt getting worse and worse.

It was at this time Ms Hoffman started pestering her aunt to allow her to go to the clinic with her. Her aunt was very reluctant for her to go, saying it was horrible with people being very ill, throwing up and having diarrhoea and she did not want her niece to be exposed to it all. Eventually Mrs Bosso agreed to Ms Hoffman being with her for the treatment, as opposed to just in the evenings.

Treatment was given on 25 May 2005. This would have been Mrs Bosso's last day had she not omitted treatment on previous days. Ms Hoffman met her aunt at 16 Beagle Street. She was surprised it was at a house and not a clinic. She was told it was Dr Boyd's house.

Ms Hoffman noted many patients in the rooms sitting on chairs and beds with intravenous tubes in them and something being pushed into their veins. She understood at some stage it was apricot kernel treatment. She saw her aunt on a chair in the lounge room with another patient nearby, with a sheet hanging between them.

Ms Hoffman told her aunt this was not a clinic, it was a house. She believed her aunt was embarrassed. Her aunt told her this was where they had been taken as the clinic after their initial tests.

It would seem Mrs Bosso was one of the patients treated in the afternoons, because Ms Hoffman said she went there at about 3:00pm and her aunt was waiting to be treated. The treatment chart for Mrs Bosso indicates treatment started at 4:05pm on 25 May 2005.

The evidence of Ms Phasey and RN Baker was, once they had seven patients, they were attempting to treat them in shifts because of the shortage of staff.

Ms Hoffman says she was introduced to Dr Boyd and felt there was a *"sense of uncertainty around the house"*. She indicated *"there was definitely a feeling of worry and concern between the nurses and people aiding at the house that day"*.

Ms Hoffman was asked to insert a substance into her aunt's tube and stated she could not believe they were asking her to do that. It was explained patients' carers were helping. She refused and apologised to her aunt. Ms Hoffman believed the nurses seemed disappointed, but did it anyway. She understood at that stage it was not legal and that was why the patients' carers were doing it.

By this time on 25 May 2005 staff at KPMHC would have known of Sandra McCarty's death that morning.

Ms Hoffman recalled her aunt feeling very sick and vomiting a lot, with diarrhoea very frequently. Her aunt was very weak. Ms Hoffman asked her aunt if she wanted to continue with the treatment and she said she did. They could hear the other patients being sick and throwing up the entire time. There was a bucket in the corner Mrs Bosso was using when she vomited and her niece says the smells, sounds and conditions in the house were horrible.

It was on this day Ms Hoffman spoke to Dr Boyd herself and was told about a patient using the treatment in Darwin, with a very good response to their cancer as a direct result of the treatment.

Overall, Sandra Hoffman's evidence is her aunt was being encouraged by KPMHC staff to continue with the treatment despite her obviously deteriorating condition. She was being reassured that what was happening was just part of the process. This is consistent with the recall of other patients' carers, and the philosophy of KPMHC as outlined in all the documentation. It is also clear Mrs Bosso herself wished to continue with the treatment and to complete it. She was very anxious there be a cure for cancer.

Ms Phasey told police, when interviewed in 2005, the decision to keep treating Mrs Bosso during the day of 25 May 2005 was in her best interest. Ms Phasey believed it would have been harmful for any of the patients had they not continued their vitamins and treatment. I accept this was Sartori's view and impressed upon all those associated with the treatment, including the patients.

At 6:15pm on 25 May 2005 Mrs Bosso's observation chart records rapid slow breaths, a high pulse rate and an oxygen saturation of 96%.[76]

Ms Hoffman said the treatment continued until late in the evening. Her aunt was getting weaker and weaker and looked pale and sick. She was the last one to receive the treatment and finished the treatment. It ended about 11:00pm. Dr Boyd was present at the time, and Keith Preston, and may be one of the nurses. I do not believe this was Ms Phasey because the evidence is she was not present at 16 Beagle Street during the latter part of 25 May 2005.

Ms Hoffman recalls some discussion about what to do with Mrs Bosso because she was so unwell, was making drowsy noises but wasn't talking or walking. She did not

[76] Volume 2, Tab 9

know where she was, what was going on, and she wasn't participating in decision making.[77]

Dr Boyd did not suggest Mrs Bosso should be hospitalised.

At around midnight it was decided to take Mrs Bosso back to the apartment and Keith Preston carried her to the car, drove her to the apartments and then carried her upstairs to put her to bed.

Ms Hoffman stayed with her aunt but slept on pillows at the foot of her bed. She did not want to disturb her because she was so ill. Although her aunt was not conscious she stayed with her because the previous night her aunt had asked her to stay because she was frightened she might not wake up.

Ms Hoffman said no-one gave her any instructions or information about her aunt. She woke up in the early hours of 26 May 2005 to see her aunt trying to stand alongside the bed and gasping for air. Ms Hoffman ran next door to call for staff to help and Keith Preston and Ms Phasey came immediately. When they arrived in the room Mrs Bosso had collapsed and lost consciousness.

Ms Hoffman's evidence was when she arrived back in the room, 2 -3 minutes after she had left to fetch the others

[77] Transcript 1.11.10, pg 56

for help, her aunt was laying on her back stretched out on the floor, and not trapped in any way.

Keith Preston and Ms Phasey both insist Mrs Bosso was slumped or trapped between the bed and the wall. They implied she had been there for sometime, in that position and Ms Hoffman had not attempted to assist her because she was asleep. I do not believe this to be the case. I do not know how long she had been in difficulty but I am satisfied Ms Hoffman was awoken by her aunt upright alongside the bed as she struggled for breath. I am quite sure had she fallen before Ms Hoffman left the room, Ms Hoffman would have tended to her before she ran for help for her aunt.

The problem, I suspect, is Keith Preston and Ms Phasey considered Ms Hoffman to be a carer in KPMHC terms, because it was a requirement of their protocols a patient be accompanied by a carer. The reality appears to be Ms Hoffman had no idea about what exactly was going on and was there to support her aunt at her request, not act as a carer. There is a blame scenario in KPMHC staffs' version of events, because Mrs Bosso's carer *"fell asleep"* and did not realise Mrs Bosso had collapsed. In reality Mrs Bosso should have been in hospital and monitored as a result of the condition she was in during and following treatment on both 24 and 25 May 2005.

Ms Phasey commenced CPR and an ambulance was called. Ms Hoffman felt there was a delay in calling the ambulance. The ambulance arrived at 2:31am and the ambulance officer noted CPR had stopped by the time he arrived at the scene. He was advised CPR had been undertaken earlier but had stopped. Ms Phasey gave evidence she was busy resuscitating Mrs Bosso and doesn't remember what happened in relation to the ambulance.

The ambulance care card indicates *"a 68 year lady post cardiac arrest this evening, patient collapsed at home in front of relatives, ? down time, ? CPR attempted by family prior to arrival. She had no pulse and was not breathing."* The ambulance sheet records Mrs Bosso's medications as 'thyroxine'. There is no mention of alternative treatments, or of caesium in particular.

The ambulance officer recorded Mrs Bosso as being in ventricular fibrillation and that her heart had stopped beating. He resuscitated her and she started breathing again and had a pulse recorded. She was taken to Fremantle Hospital.

The Fremantle Hospital records state *"staying with niece, from Eastern states"* and stated *"? alternative therapy,"* and for medications list *"thyroxine"*. Again there is no mention of caesium. From those records it appears neither the ambulance officers or the hospital were made

aware of Mrs Bosso's medications and a misleading impression was maintained she was staying with relatives. Ms Hoffman had promised her aunt she would not *"tell"* on KPMHC, but KPMHC staff should have provided the relevant information to ambulance officers.

Dr Cubitt was on duty at Fremantle Hospital Emergency Department overnight 25 – 26 May 2005. She noted Pia Bosso being brought into the ED by ambulance at 3:11am on 26 May 2005 having suffered a cardiac arrest. She had a Glasgow Coma Scale of 3, was not making any verbal sounds, her eyes were not opening and there was no motor response. She was not responsive and did not improve.

On arrival Mrs Bosso's breathing was shallow but spontaneous, her pulse was 120, with normal rhythm, but decreased to approximately 60. Her blood pressure was 150/68, her pupils were non-reactive and there was no response to pain stimulus.

Dr Cubitt described Mrs Bosso as very unwell, unconscious and, in her view, probably terminal, so likely to die. Dr Cubitt said in evidence she had no information Mrs Bosso had been treated for the previous six days with high doses of IV caesium, potassium chloride, magnesium, trace minerals, vitamin C, vitamin concentrate, B12, DMSO, folic acid, vitamin A and Laetrile. She believed that information would have been

relevant to the hospital, although she was not sure whether or not it would have changed the outcome because she had been admitted to hospital at such a late stage.[78]

> *"I guess it would be fair to say in the context of how serious her situation was that wouldn't have been your primary concern at that time? --- No*".

Dr Cubitt acknowledged she did not know some of those substances, or their effects, but it would have been worth checking to see whether or not they could have accounted for some of Mrs Bosso's presentation. Without that knowledge it was difficult to understand the blood report properly.

It also appears from the entry in the notes the hospital was concerned Mrs Bosso may also have an infection in her PICC line. This is also mentioned in Dr Margolius's post mortem report.

Ms Phasey and Sheena Sindholt visited Mrs Bosso in hospital the next morning and Ms Hoffman remembers them as being beside the bed and crying. I accept staff would have been distressed. This was the second patient they had lost during treatment. It is also clear everybody believed Mrs Bosso to be a vivacious, lively person, even if

[78] Transcript 8.11.10, pg 434

somewhat strong willed. The other carers described her as a very positive person.

In evidence Sartori's view was Fremantle Hospital killed Mrs Bosso because they did not give her potassium and magnesium to counteract the potential toxicity of the caesium chloride.[79] There is no evidence the hospital ever knew, until after her death, Mrs Bosso had any potential to be suffering caesium toxicity. He also stated they should have telephoned him and he would have told them to give her EDTA because it was a calcium channel blocker.

Mrs Bosso had only been in hospital for a little over six hours at the time she died. She never regained consciousness. She died at 9:40am on 26 May 2005, on her 49th wedding anniversary.

She was 68 years of age.

In retrospect, Ms Hoffman was relieved her aunt had been in Perth at the time of her death, as opposed to Darwin, because there she would have died completely alone. At least in Perth Ms Hoffman was with her, although Ms Hoffman was extremely distressed other, closer members of her family had not been there for support.

[79] Transcript 18.11.10, pgs 875-877

When Dr Margolius performed the autopsy of Mrs Bosso, she recorded the tumour as follows:

> *"A large tumour deposit over the right side of the neck. On histology, the tumour was a metastatic medullary carcinoma from the thyroid. The tumour deposits have invaded the lymph nodes and the skin as well as the underlying muscle. No distortion or obstruction to the airways were seen. She also had multiple tumour deposits in the lungs.*
>
> *At the time of autopsy toxicological analysis was undertaken and showed markedly raised levels of caesium. The mortuary admission blood showed caesium 240mg p/litre and the potassium was markedly raised at 270mg p/litre. There was a high level of caesium in the liver. Caffeine was also noted in the liver. The vitreous, right and left kidney and brain segments also showed high levels of caesium and potassium".*

Dr Margolius also submitted the tip of Pia Bosso's IV lines for analysis. *Staphylococcus sp.* was cultured but there was no obvious septicaemic process present. Never-the-less Dr Margolius was anxious there was a potential for septicaemia to have developed had not Mrs Bosso died from a caesium induced cardiac arrhythmia prior to the spread of the infection.

Dr Margolius reported Mrs Bosso's cause of death to be *"metastatic thyroid carcinoma in association with caesium toxicity"*.

Sandra Kokalis[80]

Sandra Kokalis lived in Marmion, Western Australia, with her partner, Nikolaos Couanis, and her son, Ramoh Kokalis. She was described by Mr Kokalis as unassuming and very loving. She was very spiritual, she enjoyed simple things and she was very kind.

Mrs Kokalis had surgery to remove a right frontal meningioma in 1995 and was diagnosed with bowel cancer in 2002, where there were already liver metastases. She had lots of conventional treatment by way of surgery, radiotherapy and chemotherapy. In 2003 lung metastases were identified and bony metastases by the end of that year.

Mrs Kokalis had numerous admissions to the Joondalup Medical Centre, and was seen in the Oncology outpatient department. She had six months of chemotherapy in 2004 and a seizure in November 2004 requiring hospitalisation. Her condition had deteriorated significantly and Dr Powell, her Oncologist, said he did not believe any further treatment would have improved her life expectancy at that point in time. He recommended she receive palliative care with Silver Chain, a community based hospice organisation.

[80] Volume 3, Tab 6

In a letter written by Dr Powell in March 2005 he stated the following:-

> *"She is not fit for any further chemotherapy and I think her management from this point onwards is going to be purely palliative/supportive. Her prognosis sadly is going to be poor and I would estimate she only has a matter of a few months to live. As a result of her debilitative state she will not be able to perform any vocational activities. She is reaching the stage where it is becoming increasingly difficult to perform her activities of daily living. She requires her partner to help her with bathing and showering, dressing and undressing, eating and drinking and to help her move around the house".*[81]

Mrs Kokalis had also sought out a variety of alternative therapies in parallel to her conventional treatment, taking a large number of non conventional tablets, including amygdalin, and undergoing nutritional therapy. In 2004 she had travelled to Mexico for treatment at the Oasis of Hope Cancer Hospital (founded by Dr Ernesto Contreras) which provides alternative therapies. She had continued to take those alternative therapies into 2005 and is recorded as being on a *"strict regime of supplemental, caffeine enemas etc:"* at the start of the KPMHC treatment.

On 9 April 2005 she had a CT scan because she was having difficulty with words and the scan showed brain metastases. Dr Powell advised her family to make her as comfortable as possible as she only had a few weeks to live.

[81] Volume 3, Tab 22, pg 53

Mrs Kokalis's son Ramoh, had met Genevive Bond in Fremantle in April 2005. Genevive Bond had spoken to Ramoh about her treatment in Darwin and that her cancer had *"dropped off"*. She put the Kokalis family in touch with KPMHC.

Sandra and Nikolaos contacted Mrs Phasey who explained she was a registered nurse and there were some *"outstanding results"* from the treatment. She explained it was done by a Sartori, from Thailand, who had developed it and was a specialist in the area. She said the treatment was going to be in Perth, under the direction of Dr Boyd, and they would be in constant contact with Sartori through the clinic.

In evidence, Mr Couanis said he had asked a lot of questions but *"the impression still in my mind was that it was very encouraging and there was no way that we wouldn't go ahead with that treatment after she explained what could happen"*[82]... *"I think the impression that I had was the treatment....she would overcome the cancer."*[83]

Mr Couanis indicated the fact Dr Boyd was involved with the treatment made him more comfortable with it, in that he had met her personally, and she was a very down to earth person who was very interested in her patients in a positive way. He thought Dr Boyd's reputation was good from other people.

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[82] Transcript 2.11.10, pg 171
[83] Transcript 2.11.10, pg 172

Mr Couanis indicated from their perspective, in view of everything Mrs Kokalis had been through and the situation with Dr Powell, there was no alternative for them but this treatment. He was not given the impression there were any risks involved with the treatment and *"it was almost like, yeah, it's going to happen and it's going to be successful, you know. It was very positive"*.[84]

On 9 May 2005 Mrs Kokalis went to see Dr Boyd at the Mosman Park surgery and was given a referral for a blood test. She was to start her treatment with the majority of the other patients on 14 May 2005. As a local patient Mrs Kokalis travelled to 16 Beagle Street, Mosman Park, for her treatment everyday, but otherwise returned home with her partner and son.

Mrs Kokalis did not need a PICC line because she already had a port-a-cath in place from her earlier treatments. She was, however, taken off all her regular medication in accordance with Sartori's regime. The steroids she was on were reduced gradually.

Mrs Kokalis had treatment everyday from 14 – 18 May 2005 (5 days).

On 15 May 2005 Mrs Phasey's e-mail to Sartori included the following:-

[84] Transcript 2.11.10, pg 173

"Oral dexamethasone reduced by 1 mg every two days, as instructed.

Today, 15/5/05, she appears more alert. Eyes look more alive. She is now, a very passive, gentle woman, who is completely trusting of the treatment her husband and son have her on. She is not unusually passive, only since her condition deteriorated. She had been having caffeine enemas at home. I have re-commenced her on those. Nick, her husband, is noticing the improvement in her already. She is able to stand briefly unaided".

Mrs Kokalis, like the other patients, vomited and had diarrhoea in response to the treatment. Overall her family remember her being up and down during the first part of the treatment.[85]

However, on 16 May 2005 her blood test results indicated her neutrophils were high, much higher than on 10 May 2005. The KPMHC observation sheet says she is *"slightly shaky"* and someone has queried whether or not she might have a urinary tract infection (UTI) on the pathology test slip. There was nothing in the e-mail exchange about this, however, Mrs Phasey gave evidence she had raised it with Dr Boyd at the time and this was Dr Boyd's writing. Dr Boyd said in evidence it was possible she wrote it, but couldn't remember doing so, and couldn't remember anything about it.[86]

[85] Transcript 2.11.10, pg 174
[86] Transcript 20.9.11, pg 1707

Mr Couanis indicated in evidence that although he couldn't remember the precise date, there was an occasion when they had not been able to return home at the end of the treatment because Mrs Kokalis was so ill she could not walk, and that she was shaky, and so they had to stay.

There is an e-mail between Mrs Phasey and Dr Sartori dated 18 May 2005 which states Mrs Kokalis had a *"shaking"* episode. The observation sheet for that date says "*shivery bowels loose"* at 4:30pm.[87]

One of the concerns with treatment via a PICC line or port is the potential for access for infection into the body. It is for this reason strict protocols are usually observed when providing this sort of treatment. It is of note the families and carers still supportive of KPMHC tend to not recall whether or not sterile protocols were used at 16 Beagle Street, however, when pushed stated they believed they were. Patient carers who are no longer supportive of KPMHC recall gloves and sterile conditions were not maintained. In particular, I note Mrs De Wilt, who was a carer for Mr Green, and also a registered nurse although she was not attending the clinic in that capacity, was quite clear she did not observe sterile protocols were consistently maintained.[88]

[87] Volume 3, Tab 11, pg 14
[88] Transcript 10.11.10, pg 577

One of the indicators for infection is a high neutrophil count, while shaking and shivering are signs a patient may have an infection.

The concern I have with the entries with respect to Mrs Kokalis is they would indicate her symptoms were not taken seriously on 18 May 2005. It is unclear when the note *"? UTI"* was written, but it would have been after the test results were received. There are no temperatures then recorded as part of the routine observations of Mrs Kokalis, which there should have been if there was a concern about infection.

This at a time when, apparently, things were not as chaotic as they became after the commencement of the additional patients on 20 May 2005. There is no mention of temperatures in Ms Phasey's e-mails to Sartori . The best interpretation I can give is the significance of Mrs Kokalis's symptoms were not picked up by KPMHC staff at the time.

Early in the morning of 19 May 2005 Mrs Kokalis had a seizure at home. Her family were extremely concerned, rang for an ambulance and she was taken to Joondalup Health Campus (JHC). The ambulance records show a call was received by the call centre at 3:54am. They were informed Mrs Kokalis had a seizure lasting less than a minute the previous afternoon and had been incontinent of urine. The only medication mentioned in that call is

dexamethasone. The ambulance officers recorded two seizures on the way to the hospital. The admission notes to JHC do not record anything about alternative treatment at all.

The treating doctor at Joondalup Health Campus was Dr Christopher Jacklyn. Dr Jacklyn described Mrs Kokalis as extremely unwell and described her condition as *"on a scale of one to 10 that would be up in the 10 range. Untreated and without any intervention we would've expected her to probably succumb to those symptoms within days to a week or so*".[89]

Dr Jacklyn listed Mrs Kokalis's problems on admission as numerous. She was hypercalcemic, she was septic and she had a systemic infection. His evidence was her underlying disease was her metastatic bowel cancer, and it was probably as a result of that disease her calcium levels were so high. He stated untreated hypercalcemia will certainly shorten life expectancy for someone whose life expectancy was already short, but more importantly it would affect her quality of life. He stated hypercalcemia interferes with a number of bodily functions and makes pain management very difficult. He indicated hypercalcemia alone can cause significant nausea, and of itself would cause significant confusion. It can lead to seizures and premature death if the level remains too high.

[89] Transcript 5.11.10, pg 383

He also said seizures were a problem because whilst unconscious more insults can be inflicted to a person than would be possible with a conscious patient. A prolonged seizure could cause brain damage or death.

In addition to the hypercalcemia, Dr Jacklyn described Mrs Kokalis as definitely septic, with a high white cell count and febrile.

Following the advice Mr Couanis had received from KPMHC,he instructed the hospital Mrs Kokalis was not to be treated with saline or dextrose as this was contraindicated by an alternative therapy she was receiving. When informed Mrs Kokalis was critically unwell, dehydrated and needed IV fluids, the family asked Dr Jacklyn to discuss the matter directly with KPMHC.

Hospital staff did their best to intervene with Ms Phasey and a discussion is recorded at 11:15am on 19 May 2005 in the notes as follows:

> *"Pat d/w "alternative" practitioner*
> *Simone (a registered nurse working in conjunction with a Dr overseas)*
> *Does not want patient to have IV dextrose or IV normal saline (family are very keen to follow her wishes with regard to patient's treatment)*
> *Agreed that using Hartmann's solution is acceptable but would also like Sandra to have magnesium (4g). I've suggested oral route more appropriate if Dr Jacklyn feels this is ok*

Patient is on oral caesium treatment and being nutritionally built up to enable increasing doses of caesium
Plan:…. Continue to liaise with Simone as per wishes of patient's family."[90]

At this stage Mrs Kokalis had already received four days of intravenous caesium therapy, however, the hospital note only records she was being provided with oral caesium. Nor does it list a number of the other substances Mrs Kokalis was receiving intravenously.

As a result of this discussion the hospital gave Mrs Kokalis Hartmann's solution intravenously to try to rehydrate her. Dr Jacklyn did not believe this was ideal in her case. An anti-convulsant medication, midazolam, had been started to stop her seizures and she was continued on sub-cutaneous clonazepam, a drug used to prevent further seizures.

The following day, 20 May 2005, Mrs Kokalis had a calcium level of 2.97 and Dr Jacklyn considered she needed either IV saline or IV glucose. He also wished to give the antibiotic, gentamicin with the normal saline. As a result Dr Jacklyn rang Ms Phasey and the hospital record he wrote at the time is as follows:

"D/W alternative therapist (her medical advisor is overseas). They have strong objections to N/S, being used, explained that high calcium is a life threatening situation and that she must have this treated. They shall phone me back re the best option of the 2 listed."

[90] Volume 3, Tab 19

In evidence Dr Jacklyn clarified there were two options by which they could treat Mrs Kokalis, one option required normal saline and the other glucose. In the interim they were continuing with the Hartmann solution.[91] Despite Dr Jacklyn conferring with KPMHC staff, a message was received via Mr Couanis that his wife was not to have either the saline or dextrose. The hospital note in response to this is recorded as *"he must speak to Dr Jacklyn in order to make informed decision re the continuation of his wife's care and that this is a life threatening situation."*

In evidence Dr Jacklyn said not only he, but the entire staff treating Mrs Kokalis, were extremely distressed they had a lady with symptoms they could, at least, ameliorate and were unable to use anything at their disposal to make her life more comfortable.

> *"And was there any reason that you could see why she should not have either normal saline or dextrose?...There was no medical reason that was apparent to me that this would be dangerous to her.*
>
> *Was there any explanation given why the alternative practitioner had a problem with those two substances?...As far as I was aware, the only explanation was it would interfere with the therapy that they were offering her, the caesium therapy.*
>
> *Ok, now, what were you told about the caesium therapy at this time?... not a great deal I was only aware – and again this is just from the notes – that she*

[91] Transcript 5.11.10, pg 383

> *was on an alternative regime and that it was – fundamentally it was oral caesium that I was told that she was having and that also she was being nutritionally built up, but that was never explained."*[92]

Mr Couanis came into Joondalup Campus and discussed the matter with Dr Jacklyn. The hospital records note the family was not willing to allow standard medical treatment and that their alternative medical practitioner was taking responsibility for Mrs Kokalis' care. Mrs Kokalis was discharged to the alternative practitioner, against Dr Jacklyn's medical advice.

Dr Jacklyn requested she, at least, continue on oral antibiotics and the alternative practitioner said they would organise an alternative to the hospital's subcutaneous pump to keep administering the anti-convulsant. The blood results were copied and sent with Mrs Kokalis and she was discharged on the afternoon of 20 May 2005.

Obviously this was an interruption in her IV treatment from the morning of 19 May through to the afternoon of 20 May 2005.

Mr Couanis gave evidence he did not believe he should tell hospital staff what his wife was being treated with because *"it might get people into trouble"* and he left the decisions in relation to the treatment to Ms Phasey after he had put Joondalup Hospital staff in contact with her. He said his wife was keen to continue with the KPMHC treatment.

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[92] Transcript 5.11.10, pg 384

Mr Couanis stated:-

> *"basically we were trying to do exactly what we were told, because we felt that would be for the benefit of the patient. We didn't have the expertise to, you know, reject or oppose what they were suggesting, because we were really in their hands".*[93]

When asked about leaving things to KPMHC and the consent documents they had signed originally Mr Couanis could not remember that in detail however, said:-

> *"It was very difficult, actually, because … you know, you have the doctors saying one thing and then you have the people running the workshop, so basically I washed my hands and I let them sort it out and whatever the outcome you know".* [94]

Mrs Kokalis's son recalled the hospital doctor, presumably Dr Jacklyn, having quite strong opinions about the appropriate treatment for his mother but ultimately they could do nothing for her cancer. He effectively stated the family went with their greatest hopes for the cure of the cancer, rather than the comfort for his mother at that time. [95]

It is apparent the discussions Mr Couanis and his son were having on behalf of Mrs Kokalis with KPMHC were

[93] Transcript 2.11.10, pg 200
[94] Transcript 2.11.10, pg 201
[95] Transcript 2.11.10, pg 219

discussions with Ms Phasey, who I have to assume was receiving advice from Sartori.

Natalie Squires, Mrs McCarty's daughter, remembered there being *"a lot of irritation at Dr Boyd's house when people found out she had been taken to hospital, Mrs Kokalis that is, as the people at 16 Beagle Street felt threatened the program would not be able to continue as the result of the intervention of a hospital"*. Natalie Squires recalled some of the KPMHC staff saying the Kokalis' should have rung them before taking Mrs Kokalis to hospital.[96]

RN Baker gave evidence there definitely was a fear in the May 2005 KPMHC/Perth of people going to conventional hospitals during their treatment, in case it then caused treatment for others at 16 Beagle Street to be terminated.[97]

This attitude is clarified when one considers the emails between Sartori and Ms Phasey. On 19 May 2005 Sartori sent a 3-step seizure protocol to Ms Phasey which outlined KPMHC staff should only involve an ambulance and conventional medicine, if seizures continued beyond two hours, or there was a cardiac or other emergency. The first step of the seizure protocol was 2-3grams of magnesium sulphate.

[96] Transcript 3.11.10, pg 2789
[97] Transcript 12.11.10, pg 779

When Mrs Kokalis arrived back at Dr Boyd's house, after being discharged against medical advice from JHC, she was given magnesium sulphate by KPMHC staff. This was clearly under instructions from Sartori who had voiced the opinion patients should not be taken to hospital unless there was an 'emergency' in his terms.

The KPMHC records indicate Mrs Kokalis' intravenous treatment then continued from 20 May 2005. She took oral antibiotics and dexamethasone but no other conventional treatment. There is a set of observations for Mrs Kokalis on 20 May 2005 on her discharge from hospital, however, there are no further observations recorded for Mrs Kokalis between 21-24 May 2005.

In addition, apart from the result of a urine dip stick test on 21 May 2005, there is nothing at all recorded as to Mrs Kokalis' clinical state in KPMHC records. In view of the fact she had been ill enough for her family to consider hospitalisation was the only opinion, this is of great concern with respect to her conventional medical care, whilst undergoing the treatment.

While I accept from 20 May onwards staff at KPMHC/Perth were working beyond capacity due to the number of patients, that fact was exacerbated by the illness of the patients. This makes it really perplexing that conventional medical treatments which would have improved patients quality of life were actively disregarded.

It is clear Mrs Kokalis was extremely unwell, and the state of the records seem to indicate a very low level of clinical care being provided to a very sick patient. It is clear KPMHC did not realise how sick she was as evidenced by later comments to police, presumably after input from Sartori.

> *"She had an infection that they gave her the wrong drugs for at the hospital and we sent them back to make sure that she got the right treatment, and they were treating a UTI. They gave her the wrong stuff that didn't work. She ended up with, I think some blood poisoning or something through giving her the wrong drugs and that's what we found out when she got the temperature and she was sick when we finished the treatment".*[98]

Ms Phasey's description of what had happened with Mrs Kokalis was as follows:

> *"She was diagnosed with a urinary tract infection, prescribed antibiotics and discharged".*[99]

These descriptions, greatly understate how unwell Mrs Kokalis was in reality. Her initial source of infection may have been a urinary tract infection but the problem was it had spread. Nothing is mentioned about the high calcium or her dehydration. This is of concern given Ms Phasey, an experienced nurse, had been told by Dr Jacklyn how unwell Mrs Kokalis was. It can only mean, while under Sartori's influence, Ms Phasey did not put any weight on the views of conventional doctors and

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[98] Keith Preston to police in July 2005, volume 9, tab 38, pg 36
[99] Volume 9, Tab 5b, pg 13

thus did not accept Dr Jackly's advice. She was instead relying on Sartori and the training he had given her in Darwin.

RN Baker gave evidence she did not know Mrs Kokalis had been diagnosed with a high calcium level, had an infection needing intravenous antibiotics, or had seizures, or had been discharged against medical advice.[100]
Similarly Dr Boyd gave evidence she did not know any of this at the time and, had she known, she would not have been comfortable for Mrs Kokalis to be cared for in her house because she was a very sick patient who needed to be in hospital.[101]

The poor record keeping after 20 May 2005, makes it very difficult to understand what was happening. However, we do know Mrs Kokalis was very unwell on discharge from JHC on 20 May 2005, and very unwell early on 26 May 2005, when she represented to hospital (SCGH) for the last time. It seems highly likely Mrs Kokalis was very unwell throughout this time and did not received appropriate medical treatment for a conventional illness which could well have been treated and improved her quality of life. It may even have extended it by relieving her body of an additional insult.

Mrs Kokalis' last day of treatment was 25 May 2005. Her husband remembers her as having markedly deteriorated

[100] Transcript 12.11.10, pg 778
[101] Transcript 29.11.10, pg 1708-9

on that day. He described her as being unable to lift her body, she couldn't stand up and she was *"totally weak"*. It was a marked change from the previous day.[102]

The KPMHC records for 25 May 2005 show some observations recorded for Mrs Kokalis. They show a BP of 101/65, pulse of 90 and respirations 39, with the notation *"very tired and weak"* at 10:00am. Later at 7:00pm a pulse rate of 75, and a respiratory rate of 36, with a notation *"PO2 96%, bowels open"*.[103] There is no temperature recorded. Such a high respiratory rate for that day without any temperature being recorded is of great concern, especially when it is understood she had been suffering sepsis which KPMHC seemed to disregard.

It is also of note she was at 16 Beagle Street at 10:00am, and still there at 7:00pm that evening. She was so unwell that instead of returning home, Dr Boyd allowed Mrs Kokalis and her family to stay and sleep on some lounge chairs.

In evidence Dr Boyd stated she believed Mrs Kokalis to have been extremely unwell, and when she came home that evening she saw Mrs Kokalis and her son in her home. Mrs Kokalis was breathing rapidly and had a fever and Dr Boyd advised them to go to hospital. However, she was told they didn't wish to move Mrs Kokalis and they would do so in the morning. Dr Boyd indicated it was

[102] Transcript 2.11.10, pg 180
[103] Volume 3, Tab 11, pg 14

obvious Mrs Kokalis had a fever but she did not examine her or take her temperature or otherwise intervene in anyway.

Dr Boyd's evidence was they then took Mrs Kokalis to hospital the following morning.[104]

In evidence Mr Couanis indicated they stayed at Dr Boyd's house that night and at about 4:00am on 26 May 2005, Keith Preston appeared. Keith Preston would have known Mrs McCarty had died, and Mrs Bosso had just been admitted to Fremantle Hospital. There was no discussion about taking Mrs Kokalis to hospital.[105]

At about 8:00am on 26 May 2005 Mrs Kokalis was having problems breathing and Mr Couanis thought she was dying because she could not breathe. He rang Keith Preston who told them to catch Dr Boyd before she left for work that morning. The impression Mr Couanis got from Keith Preston was this was a normal phase of the treatment.[106]

Dr Boyd examined Mrs Kokalis and said she thought she had pneumonia and they needed to take her to hospital straight away. Mr Couanis put Mrs Kokalis in the car as it would be quicker than waiting for an ambulance, and rushed her to SCGH.

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[104] Transcript 19.9.11, pg 1650 – 1651
[105] Transcript 2.11.10, pg 1881
[106] Transcript 2.11.10, pg 180-183

I do not accept Mr Couanis would not have taken his wife to hospital the previous evening if instructed to do so by Dr Boyd. This family was extremely compliant with anything KPMHC asked of them as was evidenced by their responses to Dr Jacklyn in JHC a few days earlier. I have no doubt, if Dr Boyd had instructed them to take Mrs Kokalis to hospital the evening before, they would have done so without hesitation.

Another significant issue at this stage was one patient was dead in Fremantle Hospital, another had been admitted as extremely unwell, and SCGH was a different venue.

Hospital records show Mrs Kokalis was admitted to SCGH at 8:59am on 26 May 2005. [107]

The emergency department records indicate a call had been taken from a GP/LMO stating a patient was expected. This was a call by Dr Boyd and taken by Dr Rogers and the entry notes say *"? pneumonia, recent UTI on augmentin, past history meningioma and cancer bowel"*. There is no record in that note of the caller GP explaining Mrs Kokalis had been receiving an alternative therapy and no record of the substances she had been given. There is no referral letter on the file.

[107] Volume 3, Tab 21, pg 34

The emergency department notes then record, presumably from the family, Mrs Kokalis had received two weeks of alternative treatment (vitamins and minerals IV) and had become increasingly unwell and drowsy. She had seen a locum that morning and been sent to hospital.

Mrs Kokalis was admitted under Dr Powell, her oncologist. Dr Powell described Mrs Kokalis' condition as follows:-

> *"I think the two main illnesses were her deteriorating cancer and severe sepsis. By that I mean she was suffering from a severe infection and the sources or sites of infection included her lungs and urinary tract....She was febrile on arrival, from memory. Her blood pressure was low and when patients present at the emergency department with a high temperature and low blood pressure, by definition they're in septic shock which is a life-threatening situation, so she was very unwell on presentation"*[108]

Dr Powell went on to describe a profound metabolic acidosis (pH 7.02), with extreme excoriation of her peri-anal area (this was noted on a number of the deceased). Dr Powell told the family Mrs Kokalis was gravely unwell and it was quite likely she would not survive.[109]

Dr Powell stated in evidence he was given some information indirectly she may have been taking substances with which the hospital was not familiar. There is a note of a distinctive aroma not identifiable to the admitting doctors. One of the concerns for the

[108] Transcript 4.11.10, pg 366
[109] Transcript 5.11.10, pg 371

hospital was whether or not dealing with Mrs Kokalis would put their staff in danger without adequate safe guards in place. However, the toxicologist did not believe this was problem and she was intensively nursed.

In addition Dr Powell was asked the following:-

> *"Now Mrs Kokalis had some of her own feeds while she was in hospital and my question is: if the substances that had been given to her had included either caesium, or DMSO would that have been relevant for you to know and would that have been of concern to you? … Very much so.*
>
> *Why? …. Well we were all concerned at the degree of her metabolic acidosis and it didn't quite gel – I mean we were wondering about alternative explanations for it and if we had known that she was ingesting substances that could've made her acidotic state worse, we would've advised her to stop those – to stop ingesting those substances and if we – in general terms if we have patients with unusual results, unusual or unexpected laboratory results, such as sudden worsening of the liver-function test or a sudden deterioration in their renal function, we politely ask our patients "look have you been taking any other medication? and quite often they will admit to taking herbs or some other substances that are not readily recognised as medical treatments and those substances may have caused the interference or temporary dysfunction of that patient's liver function or renal function. So, yes, it would've been very important to know of any ingesting of any unfamiliar substances".*

The reason for this question was the hospital notes indicate an RN, which we know was RN Baker, came that afternoon to the hospital, between the hours of 3 & 10pm,

and Mrs Kokalis' family was feeding her food supplied by KPMHC, by nasal gastric tubes.

While all KPMHC staff deny providing anything other than pureed vegetables and proteins to patients while in conventional hospitals, it is of some concern they were continuing to provide her with anything once in hospital.

Mrs Kokalis was given morphine.

It was while RN Baker was in hospital at SCGH with Mrs Kokalis, the car she had been driving was seized and searched by police. Fremantle Hospital had alerted authorities that morning to the operation of an unauthorised clinic. RN Baker had all the KPMHC patient records in the vehicle. At this time Mrs Kokalis was one of four patients to be hospitalised, and two of those hospitalised had passed away.

The toxicologist, Dr Mark Monaghan, was contacted and went to see Mrs Kokalis. He rang one of the nurses from KPMHC, it is accepted this was RN Baker, and he remembers her as being very upset and concerned about the patient and she was worried KPMHC staff may be in trouble. She gave him a list of agents administered to patients from the records she had with her. She also provided him with the names of the patients treated at the clinic, and the name and contact number of the GP overseeing the treatment. Dr Monaghan said he rang the

GP but was provided with little information. He was told the treatment regimes originated from an overseas doctor and she knew nothing about them. [110]

By 10:30pm on 26 May 2005 Mrs Kokalis was found to have a very high sodium level in her blood and a discussion about saline and dextrose arose. Even at this stage the family refused the commencement of IV dextrose as a result of instructions from KPMHC staff.

A note in the hospital records indicated the family objected to Mrs Kokalis being given dextrose, but agreed to saline.

Dr Powell said in evidence that the inability to give her dextrose affected her treatment.

> *"Her sodium level at one stage was 150. Sodium levels at that level are potentially life threatening and so when the results was realised, the evening or night doctor was requested to assess Mrs Kokalis and to do something about the high sodium reading and he has written in the notes and suggested a change of the intravenous solution from saline to dextrose which is a perfectly - which was the correct thing to do and the notes indicated that Mrs Kokalis's family refused that advice as they had been led to believe that they were not allowed to have dextrose and I think I'm correct in saying that she in fact did not receive dextrose, but I'm not sure what happened with the saline infusion but correcting her sodium to normal levels could quite potentially have had a positive impact on her outcome. It would have bought her a bit of extra time."*

[110] Volume 3, Tab 27

Dr Powell went on to explain gelofusion was administered to help raise her blood pressure.[111]

Mrs Kokalis died at 10:05pm on 27 May 2005 and on this occasion the death was reported directly to the Coroners office, although a medical cause of death had been drafted by the RMO giving the cause of death as Sepsis, without autopsy.

She was 52 years of age.

At post mortem examination Dr Margolius found two peptic ulcers in Mrs Kokalis' stomach which resulted in haemorrhage into the bowel, and markedly raised caesium levels.

Dr Margolius gave a cause of death as *"metastatic colonic carcinoma in association with caesium toxicity and gastro-intestinal haemorrhage"*.[112]

Sartori stated in evidence Mrs Kokalis had died because the hospital had not given her a blood transfusion.[113]

The mechanism of death will be expanded in the expert overview.

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[111] Transcript 5.11.10, pg 372
[112] Volume 13, Tab 5
[113] Transcript 18.11.10, pg 877

Deborah Gruber

Deborah and Peter Gruber lived in New York. Deborah Gruber was described by her husband of 23 years as the 'love of my life'. She was a woman of great religious faith, both she and her husband were practicing Jehovah's Witnesses.

Mrs Gruber had been diagnosed with breast cancer in 2001. She had a mastectomy. She developed a persistent cough in 2003 and was diagnosed with metasteses. She had chemotherapy, but the disease progressed. In May 2004 her oncologist told her he could only offer treatments which would extend her life.

Mrs Gruber was started on oral caesium while in the USA in about September 2004. She and her husband thought it was helpful, but she needed higher doses which would be preferably provided by IV caesium. They found a copy of the 1984 paper published by Sartori.

Friends in Sydney contacted the KPMHC/Darwin for them, and then visited. The friends met Genevive Bond who was also a Jehovah's Witness. The Grubers called Mrs Bond from America and she told them about the treatment and how it had caused a breast cancer tumour to die and fall from her breast. The Grubers decided to go ahead with the IV treatment, and contacted KPMHC. They arrived in Darwin in late April 2005.

Mr Gruber gave oral evidence via telephone-link from New York. He explained why they had decided to go ahead with the treatment.

> *"Okay; and did you do any Internet research in relation to Dr Sartori?---Yes, just what was on certain web sites that covered the fundamentals of the therapy. So that in conjunction with the report when we actually called Genevive - that's what convinced us that that might be the most effective decision and also in conjunction with the fact that we had heard some good reports of even some that were doing oral pH boosting through caesium here in this country, but again some folks not being able to tolerate the oral administration. We heard that the intravenous might avoid those side effects".*[114]

The Grubers understood the cost would be about $30,000 and they paid $15,000 (US) to Sartori directly on 6 April, and understood the remainder was to be paid after the treatment.

Once they arrived in Australia Mrs Gruber was commenced on oral treatments in Darwin. Prior to the start of the treatment Mrs Gruber had a cough, was very thin, weak and her health was "*certainly not the best*". Mr Gruber remembered RN Phasey being primarily involved with the treatment and Keith Preston assisting with the dietary part of the regime. Mrs Gruber developed seizures and was admitted to the Royal Darwin Hospital. A CT scan showed she had a lesion in her brain. This was the first time the Grubers knew her

[114] Transcript 2.11.10., pg 125

metasteses had reached the brain. Mrs Gruber was offered steroids, but refused them.

Mrs Gruber already had a PICC line in her arm from prior treatment in the States. It was difficult to determine when this had been inserted but it is relevant because of the later course of events. Mr Gruber remembers his wife having a PICC line inserted in the first half of 2004 for chemotherapy. It was stopped in late 2004. He was unable to remember if the line she came over with in 2005 was the same line, or a newer one put in specifically in preparation for Sartori's High pH treatment. He remembers knowing she would need a PICC line for the therapy.[115]

There is no documentation in the KPMHC records to indicate there was any discussion about whether or not it was appropriate to use an existing PICC line. Mr Gruber does not remember any discussion and RN Phasey said Mrs Gruber would have been sent to a particular GP before starting treatment in Darwin. RN Phasey would have expected that GP to consider whether or not an existing PICC line should be used, but did not remember whether there was anything about a PICC line. I accept Mrs Gruber would have seen a GP, it was consistent with the standard KPMHC practice, especially in Darwin. There are no records of this, nor of what that GP was told or understood his role to be.

[115] Transcript 2.11.10, pg 129

There are clear concerns with using an existing PICC line which become relevant later in the discussion with respect to the mechanism of Mrs Gruber's cause of death.

It is apparent there should have been discussion by KPMHC as to the appropriateness of using an existing PICC line and steps taken to ensure its appropriateness for use. The fact Mr Gruber nor RN Phasey can recall any such discussion tends me towards believing there was no concern on behalf of KPMHC as to the appropriateness of using, or at least checking, an existing PICC line.

The Grubers were told Sartori had visa problems and would not be able to come to Australia. The treatment was to be moved to Perth to enable it to be under the care of Dr Alexandra Boyd.

The Grubers certainly found it taxing to move Mrs Gruber from Darwin to Perth, but they did so and stayed at the Mosman Beach Apartments.

Originally Mr Gruber gained the impression his wife seemed to be doing ok and *"she had actually given me some thoughts that she was feeling better"*. He noted his wife's cough, which had reduced with chemotherapy in the States but returned later, also seemed to be reduced at the start of the treatment in Perth.

> *"So we were very encouraged about that and in fact I do remember that just within a day or two before she really took a turn dramatically for the worse even people at the clinic mentioned how good she looked and I agreed with that assessment. I thought she had a good look in the face. She wasn't feeling any pain. All in all things seem to be going well, but then, very quickly, you know, things changed one evening when she seemed to hallucinate and really change completely in her overall demeanour and yeah towards the end of that night, in which she did not sleep at all – that's when she was rushed to the emergency room".*[116]

Treatment commenced on 14 May 2005 at 16 Beagle Street. Ms Phasey e-mailed Sartori.

> *"Debbie– Aged 41, From New York. Weight 46 kg. Blood Type A. Metastatic breast cancer to both lungs and R side of brain. First seizures commenced on Monday 9th May, 2005. This is when the CT scan picked up secondaries in the brain. Had not been checked there before. Also, low potassium was noted at this time. Had R side mastectomy 2 years ago. 10 rounds chemotherapy. Severe lymphoedema to R arm, requiring pressure bandage and massage. Unable to use arm for approx 8 months. Commenced on oral caesium in Darwin. Up to 9g day".*

Mrs Gruber's treatment continued daily for 10 days up to and including 23 May 2005.

The KMPHC observation chart for the May 2005 clinic indicates Mrs Gruber had vomiting and a cough productive of thick mucous on the first day of treatment.

On 15 May 2005 Ms Phasey wrote to Sartori as follows:-

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[116] Transcript 2.11.10, pg 128

"Debbie's cough started 10 minutes into mineral infusion. The mucous is still quite thick and stringy, causes her to gag. Experiencing nausea, but no actual vomiting. Peppermint oil is helping. Loose bowels. Tumours are shrinking, especially nodes in the area of her right clavicle. Breast/armpit is softer".

On 16 May 2005 this was the e-mail to Sartori:-

"Tolerated treatment well. No tingling today. Lymphoedema to R arm increased, and nodes have also grown back. I suggested that this was due to lots of activity there. I also said that this would happen, up and down, throughout treatment as more cancer is broken down. Is this correct?
Experienced some diarrhoea last night after syringe of fresh veggie juice. Had 2 bouts diarrhoea during treatment, and vomiting very small amount of dark reddish brown fluid x 2.
IS NOT SLEEPING AND EXHAUSTED".

On 18 May 2005:

"Debbie's tumour in her breast has shrunk and gel like to touch. She too is very weak, and needs to sleep".

On 19 May 2005 Ms Phasey had a response from Sartori in the following tone:-

'Debbie; Treat the palpable tumour locally with haematoxylin-DMSO. Softening of the tumour means that a lot of the cells have died already. Sometimes a calcification in the tumour takes longer to resolve. This can be helped along EDTA in morning 4 hours before the IV".

Ms Phasey e-mailed Sartori the following:-

"Nausea/Vomiting/coughing within 12 minutes. Diarrhoea x 7, is up to toilet x 5 overnight".

On 21 May 2005 Ms Phasey e-mailed Sartori:-

> *"Lymphoedema still present. In R arm. Handling drips well. Vomit x 2 dark reddish brown fluid. Loose bowels x 5".*

Mr Gruber remembers his wife's cough improved over the first few days of the IV treatment. He could recall being told there was a positive change in his wife's progression. He understood the treatment would produce a quick change in her condition and in his mind it was confirmed by the disappearance of the cough, or her lung symptoms.[117]

Mr Gruber recalled his wife's strength lessening but he understood that would occur as the cancer died and the body had to clear the "debris"

Other patients and their carers/families also remember Mrs Gruber improving initially, then fluctuating, with sometimes being responsive, and other times not.

On 22 May 2005 Sartori's e-mail was as follows:-

> *"DMSO 25 mls, get it from veterinarian or feed store, 99%. Give her my best for her birthday".*

There is an entry in the KPMHC records with respect to Mrs Gruber, Daryl Green and Carmelo Vincuillo on 22 May 2005 which reads *"3g EDTA= 30 mls 4 hours pre infusion"* it is not clear why this was being given but it may relate to Sartori's view EDTA should be used as a

[117] Transcript 2.11.10, pg 132

calcium channel blocker for the resolution of calcification in established tumours.

Following this on about 23 May 2005 Mrs Gruber deteriorated markedly.

On 23 May 2005 Ms Phasey e-mailed Sartori:-

> *"Vomited today, green fluid. Felt different today whilst on drip. Weak, shaky and anxious. Very different to other days. Last night, much the same. Didn't get to Debbie with magnesium mix, sorry, too busy with Pia. She had oral mag instead".*

RN Baker's phone revealed a text message at 7:50pm on 23 May 2005 to Dr Boyd which stated "*Debbie fitted OK now please phone Simone*".

Mr Gruber told Fremantle Hospital staff on 26 May 2005 his wife had developed seizures over the past 2-3 days. It seems likely Mrs Gruber was having multiple seizures. There is no KPMHC record of this at all or what was done in response.

Mr Gruber described the seizures prior to Mrs Gruber's final presentation to Fremantle Hospital as self limiting.

On 24 May 2005 KPMHC observation charts for Mrs Gruber state *"no treatment"*. There is no indication why this is the case.

Mr Gruber thought it may have been she was too weak, but cannot remember the details.

Ms Phasey told police on 26 May 2005, *"I recall that we halted Debbie Gruber's treatment on Day 10 as we didn't feel that her husband, Peter, was feeding her enough at night."*[118]

Mr Gruber said he was never given the impression at the time it was his fault because he wasn't feeding his wife enough at night.[119] However, the tendency of KPMHC staff to blame patients or their carers for their un-wellness in May 2005 when talking to police was notable. I have no doubt this came from Sartori. In evidence, Ms Phasey was clear she considered this to be an unfair burden on families by 2011.[120]

Mrs Gruber's blood tests from 24 May 2005 show a raised white cell count. There is nothing in the records or observations to indicate there was any concern this may reflect an infection by way of review, temperature or other observations and assessment.

There are no other KPMHC records for Mrs Gruber on 24 May 2005.

[118] Volume 9, Tab 4, pg 6
[119] Transcript 2.11.09, pg 137
[120] Transcript 7.9.11, pg 1483

There is an official pharmacy receipt from Rock's Mosman Pharmacy in Mosman Park, for Deborah Gruber, for Chlorvescent Tablets Soluble, which appears to have been filled on 24 May 2005. The doctor is listed as provider 2235349 and the medication is oral potassium.

There is no record in the KPMHC files as to why this was ordered. There is a handwritten test result noting a blood potassium of 2.6, which is low, and there is a lot of emphasis in Sartori's written materials on potassium levels. It seems likely KPMHC considered low blood potassium to be the cause of her deterioration and gave her oral potassium to correct it.

Ms Phasey says she gave diazepam to Mrs Gruber under the instruction of Dr Boyd because Mrs Gruber was scared of nights and couldn't sleep, so it was to help her relax. Ms Phasey believed this was the evening of 24 May 2005. [121]

Another potassium level was ordered on 25 May 2005. It was an urgent house call request and collected at 12:30pm from the apartments in Mosman Park. It was ordered by Dr Boyd. It was normal. There are no further KPMHC records of what happened on 25 May 2005. I note this was the day Sandra McCarty had passed away in the early morning.

[121] Volume 9, Tab 4, pg 10

Fremantle Hospital staff were told later Mrs Gruber had not had any diet or oral fluids since Wednesday 25 May 2005.

The failure to recognise the relevance of the earlier seizures and blood test results to a need to urgently hospitalise Mrs Gruber can be explained by Sartori's view of seizures, which is they were an expected part of the "*healing crisis*".

Sartori gave evidence as follows:-

> *"Do you remember Deborah Gruber having seizures in the last days of her treatment?---Which, as I said, one would expect as part of the - - -*
>
> *Okay. So that would be considered part of the healing crisis?---Part of the healing crisis, yes.*
>
> *Okay; and if she had multiple seizures, would that be an indication to stop treatment?---No, that wouldn't be an indication to stop treatment, but maybe this was the connection that I gave the instructions about the protocol again.*
>
> *Okay?---Maybe that's - yeah.*
>
> *And you would expect her to have been treated using that protocol for the seizures?---Yes, that's right; that's righ."* [122]

Sartori had already given evidence he believed the death of Deborah Gruber was due to Fremantle Hospital's negligence in not treating her appropriately. Sartori did not explain why he believed the hospital to have been

[122] Transcript 18.11.10, pg 931

negligent with respect to Mrs Gruber, however, there was this exchange.

> *"But Dr Sartori, you're perfectly able to do that in relation to the hospital. You've just told me they were negligent in four separate cases. Why are you unable to do that in relation to the clinic operating under your consultancy? ....Yeah, because they were doing exactly what I was telling them and this has been proven, but this is how – while there is a certain – as every practitioner of modern medicine knows, there are certain rules of treating certain things and those rules were not followed in the hospital.*
>
> *But they were followed at Dr Boyd's house? ....They were followed. As far as I know they were followed exactly.*[123]*"*

Mrs Gruber became very unwell on the night of 25/26 May 2005 whilst at the apartments. Mrs Mcarty had died on the morning of 25 May 2005, Pia Bosso had collapsed and been taken to Fremantle Hospital early on 26 May 2005, and Mrs Kokalis was so ill she had to remain at 16 Beagle Street, Mosman Park, overnight.

Peter Gruber described his wife's deterioration overnight as follows:-

> *"Well, she had been hallucinating that night the whole night and, needless to say, besides her not getting any sleep I didn't get any sleep either and it was a very difficult night. I mean, there was clearly something going on with the activity in the brain that was causing her these symptoms and it got to the point where in the beginning she was in bed and she was - you know, she was hallucinating but then later*

[123] Transcript 18.11.10, pg 879

on she would try to get up and she would sit on the side of the bed and eventually she just had her head hanging down and I was very concerned, you know, with what was going on because she was completely unresponsive at that time. So that's when Simone came and, yeah, was, I guess, just monitoring the heart and other things. The decision was pretty quick to get her to hospital".[124]

[124] Transcript 2.11.10, pg 137

Ms Phasey told police later on 26 May 2005 that *"at about 4am on Thursday morning (26 May 2005) we called Dr Boyd to Debbie's room and under Dr Boyd's instructions I administered dexamethasone to Debbie. This medication was in our resuscitation kit".*[125]

Keith Preston drove them to Fremantle Hospital with Mrs Gruber in the back seat.

Dr Wilcox appeared to receive full and frank disclosure from Mr Gruber as to what was occurring with the treatment for his wife once she was admitted to Fremantle Hospital. Mr Gruber was still quite clear about adhering to KMPHC protocols, but was forthcoming in advising conventional doctors of the treatment his wife had been taking. I accept the information Mr Gruber provided to Dr Wilcox at Fremantle Hospital as being correct.[126]

Dr Wilcox's evidence was she had spoken to Dr Boyd who had told her she had ordered Mrs Gruber 8mg dexamethasone at 10:00pm the night before (25 May 2005).[127] While there are no written KPMHC records with respect to the dexamethasone for Mrs Gruber I believe it likely to have occurred in view of the fact both Ms Phasey and Dr Boyd advised people it had been administered.

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[125] Transcript Volume 9, Tab 4, pg 10
[126] Volume 4, Tab 14
[127] Volume 4, Tab 14, pg 7

Ms Phasey told police Deborah (Gruber) was taken to Fremantle hospital 2-3 hours after Pia (Mrs Bosso) had been taken to hospital, and that Mrs Gruber went to hospital as the result of a seizure, and Keith Preston took her to hospital.

Mrs Gruber was recorded at triage at 6:38am. She was having a seizure upon arrival and was in respiratory arrest. Dr Wilcox considered it was likely Mrs Gruber was terminal and that she would deteriorate further in the next 24-48 hours.

As stated earlier Mr Gruber was completely cooperative with the hospital with respect to informing them of his wife's history and treatment, but was adamant the hospital follow KPMHC protocols. Mr Gruber described his wife as being a patient of Dr Boyd in Mosman Park, but under direction of a hospital in Thailand. He described the treatment, which seems to be accurate, and included IV dexamethasone. He said she was on a blood type diet directed by doctors from the Mosman Park clinic. He also stated he had been told his wife's tumour markers had decreased in the 10 days since the treatment started.

Mr Gruber told Dr Wilcox his wife had a cough producing dark sputum and was short of breath. He stated she had nausea and occasional vomiting with the new treatment and described seizures lasting a few minutes; 3 in early May and then none until 2 -3 days prior. He stated the

seizures had spontaneously terminated and they didn't go to hospital. He then described the events of the night before and her prolonged seizure, which involved them taking her to the emergency department. Mr Gruber said she had a known cerebral mestastes and had her CT scan with him, which he gave to staff.

In evidence it was clear Mr Gruber was, and remained, very protective of the nurses' and Dr Boyd's involvement in the treatment at 16 Beagle Street, Mosman Park. He was, however, completely frank and honest with Fremantle Hospital about his knowledge of the substances his wife had been taking. It was Mr Gruber who provided Dr Wilcox with Dr Boyd's name and suggested she would be the appropriate person to talk to about what was involved with the treatment.

Dr Wilcox phoned Dr Boyd, who did indeed talk to Dr Wilcox, however, stated she was only *"facilitating the care",* that she hadn't prescribed the protocol and was mainly arranging blood tests. She told Dr Wilcox she thought the treatment was mainly caesium and vitamins and was unsure as to whether or not Laetrile was being used. Dr Boyd suggested they speak to Ms Phasey about the other ingredients and gave Dr Wilcox, Ms Phasey's name and telephone number. This was because Dr Wilcox was anxious to give Mrs Gruber morphine for pain, but Mr Gruber had been unsure as to whether or not his wife would be able to have opiates.

Similarly, Ms Phasey spoke to Dr Wilcox and gave a number of additional substances in the treatment including folic acid, B6, ribidium, xanadium, Vit C, B17 (Laetrile). She also indicated Mrs Gruber was having oral caesium via her naso-gastric tube and omitted to advise Dr Wilcox it was an intravenous administration. By the time she was admitted to hospital Mrs Gruber had been having intravenous caesium for 10 days.

Dr Wilcox indicated Ms Phasey told her she was unsure of the amounts because it was prescribed overseas and said she would fax Dr Wilcox a copy of the protocol later. Dr Wilcox never received a copy of the protocol. KPMHC had records of the amounts of the caesium they were giving the patients because Ms Phasey had recorded them from Sartori. KPMHC was making up the treatment to be provided to the patients. Ms Phasey did, however, tell Dr Wilcox Mrs Gruber could be given small amounts of opiates and their concern was respiratory depression.

Keith Preston, Ms Phasey and Sheena Sindholt visited Mrs Gruber in hospital. It would appear this was probably to provide her with KPMHC nutrition. Other than the small amounts of opiates to which Ms Phasey agreed when speaking with Dr Wilcox on 26 May 2005, Mr Gruber continued to request Mrs Gruber not be given morphine as it was *"contraindicated"* by the treatment plan. A nursing note at 2:00am on 28 May 2005 states:-

> *"Patient crying out and verbalised pain in back. Given opioid at 0035 for relief [records show it was 2.5 mg subcutaneously]. No visible affect. Pt has been crying intermittently since. Mr Gruber has declined offers of further analgesia or anti-anxiolytics as he is convinced the cause of the distress is psychological rather than physical… Mr Gruber states that his wife has never experienced pain and his wife is likely going through 'mental pain".*[128]

The following morning Mr Gruber told Dr Wilcox he did not want his wife to have any morphine because of respiratory depression. Mrs Gruber was not given any morphine after that point in time, however, she was unconscious and there are no further records of her complaints of pain.

In evidence Mr Gruber stated he could not remember the incident but he would not have come to the conclusion morphine was contraindicated himself. He felt himself caught between the hospital and KPMHC.[129]

According to Dr Wilcox and the hospital Mr Gruber asked to be advised of all medications before they were administered to his wife so he could authorise them. It would appear this authorisation was as a result of Mr Gruber ringing KPMHC to make sure the substances the hospital wished to administer were acceptable under the treatment protocols.

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[128] Volume 4, Tab 16
[129] Transcript 2.11.10, pg 140

There were also an issue between the hospital and Mr Gruber, acting on advice from KPMHC, as to the feeding of Mrs Gruber. Initially the hospital felt Mrs Gruber was so ill she was not to be fed until they were able to assess whether or not she could tolerate food.

On the morning of 27 May 2005 she appeared to be a little better and a dietician reviewing her assessed she could be fed by way of the naso-gastric tubes. Mr Gruber wanted KPMHC foods to be given, however, the hospital indicated they were unable to administer any food which had not been prepared by the hospital itself. Mr Gruber obtained a list of vegetables from KPMHC and the hospital kitchen agreed to make up the diet once the list had been approved by a dietician. Initially this seemed to be a good compromise.

Mr Gruber stated in evidence he had been told by the KPMHC that continuing Mrs Gruber's nutritional intake was important and without being fed correctly her body could not heal. The hospital notes indicated a dispute about water and that Mr Gruber wished to administer both water and the food prepared by the hospital (in lieu of that by KPMHC) himself.

Mr Gruber was asked whether or not there were any vitamins or minerals in the mix, which he described as mostly vegetables, and he said that there could have been or that he thought he recalled something like that. When he was asked whether or not there was caesium in

KPMHC feeds he said he thought there had been in Darwin, but couldn't remember whether or not that was the case in Perth.[130] I think it possible Mr Gruber was a little confused about Mrs Gruber's admission in Darwin where KPMHC did provide her nutrition.

The evidence about Mrs Gruber's nutrition while in Fremantle Hospital was confusing. The hospital notes and Dr Wilcox seem to imply Mrs Gruber was only fed with naso-gastric feeds made up by the hospital kitchen in accordance with the list of vegetables provided by KPMHC. Mr Gruber's evidence seemed to imply that after some resistance the hospital allowed him to give his wife naso-gastric feeds which had been made up by KPMHC as opposed to the hospital.

I do not know whether to interpret this as the hospital believed Mr Gruber was giving Mrs Gruber their feeds, when he wasn't, or the hospital understood Mr Gruber was giving her feeds provided by KPMHC. I do not believe Mr Gruber had a clear recollection by the time of the inquest and this is entirely understandable. It was an apparently trivial incident, but a very traumatic time for him.

Certainly Keith Preston and Ms Phasey indicated to police they believed the hospital not allowing Mrs Gruber to be fed with their food was vindictive and malicious. In

[130] Transcript 2.11.10, pg 142

response to a question about the appropriateness of feeding someone in Mrs Gruber's condition, Dr Wilcox said this, "i*t wouldn't contribute necessarily to their clinical improvement in their state and I think the other issue is that giving feeds to someone who is unable to tolerate feeds, ie unable to absorb them, could cause them to be regurgitated and aspirated, ie end up in the lungs and that will increase the patient's physical distress".*

"Can aspiration cause quite serious complications like pneumonia and death? .....Yes. You're putting into the lungs not only bacteria from gastro intestinal contents but also hydrochloric acid, ie, stomach acid."[131]

The best I can say from the evidence is KPMHC wished to continue to provide Mrs Gruber with their food, which they deny included Laetrile and caesium, however, the hospital protocols did not allow patients to be given anything via naso-gastric tubes which had not been provided by the hospital. I am doubtful Mr Gruber would have been able to give his wife KPMHC made up feeds unless he substituted them, but I have no evidence of that, other than his indication he thought the feeds he had given his wife had been supplied by "*the clinic*". Over the passage of time it is quite possible memories of different hospital stays became one.

[131] Transcript 8.11.10, pg 486

Another issue of concern for the hospital on Mrs Gruber's admission was her existing PICC line. Again, at the time of interviews with police Keith Preston and Ms Phasey were very angry Mrs Gruber had not been treated though her existing PICC line. They interpreted that as the hospital deliberately withholding lifesaving treatment for Mrs Gruber.

In reality that was not the case. Dr Wilcox indicated there were two issues with the existing PICC line. One issue was the fact it did not appear to be in good condition on Mrs Gruber's admission to the hospital and they were concerned about the potential for infection.

The other issue was, because of the external appearance of the PICC line, they were unsure as to whether or not it was appropriately placed within her system. The hospital were correct to be concerned about its positioning because imaging revealed it was actually misplaced, and in the ventricle rather than outside the heart.

The nursing note after admission noted *"PICC dressing attended. Entry site not red or swollen, old PICC dressing not well secured and peeling off and did not cover all of line."*

In evidence Dr Wilcox indicated her concerns related to her *"recall the line was not secured and wasn't dressed to the usual manner and as part of the initial management*

plan I gave which is on page 38. Point 8 under management plan was to redress the PICC," in that she wanted the nurses to ensure the site was secure and to clean the site to prevent infection.[132]

With respect to the positioning of the tip of the PICC line, Dr Wilcox had this to say *"if the line has been advanced too far – normally the tip of the PICC line sits in the great vessels, superior vena cava above the heart. If it's been advanced too far and the tip of the line is within the heart itself, then using the line can cause it to damage the vessels of the heart which can have – the vessels and the heart and that can have catastrophic complications".*[133]

Dr Wilcox indicated the tip had to be pulled back about 5cms and then re-Xray'd to ensure it was in the correct position before it could be used.

Mrs Gruber developed a fever early on the morning of 27 May 2005, and a provisional diagnosis of sepsis was made. She was commenced on antibiotics. Mrs Gruber grew a positive blood culture for *Staphylococcus* and a targeting antibiotic was added.

Mrs Gruber deteriorated and died at 10:50pm on 28 May 2005.

She was 42 years old when she died.

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[132] Transcript 8.11.10, pg 482
[133] Transcript 8.11.10, pg 481)

Her death was reported to the Coroner in view of the fact Fremantle Hospital now had three deaths with respect to patients treated by KPMHC in Mosman Park.

The concerns of the hospital with Mrs Gruber's PICC line are relevant to the final outcome for Mrs Gruber because when Dr Margolius performed the post mortem examination she found *"multiple microbiological cultures were done and these showed evidence of a Staphylococcus aureus growth"* and this was also located on the tip of the PICC line.

Dr Margolius also found microabscesses in the heart and lungs and acute purulent pyelonephritis, in the kidneys.[134] Dr Margolius gave a cause of death as 'Septicaemic and Metastatic Breast Carcinoma in Association with Caesium administration'.

How this relates to the mechanism of death will be covered in the expert overview.

Carmelo Vinciullo

Carmelo Vinciullo had been diagnosed with Ewing's Sarcoma of the pelvis in 2000 when he was only 24 years of age. This is a fairly rare form of cancer, however, does present in younger people. He was under the care of

[134] Volume 4, Tab 6

Dr James Trotter, an Oncologist at Royal Perth Hospital, with whom he had an extremely good relationship.[135]

Carmelo had all forms of conventional treatment available, however, in 2002 his tumour was found to have metastasised. Carmelo had multiple therapies over the following years in an attempt to cure his cancer, however, he relapsed several times and despite escalating therapies he reached a terminal stage sometime in 2005.

Dr Trotter explained Ewing's Carcinoma can be curable in a percentage of cases, depending on the site of origin and the extent of the disease at presentation. Unfortunately Carmelo had presented with a very large mass in his pelvis arising from the pelvic bone which made the chance of cure in the range of 50%.[136]

Despite Carmelo's ongoing battle with his disease his mother described how he achieved a Bachelor of Arts in Broadcasting during the course of his treatment. His dream was to be a journalist and he was extremely proud of the fact he had been able to finish his three year course and get a Bachelor of Arts degree. His mother described a very intelligent young man and *"so he did want to live"*. He had everything to live for.[137]

[135] Transcript 1.11.10, pg 95
[136] Transcript 5.11.10, pg 411
[137] Transcript 1.11.10, pg 95

By August 2004 Dr Trotter diagnosed Carmelo with a left lung mass and indicated it was considered further treatment would be merely palliative, rather than curative, given his previous extensive treatment. While there were still forms of chemotherapy available they might only offer him a mild extension of his life.

The pain control management regime which had been achieved for Carmelo was designed to provide him with the best quality of life for his remaining life. It was at this stage Carmelo considered some alternative therapies.

Of Carmelo's pain, which was considerable, Dr Trotter had this to say:-

> *"He was one the most difficult pain issues that I've had to deal with as a clinician in my entire career. These are huge doses of analgesics. He was requiring fentanyl, four patches at a time. That's the strongest fentanyl patch, so he was on four of those at a time. Ketamine lozenges, which is an unusual thing to use. The pharmacy at Royal Perth makes those specially for us. Hydromorphone, in addition. These are doses that would be easily lethal in person who was not exposed long term to these sorts of ….*
>
> *He'd been on them a long time and his pain had been slowly escalating and because it was such a difficult pain issue I had the acute pain service, Royal Perth Hospital, intimately involved with managing that medication. The palliative care service was also involved, as were we as medical oncologists, trying to coordinate the pain issue".*[138]

[138] Transcript 5.11.10, pg 412

Considering Dr Trotter was retired at the time he gave this evidence, after a long and successful career, the fact it was one of the worst pain management issues he had seen in his career is significant. Dr Trotter confirmed Carmelo's pain came due to the position of his tumour, originally in his pelvis, and later the extent of his lung metastases.

Dr Trotter's evidence was by mid April 2005 Carmelo's pain was reasonably well controlled and involved juggling the doses of medications to get a dose which controlled his pain, but also did not affect his alertness to an undesirable extent considering he was involved in study. Dr Trotter pointed out pain control was essential to allow some quality of life for cancer patients.

Mrs Vinciullo backed up Dr Trotter's evidence as follows:-

> *"It took a long time for my son to have his pain managed. Like, it took from Christmas until just before his birthday, which was in March, because he ended up going to RPH and they were going to insert pain relief into his actual spinal cord, because that's how bad his pain was even after having patches on his back and being on ketamine and oxycontin and, you know, you've got no idea the amount of medication he was on, but they couldn't seem to control his pain until he actually went to – Dr Trotter actually instructed the pain clinic, the pain doctors to put him on methadone and he was on methadone. So when he started that treatment that might have been the best he had ever been with his pain management. So he was concerned, yeah, because he'd suffered.... For months and*

months. You know, he didn't want to – when your pain is at 9 or 10 I don't think you want to go there"[139]

The police investigating the 2005 deaths obtained a statement from Carmelo prior to his death. In that Carmelo described how he had been become involved with KPMHC.

"I have had limited success with conventional medical treatments and as a result I started trying alternative medical treatment".

He went on to describe how he heard about Paul Rana and became involved with Paul Rana's NuEra Health manuals. It was Paul Rana who referred him to KPHMC and Sartori. Carmelo was told the treatment would cost $40,000 and he was told by both Paul Rana and one of the nurses at KPMHC that the treatment had a 95% success rate.[140]

Mrs Vinciullo remembers the money being an issue but she was determined to assist Carmelo raise the money if he believed in the treatment. She described how a group of Carmelo's friends had worked together to provide funding for Carmelo to pay for the treatment.

The fact of a 95% success rate being quoted to prospective patients was supported by Covianna Young, who was employed by Paul Rana to assist the Vinciullos' and Mr Green in Perth.

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[139] Transcript 1.11.10, pg 109-10
[140] Volume 5, Tab 13 - Transcript 1.11.10, pg 97

In evidence Ms Young was asked this:-

> *"Mrs Vinciullo remembers Paul Rana telling them that the treatment had a 95 % success rate. This is Dr Sartori's treatment. Is that something you heard?....---Probably would've been, yes.*
>
> *That sounds about right?---Yeah".*[141]

In addition Mrs Vinciullo brought a bundle of documents to court[142] which contained KPMHC documents given to Carmelo at the commencement of the treatment. They contain the same claims as the documents previously referred to as the consent materials provided by Mr McCarty.[143]

Mrs Vinciullo said Carmelo did most of the research with respect to the treatment and she left the researches and investigation to him. She agreed she was somewhat sceptical about the success of the treatment, but on the off chance there was a chance, slim chance, she said they decided to take it. She also described Carmelo having doubts at some stages and wondering whether or not the whole thing had been a scam. This was due to him having difficulty in finding anything concrete to support the treatment. Mrs Vinciullo wished her son to take any chance possible because obviously he was very young.

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[141] Transcript 10.11.10, pg 607
[142] Exhibit 24
[143] Exhibit 36

Mrs Vinciullo was quite certain neither she nor Carmelo were ever alerted to any risks with the treatment itself.[144]

Carmelo's statement described how $32,000 was deposited into Keith Preston's KPMHC bank account, with the remainder being paid to Paul Rana and Covianna Young, both into an account and as cash for Covianna's immediate use.

Paul Rana and Covianna Young also visited Carmelo and his mother in Maylands and gave them a list of things they needed to purchase from a pharmacy to enable his pre- treatment preparation. They wished him to have a particular juicer. Carmelo understood the payments to be for pre-treatment tonics which were supposed to help his immune system.

Carmelo discussed with Dr Trotter his wish to try alternative treatment and Dr Trotter was perfectly open to these suggestions. Dr Trotter acknowledged a person in the terminal stages of cancer would hope some treatment, as yet unproven, may assist them. A doctor would always encourage a patient to attempt whatever they believed may give them some quality of life. Dr Trotter would prefer the proposed therapies were discussed with treating doctors, however, would understand when they were not. Dr Trotter had a note in Carmelo's file for 12 May 2005 he

[144] Transcript 1.11.10, pg 100-101

had been seeing a Paul Rana for *"holistic naturopathic treatments"*.

In the bundle of documents Carmelo had for the Rana system he noted it was important he be *"totally and utterly pain free by ridding my body of cancer"*.

On 15 May 2005 he wrote "*breathing took a major turn for the worse reflecting the tumour movement and growth in my left lung"*. Carmelo recorded he had pain in the chest and back areas, specifically around the heart and centre solar plexus and that he was mostly pain free with his current medication regime. Carmelo and his mother were very concerned about his pain management and repeatedly checked with KPMHC the fact Sartori required him to withdraw from all pain control.

The fact Carmelo repeatedly brought this up with KPMHC is confirmed in an e-mail from Ms Phasey to Sartori on about 16 May 2005, prior to Carmelo commencing treatment. It is also the day Carmelo moved into the Mosman Beach Apartments with his mother.

> *"We have 2 new patients starting treatment, once their PICC lines are insitu. Their results are somewhat disconcerting however…*
>
> *Carmelo Vinciullo – DOB 31/3/76 WT: approx 75 kg (will confirm)*
> *This young man is another Paul Rana referral*
> *DIAGNOSIS – INITIAL – Ewings Sarcoma. Chemo. Didn't work so had tumour removed. More chemo. 2 years later found metastasizes in one lung. Surgery to*

remove. 6 months later, metastasizes to both lungs. Had increased dose chemo, followed by stem cell transplant. This lasted 18 months, then had radiation to chest. This burnt and scarred lungs – lost 35% lung capacity. Xray last week shows both tumours have grown and put pressure on heart and bronchial tubes.

CURRENT MEDS

Methadone 4 tabs (40) TDS
Gabapentin TDS
Prednisolone 20 mg mane
Patches: Hydropmorphone (for breakthrough)
Lorazepam – 2 mg nocte
Zoloft – 2 tabs daily.

Will have to wean him off this. Is too much to go Cold Turkey.

(Lists bloods)

Maybe there is something Paul Rana has these guys on that is playing with their Ferritin levels. Will get a list of their supplementation later."[145]

On 17 May 2005 Carmelo was referred to Dr Kaard, SKG Radiology, for a PICC line by Dr Boyd. The referral letter states *'he wants some alleviation for his symptoms that would be better administered via a better entrance"*. This is clearly an evasive referral.

On 19 May 2005 Ms Phasey wrote to Sartori:-

> *"I am not too happy with Carmelo going cold turkey on me. What supplements can he have to minimize side effects of this?"*

[145] Volume 15, Tab 2

Both Carmelo, in his statement, and his mother, in evidence, indicated Carmelo was instructed to go *"cold turkey"* and to control the pain with his mind. They were informed this came from Sartori directly, however, Ms Phasey had decided to reduce his pain killers over a period time instead as she felt sorry for him.

Covianna Young also remembered Carmelo being extremely stressed at the thought of stopping all his pain medication.[146]

When interviewed by police in July 2005 Keith Preston said:

> *"He was just on so much....that it was frightening...they had to bring him down over a few days, you would have to, he was a pure junkie, if you had the gear he was having, one day's worth of it would kill a donkey stone dead...it was very hard for him to come off it. He did try and he did very well. He cut it down a horrendous amount."*[147]

Prior to commencing the treatment Carmelo also had a blood transfusion. Dr Trotter indicated this was standard treatment for some cancer patients to increase their haemoglobin levels. However, prior to his commencement on the pre-treatment pack there is a note from Clinipath which indicates his haemoglobin levels had been stable.

Finally Carmelo was able to commence the treatment on 20 May 2005 and the records indicate he had 5 days of

[146] Transcript 10.11.10, pg 610
[147] Volume 9, Tab 3a, pg 19-20

treatment. Most of the input with respect to Carmelo comes from the e-mails between Ms Phasey and Sartori because the records of KPMHC from 20 May onward are particularly sparse.

20 May 2005:-

> *"Nausea, burning of legs, and profuse sweating started within 11 mins/Spent most of time in toilet. Has reduced analgesia and will continue to do so."*

On 21 May 2005:-

> *"Hot, burning to legs at start of infusion. No vomits, but loose bowels x 4. Pain score tonight 8 out of 10. Given panadol. Offered hydromorphone but declined. Narcotic analgesia much reduced. From 12 methadone daily down to 3 and 3 Gabapentin down from 6. Prednisolone reducing."*

On 22 May 2005 – from Sartori to Ms Phasey:-

"Keep on reducing pain meds. No hydromorphone!".

An entry in the records with respect to Debbie (Gruber), Darryl (Green) and Carmelo from Ms Phasey indicates *"3 g EDTA= 30 mls 4 hours pre infusion."*

On 23 May 2005 Ms Phasey wrote to Sartori:-

> *"Very nauseous, but no vomit. Diarrhoea x 4. Burning sensation to legs. Pain continues, but improving. Analgesics reducing. Sweats profusely. BSLs ok. Will probably tube him today."*

On 23 May 2005 there is a note on the treatment records indicating Carmelo's mineral drip (including caesium) was

ceased after 15 minutes at his request. The observation notes describe pain, hot sweating burning legs, loose bowels and vomiting, a very high pulse rate and low oxygen saturations.

In his statement Carmelo remembered that during the first four days of treatment he suffered a lot of chest and heart pain, which got worse as time went on and eventually became unbearable. He raised his concerns with the nurses daily but they were busy, and they didn't seem concerned. He was continually reminded he was a young man, to be a man and to fight his way through the pain. He records Keith Preston telling him it was withdrawal symptoms, presumably from his pain medication and Mrs Vinciullo remembers Keith Preston going to the apartments to encourage him with the treatment, and also probably providing him with the EDTA, although she has no knowledge of what it was Keith gave Carmelo to take.[148].

In evidence Mrs Vinciullo confirmed KPMHC staff encouraged him to go on with the treatment. She said the pain had got to the point that it was unbearable and her son was a bundle of pain.

Covianna Young tried to talk him through his pain and did a coffee enema, but he refused any more. Mrs Vinciullo said his pain got to the stage it was constant

[148] Volume 5, Tab 13, Transcript 1.11.10, pg 158

all the time and she went and bought him some hydromorphore because he was feeling so unwell. He tried to confer with the nurses but they were so busy he could not get their attention. One evening, when at the apartment, he wanted some clarification and help with pain but no one was available. Mrs Vinciullo says he could feel the sensations when the treatment was going into his system, he felt heart palpitations and was getting distressed and wanted to stop.[149]

Covianna Young also confirmed in evidence Carmelo had a lot of difficulty with pain during the treatment but it is clear to some extent KPMHC staff and associates considered his pain to be more to do with his withdrawal from medication than pain relating to the treatment.[150]

> *"Now, Carmelo has said that he had a lot of chest and heart pain while he was being treated and it got worse and eventually became unbearable. Do you remember that?..Yes, but he began that way.*
>
> *He began that way. So was your impression that the pain just stayed the same level? It didn't particularly get worse?...I think the pain got worse for him because his mum rang me at 3 am one morning and she was beside herself with his level of pain.*
>
> *Why did she ring you?...She wanted to know if there's something I could do to help him.*
>
> *And was there?...Yes, actually. It was one of the highlights of my visit.*

[149] Transcript 1.11.10, pg 112-13
[150] Transcript 10.11.10, pg 611

What happened?---I offered to massage him to try and relax him and he only had a part massage. He just said, "No more." So then it was a case of comfort him and I actually sat - sat him on the side of the bed and I sat behind him and just cradled him in my arms and took him through the creative visualisation that he'd explained to me he'd been taught and we just kept working at that until he said he felt he could go to sleep....

When you arrived, how much pain did he seem to be in?...Can I just complete that?

Sorry, yes, of course?...Yes, so I think I got to bed about 5 o'clock or 6 o'clock in the morning and when I actually surfaced at about 1 o'clock in the afternoon, his mum told me, "It's the best sleep he's had since she could remember."

So I was really happy that it had worked even if it was for a little bit.

And I guess when you arrived at 3.00pm, how much pain did he appear to be in?...He was - yeah, he was in agony. He was very, very distressed. He was frightened by his level of pain, I think.

And could you tell he was in pain by just looking at him?
...Yeah.

How?...How; probably facial expressions"

Covianna Young confirmed Carmelo was encouraged to continue with treatment by KPMHC staff and that his pain was put down to withdrawal from his medication.

In evidence Sartori discussed his belief that morphine blocks every pathway and prevents the absorption of nutrients into the blood stream and therefore into the

cells. In his view morphine was the worst drug of all. It was most important patients not have morphine and tolerate the pain until the caesium had the opportunity to take the pain away in a day or two. Sartori did not believe knowledge of the history of Carmelo's pain management was important because in his view all of Carmelo's symptoms, including a racing heart and palpitations, were caused by the morphine.[151]

Other than the blood transfusions prior to the commencement of the treatment, Carmelo stated he was not checked for the location or extent of his cancer in any way. He confirmed he had his blood pressure checked each day, as well as his pulse and oxygen levels, but no other tests. He claimed he continually attempted to speak with Sartori but was never given the opportunity to communicate directly with Sartori, either by video-cam or telephone.

With respect to the administration of Laetrile, Carmelo described how the nurses would hook the syringe containing Laetrile up to his PICC line, but then have either his mother or another carer administer the medication. Mrs Vinciulla confirmed she had been asked to administer the medication but couldn't, and she thought her son had then done it himself. [152]

[151] Transcript 18.11.10, pg 910-911
[152] Transcript 2.11.10, pg 160

Further, with respect to the arranging of the provision of Laetrile Carmelo Vinciulla had this to say:-

> *"At no time did we arrange for any of the medication to be available. It was all provided by the nurses. It has been suggested to me that my mother or I somehow arrange the B17 to be ordered from overseas to assist with this treatment. At no time did my mother or I arrange for any medication to be available for this treatment. I have no idea how to get B17. B17 was provided to me by the nurses. They provided us with all the medication that was used. I know what B17 is. It's derived from Apricot Kernel and it is meant to have beneficial properties to attack cancer cells. I knew the caesium was a cancer killing drug but that's about it. I'm not sure what the side effects are. It was never fully explained to me what caesium was.*

> *"To my knowledge Keith Preston ordered all the vitamins and medications that were used for this treatment*[153]*"*

Carmelo decided he was not coping with the pain and made an appointment to see Dr Boyd at her Stirling Highway address on 25 May 2005. Dr Boyd sent him for a scan of his chest and he had an x-ray and CT scan performed at SKG. There is also an order form for blood tests signed by Dr Boyd for 25 May 2005.

Carmelo was supposed to see Dr Trotter on that day but never attended the appointment. Dr Trotter had believed he would be discussing the proposed treatment with Carmelo on that day, but was not unduly perturbed at his failure to attend because he believed Carmelo needed to

[153] Volume 5, Tab 13

pursue whatever he wished with respect to attempting to extend his life.

In the KPMHC records there is an order for a CT scan of the thorax for Carmelo signed by Dr Boyd which states *"? cardiomegaly ? pericarditis"*. The response to Dr Boyd from SKG describing a CXR states:-

> *"Probable marked cardiomegaly or very large pericardial effusion with marked elevation of the left mainstem bronchus, at least two large pulmonary metastases. CT will be required for definitive evaluation".*

The CT scan results:-

> *"Large heterogenous soft tissue mass occupying the mid to lower two-thirds of the left hemithorax with significant mass-effect upon the heart and adjacent mediastinal structures".*[154]

Carmelo returned to the Mosman Beach Apartments and there was seen by both Keith Preston and Paul Rana. Keith Preston was trying to encourage Carmelo to continue with the treatment, but Paul Rana stated he could see Carmelo was very anxious and he told him, if he did not wish to continue the treatment, he should stop.

The KPMHC records for Carmelo indicate he did not attend the clinic on 25 May 2005 making his last treatment administration 24 May 2005, although it appears he stopped the infusion soon after starting on

[154] Volume 5, Tab 11

23 May 2005. It would appear he had five days of treatment and the records indicate he had 9grams of caesium from 20 - 22 May, ? 8grams on 24 May 2005, and whatever would have been contained in 15 mins of infusion on 23 May 2005 along with various other substances. He had DMSO recorded for the first two days of treatment but it was omitted from the record for the last three.

There is no indication in the personalised records as to what is contained within the trace minerals solution or vitamin concentrate solution, but Keith Preston indicated it was based upon Dr Brewer's therapy, which had been refined by Sartori. Certainly information published by Sartori refers to work by Dr von Warburg and Dr Brewer.[155]

Carmelo was also extremely critical of the fact he was not required to provide any prior scans or medical notes relating to his condition. Although he was provided with a series of pre-treatment forms relating to his cancer and prior treatment, they were never collected before he was commenced on treatment and, as far as he was aware, no-one had ever read them or applied them, to the administration of the treatment.

[155] Volume 15, Tab 1, pg15

In addition, he was never refunded any of the money he was charged by Paul Rana.[156]

After Dr Boyd had reviewed the results from the investigations she ordered she told him the treatment would not be able to do anything for his cancer and he should start retaking his pain killers, immediately, and try to relax.

Both Keith Preston, when interviewed by police at the time, and Sartori, in evidence, stated the problem with Carmelo's treatment was the huge amount of pain killers he had been on to start with. He should have continued with the treatment until he got through the pain barrier.[157]

Carmelo's mother stated in evidence the reason Carmelo stopped his treatment was because right from the beginning of the administration of the caesium he believed the caesium was making him have *"these heart palpitations"*.[158]

After withdrawing from the treatment Carmelo went back to see Dr Trotter at the beginning of June 2005.

Dr Trotter's notes of his review on 1 June 2005 indicate Carmelo told him he had been having caesium treatment

[156] Volume 5, Tab 8 and Tab 13
[157] Transcript 18.11.10, pg 912)
[158] Transcript 2.11.10, pg 167

and that he had only had four days due to severe chest pains and perfuse sweating while the caesium infusion was in progress. Carmelo explained to Dr Trotter that on the third or fourth day of the treatment his heart was racing and the nurses were asked to stop the treatment. Carmelo said that after the caesium he was given the vitamin B17. Carmelo told Dr Trotter that the B17 caused him to have hallucinations and a feeling of being separated from his body.

Carmelo explained he had been taken off all his analgesic medication during the treatment. By 1 June 2005 he was back on analgesics although the ketamine had been ceased.

It was as a result of wishing to review Carmelo's pain medication Dr Trotter wrote to the pain doctor and provided this history to explain Carmelo's situation.

> *"I saw Carmelo at the Medical Oncology Clinic on 2 June. He has had quite an eventful fortnight. Unbeknownst to me he was having a course of Caesium and Laetrile therapy but became so unwell during the treatment after the 4th dose (he thought he was "going to die") that he stopped the treatment. In view of the significant number of deaths that occurred in the cohort of patients that were being treated with him on this unproven therapy, his decision to quit was fortuitous. The problems associated with the treatment he was having were accentuated by the fact that he had been advised to cease all his analgesic medication and, as a consequence, he was in severe pain. Fortunately, withdrawal problems did not become a*

major issue and he is now back on his former medication.

It would seem also that the staff giving the caesium therapy were not fully cognisant of the extent of Carmelo's tumour as, at his request, a chest X-Ray and CT scan were undertaken to evaluate his symptomatology and when the extent of his disease was identified, he was advised to have no further treatment.

The CT Scan confirms a large left intra-thoracic mass which largely fills the left hemi-thorax. There are two right sided lung metastases. All of this disease has been previously documented".[159]

In evidence Dr Trotter agreed, although he had not seen Carmelo on 25 May 2005, he had by the time of the inquest been shown the CT scan taken on 25 May 2005. In his view there had been no dramatic change between the scans he was aware of prior to the treatment, and the scan taken on the last day of treatment.

Dr Trotter indicated the difficulty with attempting to provide Carmelo with appropriate pain management after the treatment was exacerbated by the time he had spent off his medications. Dr Trotter indicated Carmelo now needed more analgesia, not less.

As to whether or not caesium chloride had actually exacerbated Carmelo's decline Dr Trotter had this to say, with the proviso he is not an expert in toxicology, and he considered that should be left to the toxicologist.

[159] Transcript 5.11.10, pg 416

> *"Caesium chloride has a short half life and it was unlikely he would have any ongoing problems if he had recovered from any acute episodes. It was recommended that I check serum potassium and his renal function. On 8 June 2005 both of those were within the normal range".*[160]

With respect to Carmelo's heart symptoms during the treatment Dr Trotter had this to say:-

> *"it was temporarily related to the treatment, not to anything else, it would seem. He had perfuse sweating which – at the time of the infusion and his heart was racing. That may well had been a tachyarrhythmia or a cardiac dysarrhythmia and the fact that he felt he was going to die and had an out of body experience indicates he may well have had a temporary arrhythmia".*

Dr Trotter indicated that was supposition from what he was told because he was not there at the time, but it was certainly consistent with the caesium and Laetrile having caused those symptoms and, the difficulty with a tachyarrhythmia, is that it can lead to a sudden cardiac arrest.

Dr Trotter confirmed it was his understanding there is a concern cardiac problems are part of the toxic effects of caesium, however, it is an acute situation which, after that acute response has settled, does not cause continuing alarm. While Dr Trotter was not prepared to say that during the treatment Carmelo was at risk of

[160] Transcript 5.11.10, pg 418

suffering a heart attack or an arrhythmia, he was prepared to say the symptoms which Carmelo described to him are consistent with that occurring. [161]

Carmelo became increasingly unwell through June and on 27 June he was seen by the Oncology clinic and provided with a 2 unit blood transfusion because he was becoming increasingly drowsy and sleeping for long periods. Dr Trotter indicated this is a very common occurrence in the terminal phases of illness as the development of respiratory depression.

Carmelo was admitted to RPH on 30 June 2005 in respiratory distress, with respiratory failure secondary to tumour progression, and died there on 1 July 2005.

Dr Trotter was of the view his death was due to the advancing cancer causing respiratory failure and he did not consider caesium treatment was a contributory factory in his death by that time.

At post mortem examination Dr Margolius found residual caesium in Carmelo's aortic blood, brain, kidney and liver, at higher levels than she would have expected from a background exposure. She gave Carmelo's cause of death as *"Metastatic Ewings Carcinoma in a man subject to recent caesium administration"*. He left lung was severely compromised with tumour by the time of his death.

[161] Transcript 5.11.10, pg 419-420

The mechanism of death and the residual levels of caesium in his system will be discussed later in the expert overview.

Carmelo was only 29 years old when he died.

POST MORTEM EXAMINATIONS

Dr Karin Margolius carried out the post mortem examinations for all five of the 2005 deaths associated with KPMHC/Perth. Unfortunately, Dr Margolius died from metastatic ovarian cancer before the inquest hearings commenced and consequently was not able to give evidence to the inquest. However, we do have post mortem information which Dr Margolius had discussed quite extensively with Dr Joyce prior to her death, due to his expertise in the area of pharmaceutical toxicology, and the extraordinarily high levels of caesium and potassium located in the tissues of all five patients.

The toxicological analysis with respect to all five patients was carried out by Mr Robert Hansson, Principle Chemist, at the State Forensic Science Laboratory and provided to all expert witnesses.

A death certificate had already been issued by Fremantle Hospital for **Sandra McCarty**, before Dr Margolius performed a post mortem examination, due to the fact Fremantle Hospital had not understood at the time of Mrs McCarty's death there was a cohort of patients treated by KPMHC which would die. Mrs McCarty was the first.

The death certificate from Fremantle Hospital indicated Mrs McCarty had died of a gastro-intestinal bleed of some six hours duration, arising out of metastatic liver disease

of three years duration, and breast cancer of ten years duration.

Due to the fact the McCarty family wished to return with Mrs McCarty to Victoria, she was in the process of being embalmed when it was realised this was one of a series of deaths which would need coronial investigation. Dr Margolius noted the embalming process had affected her ability to locate the source of the gastro-intestinal haemorrhage.

All the tissue samples Dr Margolius sent through to the Chemistry Centre for analysis recorded exceptionally high levels of caesium and potassium, many times greater than the reference cases available for known deaths arising out of treatment with caesium chloride of cancer patients. Caffeine was also present and we know Mrs McCarty had a caffeine enema shortly prior to there being obvious and significant blood loss.[162]

Dr Margolius gave the initiating trigger for Mrs McCarty's death as *"wide spread metastatic breast carcinoma in association with the administration of caesium"*. This acknowledges Mrs McCarty's naturally occurring disease as the reason for her undergoing treatment. In this case, due to the very high levels of toxic elements, Dr Margolius noted there appeared to be some involvement of

[162] Volume 1, Tab 7

exceptionally high levels of caesium with a death originating in Mrs McCarty known disease process.

By the time Dr Margolius performed the post mortem examination of **Pia Bosso** on 30 May 2005, Fremantle Hospital had been alerted to the need for there to be post mortem examination for this group of deceased. Therefore, the post mortem examination on this occasion was not hampered by embalming. Dr Margolius again sent tissues to Mr Hansson for analysis, and discussed the meaning of the results with Dr Joyce. Again, in all tissues examined there were extremely high levels of both caesium and potassium. Caffeine was also noted in Mrs Bosso's liver.

Dr Margolius submitted the tip of Mrs Bosso's port-a-cath line for analysis and *Staphylococcus sps* were cultured although Dr Margolius observed no obvious septicaemic process in the rest of the post mortem examination. On her review of the available records of Mrs Bosso's last four or five days of life, Dr Margolius noticed there were episodes which she believed may well have been related to the high levels of caesium noted at post mortem examination. As Dr Margolius stated:-

> *"The side effects of caesium are well known and these include fainting, then ventricular tachycardia and alterations in the QT interval. Previous deaths have been related to cardiac complications".* [163]

[163] Volume 2, Tab 6

Dr Margolius noted particular concern with respect to the ambulance officers recording cardiac arrhythmias for Mrs Bosso at the time of her admission to Fremantle Hospital, and the potential for septicaemia to be present, but death occurring before wide spread infection through the organs.

Dr Margolius gave Pia Bosso's cause of death as *"metastatic thyroid carcinoma in association with caesium toxicity."* [164]

Sandra Kokalis died at SCGH and, at the time of her death, that hospital was not aware of the cohort of patients treated by KPMHC. Consequently SCGH issued a medical certificate which recorded Ms Kokalis's death as sepsis, with the duration of two days, arising out of end stage bowel cancer.

However, before Mrs Kokalis was taken to a funeral home, it was realised this was part of a cohort of patients and her death was reported to the coroner, resulting in a post mortem examination by Dr Margolius.

Sandra Kokalis' post mortem examination was undertaken on the same day as that of Sandra McCarty and again Dr Margolius took samples for examination at the Chemistry Centre. Again there were extraordinarily high levels of potassium and caesium in every tissue sampled.

[164] Volume 2, Tab 6

The post mortem examination also confirmed Mrs Kokalis metastatic colonic carcinoma. [165]

In the case of Sandra Kokalis Dr Margolius was able to identify the gastro-intestinal haemorrhage as arising out of two small peptic ulcers in her stomach. Dr Margolius gave Mrs Kokalis' cause of death as *"metastatic colonic carcinoma in association with caesium toxicity and gastro-intestinal haemorrhage."*

Fremantle Hospital did not provide a medical certificate for **Deborah Gruber** because by the time of her death they were fully cognisant of the fact these were coronial cases. Fremantle Hospital was concerned there was something about the circumstances of the deaths which may have caused the deaths at that particular time.

Dr Margolius performed the post mortem examination of Deborah Gruber on 31 May 2005 and noted wide spread microabcesses which grew *Staphylococcus aureus* on culture.

The post mortem examination confirmed wide spread tumour deposits in her brain, lungs, lymph nodes, uterus and ovaries, as well as pleural effusions, acites and fluid in her pericardial sac. Her left kidney showed multiple

[165] Volume 3, Tab 7

nodules in keeping with the infection, as did many other organs.[166]

Again toxicological analysis indicated extremely high levels of caesium and potassium. No caffeine was noted in Mrs Gruber.[167] Dr Margolius gave her cause of death as *"Septicaemia and metastatic breast carcinoma in association with caesium administration."*

The post mortem examination of **Carmelo Vinciullo** was undertaken on 5 July 2005. At post mortem examination Dr Margolius noted the extent of Carmelo's tumours and indicated the tumour in Carmelo's left lung appeared more extensive than it had prior to him having had the caesium therapy. She noted his caesium therapy had been curtailed after only three to four treatments but tissues sent for toxicological analysis still showed residual caesium and potassium. The levels, although not nearly as high as those in the previous four patients, were still higher than had been associated with death from caesium chloride administration to cancer patients before.

Dr Margolius had this to say *"it is possible that the chest pain suffered during caesium administration may have been related to the caesium as it is noted to cause tachycardia, arrhythmias and an altered QT interval. The*

[166] Volume 4, Tab 6
[167] Volume 4, Tab 8

potassium levels are extremely abnormal as is the case with treatment utilising caesium".[168]

Dr Margolius gave Carmelo's cause of death as *"metastatic Ewing's carcinoma in man subject to recent caesium administration".*

Daryl Green died in South Australia on 20 July 2005. He had been treated by KPMHC, but ceased treatment due to concern about the intervention of police. He returned to South Australia and Ms Phasey and Mr Preston followed him there and completed the treatment.

He was known to be involved with KPMHC and as a result a post mortem examination was conducted by Dr Roger Byard at the City (Adelaide) Mortuary on 21 July 2005.

Dr Byard indicated Mr Green died as the result of *"metastatic adenocarcinoma with widespread of the tumour to lymph nodes throughout the body, liver, lungs and skeleton."* This was associated with ascites and pleural effusions. Dr Byard also noted significant coronary artery disease but believed death was more likely as a result of the prostatic adenocarcinoma.

Dr Byard did not believe caesium administration played a direct role in the death of Mr Green.[169] There was certainly no evidence caesium therapy had any effect on

[168] Volume 5, Tab 4
[169] Volume 6, Tab 9

the spread of his cancer. (All the information with respect to Mr Green was provided by the South Australian Coroners office).

EXPERT OVERVIEW OF TREATMENT

The coronial process collected medical records for all patients treated at KPMHC/Perth, both pre, and post-treatment for those who survived, and these were made available to:-

- Dr van Hazel as an experienced Senior Oncologist;
- Professor Joyce as a Senior Clinical Pharmacologist/Toxicologist; and
- Dr Speers, Infectious Diseases Physician and Head Clinical Microbiologist of the Department of Microbiology at SCGH.

Dr van Hazel was asked to review the records and provide his opinion with respect to the life expectancy for the patients, prior to their commencement of treatment. Originally, it was not understood how many of the patients had undertaken the pre- treatment packs which also included high levels of oral caesium, Laetrile and different vitamins.

As the inquest process became aware of the pre-and post-treatment packs, and the amounts of oral substances utilised both in the packs and the IV treatment itself, so the expert Consultants updated their opinions. By the time they were able to give evidence they were also in receipt of some of the information gleaned from evidence given in the earlier (2010) part of the inquest.

It is only my intention to give a summary of their evidence in so far as it explains the relationship between the treatment and the deaths.

Effectively, the information gathered as a result of seizing the records for this group of seven people, and some limited information in relation to all other patients treated in Australia, provides the most extensive information available to date about the effects of those amounts of these substances when used in persons suffering cancer. It is not enough information to consider it significant, by way of an experimental trail, but it does support the general acceptance in the medical practice of medicine that generalised caesium administration is mostly fatal due to its interference with various metabolic processes.

All four women who died had evidence of serious gastro-intestinal toxicity, as did Antonio Ranieri. Both Pia Bosso and Deborah Gruber had evidence of septicaemia, with Sandra Kokalis a suspected septic process, and both Pia Bosso and Carmelo Vinciullo had evidence of cardiac disturbance.

It is accepted all patients treated in Perth by KPMHC in May 2005 had significant disease and, without that disease, would not have undertaken the treatment. Their disease was the trigger for their consent to treatment. It is the consent to the treatment and how it was achieved which is one of the issues.

Dr Guy van Hazel

Dr Guy van Hazel is a Consultant Oncologist and Clinical Professor of Medicine at SCGH. He has extensive experience, both as a clinician, and as a researcher with respect to clinical trials of drugs being considered for the treatment of various forms of cancer. He was asked to provide evidence with respect to the life expectancy of the patients, the treatment, and the appropriate conduct of experimental trials. As a clinician, he has experience as to the expectation of the medical profession for the appropriate conduct of general practitioners with cancer patients, and the clinical practice of nurses in a hospital.

Dr van Hazel originally[170] reported the treatment administered to the five deceased comprised a combination of caesium, various vitamins including high dose Vitamin C, Laetrile (amygdalin/B17) EDTA and DMSO all given by an IV route. It was his informed opinion none of those substances had been indicated to have any efficacy in the treatment of cancer, either in 2005 or 2011.

In Dr van Hazel's view amygdalin (Laetrile) was a notorious alternative therapy drug which had been subject to a randomised clinical trial at the Mayo Clinic. This showed conclusively Laetrile was not effective in the

[170] Volume 21, Tab 3, 22.05.09

treatment of cancer, and in addition, several patients in the trials showed symptoms of cyanide toxicity.

With respect to high doses of vitamin C, there had been some experimental work, which was later clarified by randomised trials at the Mayo Clinic. Those trials did not indicate high doses of vitamin C were effective in the treatment of cancer. Further, Dr Joyce pointed out some of the interactions between the different substances used in the treatment would tend to have, in some cases, known complicating effects, and in other cases it was quite possible there were unknown complicating effects.

Dr van Hazel could only find the 1984 paper of Sartori as a study in the literature. Dr van Hazel located the paper in the Journal Pharmacology, Biochemistry and Behaviour and stated, *"this is a journal that purports to be peer reviewed but it is quite clear that report by Dr Sartori has not been peer reviewed by any competent cancer researcher".*[171]

Dr van Hazel indicated, from a medical perspective, the level of mortality in the reported study was totally unacceptable, Dr van Hazel said this *"if a death rate of 1-in-4 had been discovered then the trial using that dose and schedule would have been terminated. Given Dr Sartori's subsequent problems with legal authorities I am highly suspicious of the integrity of even this poor data".* As

[171] Volume 21, Tab 3

Dr van Hazel emphasised the study reported the use of oral caesium and there were no reports in the literature with respect to high dose IV caesium therapy.

Dr van Hazel stated he was of the view there was *"no evidence for the use of either DMSO or EDTA, either alone or in conjunction with other drugs, as an anti cancer agent".*

Not surprisingly, Dr van Hazel would never use any of the therapies, and it was his view, as a registered medical practitioner, that Dr Boyd's involvement with the KPMHC could only be in a medical practitioner/patient relationship. Dr van Hazel was of the opinion Dr Boyd was an essential component in the administration of the therapies, even if she did not actually mix or administer the therapies, in a physical sense, herself.

It was Dr van Hazel's view Dr Boyd was *"conducting an experiment on these patients without their knowledge and certainly without any informed consent".* In Dr van Hazel's view it was inappropriate to provide desperate patients with *"unproven, unregistered, highly toxic treatment, without any informed consent to explain to them the dire consequences that may ensue from such treatment. It is clear that these patients all thought they had a high chance of being completely cured with the treatment".*

With respect to the risks associated with the treatment Dr van Hazel emphasised there are *"no reliable toxicity*

studies with high dose IV caesium, either alone, or in the combinations given with these patients". It was his view the alleged oral study by Sartori was of doubtful integrity and, as stated above, the death rate he would admit to was totally unacceptable. Dr van Hazel said the study outlined by Sartori using oral caesium should have been enough to stop any treatment with caesium and certainly not encourage use of higher doses intravenously.

The fact the study referred to oral doses, and the treatment used IV administration, after oral pre-treatment, was a significant factor in eradicating the credibility of its proponent.

> *"There's plenty of medications that you can give orally and are fatal intravenously.....the whole dosage regime has to be looked at differently. It's almost certainly much more toxic given intravenously. It matters enormously."*[172]

Dr van Hazel pointed out there are documented deaths after caesium treatment, there are reports of cyanide toxicity with the use of Laetrile and, while there are no reported deaths from the use of high Vitamin C, DMSO and EDTA there was no evidence of their use in combination with one another.

Dr van Hazel's initial view with respect to the life expectancies of the five patients was based on his review of their medical histories up until the commencement of

[172] Transcript 29.09.11, pg 2014

the treatment, from their conventional practitioners. Originally, he was unaware of the amounts of substances in the pre-treatment packs and whether or not the particular patients had used those.

Dr Joyce had some input to the inquest in the area of the effect of pre-treatment packs, followed by the treatment**.**

Dr van Hazel's life expectancy estimates are based purely on the health of the five patients at the commencement of the treatment, as far as we can ascertain, from the evidence available.

Sandra McCarty had been reviewed by her doctor on 28 April 2005, the day before she flew to Northern Territory to commence at the Darwin KPMHC. She had been diagnosed with breast carcinoma in October 1995 which was a poorly differentiated grade 3 invasive ductal cancer with extensive intra-duct component with three of five nodes positive. She had conventional treatment completed in April 1997 and remained in remission on hormone therapy until November 2002 when liver metastases were diagnosed. Again she had conventional therapy and remained relatively stable until November 2004. She was then commenced on another therapy.

Dr van Hazel indicated the blood tests performed by Dr Boyd on 13 May 2005 revealed abnormalities in her liver function tests, however, he was not aware prior to the

inquest of the fact Sandra McCarty had already been on the pre treatment pack with oral caesium, amygdalin and other compounds. He did not believe that would have made a significant difference to her life expectancy, however, believed it may have explained the difference in her blood results from before any form of the treatment started in April.

Dr van Hazel was of the view Sandra had months to live at the most, however, he noted Sandra became significantly unwell after she had commenced the treatment pre-pack oral caesium by way of naso-gastric tube in Darwin. He stated by the time she arrived in Perth she had deteriorated, and he would have put her survival at weeks. She had already by then been adversely affected by the pre-treatment substances.

Pia Bosso had a medullary cell carcinoma in her thyroid gland in 1997 which was originally treated surgically. It was later found to have metastasized, however, she had remained relatively well over the years which, Dr van Hazel said, was not unusual with her form of cancer. He had access to her CT scan in August 2004, and blood tests and liver function tests carried out by Dr Boyd on 13 May 2005 gave a normal picture of her state of health.

In Dr van Hazel's view Pia Bosso was in no imminent danger of death and he would have thought she had months, if not years still to live at the time she

commenced treatment. This seems to be supported by the evidence of her niece, Ms Hoffman, who had not seen her aunt for a while but believed she seemed to be as full of life and energetic as she remembered her. Pia Bosso had certainly organised her trip to Perth from Victoria, and had travelled perfectly competently, on her own. There was no indication on the 13 May 2005 there was any reason to fear her death in two weeks. Dr van Hazel had no doubt Pia Bosso's death, arising out of a wish to cure her cancer, was premature and almost certainly caused by the IV caesium treatment.

Sandra Kokalis had carcinoma of the colon diagnosed in 2002 at which time she already had liver metasteses. She had conventional surgery and chemotherapy but relapsed in 2003. By December 2003 she had metasteses in the bone. Sandra Kokalis was reviewed by Dr Powell, her Oncologist, in May 2004 and continued with third line chemotherapy until November 2004 when there was evidence of progression. A CT scan of Mrs Kokalis' head indicated in April 2005 she had Meningeal cancer. Her liver function test prior to treatment showed some abnormalities and Dr van Hazel estimated prior to the treatment Mrs Kokalis had weeks to a few months to live.

The situation with **Debra Gruber** was harder to evaluate due to her original medical treatment having been undertaken in the States and her history being provided by Mr Gruber, without the benefit of medical reports.

Mrs Gruber had chosen both conventional therapy for her breast cancer, which was diagnosed in 2001, and later alternative treatment with Dr Gonzales in Mexico. In 2003 she had lung metasteses and continued with conventional chemotherapy, which was not effective, and the Grubers turned to alternative therapy. Mrs Gruber had commenced oral caesium in United States in September 2004.

The Grubers flew to Darwin in April 2005 where Debra Gruber had a naso-gastric tube inserted. A CT scan revealed brain metasteses. She was unwell when she flew from Darwin to Perth and commenced the IV treatment.

Dr van Hazel found the prognosis with Mrs Gruber difficult. Although she had failed at least one type of chemotherapy in the past she had little standard chemotherapy, and there are various regimes which may be trialed. Dr van Hazel thought she may have benefited from cerebral irradiation and he was unaware of the state of some of her markers.

Without knowledge as to what exactly she had tried, Dr van Hazel thought it was quite possible there were still conventional therapies which would have been successful with Mrs Gruber, and may have extended her life from months to years. Without those conventional treatments Dr van Hazel was of the view Debra Gruber had weeks to a

few months to live at the time she commenced the IV treatment.

Dr van Hazel had good medical histories for **Carmelo Vinciullo**, whose Ewing's sarcoma of the pelvis had been diagnosed in 2000, with metateses in the lungs in 2005. Dr van Hazel was aware Mr Vinciullo only had three to four days of treatment and had then returned to conventional care, and died on 1 July 2005 of progressive disease.

Dr van Hazel did not think the treatment caused his death, however, he was concerned Carmelo may not have survived the treatment had he continued. Dr Trotter, his treating Oncologist, agreed with the proposition the sensations Carmelo described during infusion were consistent with the known toxic effects of caesium, and had he not ceased treatment he may well have suffered cardiac disturbance to the extent it was fatal.

Carmelo was the only patient, suffering toxic effects of the treatment, who ignored the philosophy of Sartori's treatment and ceased treatment. It is my view that decision gave Carmelo Vinciullo his extra weeks of life.

Dr van Hazel had no doubt the philosophy of the treatment was unethical due to the known unacceptable effects of caesium alone. Even in a properly run experimental setting he did not believe permission would

ever have been granted to conduct the treatment on information all ready to hand. The patients had not been made aware of any risks to do with the treatment substances themselves, and he felt they had been treated in inadequate facilities with inadequate supervision. Further he felt the attempts made by the nurses and Dr Boyd to protect themselves from known involvement with the treatment made him feel they were aware of the problems with the treatment and trying to distance themselves from it. In his view that was ineffective and there was no doubt the nurses and Dr Boyd were involved with the treatment whether they actually *"pushed through"* inappropriate substance themselves or not.

In evidence Dr van Hazel further clarified, in his view, there was no doubt there was a doctor/patient relationship between Dr Boyd and the patients who died[173] and in his view there was no doubt the same applied to the nurses.[174]

It was Dr van Hazel's view the fact instructions originated with Sartori was irrelevant to the ethical appropriateness of Australian Registered Nurses and Doctors complying with his instructions[175]

Dr van Hazel could not understand how sensible people, let alone accredited people, could continue with a

[173] Transcript 29.9.11. pg 2025 – 2028
[174] Transcript 29.9.11, pg 2028 -2035
[175] Transcript 29.9.11, pg 2030

treatment where four patients out of seven had died in four days. The fact Ms Phasey then flew to South Australia to continue treatment with Daryl Green, he clearly found inexplicable. He accepted a nurse may not appreciate Sartori's original paper was an unsafe basis for an experimental trial due to its acknowledged death rate.

We have no information as to whether or not Ms Phasey understood the original paper was not the paper which appeared in all the KPMHC literature. There were significant alterations, in the administration, number and amounts of known toxic substances. However, Dr van Hazel pointed out the gold standard of efficacy for treatment is that it must improve survival compared to a control group and, survival with quality, obviously. He said there are some specific surrogate end points used to mark efficacy, such as time to remission, time in remission, time to progression and response rates as to the shrinkage of tumour, which must be of at least 50%, for a trial to be considered as having some effect. This alone would not be enough without other markers.

Dr van Hazel said on the results he had, he had been able to evaluate the treatment and it was his view the treatment did not work in anyone.[176] .

[176] Transcript 29.9.11, pg 2007

Dr David Speers

Dr Speers is an Infectious Diseases Physician at SGGH where he is the Head and Clinical Microbiologist of the Department of Microbiology. He was asked for his input with respect to the treatment of Deborah Gruber, Sandra Kokalis and Pia Bosso, and their deaths during, or at the conclusion of their treatment. He was asked for his opinion due to his expertise in infectious diseases and concerns raised by Fremantle Hospital as to the status of Deborah Gruber's PICC line when she first attended hospital. Later investigations indicated Sandra Kokalis and Pia Bosso may also have been showing signs of an infective process.

Although **Deborah Gruber** was found at post mortem examination to have quite significant metastases from her breast cancer, including brain metastases, it was the view of all experts involved in reviewing the information, both pre-and post-the treatment (hospitalisation), Mrs Gruber, with appropriate treatment, should not have been in danger of losing her life imminently.

The evidence with respect to Deborah Gruber was she had a PICC line in place before she came to Australia because of her earlier therapies in the States. There is some evidence she had a PICC line in the first half of 2004, but it is unclear whether or not this was still the same line with which she came to Australia, in April 2005.

The evidence from Fremantle Hospital on her admission was they were concerned about the state of the PICC line because it did not seem to be properly secured, and they had no information as to its positioning. Consequently, Fremantle Hospital declined to use that PICC line until it had been checked, and indeed it was found the tip of the PICC line was in Mrs Gruber's heart rather than the blood vessel outside the heart.

From the KPMHC records Dr Speers believed the PICC line had been used by KPMHC on 14 May 2005, without any information as to the time of its last use, or whether or not it's positioning had been checked prior to its first use.

Dr Speers was provided with a port-a-cath protocol from Royal Darwin Hospital, said to be in use at KPMHC, but none with respect to care of a PICC line. Dr Speers noted there were no temperature recordings, although he did observe several episodes of low blood pressure. He noted the dark brown and yellow sputum produced on 16 & 21 May 2005, which may have indicated purulence but because Mrs Gruber was noted to have a cough, and there was no consolidation found at post mortem, he believed bronchitis may have been present. No sputum sample had been taken from the recorded dark brown or yellow sputums to confirm whether or not there was infection.[177]

[177] Volume 21, tab 5

Of note is the observation *"felt different today whilst on drip. Weak, shaken anxious. Very different to other days,"* which Ms Phasey had commented upon to Sartori via e-mail as well. Dr Speers indicated it was possible Mrs Gruber's PICC line was colonised with bacteria, which had actually been flushed into her system by the infusion, during the course of treatment. Both Dr van Hazel and Dr Speers commented on that entry being significant for the spread of an infection, about which nothing appeared to have been done by KPMHC.

Mrs Gruber continued to receive infusions until 23 May 2005, but did not have an infusion on 24 May 205. She was admitted to Fremantle Hospital on 26 May 205 as a result of seizures and delirium and found to be sweaty, hypertensive, with an increased respiratory rate. Due to the questions surrounding the PICC line it was not used. On 27 May 2005, she was noted to be febrile but blood cultures were unsuccessful due to poor venous access. Because venous access could not be obtained the PICC line then had to be used after investigation and repositioning. The blood cultures obtained from the PICC line later grew *Staphylococcus aureus* species. Mrs Gruber was started on IV antibiotics but died on 28 May 2005.

Dr Speers indicated Mrs Gruber's blood pathology results taken from the commencement of the treatment until her admission to Fremantle Hospital support the progress of a sepsis. In addition, acidosis was found on admission to

Fremantle Hospital (26.05.05) which is also consistent with sepsis, but Dr Speers did note the acid balance of her blood was difficult to interpret with the chemicals which had been administered to date. Her blood inflammatory markers were elevated and Dr Speers was concerned she may have had an infective process at the commencement of the treatment which was not picked up by KPMHC. This was then exacerbated by the infusion flooding her system with bacterium.

Dr Speers was of the view had Mrs Gruber been sent to hospital the night before she was sent to hospital by Dr Boyd, her life may have been saved.[178]

Dr Speers supported septicaemia as a cause of death due to the macroscopic finding at post mortem of a peripherally inserted central venous catheter (PICC), pleura and peritoneal effusions and white nodules over the left kidney surface, and microscopic findings of microabscesses within the heart and lungs and acute perulent bilateral pyelonephritis. The microbiological findings showed wide spread *Staphylococcus aureus* sepsis with positive cultures from internal bodily fluids and organs. *Staphylococcus aureus* was cultured from the PICC tip.[179]

As a consequence, Dr Speers was quite comfortable the actual cause of death for Mrs Gruber was consistent with

[178] Transcript 28.9.11, pg 1963
[179] Volume 21, Tab 5, pg 2

sepsis due to *Staphylococcus aureus* bacteraemia, almost certainly secondary to an infected PICC line. While he indicated there was a potential for some of the infusions also to have been bacterially contaminated he thought that was less likely. However, Dr Speers did express some concern as to the administration of some of the components of the IV infusions being drawn from multi-dose bottles.[180]

Dr Speers stated multi-dose bottles of intravenous agents are not used in the clinical areas of health care facilities. These have been linked to a number of transmissions of infective agents between patients, especially blood born viruses, and increases the risk of bacterial contamination of the bottle due to repeated punches of the seal and entry into the sterile liquid inside.

It is apparent the practices and protocols, or the clinical conditions and manner in which the substances used in the treatment were administered played a very significant role in accelerating Mrs Gruber's death. If Mrs Gruber had not had the PICC line in place for the infusions she would not have developed the sepsis which subsequently caused her death.[181]

None of the markers indicative of an infective process taking place were noted or acted upon by any of those acting on behalf of KPMHC.

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[180] Volume 21, Tab 5A, pg 4
[181] Volume 21, Tab 5 & 5a. Transcript 28.09.11, pg 1960 – 1965

Dr Speers was asked whether or not the evidence of Sartori about the use of ozone as a blood steriliser may have been of benefit to those undergoing the IV infusions as a way for overcoming the problems with infection. Dr Speer's opinion was the use of ozone as a treatment for bacterium and disseminated sepsis had no orthodox medical support. Ozone is an intrinsically toxic gas which has been used in high doses to sterilise surgical instruments and water. He stated that where it has been used intravenously on patients it is toxic, and there have been reported deaths from patients where that sort of experimentation has occurred.[182]

Dr Speers noted **Sandra Kokalis** had a pre-existing port-a-cath in place. She commenced her treatment on 14 May 2005 and there was a recording of her shaking during treatment on 18 May 2005, with confusion and deteriorating condition.

Mrs Kokalis was living at home when not actively being infused with the treatment and, on the morning of 19 May 2005, her family took her to Joondalup Health Campus as the result of her seizures. Joondalup Health Campus noted she was dehydrated and suffering hypercalcemia and her urine analysis indicated an infectious process in place.

[182] Volume 21, Tab 5A, pg 2

Mrs Kokalis, however, discharged herself against medical advice from Joondalup Health Campus and the only conventional treatment to which she and KPMHC consented was the on-going use of oral antibiotics. She returned to KPMHC and the treatment, but continued to deteriorate with breathing difficulties. She was eventually admitted to SCGH, almost simultaneously with Deborah Gruber presenting to Fremantle Hospital.

At this stage SCGH were not alerted to the problems surrounding KPMHC May 2005 clinic. Due to the fact her family advised she was being treated for an infection, she received presumptive treatment for an infection. However, aggressive therapy for an infection was too late and despite IV antibiotics and fluid replacement she died the next day.

Dr Speers traced Mrs Kokalis's blood pathology whilst undergoing the treatment at 16 Beagle Street, and it was clear there were definite markers for an infective process.

At post mortem examination there was wide spread cancer, but no microscopic findings of infection nor was anything grown on culture. This can be explained by the oral antibiotics administered from the time of her stay at Joondalup Health Campus (JHC). There was no microbiological analysis of the port-a-cath tip.

Dr Speers believed the death of Mrs Kokalis was a combination of acute gastrointestinal bleeding and severe metabolic derangement. He considered her rapid respiratory rate on admission to SCGH was most likely due to her severe metabolic acidosis, with secondary hyperventilation. He was of the view her blood pathology indicated severe infection, even though there was no microbiological proof of infection.[183]

There was no obvious internal infectious process, as there had been with Deborah Gruber, however that does not mean septicaemia was not present.

Dr Speers pointed out Mrs Kokalis' discharge, against medical advice from JHC, with dehydration and hypercalcemia was an immediately life threatening situation. It may have been overcome had she stayed at JHC and been appropriately re-hydrated and continued with IV antibiotics.

Dr Speers considered it was unreasonable no observations or recordings were noted or, if noted, not acted upon, between her return to KPMHC on 20 May 2005 and her representation to SCGH on 26 May 2005. He pointed out there are no sets of observations recorded for those days until 25 May, when there was a significantly elevated respiratory rate, which did not prompt an urgent medical review and investigation.

[183] Volume 21, Tab 5, pg 4

Dr Speers believed that without evidence for sepsis he could not conclude IV antibiotics would have made a difference to the timing of her death. However, he did believe appropriate management of her metabolic and fluid derangements would have made a difference. This was impossible due to her refusing appropriate treatments by adhering to KPMHC protocols.

Dr Powell was also of the view that had Sandra Kokalis been able to be appropriately treated, once in hospital, it may have bought the physicians extra time within which to bring her metabolism under control and thereby extended her life. The fact none of the physicians were clear about the treatment was an impediment to her care at both JHC and SCGH.

Pia Bosso was infused by way of a port-a-cath which was left in place from earlier therapy. It was not checked before use. In this case KPMHC decided they were not comfortable with it due to her pain on first infusion. A PICC line was inserted at Hollywood Hospital on 19 May 2005. The port-a-cath was assessed by the radiologist at the time and found to be patent. This seems to be inconsistent with KPMHC records.

During treatment Mrs Bosso was found to be hypotensive and bradycardic. She recorded various episodes throughout her treatment categorised as different sorts of

seizure/fainting. She collapsed in the early hours of 22 May 2005, and was found to be in ventricular fibrillation in the ambulance on the way to Fremantle Hospital on 26 May 2005, where she later died.

Again, at post mortem examination Mrs Bosso had no macroscopic signs of sepsis, however, there was pyelonephritis of one of her kidneys, and microbiology of post mortem specimens and the tip of the PICC disclosed coagulase negative *Staphylococcal* infection. This was not present on the port-a-cath tip. This would imply the infection had been incurred as a result of the PICC/infusions used by KPMHC.

The Fremantle Hospital admission noted *"PICC right upper arm → ? cellulitis right axilla"*. Dr Speers pointed out these organisms are recognised causes of central venous line infection as, like *Staphylococcal aureus*, they colonise the skin, gain access to the catheter and have adherent properties to plastics and metals. They are known to cause infection in people with prosthetic devices such as artificial heart valves, cardiac pacemakers, joints and other implants.

The infection of a PICC line can result in fevers and malaise despite there not being evidence for more disseminated infection in Mrs Bosso. Dr Speers stated the coagulase-negative *Staphylococci* are less virulent organisms compared to *Staphylococcus aureus*. He

considered the intravascular infection identified post mortem could have caused increased cardiac irritability in life, through either the fever generated, or systemic inflammatory actions, to the extent he could not exclude some contribution to the cardiac arrhythmias documented for Mrs Bosso, which ultimately are believed to have led to her death.[184]

Therefore, there is some evidence Mrs Bosso's cardiac symptoms may have been contributed to by the clinical conditions of the treatment, as well as the substances used in the treatment, namely caesium.

Dr Speers provided a lot of information with respect to the appropriate care of central venous catheters to prevent the introduction of infection directly into the blood stream of a patient resulting in septicaemia and endocarditis. Dr Speers was especially concerned with the use of multi-dose bottles when administering various substances into the infusions, and the general inability to maintain a sterile environment in a house location, as opposed to a designated sterile situation. He believed all of these factors would have contributed to the high level of infection in this cohort of patients.

The evidence as a whole indicates patients treated in May 2005 at 16 Beagle Street, Mosman Park, must have been exposed to infective processes purely as a matter of the

[184] Volume 21, Tab 5 pg 6

circumstance of the administration of the treatment. The description of the carers as to the conditions, the fact three out of seven patients demonstrated infective processes in their blood pathology prior to death, and from post mortem results, indicate it was a significant threat to vulnerable patients.

There is substantial evidence Mr Ranieri also suffered an infective process.[185]

Dr David Joyce

Dr Joyce is a Clinical Pharmacologist and Toxicologist and provided evidence to the inquest about the compounds used in the treatment and their known, or unknown, toxicity.

Dr Joyce had originally provided reports to the inquest process on the documentation available before any evidence had been heard. As the process continued and people gave evidence so transcript and further documentation was provided to Dr Joyce to enable him to refine his views with respect to the toxic effect of the substances administered. He also provided evidence supporting that of Dr Speers and Dr van Hazel as to infective processes, clinical conditions and the manner in which the infusions were administered.

[185] Volume 21, Tab 5A & Transcript 28.09.11, pg 1976 (See pg 237-248)

Patients were encouraged to continue with the treatment regardless of the indicators they were severely unwell.

Overall, from a toxicological perspective, Dr Joyce's evidence was it was not reasonable to give any patient, in the circumstances of those patients of KPMHC in May 2005, the substances contained in the infusions. A number of the substances administered have known toxicity and no known *"safe"* administration levels.

In the case of caesium, even a clinical drug trial would violate ethical standards for human research because:

(1) there are no reasonable grounds for proposing a caesium treatment might be a advantageous in humans and the only annotations of efficacy were in the writings of Sartori and Dr Brewer. These *"studies"* do not even meet the most basic standards for an objective measurement of efficacy, as outlined by Dr van Hazel earlier.

(2) the treatments provided were notably toxic in that the amounts given were well within the described incidents of life threatening toxicity in doses to which humans have been known to be exposed.

(3) If there was some study, involving known amounts in animal experiments, indicating there was an extraordinary efficacy then there may have been enough to warrant an experimental trial in humans. However, it is known caesium has serious cardio toxicity and a reasonable dosage would need to be established before any experimental human evaluation might proceed ethically.

The minimum monitoring required, in early studies, would be continuous cardiac monitoring in a cardiac care ward environment, with attending staff trained and experienced in managing lethal cardiac rhythm disturbance, gastrointestinal toxicity and seizure. Systemic monitoring of vital signs, (including blood pressure), adverse events (which would include the gastrointestinal toxicity in these cases) and laboratory parameters would be essential.

It is quite clear there was no appropriate cardiac monitoring at 16 Beagle Street, and the gastro-intestinal toxicity resulting in seizures were explained as *"healing crises"* rather than life threatening events.

Dr Joyce described the toxic effects of the inappropriate administration of a number of the substances used in the infusions. Of those the most concerning, he believed, were caesium, Laetrile and DMSO. This was because of their individual adverse effects on metabolism. Dr Joyce was unable to comment on the practice of administering a number of toxic substances in conjunction with one another.[186]

Dr Joyce gave detailed evidence about metabolic processes and the relationships and effects these substances may have on different metabolic processes. At the conclusion of his explanation for the metabolic acidosis, hypercalcemia, gut toxicity and other known adverse

[186] Transcript 29.09.11, pg 1909

effects seen during the course of treatment between 14-25 May 2005, I put this to Dr Joyce.

> *"So in lay terms basically the whole of this treatment, as in the sum of all the parts of this treatment, relate to a very very complicated physiological situation which can't possibly be controlled properly when you're shunting unknown amounts of things through a system which is already sick because it's got a terminal illness. Would that be a fair summary?...Yes that's a fair summary..."*[187]

Dr Joyce then went on to explain a little of the pre-treatment pack and post treatment processes patients were supposed to follow prior to the intravenous treatment, and after the treatment. With respect to the pre-and-post treatment oral caesium chloride. Dr Joyce had this to say:

> *"even if caesium was the safest stuff on earth that would within three months have inevitably killed whoever had taken it – by what means I don't know, but caesium takes 50-60 days to eliminate half of it, so if someone was taking nine grams of caesium chloride a day for three months a significant portion of it would be caesium. So I can't believe that anybody would actually survive that."*

With respect to the amygdalin he had this to say,

> *"I saw in Pia Bosso's notes that the amygdalin tablets she was taking was 500milligrams so that might be 3grams of amygdalin a day. The amygdalin seems to be sold in two sizes, 100 and 50's so she might have been taking 600milligrams if she was taking two 100s three times a day, or might have been taking 3grams. 600milligrams of amygdalin is probably pretty*

[187] Transcript 26.09.11, pg 1914

safe…3grams per day, there have been serious intoxications linked to 3grams per day. The most vivid case is one where the woman was also taking vitamin C, so it's believed to have interfered with the ability to release or manage the cyanide from it. So 3grams of amygdalin a day sounds risky, but probably not to everyone". [188]

So in the context of, the substances administered were of themselves individually potentially toxic, especially in patients with a terminal illness, and the interrelationship between those substances and the amounts given, are an unknown entity, and certainly at odds with any ethically based experimental trial.

The patients at 16 Beagle Street were not even being used as experimental patients, but were paying patients, totally unaware of the risks of the treatment they were undertaking.

The substances used in the treatment administered by KPMHC in May 2005 included different mixes of the following:

1. Brewer's caesium chloride concentrate made by Apothécure
2. Biolink CT Caesium capsules made by Health Australasia
3. Caesium Potassium made by Rainbow Minerals
4. Liquid mineral caesium dietary supplement made by Rainbow minerals
5. Laetrile/Amygdalin/B17 from Medicina Alternativa

[188] Transcript 26.09.11, pg 1915

6. DMSO made by Apothécure
7. Magnesium sulphate 50% 50 ml vial made by Apothécure
8. Potassium Chloride 40EG 20 ml vial made by Apothécure
9. Potassium Chloride 1g/10 ml made by Apothécure
   Brewer's trace minerals concentrate made by Apothécure
10. Vitamin A INJ 10,000 IU/ml made by Apothécure
11. Ascorbic Acid 500mb/cc made by Apothécure
12. Brewer's Vitamin Concentrate made by Apothécure
13. Cyano-B12 2 mg/ml 30 ml made by Apothécure
14. Folic acid 10mg/ml made by Apothécure
15. Pyridoxine 100 mg/ml made by Apothécure
16. Dexpanthenol 200mg/ml made by Apothécure
17. EDTA Calcium Disodium 300mg/ml made by Apothécure
18. EDTA 150 mg/ml made by Apothécure
19. Rubidium 20 mcg/ml 200 ml INJ made by Apothécure
20. Rubidium Mineral ultra concentrate made by Ministry Minerals
21. DMSO Gel 91% 8 oz/16 oz made by Health Australasia
22. DMSO 1 Gallon made by Ministry Minerals
23. Liquid Mineral Potassium Dietary Supplement made by Rainbow Minerals
24. Super Magnesium 32 oz mineral water made by Rainbow Minerals
25. Liquid Mineral Magnesium made by Rainbow Minerals
26. Oxy /Bob Barefoot's Oxy Supreme made by Health Australasia
27. Bio-Link Coral Calcium capsules made by Health Australasia
28. Biolink Potassium chloride capsules made by Health Australasia
29. Biolink Vitamin D3 1000 (IU) capsules made by Health Australasia

30. Raintree Graviola Capsules made by Health Australasia
31. Gold Gel (Real Gold) 1 oz made by Health Australasia

These substances were mixed orally in the pre-and post-treatment packs and administered IV in the 12 day treatment course.

Dr Joyce noted all patients receiving the IV treatment experienced gut toxicity. There was not one person to whom the treatment was administered who did not experience gut toxicity during the time of the infusions. This was demonstrated both by the vomiting and diarrhoea, but also some of the few observations we have. The infusions usually ran for between 3-4 hours and on some occasions, when some patients were having particular difficulty during the course of the infusion, over eight hours.

Dr Joyce gave evidence he considered the gastrointestinal bleed suffered by **Sandra McCarty**, which was the primary cause of her death, was caused by the gut toxicity engendered by the treatment, particularly caesium, both in the pre- treatment pack and the treatment as a whole.

In the case of Sandra McCarty there were observations taken during the course of her treatment which in Dr Joyce's view warranted medical assessment. No appropriate medical assessment was undertaken. There were few blood pressure readings and towards the end

when there was one which was of concern, there were very few temperature measurement taken. The observations do not record the type of blood in Sandra's stools, although they were brought to Ms Phasey's attention. Ms Phasey disputed there was frank blood in the stools against the evidence of the family but there is no note of any description as to Ms Phasey's observations.

I am satisfied the state of Sandra McCarty's stools were drawn to Ms Phasey's attention, she confirmed it, and I accept the family were told the condition of Sandra's stools were a good sign and a symptom of healing. Sartori gave evidence he believed that was the case.[189]

I accept the blood may not have been frank originally with lesser bleeds, but there was no doubting it before her admission to hospital, by which time it was catastrophic. By the time Sandra McCarty was admitted to hospital she was passing bright red blood from her rectum. She also had painful abdominal swelling, a very low temperature and low blood pressure on admission to hospital at 9:14pm. Fremantle Hospital identified a coagulation disorder and an elevated plasma potassium concentration, low plasma sodium and acidosis consistent with hypovolaemic shock.

Sandra McCarty was a patient severely unwell with her naturally occurring disease. On that background a

[189] Transcript 18.11.10, pg 840

number of her medications were withdrawn which allowed fluid accumulation in her abdomen. Into this scenario were introduced volumes of electrolyte solution (caesium chloride and water) which contributed to her ascites. The withdrawal of her maxolon anti-emetic may have allowed the re-emergence of nausea related to her underlying ascites and her hepatic cancer deposits.

Dr Joyce did not accept the improvement in Sandra McCarty's liver function tests between 13-16 May was a reassurance her condition was improving in view of her other signs.[190] Nor did her tests improve thereafter, but it was not until late on 24 May she was admitted to hospital, close to death.

Added to that, Sandra McCarty's deteriorating clinical status, characterised by the nausea and vomiting during most days of infusion, is consistent with clinical toxicity from DMSO or magnesium. Similar experiences are mentioned in reports of human toxicity with caesium and with experimental caesium intoxication in animals.

Consequently, Dr Joyce believed the caesium salt may be a contributor to the gastrointestinal symptoms occurring during the treatment of Mrs McCarty. The fact her renal function and liver function further deteriorated during the IV treatment is consistent with the known toxicology of at

[190] Transcript 22.9.11, pg 1927

least DMSO, and probably the mixture of substances as a whole.

The fact the IV treatment contributed to her deteriorating health, Dr Joyce believed is inferred by the appearance of her clinical illness (nausea, vomiting, probable diarrhoea) during the infusions. Further deterioration in her liver function and kidney function occurred synchronously with the IV infusions, and there was then a syndrome of clinical toxicity (gastrointestinal toxicity and fluid accumulation) suggesting these too were linked with the infusions, and not simply part of the natural progression of her malignancy.

In Mrs McCarty's case Dr Joyce was also concerned her gastrointestinal bleeding may have been caused by the treatment. It occurred in two of the patients examined by this inquest, as did the gastrointestinal toxicity of all patients. In addition, Dr Joyce was concerned Mrs McCarty's health deteriorated during the administration of the treatment which meant when she developed the gastrointestinal bleed she was in a very poor condition, and much less able to survive the additional insult to her body.

In evidence it was noted the beginning of deterioration of Sandra McCarty in Darwin was consistent with the administration of the pre-treatment oral caesium. Before

that time she had been functioning relatively well in view of her illness[191]

The care received by Sandra McCarty also contributed to her demise because she developed known symptoms, which could have been treated and so reduced her susceptibility to added insult. Dr Joyce indicated her increasing ascites, and bleeding from her bowel were serious adverse events, even for a patient with cancer. Low blood pressure is of concern and Dr Joyce was of the view it should have been apparent to nursing staff she was unwell. It would have been appropriate for Dr Boyd or Sartori, as a result of information sent to him via Ms Phasey, to react appropriately to Mrs McCarty's deteriorating condition and stabilise her biochemistry.

In the case of Mrs McCarty the treatment should have been stopped, she should have been given proper medical assessment and urgently referred to hospital for correction as far as possible, of the metabolic derangement which had occurred.

Instead, Mrs McCarty was given a series of ineffective alternative type treatments, with reassurances from the staff to her family she was fine; the treatment should continue.

[191] Transcript 22.9.11, pg 1822

While conditions at the clinic were such it was very difficult for the nurses to maintain proper records, it is difficult to now know how much of her deterioration the nurses understood. However, they were aware of her rectal bleeding, frank or not, and her oedema, and if their claims of *"better than hospital care"* were correct, they should have made sure she was properly medically assessed, even if they had no time to record the observations appropriately.

Natalia Squires indicated the family repeatedly drew attention to her mother's deteriorating state and was reassured the symptoms were expected, and desirable, effects of the treatment, because it was *"her body getting rid of the cancer".*

I am satisfied Sartori's failure to allow conventional medicines to be taken, and Dr Boyd's failure to properly assess Mrs McCarty in a timely manner, ensured further derangement by way of dehydration, leading to severe electrolyte imbalance which then exacerbated the situation.

Dr Joyce considered that if Mrs McCarty's treatment had been stopped, and she had been taken to hospital earlier, she may well have survived. Her coagulation problems were reversible and this may have been sufficient to stop her bleeding and then the blood loss and its effects could have been corrected.

Instead, treatment continued and she was belatedly referred to hospital, when it was clear she was close to death. KMPHC staff did not advise the hospital of the extent of the treatment, and the influence of the philosophy of the treatment prevented the family from encouraging Mrs McCarty to take appropriate medication as recommended by the hospital.

The referral letter to the hospital was inadequate, and the information provided to hospital staff did not assist the hospital understand the origins of Mrs McCarty's gastrointestinal toxicity, or fully appraise her clinicians her condition may well have been due to chemical derangement rather than the natural progression of her malignancy. Natural progression of her malignancy may not have been reversible, but acute poisoning may well have been with appropriate fluid replacement, if the hospital had known that fact. Additionally, some of her pain could have been ameliorated.[192]

Dr Joyce said *"there's at least a possibility and may be a likelihood"* that failure to provide hospital staff with all the relevant information contributed directly to Mrs McCarty's death.[193] They may not have understood immediately what all the information meant, but it would be obvious there was a potential for toxicity rather than malignancy alone.

[192] Transcript 22.9.11, pg 1830
[193] Transcript 26.09.11, pg 1901

It is also the case the treatment, that is the substances administered, the clinical conditions and manner in which that occurred, caused Mrs McCarty significant suffering. Withdrawing her diuretic medication caused her to develop severe oedema and ascites which was very uncomfortable. She was in pain and had severe nausea, vomiting, diarrhoea and was unable to sleep.

Her daughter gave evidence the way in which Mrs McCarty eventually had to die *"was not fitting for someone who had spent their whole life being so good".*

David Joyce gave his original opinion as to **Pia Bosso's** death after reviewing the available documentation from:

- KPMHC;
- the receiving hospital when she was taken to hospital; and
- those hospital records in conjunction with the post mortem examination findings.

Dr Joyce described Mrs Bosso as dying of a heart rhythm disturbance, characteristic of other people who have been resuscitated from lethal heart rhythm disturbance after caesium administration. It is a disturbance which would be predicted from well characterised animal toxicology of caesium. Rarely, rhythm disturbances of this nature may occur in a person without known heart disease. However, the appearance of a rhythm disturbance typical for

caesium toxicity in a woman without a prior history of cardiac disease, and with a normal heart and coronary circulation at post mortem examination, makes it of likely caesium poisoning was the direct cause of death for Mrs Bosso.[194]

Dr Joyce pointed out Mrs Bosso had a classical clinical history,[195] for caesium induced rhythm disturbance. During the course of treatment there were many signs she may have been suffering caesium induced tachyarrhythmia. If they had been appropriately responded to and treatment stopped, Dr Joyce believed Mrs Bosso's life could have been saved.

Mrs Bosso developed an irregular pulse, drops in her blood pressure and multiple collapses of obviously different types. Dr Joyce said these would be alarming by themselves, but in the context of administration of a drug that had the ability to cause ventricular tachyarrhythmia they should have been *"very alarming"*.[196] Dr Joyce stated it seemed likely her collapses were caused by heart rhythm disturbances which were being caused by the caesium in the treatment provided by KPMHC.

In response to the originally perceived *"allergic reaction"* to Vitamin A, Dr Joyce indicated it was possible that was a cardiac event. A true allergic reaction to Vitamin A would

[194] Volume 21, Tab 11 pg 29
[195] Transcript 22.9.11, pg 1835
[196] Transcript 22.09.11, pg 1835

be rare. While the evidence is unclear, he considered if that reaction was in fact a period of collapse, or loss of consciousness, the first concern of the staff should have been that it was actually a life threatening cardiac ventricular tachyarrhythmia. If that was the case then the adrenalin which was given could have increased the risk of a lethal outcome at that stage. He said it was not reasonable for Dr Boyd to have agreed to the use of adrenaline without being sure of the origin of the collapse. The appropriate response to those symptoms at that time would have been to stop treatment and do a proper medical review which should have included an ECG at that time.

However, treatment was not stopped, and an ECG was not done until the evening of 22 May 2005. The indications are Mrs Bosso never underwent a proper medical review relating to her collapses, and whether or not the treatment could be causing those collapses.

The ECG tracing found in the car on 26 May 2005 was dated 22 May 2005, and Ms Phasey confirmed in evidence it was the tracing ordered by Dr Boyd that night. The ECG showed the changes which would be expected if someone was having heart rhythm disturbances caused by caesium, in that it showed a very prolonged QT interval, an irregular rhythm with multiple early narrow complexes and some falling on top of the T wave. Dr Joyce described it in evidence as indicating *"a*

particular risk of abnormal rapid rhythms degenerating into unsurvivable rhythms".[197] A proper response would have been urgent hospitalisation at that stage. Instead, she was given medication by Dr Boyd which did not offer any benefit to heart rhythm disturbances, and then sent home to the apartments. Her treatment continued the next day.

Mrs Bosso continued to have what KPMHC staff described as seizures but it seems more likely it was further heart rhythm disturbances. She was not given another ECG. Pia Bosso was provided with other treatments in response to her *"seizures"* and *"vasovagal episodes,"* none of which Dr Joyce believed to be appropriate for the alleged difficulty or the likely ventricular arrhythmia[198]

In Dr Joyce's view the practice of putting pressure on Mrs Bosso's *"governing vessel"* indicated how far the care Mrs Bosso received deviated from that which was reasonable in all her circumstances. Again, there is the issue of reasonable observations to ensure effective care.

Mrs Hoffman described Mrs Bosso as becoming increasingly unwell, and so sick, that by the evening of 25 May 2005, she was in an altered conscious state, unable to talk, and had to be carried away from the clinic following treatment.

[197] Transcript 22.09.11, pg 1835
[198] Transcript 22.09.11, pg 1839

Dr Joyce said in evidence *"someone who is so sick they can't walk themselves is in an urgent need of a diagnosis."*[199] Instead Pia Bosso was not provided with a detailed medical review, referred to hospital or given even an ECG. She was left on the bed in her apartment, with her niece to watch over her, who had absolutely no idea of what was occurring, nor was she advised by KPMHC staff. There was obviously no comprehension of just how sick Mrs Bosso had become. If KPMHC staff did not understand, how could her niece.

Mrs Bosso collapsed early the next morning, however, CPR was not sustained until the arrival of an ambulance. The ambulance officers were not told of the possibility of Mrs Bosso suffering a toxic reaction to caesium, despite the fact they managed to resuscitate her after CPR had been ceased. Dr Joyce was of the view withholding information on caesium administration meant there was no prospect of her being appropriately treated for the true cause of her illness and therefore successfully managed for a caesium induced ventricular tachyarrhythmia. This was not reasonable, however, it did not affect her appropriate resuscitation at that stage. This was despite KPMHC, not because of it.

Earlier presentation to hospital, with information of a caesium related toxicity, may have increased Mrs Bosso's chances of survival. If the final lethal arrhythmia had

[199] Transcript 22.09.11, pg 1842

occurred in hospital she would have had an increased chance of surviving. Dr Joyce indicated the treatment should have been stopped within the first few days, when Pia Bosso had her first collapse. This would have lessened the risk of the final lethal arrhythmia.[200]

The failure by KPMHC to even consider the possibility the substances she was being given may be causing harm is one of the perplexing and particularly concerning features of KPMHC while in Perth. There seems to have been no concern at all by Sartori or other medical/health care practitioners the treatment may be connected to her deterioration in health, and then her death.

Ms Phasey told police a few months later she believed Mrs Bosso died because her heart stopped because her airway was occluded.[201] Ms Phasey and Keith Preston insisted the reason Mrs Bosso died was because of the position in which she fell. This, they blamed upon Ms Hoffman, and to some extent Mrs Bosso herself for not providing an adequate carer. This does not explain why CPR was not continued for a reasonable period. The fact Pia Bosso was resuscitated by the ambulance officers indicates her 'down time' was not as prolonged as KPMHC staff allege. The fact she never regained consciousness, indicates how bad an arrhythmia it was.

[200] Transcript 22.09.11, pg 1844
[201] Volume 9, Tab 5A pg 30

It was clear from Sartori's evidence he has a tendency to blame patients and their carers for any adverse out comes from his treatment. While I accept KPMHC staff were unduly influenced by Sartori's doctrines this does not excuse the fact they were the carers present at the time and should have understood how sick and dependent on their appropriate input these patients were.

The blame attitude was reflected by Keith Preston when he told the police in July 2005.

> *"While she was under our care she was perfect but as soon as she had a carer that fell asleep and didn't look after her then was all it was she did exactly what she was told she hadn't to do, she hadn't to move anywhere at night time without somebody being with her and she got up out of bed, obviously she had a dizzy spell or something because she was a very quick lady….she has got up out of bed quick, the blood has not got to the head quickly enough, she has gone dizzy and I believe she banged her head on the wall because there was only a small amount of room between the wall and the bed and then she has gone down in a heap and her legs were trapped under her and her neck was trapped down and we believe that she would have chocked herself because we didn't know how long she was there. When we were looking after her she was okay, but as soon as she had a relative looking after her that fell asleep at the bottom of the bed. We don't know whether she left her there for 10 minutes, for an hour or two hours, or three hours, but when the girl woke up she came looking for us and I went in there with Simone and she was just collapsed in a heap and very very cold".*[202]

[202] Volume 9, Tab 3A, pg 22

It clear from his evidence a similar version of the event had been given to Sartori by KPMHC staff in Perth. It was also repeated to Covannia Young[203] and Mrs Ranieri.[204] It acted as a protective safety net to deflect concern in others about the administration of the treatment.

Mrs Bosso had gone from being a relatively well person with cancer, Mrs Ranieri commented how bright and bubbly she had been and how she kept everybody happy during treatment, to someone who died away from her immediate family and support.

Mrs Hoffman had this to say:-

> *"Its still pains her husband, the family, me and (Zia's) friends about her surprised death, with the worst being that nobody got to say goodbye to her or tell her anything personal before she died. Nobody other than I got to help or support her at a real time of need and nobody got to tell her all the things that need to be said when a person is leaving this earth, like – dying like, 'I love you' or 'thank you' or I'm sad you're going so soon". Nobody that knew her expected her to die during that treatment that Dr Boyd had arranged. Nobody, let alone someone's husband was expecting to be told over the telephone over 3,000klms away that his wife of 49 years is dead especially on their wedding anniversary....at the time of her death her parents, my grandparents, were still alive, being respectively 98 and 93 years of age. They didn't get to see their daughter before she died. They couldn't tell her that they loved her and all of the other things that parents want to tell their child before their death.....none of her nephews or nieces or friends got to say goodbye either and they were left speechless after*

[203] Transcript 11.11.10, pg 640
[204] Transcript 4.11.10, pg 334

> *her death and many have found it difficult to mourn after her sudden death.... The main issue for me is that the people that organised and carried out this so called cancer treatment took away her dignity in her last days, her dignity in how she was treated in her last days of life, the dignity in how she died and lack of necessary care or medical service during or after the treatment at Dr Boyd's house".* [205]

Dr Joyce indicated, if Mrs Bosso had been sent to hospital on 22 May after her abnormal ECG, with full and frank disclosure of the caesium treatment, she could have survived. The hospital would have had a chance to get familiar with the abnormal patho-physiology in her heart and to get studies underway to work out whether any of the anti-arrhythmic drugs were going to be able to control the risk while the caesium was eliminated. It would also have given the hospital the opportunity to consider dialysis to expel the caesium.[206]

Dr Joyce agreed with Dr Speers, a number of factors, related to the treatment received, led to **Sandra Kokalis'** death from a combination of causes.

Dr Joyce accepted Mrs Kokalis was in a *"very advanced state of malignant cachexia"*[207] indicating she was approaching the end of her life. Nevertheless, he was of the view the treatment she received from KMPHC accelerated her death and she died earlier than she would have done had she not undergone the treatment. In

[205] Transcript 1.11.10, pg 62/3
[206] Transcript 22.9.11, pg 1844
[207] Transcript 22.09.11, pg 1848

Dr Joyce's view there was good reason to suspect the gastrointestinal bleeding seen at post mortem examination was a toxic effect of the treatment. It occurred in two of the seven patients and related to the gastrointestinal toxicity, resulting in serious vomiting and diarrhoea in all patients who received it, and was therefore probably related to the treatment. [208].

At the very least, the gut toxicity exhibited by the vomiting and diarrhoea, would have caused deterioration in Mrs Kokalis' already compromised condition and affected her ability to withstand any further insult to her system.

Overall, Dr Joyce thought it was likely the care Mrs Kokalis received at 16 Beagle Street contributed to her death because of the known gut toxicity, the resulting gastrointestinal bleed, and Mrs Kokalis' metabolic derangement. In Mrs Kokalis' case there was the added difficulty of high calcium also affecting her metabolic derangement as a result of her type of cancer.

Dr Joyce advised the court people with too much calcium have problems with their kidneys and their brain. They are unable to control the waste disposal of sodium and their thinking function deteriorates. He indicated they may have an epileptic seizure and the more serious consequences which go along with an ability to maintain

[208] Transcript 22.09.11, pg 1875

normal neurological control of physiology processes. Uncontrolled hypercalcemia is a lethal illness.[209]

There was also the issue of Mrs Kokalis potential for infection as described by Dr Speers. Both Dr Speers and Dr Joyce referred to the inflammatory markers observed in Mrs Kokalis after commencement of the IV treatment. Despite this KPMHC did nothing, and indeed, were disconcerted when she presented to Joondalup Health Campus (JHC) early on the morning of 19 May 2005 requiring treatment with IV antibiotics.

Dr Joyce said the few observations indicated she had been developing an illness over the days beforehand. Those observations should have elicited a medical assessment and transfer to hospital before the seizure of the 19 May 2005. The fact she was then persuaded, by her belief in the philosophy of the treatment, to be discharged against medical advice, without suitable rehydration and stabilisation, other than oral antibiotics, placed her in a very vulnerable condition. Mrs Kokalis also had hypercalcaemia, which was not corrected, and a compensated metabolic acidosis, which was probably related to changes in her kidney function and an infection.

Dr Joyce, along with Dr Speers, was of the view the incompletely diagnosed and incompletely controlled infection, the hypercalcaemia and persisting compensated

[209] Transcript 29.09.11, pg 1876

metabolic acidosis, along with Mrs Kokalis' advanced malignancy, all contributed to her death.

Dr Joyce stated the restrictions on the interventions allowed for Mrs Kokalis would have greatly reduced the likelihood her illness could be successfully managed. The failure to administer IV fluids containing sodium was central to the treatment of the acidosis and hypercalcaemia and could have controlled them. The giving of magnesium as proposed by Sartori to Ms Phasey would have been of no benefit to Mrs Kokalis.

Dr Joyce stated in evidence the JHC notes indicate Sandra Kokalis presented as a patient with an uncontrolled infection. She also had hypercalcemia and a compensated metabolic acidosis, probably related to both her kidney function and the infection. Those problems in conjunction with her advanced malignancy meant she was very sick and had been for sometime as evidenced by the KPMHC observations and blood test inflammatory markers. Had she been able to be properly stabilised by JHC at that stage her prognosis would have been improved.[210]

Discharge from JHC with none of those problems resolved made for added suffering from untreated hypercalcaemia, dehydration, and the infection. This infection was not diagnosed in the time frame available and therefore not specifically targeted by ongoing oral antibiotics. Nothing

[210] Transcript 22.09.11, pg 1849/50

was able to be done to ameliorate the effects of hypercalcaemia. Dr Joyce thought the metabolic acidosis itself was a consequence of the infection. He would have expected that to settle once an infection was brought under control but this was inhibited by her discharge from JHC and the oral, as opposed to targeted IV, antibiotics.

Sandra Kokalis was very unwell at the time of her discharge from JHC and KPMHC should have been aware of this. They only agreed to her continued use of oral antibiotics. They did not alter their treatment of her once she returned to KPMHC and the daily treatment.

While Sartori provided a seizure protocol by email, even he agreed in evidence it was not ideal. Dr Joyce's view was Sartori's seizure protocol was *"not safe enough or efficacious enough to make it medically acceptable".*[211] He went on to explain magnesium sulphate would be contra-indicated in someone with severe liver disease, such as Mrs Kokalis, and that it should not be given without ECG monitoring, which obviously did not occur, because of the risk of cardio toxicity. The instruction to give diazepam which was Sartori's second line treatment creates the risk of giving a dose which would suppress breathing, and the delay recommended for treating the seizures was too long. Further, Dr Joyce indicated the dosage of phenytoin was a serious over dosage and neurological toxicity would be a likely outcome, with cardiac toxicity a possibility.

[211] Volume 21, tab 2, pg 5

In addition to the seizure protocol there was a failure on behalf of KPMHC to take vital observations of Mrs Kokalis, even though it was known she was unwell on her release from JHC. While I accept this period coincides with the increase in patients which the nurses were having difficulty caring for appropriately, it does not excuse why someone who was known to be sick, was not provided with observations which would follow her illness. Mrs Kokalis had no temperatures recorded, no blood tests taken, nor was she given appropriate medications to treat her condition.

Dr Joyce's believed if it had been realised how unwell she was, and she had been returned to hospital, it would have allowed proper management of her conditions and enabled them to be effectively treated. Rather, with the continuation of treatment, so she continued to deteriorate.

By the evening of 25 May 2005 Dr Joyce said it was obvious Mrs Kokalis had deteriorated, was very tired, weak and extremely sick. She was not reviewed, diagnosed or transferred to hospital. She was in urgent need of a comprehensive medical assessment and it was unreasonable for that not to occur.

I accept Dr Boyd stated in evidence she suggested they go to hospital that evening, however, I am quite sure Nikolaos Couanis would not have hesitated to take Mrs Kokalis if

that had been Dr Boyd's unequivocal advice. This family tried very hard to comply with KPMHC advice.

By the time Dr Boyd did suggest Mrs Kokalis be transferred to hospital the following morning she was extremely unwell, and the information Dr Boyd provided the hospital did not mention her treatment. Whether or not it would have been used at that time, it was very relevant information for the hospital and Dr Boyd would have known that. Dr Boyd also failed to mention Mrs Kokalis' previous admission to JHC which would have given SCGH the opportunity to contact that hospital for their information and history.

Whether or not Dr Boyd knew of the admission to JHC is irrelevant in the overall expectation of a doctor/patient relationship. She should have known and provided the information, and if she did not know it is an indication of how much she was not involved in the conventional treatment of these patients in contravention of their understanding of her position in their treatment. .

I accept RN Baker attempted to provide more information later in the day. However, the family were still clearly refusing saline and dextrose which would have alleviated Mrs Kokalis' distress and assisted her, even though it may not have made a difference to the outcome at such a late stage.

Dr Joyce was also concerned Mrs Kokalis had symptoms of cyanide toxicity which would have related to oral, as opposed to IV, Laetrile. KMPHC insist no Laetrile was administered via naso-gastric tubes during the 12 days of IV treatment, only as part of the pre-and post-treatment packs. The naso-gastric tubes were for the nutrition of the patients only due to the difficulties with nausea and vomiting. Mrs Kokalis' metabolic derangement can be explained by the contribution of factors already referred to, however, a feeling of unease arises about the continuation of the treatment orally when KMPHC were unable to administer it IV, due to the very strong philosophy of the treatment.

I accept Mrs Kokalis' family were not distressed at the treatment of Mrs Kokalis by KMPHC, and understood the treatment to be frowned upon by conventional clinicians. Hence, their anxiety to remove Mrs Kokalis from JHC once she had been provided with antibiotics. They accepted her clinical care could have been better, they also accepted the nurses were extremely busy and unable to provide more care.

In their view Mrs Kokalis was so unwell with her malignancy they were prepared to take the risk she died prematurely if the treatment did not work because her quality of life was so depleted.

I am not sure her family understood her life could have been both easier and prolonged had she accepted conventional palliative care, but I understand survival alone may not have been an issue for them by that time. I accept they were resigned to her death within a relatively short time should the treatment fail.

It is my view, however, the poor clinical care provided to Mrs Kokalis by KMPHC and her premature discharge from JHC, without proper stabilisation, accelerated her death and provided little relief from her deteriorating health. I accept this was her choice but I am not satisfied she was sufficiently aware of the risks of the treatment itself and the potential for it to accelerate her death, at the time she commenced the treatment. She died in extremely distressing circumstances.

Dr Joyce agreed with Dr Speers and Dr van Hazel it was likely **Deborah Gruber's** treatment at 16 Beagle Street not only caused her infection, but also failed to appropriately diagnose and then treat the infection and so improve her chances of survival. Dr Joyce pointed out Mrs Gruber's clinical deterioration began and ended during the time of the administration of the treatment, and the one element which was a clear consequence of the treatment, was the gastrointestinal toxicity suffered by all patients. He also believed there was an additional element, the seizures experienced by Mrs Gruber, which lie amongst the described adverse affects of the treatment. He thought it

possible the seizures and gut toxicity could have been survivable on their own for Mrs Gruber, but became overwhelmed by her state of infection.

Overall, I am satisfied there were not sufficient procedures and protocols in place to protect the patients from the likelihood of infection considering the clinical conditions in which it had to be administered. Whether or not gloves were worn, or lines were flushed, it was impossible to safely conduct the IV administration of substances in an environment where there was little separation of a number of patients with serious gastro-intestinal toxicity and the preparation of the substances being used.

The difficulty with Mrs Gruber's PICC line was noted as soon as she was admitted to Fremantle Hospital, and appropriate steps were taken to ensure both its positioning and viability, before it was used.

I accept Ms Phasey believed appropriate protocols were undertaken at 16 Beagle Street, but it is a matter of logic the conditions were such this was impossible.[212] I note also Ms De Wilt's evidence she did not believe conditions were sterile during the administration of treatment, although she indicated gloves were worn and PICC lines flushed. [213]

[212] Transcript 18.09.11, pg 1972 – 1977
[213] Transcript 10.11.10, pg 576/7)

In the case of **Carmelo Vinciullo** all experts agreed they did not believe the four days treatment he received accelerated his death.

Dr Joyce did note, however, Carmelo Vinciullo still had residual caesium in his post mortem results, at a level which has been associated with lethal outcomes in other patients. This is due to caesium's long half-life and slow excretion from the body, and is consistent with lethal outcomes due to a cumulative effect of the ingestion of caesium.

Dr Joyce raised concern the racing heart Mr Vinciullo discussed with Dr Trotter in June 20205 should have stimulated a medical assessment at the time Mr Vinciullo commenced treatment on 20 May 2005. While it would seem to be clear Mr Vinciullo's voluntary cessation of treatment protected him from further accumulation of caesium, there was always the likelihood with his symptoms, he would have succumbed to some form of cardio-toxicity. He had extensive adhesive pericarditis at post mortem examination. His heart was already compromised and it was likely further accumulations of caesium would have had an adverse affect. It is a tragedy he was the only patient perceptive enough to realise the treatment could kill him if he continued with it.

The main issue of concern with Mr Vinciullo's treatment at 16 Beagle Street was the withdrawal, albeit more gradually than Sartori intended, of his pain medication. Mr Vinciullo had a serious pain problem which had been very difficult to manage and he had a significant fear of being in further pain. After a long time his doctors had only just been able to control his pain with large doses of numerous medications. Dr Trotter said Mr Vinciullo was one of the most difficult pain issues he had to deal with in his entire career.

Mr Vinciullo suffered significant pain with the reduction in his pain medication and the administration of the infusion. Rather than provide him with effective pain relief, he was repeatedly told he had to come off his medications and encouraged to get on with the treatment. The positioning of Mr Vinciullo's tumour and its growth was exceptionally painful in and of itself, and to allow that pain to re-emerge to an intolerable level was an inhuman thing to do. [214]

He was also at risk of the additional suffering caused by opiate withdrawal but it seems he returned to medication before that became significant. Sartori was well aware of the medications Mr Vinciullo was taking because they were emailed to him by Ms Phasey. Sartori insisted Mr Vinciullo be removed from all pain

[214] Transcript 26.09.11, pg 1180

medication, and it was only the empathy of Ms Phasey which attempted to ameliorate that to some extent, by withdrawing him gradually.

In addition to his pain, Mr Vinciullo suffered from palpitations and a racing heart during the infusions themselves. This was not noted in his observations. It is clear Dr Boyd was aware of them when giving her order for a CT scan prior to advising Mr Vinciullo to cease treatment. They were recorded by Dr Trotter when Mr Vinciullo told him about them days after treatment had stopped.

Dr Joyce gave evidence this should have raised concern Mr Vinciullo was having caesium induced tachyarrhythmias. KPMHC staff should have stopped his treatment at that time, and he should have been given a clinical assessment with an ECG, rather than the treatment continuing until he went to Dr Boyd himself for a review.

Dr Boyd indicated her imaging showed Mr Vinciullo's cancer had spread and therefore was incompatible with the treatment, however the scans showed nothing which had not been present before the commencement of the treatment. If the position and size of his tumour was a cause for concern he should have been advised not to commence the treatment. If KMPHC had been providing appropriate medical care there would have been a proper

conventional medical assessment from which to derive base line results.

Antonio Ranieri

A death certificate was produced for **Antonio Ranieri** when he died on 1 November 2009. His cause of death was given as *"acute respiratory distress syndrome, chronic lymphocytic leukaemia"* and as a contributory cause *"asbestosis"*. There are blood profiles for Mr Ranieri reflecting his liver function and renal function at the time of the May 2005 clinic. There is no doubt he was significantly unwell during treatment, however, Mr Ranieri had many other treatments following that of the May 2005 clinic because there had been no effect on the progress of his disease.

Dr van Hazel and Dr Joyce were both asked to comment upon the effect of the treatment on Antonio Ranieri. Dr van Hazel only had Mrs Ranieri's statement when he provided his opinion which was essentially unaffected by the evidence Mrs Ranieri gave in court, other than she explained some of the background information a little better.

Antonio Ranieri had presented to his GP in late December 2003. Dr Carbone referred him to an Oncologist on 5 January 2004. Dr van Hazel said he did not believe an Oncologist would have told Mr Ranieri he only had six months to live with a low grade lymphoma. This needs to be put into context with Mrs Ranieri's evidence in court.

Mrs Ranieri explained her mother had been diagnosed in 1996 with exactly the same cancer as was later diagnosed in her husband in 2003. At that time Mrs Ranieri's mother had been told precisely the information which Dr van Hazel said was relevant to the cancer from which both Mrs Ranieri's mother and Mr Ranieri were suffering. Dr van Hazel's evidence was any experienced haematologist would know patients with low grade lymphomas do very well, with some patients living many years after the diagnosis, sometimes with very little treatment. He gave ten years as an estimate of a life expectancy with that diagnosis.

Mrs Ranieri explained the family had been very happy when told her mother had a long time to live and were extremely shocked when she seemed to deteriorate very quickly, despite chemotherapy. Due to her mother's rapid deterioration her family began to look for alternatives to chemotherapy for her mother, and through that research located a Dr Contreras at Oasis Hospital in Mexico. They were in contact with Dr Contreras three months before Mrs Ranieri's mother died. He communicated information to them which they felt helped her mother. He told them she should stop chemotherapy and travel to Mexico. Unfortunately, Mrs Ranieri's mother suffered extreme liver failure and was too unwell to travel to Mexico and died approximately seven months from the date of her diagnosis.

Consequently, when Antonio Ranieri was diagnosed with the same cancer in late 2003, the Ranieri family considered realistically six months was how long Mrs Ranieri's mother had lived. They considered it essential Antonio Ranieri accessed the alternatives as quickly as possible. Because they had already been in contact with Dr Contreras in Mexico they contacted him, and whilst Antonio Ranieri was still well, they travelled to Mexico to undergo treatment with Laetrile. They made that decision in approximately January 2004 following a discussion with their haematologist about his prognosis.

Mrs Ranieri's evidence was the treatment in Mexico lasted for four weeks and her husband was very well on the treatment. When they returned to Australia she continued to administer Laetrile which she obtained from overseas.[215]

On their return to Australia Mrs Ranieri and her husband met Genieve Bond and communicated with her about the treatment in Darwin. Genevive Bond was obviously very positive about how she believed she had benefited from the treatment and explained to the Ranieris it was harsh, in that she felt unwell and had a lot of vomiting and diarrhoea, but she believed it had been effective.

[215] Transcript 4.11.10, pg 322

The Ranieris contacted the KPMHC in Darwin and were advised they would need a PICC line for the treatment to commence. Antonio Ranieri already had a PICC line from his Laetrile administration, but went to Dr Boyd for thermal imaging, and then commenced treatment once it was available in Perth. He was required to stop all other treatment, including the Laetrile, one week before commencement of the treatment.

Mrs Ranieri explained the treatment lasted for her husband for approximately 2-3 hours per day. He was the first patient to be treated each morning and as far as she was aware her husband had 11-12 days of treatment. They returned home after his treatment and therefore were not so involved with the other patients in the clinic.

Mrs Ranieri however, had a very clear memory of Pia Bosso being a bright, bubbly, wonderful personality, who suddenly was no longer there. She recalled Deborah Gruber and Sandra McCarty as being extremely sick.

Mrs Ranieri described her husband as being reasonably well at the start of treatment but becoming very unwell after 2-3 days of treatment. She said he would have diarrhoea or vomiting four or five times during the 2-3 hours of the infusion and by the end of the first week he was very ill. She said he did not have pain, however, he lost 8 kilograms in 12 days and was extremely sick. After the conclusion of the treatment Antonio Ranieiri remained

extremely sick, and when reviewed by Dr Carbone on 3 June 2005 he was very unwell. He contracted pneumonia from which he could not recover without hospitalisation for a period of time at Hollywood hospital. Eventually, Mr Ranieri recovered from the treatment but his cancer was still present.

After that the Ranieris continued with a combination of alternative and conventional treatments. In May 2008 they went back to Mexico where Mr Ranieri had IV caesium with Dr Maheer at St Marks Hospital.

Mrs Ranieri commented that both at the Oasis Hospital in Mexico with the administration of Laetrile (B17), and at St Marks, she and her husband were very well educated about the treatments they were utilising. Her husband was not unwell on either of those occasions and when asked to compare the treatments with that provided by KPMHC in Perth, Mrs Ranieri was quite adamant Sartori did not know what he was doing.

It was her view Sartori had done harm, whereas Dr Maheer at St Marks had certainly done no harm, even if he had not done any good. In Mrs Ranieri's words,

> *"the treatment we done in Mexico with Dr Maheer didn't do any harm to Tony even if it didn't do any good. If you want to say it didn't do any good to Tony's life extension, that's okay but he didn't do any harm either. He was well when we were leaving the*

> *hospital"*[216] and *"something was missing from Dr Sartori's knowledge to be in the caesium treatment that made the caesium to make them unwell. Something is missing. What it is I could not tell you because I am not a doctor"*[217]

Mrs Ranieri said,

> *"the clinic at 16 Beagle Street was full of sick people and (her husband) left very unwell. The treatment in Mexico was full of happy people who were laughing and left the clinic well, even if not cured".*

In her view the vomiting and diarrhoea at 16 Beagle Street made everybody sick, even if they were well and didn't have cancer.

Dr van Hazel's view was Mr Ranieri survived the May 2005 treatment because he was not as ill with his cancer, and therefore not as vulnerable to the difficulties with the treatment. Even with conventional chemotherapy different people react in different ways, and conventional medicine changes medication in an attempt to match patients with an effective proven medication.

Dr van Hazel noted Antonio Ranieri did have some conventional chemotherapy in Mexico when he was having the original (B17) Laetrile treatment. He said on Mr Ranieri's return to Australia he continued with the Laetrile treatment. I suspect this causes some angst for Dr van Hazel because, as he stated in evidence, if people are undertaking both an alternative therapy and

[216] Transcript 4.11.10, pg 338
[217] Transcript 4.11.10, pg 336

conventional therapy, and remain relatively stable, patients tend to credit that to the alternative or unproven therapy, rather than the conventional therapy.[218]

While Mrs Ranieri believed their oncologist had told her husband he had only had six months to live, the notes of the haematologist indicated he discussed with Mr Ranieri, at some length, that the small lymphocytic lymphoma which had been diagnosed from biopsy in August 2004, was a low grade lymphoma. This was generally sensitive to chemotherapy and radiotherapy and there was a likelihood Mr Ranieri would experience prolonged remission which in some cases could last for many years. Despite this, probably as a result of the history with Mrs Ranieri's mother, Mr Ranieri did not accept conventional treatment and tried alternative treatments both in Mexico and the May 2005 clinic in Mosman Park.

Dr van Hazel indicated a CT scan before the May treatment, and the ones he reviewed following Mr Ranieri's KPMHC treatment indicated no change in Mr Ranieri's lymphoma. Mr Ranieri was admitted to hospital in June 2005 suffering pneumonia, due to his weakened state after the May 2005 KPMHC clinic.

In November 2006 Mr Ranieri was admitted to SCGH with a five kilogram weight loss, night sweats, anorexia and lengthy massive intra-abdominal disease. His bone

[218] Transcript 21.09.11 pg 2040

marrow was positive. Mr Ranieri finally consented to conventional chemotherapy.

A CT scan just prior to that treatment showed no significant change since September 2005, which was showing extensive cervical, axillae, thoracic, abdominal and pelvic lymphadenopathy Mr Ranieri had a second cycle of chemotherapy in January 2007 and a staging scan on 30 January 2007 showed approximately 50% volume reduction in his disease. A 50% volume reduction in tumours is acknowledged to be a positive outcome from treatment. This was after conventional chemotherapy rather than any of the alternative treatments.

Mr Ranieri then remained well until October 2007 when it was clear his disease was again progressing. He had further chemotherapy in November 2007 and January 2008, but these rounds of chemotherapy barely improved his situation. By June 2008 Mr Ranieri required re-admission to SCGH with an exacerbation of his chronic obstructive pulmonary disease. A CT scan showed mild reduction in the lymphadenopathy. He was discharged home on oxygen in May 2009.

Mr Ranieri was finally admitted to SCGH on 14 October 2009 with worsening respiratory disease, together with low grade neutropenia due to bone marrow infiltration.

He died on 1 November 2009.

As the result of the length of this medical history Dr van Hazel was concerned Mr Ranieri had rejected conventional chemotherapy, originally. The general expectation would be Mr Ranieri had a 50 percent chance of surviving ten years with his disease as it was in August 2004. However, that was not the only difficulty for Mr Ranieri. His history of asbestosis clouded the clarity of any prognosis for Mr Ranieri.

Dr van Hazel's final conclusion as to Mr Ranieri's life expectancy was as follows:

> *"However, despite this he managed to survive almost six years from diagnosis. I believe the alternative treatment that he had had no effect on his life expectancy in a direct manner. The evidence for this is the lack of change seen on his CT scans before and after the therapy in the middle of 2005. However, I believe that it had indirect effect by frightening him off conventional treatment and giving him false assurance he was getting effective treatment. I believe if he had more conventional treatment he may have lived longer. However, I note the proper cause of death was progressive lung disease rather than the lymphoma itself"* [219]

Overall, from the hard evidence of the scans, it would seem the only effective treatment in reducing Mr Ranieri's lymphoma for a period of time was the 50% volume reduction following conventional therapy in January 2007.

[219] (Volume 21, pg 24

Dr Joyce was also concerned the treatment provided by the May 2005 KPMHC clinic made Mr Ranieri unnecessarily unwell, with no perceived benefit.

As with Dr van Hazel, Dr Joyce's view arose from a comparison of CT scans of Mr Ranieri's chest and abdomen two months before treatment, and four months after treatment, at the May 2005 clinic.

In addition to the status of his lymphoma the concern was how unwell the treatment made Mr Ranieri. Dr Joyce listed four serious consequences of the treatment for Mr Ranieri from looking at his blood tests:

- prior to treatment, or the perceived base line,
- the blood tests over the time of the treatment, and his blood after treatment.

Dr Carbone, his GP, started caring for him again approximately 10 days after the conclusion of the May 2005 clinic.

1. Dr Joyce stated Mr Ranieri experienced severe dehydration as a result of gut toxicity from the caesium, vitamin, Laetrile, mineral, DMSO infusions. There was a concentration of his haemoglobin and proteins as his kidney function deteriorated during the period of treatment. Dr Joyce believed the reason for this was the excessive diarrhoea and vomiting recorded for all patients during treatment.

2. Mr Ranieri also developed hepatic function derangement during the treatment, which Dr Joyce thought was a consequence of the infusions. There was no alternate explanation for the deterioration which happened chronologically in relation to the administration of the infusions, and then resolved once the infusions had stopped.

3. Dr Joyce also observed Mr Ranieri had developed a high magnesium concentration in his blood, hypermagnesium, due to the large amounts of magnesium administered through the treatment. Dr Joyce indicated, in the context of dehydration related to acute renal impairment, this would not normally be a problem unless there was failing kidney function.

4. Finally, Dr Joyce was of the view Mr Ranieri had been developing an inflammatory condition by the time of his last infusion. His very vulnerable state was making him susceptible to infection, and his history over the next few days, when back under Dr Carbone's care, was that of the involvement of an illness which caused Mr Ranieri's hospitalisation on 13 June 2005 with pneumonia.[220]

[220] Transcript 26.0.11, pg 1884/5

Dr Joyce based his conclusion on consideration of the laboratory results conducted towards the end of the infusion regime, the notes and records from Dr Carbone after he took over the care of Mr Ranieri for a respiratory infection, and his final hospitalisation for that condition on 13 June 2005.

Overall, Dr Joyce was of the view Mr Ranieri was surprisingly sick from dehydration for a man who had been able to manage at home quite well up until the May 2005 clinic. Dr Joyce said that was typical of dehydration seen from gut infections and gut toxicity. Dr Joyce thought Mr Ranieri had recovered surprisingly well on his return home from the treatment as there was an improvement in his hydration, and consequently his kidney function, on his return home. However, that did not prevent his inflammatory condition worsening to the stage he had to be hospitalised for pneumonia.

Dr Joyce considered Mr Ranieri's blood tests at the conclusion of the May 2005 clinic would have warranted hospitalisation for rehydration, in and of themselves.

Dr Speers was not asked to comment on Mr Ranieri because Dr Joyce had all the relevant medical records.

PATIENT SUMMARY	*Age*	*Gender*	DR MARGOLIUS **Forensic Pathologist** With chemical analysis Mr Robert Hansson **Chief Chemist**	DR VAN HAZEL **Clinical Oncologist**	DR SPEERS **Clinical Microbiologist**	DR JOYCE **Clinical Pharmacology & Toxicology**
SANDRA McCarty Diagnosed (1995) Metastatic /Breast Cancer Treatment -11 days Admitted to Fremantle Hospital 09.14pm on 24.05.05 Died 05:55am on 25.05.05	53	♀	Widespread Metastatic Breast Carcinoma in Association with Caesium Administration	3-4 months without treatment (?liver function) test pre pac	Not considered	Treatment induced gut toxicity → G1H and metabolic derangement from which she could not recover
PIA BOSS Diagnosed (1997) Metastatic Medullary Carcinoma of Thyroid Treatment ? 8 days Admitted to Fremantle Hospital 02:30am on 26.05.05 Died 09:40pm 26.05.05	68	♀	Metastatic Thyroid Carcinoma in Association with Caesium Toxicity	Months to years	Cannot exclude some contribution to cardiac arrhythmia from infection	Caesium induced arrhythmia
SANDRA KOKALIS Diagnosed (1995) Metastatic Colonic Carcinoma Treatment 11 days Admitted to SCGH 08:59am on 26.05.05 Died 10:05pm on 27.05.05	52	♀	Metastatic Colonic Carcinoma in Association with Caesium Toxicity and Gastrointestinal Haemorrhage	Weeks to months	Discharged from JHC on 19.05.05 with oral antibiotics. She was metabolically deranged. Proper management could have made difference to out come.	GI H from gut toxicity. Metabolic derangement, hypercalcemia and seizures
DEBORAH GRUBER Diagnosed (2001) Breast Cancer/Metastasised Treatment 10 days Admitted to Fremantle Hospital 09:10am on 26.05.05 Died 10:50pm on 28.05.05	42	♀	Septicaemia and Metastatic Breast Carcinoma in Association with Caesium Administration	Months but? Months to years if conventionally treated	Sepsis due to *S.aureus* bacteraemia secondary to an infected PICC	Sepsis due to lack of appropriate clinical care
CARMELLO VINCIULLO Diagnosed (2000) Ewing's Sarcoma Treatment 4/5days Died on 01.07.05	29	♂	Metastatic Ewing's Sarcoma in a man subject to recent Caesium Administration	No different	Not considered	No effect but - ? Continued
ANTONIO RANIERI Diagnosed (2003) Chronic lymphocytic lymphoma Treatment 12 days (11 recorded) very sick 25.05.05 Went on to have mixture. Alternative and Conventional. Died 01.11.09		♂	Acute Respiratory Distress Syndrome Chronic Lymphocytic Leukaemia. Contributory Asbestosis	Conventional treatment earlier may have extended life to 2012	Not considered	Certainly caused his Sickness → Pneumonia

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied Sandra McCarty, Pia Bosso, Sandra Kokalis, Deborah Gruber and Carmello Vinciullo all suffered incurable cancer of one form or another. Most of them had lived with their cancer for a number of years and during that time had seen periods of remission and progression of their malignancy. Some of them had tried conventional therapies by way of surgery, radiotherapy and chemotherapy, and in addition had experimented with unproven therapies.

The conventional medical doctors from whom the court heard who were involved in the care of these patients, prior to their treatment at 16 Beagle Street, were at the stage of their doctor/patient relationship of easing their patients into an acceptance of the inability of conventional medicine to end their disease, and were preparing their patients for palliative care.

While palliative care signifies to many the terminal element of their malignancy, it can, with proper adjustment of medication also ameliorate pain and suffering and allow the recipient an improved quality of life over the continuation of active interventions. Sometimes this also acts to extend life beyond that expected by their treating doctors.

All patients were anxious to survive. They, and most certainly their families, had lives they loved and wished to continue, without illness. This made them very vulnerable to a claim their cancer could not only be stalled, but most probably cured. All they had to do was believe.

Most conventional clinicians are quite philosophical about their patients wishing to experiment with alternative medicines at this stage. As Dr Trotter stated with respect to Carmello, he would have hoped Carmello would have discussed the proposed unproven therapy with him, but he could understand why Carmello did not.

Sartori had been promoting his form of treatment for a number of years. There is no doubt he now perceives families desperate enough to turn to him, as experimental subjects who will pay for a chance, any chance, to survive.

Into this scenario entered the Prestons in 2004 and their belief they had found a cure for Kathleen Preston's cancer which was thwarted by a surgical error in conventional medicine.

It was Keith Preston's belief which inspired KPMHC and the treatment in Australia, as opposed to off-shore. Mr Preston did not have the expertise or knowledge to understand the science behind the alleged cure. To him conventional therapies were extremely stressful, and patients undergoing chemotherapy and radiotherapy often

suffered. Consequently, the thought of what he described as a *"harsh"* treatment, for a short period of time, seemed a reasonable alternative.

I do not doubt the *"healthy"* as opposed to *"natural"* nutrition supplied to patients, was beneficial in patients having difficulty with their appetite.

The difficulty with the high pH treatment promoted by Sartori was the fact there was no scientific or ethical basis whatsoever for its administration. There was not even a sound experimental clinical trial upon which certain expectations may be grounded.

The fact it was not a recognised clinical trial meant the conditions in which it had to be undertaken, further exacerbated the risk to the people undertaking the treatment. Unfortunately, none of those people understood the reality of the treatment they were undertaking and the very philosophy of the treatment indoctrinated them into a state of mind which prevented them questioning the surrounding circumstances.

I have no doubt Sartori was extremely enthusiastic at the prospect of a *"clinic"*, where he could use real patients to refine his theory. Sartori knew full well the dangers with the substances he was using, especially caesium, but appeared to believe he could control some of the metabolic derangement suffered by patients by indiscriminately

manipulating their biochemistry. He does not appear to have been concerned, or dissuaded, by the interaction of the substances on his patients. The whole treatment resulted in a concoction of unknown effect, on different types of cancer, in different individuals. The fact the cancers were present in living people, all of whom would be affected by the substances, seemed to be of secondary importance.

Of significance is the fact the patients, and particularly their families, were desperate for their loved ones to live. This made both the patients and their families extremely vulnerable to the effects of a doctrine which demanded total and unquestioning compliance. By the time families, or patients, were in a position to question the viability of the treatment, they were usually at such a stage of involvement it was difficult to extract themselves without always wondering if they may in fact have been *"cured"* if they had continued.

I believe it was for this reason a number of patients, and their families, who considered stopping the treatment, decided to continue.

I am satisfied, however, on the whole of the evidence, the doctrines espoused by the proponents of the treatment, encouraged compliance in patients, and their families, which ultimately led to the death of the four women who continued treatment, despite understanding they were

extremely ill. The most concerning element of the treatment was the total lack of realisation the treatment itself was a threat to their life.

In not one case of people treated by KPMHC was there any evidence cancer had been reversed, or even inhibited, in any of the persons undertaking the treatment. Some mention was made of the fact some people survived after the treatment and so it must have extended their lives. There is no reliable evidence this is the case. There is no reliable evidence those people would have died any earlier because of their cancer.

The only reliable evidence we have to date is that gleaned from the records of the patients studied for the purposes of the inquest.

Of those we have been able to study, the evidence is clear Sandra McCarty, Pia Bosso, Sandra Kokalis and Deborah Gruber would not have died naturally from their malignancies at the time they died from the effects of the treatment on their already compromised systems.

I accept the starting point for each and every patient was well advanced cancer from which there was no longer any hope of cure by conventional medicine. I accept most patients consented to the treatment understanding it was "*not mainstream*". I do not believe any of the patients, or their families, understood there was a chance the

treatment itself could kill them. This was not informed consent.

The extent of their understanding of the treatment was that it was highly likely it would cure them of their cancer, regardless of its stage or type. In the event the treatment did not cure them of their cancer, they would then die from their malignancy which was the prospect they faced before commencement of the treatment. To these people, who were very anxious to live, there was nothing to lose.

While without their cancer none of these patients would have undertaken the treatment, in the end it was the treatment that caused their deaths at the time death occurred, rather than their malignancy.

The whole issue of the treatment moving from Darwin to Perth because of Sartori's physical absence really emphasises KPMHC's need for Dr Boyd's participation for the treatment to continue for patients already prepared to pay for and commence the treatment.

One has to assume that but for Sartori's absence, the same process could have been undertaken in Darwin, with the general medical practitioners already in place, and familiar with KPMHC, in that location.

Those doctors were sympathetic to alternative/unproven therapies and had provided conventional medical input to

KPMHC. Presumably the same process could have been undergone in Darwin, as did in Perth, with RN Phasey communicating remotely with Sartori, however, those doctors were not prepared to continue in Sartori's absence.

Instead KPMHC was moved to Perth so Dr Boyd could act in Sartori's stead, and provide the support the conventional doctors had in Darwin. While Dr Boyd denies this was the situation there can be no other explanation for the perceived need to move the treatment to Perth.

Once in Perth and in operation, Dr Boyd attempted to distance herself discreetly from the treatment. However, that did not end the doctor/patient relationship into which all patients believed they had entered, as a result of the information with which they were provided as to their care whilst undergoing the treatment. The fact Dr Boyd distanced herself, especially when realising how unwell the patients were, is significant. Dr Boyd must have recognised there were problems with the treatment and the reasonable thing to have done would have been to stop the treatment. She may have saved the lives of those four women being treated in her home.

RN Baker was totally seduced by the concept of being a pioneer in an alternative/unproven therapy and her trust

in Dr Boyd blunted her perception of the ill effects of Sartori's therapy.

Ms Phasey appears to have been totally convinced by Sartori, when trained by him in Darwin, and I have no doubt she was educated enough to understand what he was trying to do, but not educated enough to understand the treatment itself was producing adverse results. I accept Ms Phasey was resentful of the lack of support she received from Dr Boyd. This was not unreasonable in a doctor/nurse relationship. This consequently made her more dependent on Sartori's, very biased, input. To Sartori this was a perfect situation; he claimed not to be responsible for the outcomes because he was not present, but had a perfect conduit via Ms Phasey who, mostly, followed his advice closely.

The outcome of this combination was fatal for Sandra McCarty, Pia Bosso, Sandra Kokalis and Deborah Gruber. These people placed complete faith in the treatment, desperately wanted to live, and faithfully abided by the philosophy of the treatment in the belief that would see their cure.

They did everything KPMHC asked of them. They followed the policies and protocols of KPMHC to the exclusion of life saving conventional medications, which would have lessened their suffering, and allowed them some stability with which to approach their remaining lives.

The conclusion I have to draw from all of the evidence with respect to **Sandra McCarty** was she was very unwell with her cancer, but had a life expectancy of 2-3 months at the time she was commenced on the pre-treatment pack in Darwin. Consequently, the treatment she received from KPMHC hastened her death by way of a GIH arising out of the toxic effect of the treatment on her now deranged metabolism.

I accept KPMHC staff indicated they were unaware of the fact caesium could cause cardiac toxicity, however, that simply is not a reasonable response from medical/health/general practitioners involved in promoting a treatment which uses IV caesium. Sartori clearly knew.[221] This was an almost classic caesium toxicity situation and should have been responded to appropriately by stopping the IV treatments and referring **Pia Bosso** to a hospital before her final caesium induced arrhythmia. Instead she was given further high doses of IV caesium, when she was suffering cardiac symptoms known to be related to caesium administration. It is also impossible to find Mrs Bosso's care by KPMHC staff, and the delay in providing her with appropriate treatment, did not cause or at the very least significantly contribute to, her death by fatal caesium induced cardiac toxicity.

[221] Transcript 18.11.10, pg 840

Overall, **Sandra Kokalis'** illness was not recognised by KPMHC throughout the treatment. Her deteriorating health was not appropriately dealt with, she was not diagnosed and had conditions left untreated. Her continued treatment with the high pH therapy in someone so critically unwell was tragic. A failure to refer her to tertiary care at an appropriate time, or return her after her discharge against medical advice, exacerbated her circumstances and led to a premature death by a constellation of metabolic disturbances. Even Sartori conceded there were problems with the level of care being provided to Mrs Kokalis by those representing KPMHC.[222]

There is no doubt **Deborah Gruber's** death, at the time it occurred, was as a result of sepsis on her already weakened and fragile state. That sepsis arose out of the lack of clinical care and conditions on the part of KMPHC and the treatment generally.

It is my view it is highly likely, in view of the symptoms **Carmelo Vinciullo** did experience with the administration of the infusion, he would have died of caesium induced cardiac toxicity, like Mrs Bosso, had he continued with the treatment. However, he withdrew:-

I find Carmelo Vinciullo's death arose by way of Natural Causes.

[222] Transcript 18.11.10, pg 941

I am satisfied, as a result of the whole of the expert evidence, the deaths of Sandra McCarty, Pia Bosso, Sandra Kokalis and Deborah Gruber were hastened by the treatment undertaken at 16 Beagle Street in May 2005. The mechanism of death may have varied between patients but I am of the view they all had their genesis in the treatment as a whole due to toxicity, probably mainly from caesium, but also the unknown effects of the combination of all the substances involved. This was in conjunction with the substandard clinical conditions in which they were given to vulnerable patients, made more vulnerable by the substances used.

I am concerned there was no perception by KPMHC the treatment they were administering to the patients might have been responsible for four deaths in four consecutive days. Even at the time of Pia Bosso's death I cannot comfortably comprehend how those associated with KPMHC/Perth did not connect two unexpected deaths, of people receiving a treatment of largely unknown toxicity, and stop all other treatment immediately.

Instead Ms Phasey and Keith Preston flew to South Australia in June 2005 to treat Daryl Green.

The philosophy, or the manner in which the treatment was given, prevented all those patients from seeking independent medical treatment which may have stabilised them and extended their lives once it became apparent

they were in danger of death from the effects of the treatment.

One would not necessarily expect sick patients to recognise this but I have no doubt two Australian Registered Nurses and an Australian Registered Doctor should have sought conventional medical treatment for all four patients, when they first showed signs of clinical deterioration as evidenced by seizures, palpitations, low blood pressure, fluctuating temperatures, dehydration, raised inflammatory markers, electrolyte imbalance as a result of gut toxicity, metabolic derangement and extreme deterioration consistent with the administration of the pre-treatment packs and IV infusions.

Had any of those Australian Accredited Practitioners acted upon clear clinical signs and stopped treatment before it became lethal, those four people may have survived with enough time to die in appropriate surroundings with loved ones to hand.

OTHER PATIENTS AND SARTORI'S HIGH pH CANCER THERAPY

During the course of the evidence reference was made to other patients who had been treated by KPMHC in Darwin or Perth as far as we were able to trace them. Of those recorded as treated only one was still alive at the time of the inquest start and that person had, like Mr Vincuillo, ceased treatment of her own volition after a short exposure, due to her concern the treatment was causing

her harm. That patient still has her original cancer, which she is apparently managing very well without medical intervention.

Of the other patients, police obtained relevant death certificates, and none of those treated had their cancers cured. All death certificates indicated death by way of their malignant disease of whichever type it was.

The best we can say is it would appear the treatment did not kill those people however, there is no evidence it was of any benefit to them either.

In evidence some KPMHC staff indicated their belief the treatment must have extended those peoples lives, because they had not died during treatment. There is nothing to indicate anybody receiving the treatment in Australia was expected to die within 12 days from their malignancy at the time they commenced the IV treatment. The fact four out of seven died in May 2005 before their expected time would indicate the treatment had no benefit for anybody using it. It is most certainly not a death ratio any experimental clinical trial would tolerate.

Sartori maintained, in his evidence, his treatment not only extended life expectancy but, in the majority of cases cured cancer. He claimed patients only needed to follow three quarters of his regime to be cured.[223] This was not

[223] Transcript 18.11.10, pg 825

the outcome for any of the patients treated in Australia, who were clearly used as paying experimental subjects by Sartori.

Interestingly, Sartori now states he only uses oral treatments in his work, because it is not undertaken in hospital conditions,[224] and those purporting to provide high pH therapy in South America do not know what they are doing.

Mrs Ranieri was quite clear the treatments her husband received after May 2005 at other institutions, both unconventional and conventional, did her husband no harm. She did not believe that to be the case for the May 2005 KPMHC/Perth. Her husband was extraordinarily unwell at the conclusion of that treatment, something he did not experience with any of his other treatments until the time of his death, which even then was mostly due to his other co- morbidities.

PUBLIC HEALTH IN AUSTRALIA

It is necessary to establish a context within which to consider the term treatment as it is generally accepted in *"main stream"* or *"conventional"* medical care in Australia. It needs to be understood conventional treatment and care has been developed in an attempt to protect the unsuspecting patient from harm, not prevent the sick from being cured.

[224] Transcript 18.11.01, pg 825

Legislation in place, along with individual professional ethics and codes of conduct are there to provide a standard by which to measure the potential for harm versus benefit.

Sometimes things go wrong and harm is done, but the potential for great harm is lessened when there are standards set by which benefit or harm can be measured. It is for this reason I defined the term *"the treatment"* at the beginning of this finding as *"the substances used"* as well as the *"clinical conditions"* and the *"manner"* in which it was delivered. All those aspects have a meaning when considering the overall effect of Sartori's high pH cancer therapy as delivered in Australia in 2004/5.

Its philosophy, combined with the manner in which the treatment was delivered, conditioned those involved to not question its efficacy because that would then be considered the reason for its failure. In addition, anyone lucky enough to actually survive the treatment was then reputed to be a success, regardless of the fact there was no evidence they were in danger of dying within 12-14 days to start with. Nor is there any evidence their malignancy had been inhibited in any way by the treatment .

Individuals with cancer, and often more pertinently their families, are extremely vulnerable to manipulation of their

hopes and dreams for longevity. Terms like *"terminal", "alternative", "quantity"* and *"quality"* can become quite emotive so I have prefaced this section of the finding with some of the comments on terms used which I found helpful.

Dr Trotter, Carmelo Vinciullo's Oncologist and Head of Department at Royal Perth Hospital in 2005, used the term *"unproven therapies"*, rather than *"alternative"* when talking about Sartori's high pH cancer therapy because he believed the term alternative implies *"equivalent",* which a therapy which has not been tested isn't, it is unproven.

> *"Treatments ……. Oncologist or clinicians in general use … have to be proven in randomised controlled trials, be better than an existing treatment or to be able to deliver something for patient in terms of … tumour control, tumour shrinkage, improved survival, or improved quality of life or all of those things. Unproven therapies are therapies that need to be compared with existing, proven therapies…. In controlled studies to see if they are as good or better …. if they have not been proven to be better than existing therapies then they are unproven therapies".*[225]

Also use of the term *"terminal"* tends to imply death is more immediate than may be implied by use of the word incurable, which tends to convey an option of living with a condition, rather than dying from a condition.[226] The term incurable is preferable when evaluating the progression and life expectancy of cancers.[227]

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[225] Transcript 5.11.10, pg 421
[226] Transcript 29.09.11, pg 2010
[227] Transcript 29.9.11, pg 2021

People turning to unproven therapies tend to very much want to live so they are particularly vulnerable to any attempt to make a therapy appear *"alternative"* rather than *"unproven"*. They are exactly the sorts of vulnerable patients the legislation and professional standards are trying to protect by attempting to ensure people pursuing unproven therapies are properly informed about what exactly it is they are pursuing.

Regulation by legislation and standards makes the unproven therapy harder to obtain because it is difficult, for the treatment to comply. For example, the *"special access scheme"* and *"personal import scheme"* provisions of the Therapeutic Goods Administration (TGA) allows registered medical practitioners and patients to access restricted therapeutic products.[228] However, in getting to that point one assumes they would have been thoroughly informed as to why a product's access is controlled; it has not been proved, or may not be considered to be as good as other products, and may in some circumstances be dangerous.

By the time people have actually managed to obtain a substance such as Laetrile to use, one would hope they were also aware of the risks. Having someone provide people with a restricted substance or product with an assurance there are no risks involved, and regulation is

[228] Transcript 29.09.11, pg 1921-3

just a conspiracy theory to protect doctors and drug companies, ensures they are not informed about the risks to which they may be exposed by its use.

This is one of the reasons the experts involved in the inquest were so condemning of, not just the use of Sartori's 1984 paper, but rather its fraudulent misuse. It gave the appearance of a study, with proven results, which made vulnerable patients believe it was an alternative treatment, instead of a dangerous, unproven therapy, or toxic treatment.[229] Psychological benefit may result from a placebo and make it appear effective, but it cannot remain effective if the placebo is in reality a non-targeted toxin, with generalised cumulative affect.

One of the aims of many patients who have exhausted conventional cancer therapies is to remain alive until conventional medicine has produced a cure for whatever cancer they may have. This is often a reason for turning to unproven therapies; if they may not cure them, they may at least extend life.

Unless a person were secretly hoping for death, no patient attempting an unproven therapy would risk one which they understood had a risk of killing them, of itself. Accepting an alternative may not cure their cancer is one thing, understanding it may actually kill them is quite another. This should lead any health practitioner to query

[229] Transcript 29.09.11, pg 2045

why any treatment remains unproven (especially one with such purported success as long ago as 1984 ?!). If any one treatment could cure any cancer, it would have been properly developed and tested and be in common use today because it would, save many lives, be cost effective and indeed make someone a fortune. It would also, once prescribed, cost less for the patient.

One of the frauds perpetrated by way of the information and consent documents provided to prospective patients was the distribution of a version of Sartori's 1984 published study with respect to *"his treatment"*.[230] Aside from the fact the 1984 publication drew criticism from the Memorial Sloan – Kettering Cancer Centre (US) as well as Australian Oncologists and Toxicologists for its original content, the version provided to prospective patients had been altered from the original. The published paper refers to oral caesium chloride and other preparations; while the treatment to which the patients consented, and was referred to in the altered documents they received, used IV preparations and substances not covered in the 1984 paper.[231]

Whether a preparation is oral or intravenous can make a significant difference to its toxic effect on a patient.

In Dr Jacklyn's view IV caesium would be a higher risk than oral because a gut would play a protective role in

[230] Exhibit 38A-F
[231] Transcript 19.11.10, pg 973-980 & Transcript 29.9.11, pg 2005

removing some it from the system.[232] Dr Joyce indicated one of the toxic effects of caesium is gut toxicity and where that leads to serious haemorrhage it can be fatal; and regardless of how it is administered, a lot of caesium is known to be fatal and IV administration allows more to be given than can be tolerated orally.[233]

Oral Laetrile causes more problems by way of toxicity than does the IV administration, because oral administration produces cyanide, while IV administration produces less. However, one can administer more IV than would be possible orally, so it may still be an unknown toxic element especially if used IV with other toxic substances.[234]

One of the most concerning phrases in the information provided to prospective patients and their carers was *"almost all patients we lose have not been adequately fed or properly cared for by their families who often simply seem to be unable to carryout simple and most explicit instructions*"[235].

This philosophy is reflected in KPMHC staff where there is a tendency to blame patients and their carers for problems encountered during treatment, Carmelo Vinciullo wanting to eat pizza, Sandra Hoffman not watching Pia Bosso even though she had no knowledge of the *"responsibilities"* of

[232] Transcript 5.11.10, pg 384
[233] Transcript 26.09.11, pg 892
[234] Transcript 26.9.11, pg 1874- 1875
[235] Exhibits 24/36, Transcript 29.11.11, pg 2015

carers, and Sandra Kokalis going to Joondalup Health Campus following a seizure, without seeking input from KPMHC.

Its effect is also well demonstrated in family members refusing conventional medical assistance which may well have improved a patient's prognosis because they were frightened they may breach KPMHC protocols. Mr McCarty told his wife her sodium levels were too high, when in fact they were low; and Mr Couanis refused dextrose for Mrs Kokalis when her sodium levels needed to be lowered. Mr Gruber also did not allow his wife to be fed unless on a KPMHC formula.

There was certainly fear from all family carers, who knew they were *"carers"*, that failing to abide by the protocols outlined would make them responsible for any lack of success of treatment, or indeed death, which might occur.

Dr van Hazel, in evidence, pointed out those are fraudulent techniques used to absolve blame from the provider of the treatment when it goes wrong, rather than reasonable evidence of any treatments' effectiveness.[236]

Sartori, true to his philosophy of death being the fault of either the patient, their carers, or conventional medicine stated in an email to counsel assisting when discussing his attendance, or not, at the inquest:-

[236] Transcript 29.9.11, pg 2015.

> *"The death of the terminal cancer patients in the Perth hospital was caused by flagrant malevolence at the ignorance and unbelievable arrogance of the doctors of this hospital..... whoever not even let near a laboratory rat who in the United States would have faced in the hands of a skilled personal injury attorney a malpractice suit with awards of at least a $US100,000.000, where out of court perhaps $US50,000.000 and this because these doctors with malice aforethought... prevented the necessary nutritional support of these patients in an attempt to give alternative methods proven effective over 10,000 cases with the method used on them and in millions of cases in general and their proponents a bad name. Also I was not allowed to enter Australia and thus was in Chiang Mai, Thailand. Are you seriously considering I have a means of killing people over the telephone".*[237]

In evidence, Sartori indicated the hospitals did not do certain things they should have done to correct caesium toxicity. However, Sartori, and KPMHC staff under his influence, went to great lengths to ensure hospitals treating these patients did not know they were dealing with the possibility of caesium toxicity. Lack of that information at an early enough time led doctors to believe the earlier patients, such as Mrs McCarty, were dying as a result of their malignancy, rather than a caesium induced toxic effect.

I do not accept, on the whole of the evidence, the deaths in Perth arose by way of any failing on the part of the conventional public hospitals involved.

[237] Transcript 18.11.10, pg 881/2

In addition, none of the experts called supported Sartori's contention the morphine administered to the four people dying in Perth hospitals contributed to their deaths. The amounts administered were consistent with those given to patients undergoing palliative end care to ease their pain.

It is obvious from the above, I hope, I consider the layers of legislation and regulation surrounding the *"administration"* of *"treatments"* in Australia, as frustrating as they may be, to have been developed with protection in mind. Those layers are three fold.

There is the Therapeutic Goods Administration (TGA) at a Commonwealth level which attempts to control medicines and medical devices. Of relevance to KPMHC/Perth is the fact Brewer's caesium chloride concentrate, or any other form of caesium for IV administration, has never been included in the Australian Registrar of Therapeutic Goods. Technically that means it should not be imported into Australia if it were intended for therapeutic use.[238]

The TGA however, does not regulate medical practice, so if a product is an authorised product for a registered medical practitioner to use or prescribe, the TGA cannot regulate how a doctor then prescribes it.

The State becomes involved at the next layer down, and the State does have input to the levels of access of

[238] Transcript 27.09.11, pg 1925.

different professionals in the community to different products, depending on their safety. This is done by the regulation and licensing, by various schedules, in the Poisons Act.[239] The more toxic a substance is considered to be the more administratively complicated it is to access and use. However, just because a substance is not scheduled does not mean it is safe for human administration. It is more likely to mean no one has seriously considered its human administration, because it is accepted as toxic and therefore dangerous, and not expected to be contemplated for human therapies.[240]

It is at the level of *"known to be toxic and therefore would not be considered for human administration"*, the various professional registrations, accreditations, standards and ethical considerations are expected to apply, as the third layer of protection for unsuspecting patients.

In this case it did not. In this case it was the involvement of a doctor patients believed was registered, somewhere, and an Australian registered doctor and two Australian registered nurses which led the patients of the 2005 May KPMHC/Perth to believe they were engaging in alternative therapy from which they were not at risk.

This was simply not true. They were sick vulnerable patients with fragile physiologies as a result of their illness. They were then further insulted, and their

[239] Transcript 27.09.11, pg 1932
[240] Transcript 27.09.11, pg 1934-5

metabolisms severely deranged by a toxic treatment for which they were unable to compensate. Four out of seven of the patients died before 12 full days of treatment could be completed, another two died shortly after, both of whom had interrupted treatments which may have given their bodies a chance to overcome some toxic effects, and the seventh, Mr Raneri, finished the treatment a very sick man. He recovered from the treatment with conventional medical help, but did not over come his cancer.[241]

[241] Transcript 4.11.10, pg 326 & 336

RECOMMENDATIONS

Some of the products and compounds used by KPMHC in May 2005, are not scheduled, or controlled in any way, due to the fact they have not been considered for human administration. There have been no clinical experimental trials utilising the substances which would have warranted their consideration for human therapies.

There are some schemes at a Commonwealth level, and Schedules at a State level which do allow people access to substances not approved for use in human administration in Australia but recognised as being substances people may believe have a beneficial effect. B17 is one example.

I accept people should be able to pursue therapies they may reasonably feel could assist them. However, difficulty in accessing some questionable products may lead to appropriate questioning as to the efficacy of those products as experimental *"medicines"*.

It does seem caesium chloride and some caesium salts are considered for unproven therapies. In light of the serious concerns raised at the inquest as to the consequences of their use, I am of the view it would be sensible to restrict or control their procurement in some way.

It may be useful for the TGA at a Commonwealth Level, and the Committees advising the Scheduling of Poisons at a State level, to consider the list of substances utilised in

this therapy at page 207/08 of this finding to determine whether or not some of those should require restricted access.

I recommend a form of restricted access for caesium chloride and other caesium salts in the same way as has been provided for Laetrile (B17).

I recommend any Visa application for entry into Australia by Sartori be closely scrutinised by the Department of Immigration & Citizenship (DIAC).

I recommend the data available from the operation of KPMHC in Perth be comprehensively evaluated by relevant experts to provide education and information to medical health practitioners as to the effects of administration of these substances.

AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY (AHPRA)

The treatment would not have been possible in Australia without the input of the two Australian Registered Nurses and the Australian Registered Doctor. I consider I have no option but to refer Simone Phasey, Merrilee Baker and Alexandra Boyd to their relevant registering authorities for their determination as to the appropriateness of those practitioners conduct by participating in the treatment, in view of the effects and conditions disclosed surrounding

the operation of KPMHC at 16 Beagle Street, Mosman Park.

DIRECTOR OF PUBLIC PROSECUTIONS (DPP)

In addition, in view of my finding the treatment, as defined, hastened the deaths of four people, whom I reasonably believe would not have died on 25, 26, 27 and 28 May 2005, without the administration of the treatment, I am required to refer the matter to the DPP for his determination as to whether an offence has been committed, and whether it would be in the public interest to pursue those contributing to those deaths on those dates.

E F VICKER
Deputy State Coroner

29 June 2012

Appendix I

Prof. Abdul-Haqq Sartori, M.D.

Medicina Alternativa **Professor of Alternative Medicines**

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RE: Enhanced High-pH Therapy for Cancer now available through Dr. Sartori in Australia

Thank you for contacting me to enquire about **Cesium chloride (CsCl)** and the **Enhanced High-pH Therapy for Cancer** originated by A. Keith Brewer, Ph.D., and since 1980 enhanced and perfected by myself. Though the results were published in a major peer-reviewed medical journal, *Pharmacology, Biochemistry, and Behavior* in the December 1984 Supplement I, there was, except for the late Dr. Hans Nieper, a minimum of response from both the orthodox and alternative medical community. Therefore, unfortunately, I am the only physician left who uses this **by far most consistently effective therapy for all fast-growing cancers, no matter what stage or type or extent.**

Since 1980, over 700 cancer patients have been treated with this therapy. In all cases, **fast-growing tumors were promptly reduced in size with minimum discomfort to the patient** (as compared to the common and sometimes horrendous adverse effects of chemotherapy and radiation). With the intravenous (I.V.) application of this therapy, we consistently achieved primary & metastatic tumor reductions of 1.0 to 2.0 cm (2/5 to 2/5 of an inch) per day, i.e., disappearance of 5.0 cm (2.0") tumors in about four days, and of 10.0 cm (4.0") tumors in about eight days, and reductions of lymph node metastases of 2-5 mm/day. Besides the **higher and more consistent effectiveness, I.V. application of CsCl and other minerals, vitamins, mandelonitriles** (e.g., Laetrile®), etc., **avoids all side effects from oral therapy** such as **nausea, vomiting, diarrhea, abdominal discomfort,** etc. Furthermore, **I.V. application guarantees that all ingredients are taken up by the body,** as nutrient absorption may frequently be compromised, particularly in patients with any type of malabsorption from gastrointestinal problems or in many advanced cancers or simply from lack of hydrochloric acid. The only "side effects" seen with this therapy is the sometimes considerable, but brief, discomfort from the I.V. application of Ozone that is, in fact, a most beneficial homeopathic-type "healing crisis". Best of all, this **healing crisis reverses virtually all tendencies towards any type of illness** and, in due time, almost all patients report that they have "never felt better" in their entire life.

In a tireless effort, since 1998, B. Keith Preston in collaboration with Dr Sartori, developed the most effective and comprehensive system in preparation for and as follow up of the Enhanced High pH Therapy. **The PRE & POST TREATMENT SYSTEM (P&PTS) is an integral part of our therapy and you should follow it for at least one year** or, preferably, for the rest of your life. Following this System gives you not only the **highest success rates in permanently overcoming cancer** but also greatly **enhances your overall health, happiness, vigor, and longevity.**

The **Enhanced High-pH Therapy for cancer within the framework of the P&PTS** is now available in Australia at a fraction of the financial costs of any **conventional therapy** that, besides very poor results in most cancers, **causes severe suffering and in many cases permanent damages,** and **is the main cause for premature deaths in cancer patients.** Since 1970, the start of President Nixon's "War on Cancer", the yearly death rate in the U.S.A. went up from 135,000 to over 800,000 and the average cost per patient is around US$ 300,000.00 ($ 100,000 to over $ 1,000,000.00) with an average out of pocket expenses for insured patients of about **$ 60,000.00** ($ 20k to >200k). Compared with this, the **total all-inclusive investment for six weeks of treatment in Australia including two weeks of the Enhanced High-pH Therapy for cancer (with room & board for a companion) and one full year of follow-up, as well as setup & three months of all supplements for The Rana / B. Keith Preston System is US$ 30,000** (€ 24,000/¥ 3,200,000/CAN$ 40,000). If you are one of those patients that seek us out first when their primary tumor is less than 5.0 cm (2.0") in diameter (and which have not yet undergone any conventional treatment), the I.V. treatment course is eight days at a total investment of $ 22,000 (€ 18,000/¥ 2,500,000/CAN$ 28,000).

Also enclosed are my letters on **HOW TO TURN *CANCER* INTO A NEW LEASE ON LIFE** and **NOW THAT YOU HAVE LEARNED THAT YOU HAVE TERMINAL/INCURABLE CANCER,** as well as additional information on the high-pH therapy of cancer, most of which was drawn from the Internet.

Best wishes that you may regain your health soon and kind regards,

Abdul-Haqq Sartori, M.D.

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NOW THAT YOU HAVE LEARNED THAT YOU HAVE TERMINAL/INCURABLE CANCER

Cancer is perhaps the most feared disease on Earth since more and more people find out that the treatments offered for it in modern hospitals - surgery, radiation, and chemotherapy - seem to help only a small percentage of people who, in most cases, suffer from crippling mutilations and burns (from surgery and radiation), or severe, often life threatening, side effects from the poisonous chemicals used for chemotherapy.

Don't despair! There is still hope for you even if your doctor sends you home to die perhaps telling you "We have done everything we know, there is nothing else we have to offer to help you, except letting you die in peace". Did you ever wonder that before about 1900, cancer was a rare disease and that in some parts of the world there is **NO** CANCER at all? Research that goes back to Dr Otto von Warburg in the 1920s revealed the true nature of cancer and Dr A. Keith Brewer since the 1950, in part through investigation of **cancer-free populations**, formulated an effective treatment for cancer. This treatment was applied to many cancer patients and further enhanced by Dr Sartori since1980. Almost all cancers in over 700 patients treated so far with this **enhanced high pH therapy**, responded within a few days and with I.V. application, daily shrinking of tumors between 1.0 and 2.0 cm can be expected. The only discomfort from this treatment comes from a "healing crisis" reaction that leaves you, after some initial discomfort, feeling better after a few hours or, at most, a day or two.

How does this all work? Dr von Warburg found that cancer cells, like plant cells, function without oxygen and thus are very sensitive to oxygen and very strong alkaline elements. Because of the lack of oxygen, cancer cells break down their fuel, glucose, to lactic acid. This causes cancer cells to become acidic (i.e., the pH in the cancer cell is lowered to 6.8, even 5.8) which, in turn, causes them to grow out of control. Alkaline elements, particularly cesium, but also rubidium and potassium can freely enter cancer cells (but not normal cells) causing them to become alkaline or raise the pH in the cancer cell. This raised pH slows down the cancer growth and at a pH of 8.0 all cancer cell growth stops and the cancer cells either die or are turned into normal cells. While we all depend on oxygen to survive, cancer cells die if exposed to oxygen and, particularly, its most powerful form, ozone.

People who live very long are free of cancer, is a fact that prompted Dr Brewer to investigate their nutrition and found that their diet contains the alkaline elements cesium (Cs), rubidium (Rb), and potassium (K), and other nutrients that were found to reduce the cancer incidence such as zinc (Zn), selenium (Se), molybdenum (Mo), vanadium (V), and the vitamins A, C and E, as well as amygdalins from apricot pits. After extensive studies of cancer cell cultures, Dr Brewer found the following: Zinc and selenium attach to the cancer cell membrane and make it easier for the cesium and rubidium to enter the cancer cells. Vitamins A and C are weak acids that attract these elements to the inside of cancer cells. Magnesium (Mg) and calcium (Ca) that normally transport the oxygen into cells are depleted in cancer cells. These and other findings were the basis for Dr Brewer to formulate the high pH therapy for cancer. His method was enhanced in the 1980s by adding I.V. ozone (which is the most active form of oxygen), herbal combinations, and other modalities, which made it even more effective.

Up to 98% of animals with cancers were cured by Dr Brewer's high pH therapy. Tests on mice fed cesium and rubidium showed marked shrinkage in the tumor masses of abdominal implants of **mammary tumors** ("breast cancers") within 2 weeks. In addition, the mice showed none of the side effects of cancer. Cesium chloride, zinc gluconate and vitamin A were used together to alter growth of **colon cancer** implants in mice and the use of these compounds was responsible for the disappearance of tumors in 98% of the animals. Sarcoma I implants in mice and Novikoff hepatoma in rats disappeared if the proper ratio between cesium and potassium was maintained. With Dr Brewer's complete protocol, using cesium (&/or rubidium), potassium & magnesium, vitamins A, C, & E, zinc, selenium, & amygdalin, there was a prompt reduction of all tumors treated by Dr Sartori including lymphomas in cats and dogs, skin cancers in dogs, cancers of the mammary glands, mouth , and esophagus in horses, and cancers of unknown primary in chickens. Like with all "nutritional" treatments, the principle of the weakest link of the chain holds true, and **if even one essential nutrient is lacking, the treatment may fail.**

In virtually all of over 700 patients with different types of cancer, the enhanced high pH therapy was effective in reducing the tumor mass. Over 90% of these patients were terminal with extensive metastasis and had received maximum conventional cancer treatments. Malignancies treated with this protocol included cancers of the lungs, liver (& gallbladder), pancreas, breast, prostate, colon & rectum, stomach, brain, cervix & uterus, ovaries, testicles, adrenals, kidneys & bladder, of unknown primary, rectovaginal, etc., as well as lymphomas & leukemias, melanomas, & sarcomas. The results with the LSU/UL & Cancer treatment in 100 cancers were as follows:

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Summary of and Comments on the LSU (now ULS) Cancer Treatment Results

There are several factors that should be pointed out with regard to the data summarized in Table **I**

(a) Out of over 500 cancer patients treated from 1980 to 1987, only 97 fulfilled the criteria of having been followed up for at least 5 years or until their death. This might negatively bias the number of patients that have died by a factor of up to five since almost all of the over 500 patients were followed for at least 3 months.

(b) According to Arlin J. Brown (AJB), cancer survival statistics as published by the National Cancer Institute (NCI) are not point-to-point, but are determined from the number that can be located 5 years after being diagnosed with cancer (and not even the beginning their first treatment, e.g., at) at NIH/NCI. In cancers with high mortality such as small cell lung cancers (1.0% 5-year survival according to NCI) and pancreas cancers (3.0% 5-year survival according to NCI), AJB found point-to-point survival rates of less than 0.01% and less than 0.05% respectively (perhaps because >99% of the patients had died so long ago that they could not be located anymore).

(c) By far, the majority of the patients seem at LSU were using our therapy as their last resort after all other treatments (both conventional & alternative) had been unsuccessful and most patients were simply sent home to die.

(d) In view of the extremely unfavorable patient population as outlined under (a) through (c), we believe that the results of the LSU treatment are quite remarkable and by far the best offered anywhere in the world.

(e) For reasons beyond the control of the authors, only about 200 cancer patients were treated from 1988 through 2003. In all of these patients, **ozone and the minerals and vitamins** were applied **intravenously (I.V.).** The I.V. application of minerals and vitamins proved to be a dramatic improvement in that (i) in virtually all cases, the size/diameter of all fast–growing tumors was reduced by 1.0 to 2.0 cm (0.4 to 0.8 inches) per day, i.e., a disappearance of a 5.0 cm (2 inch) tumor within four days and of a 10 cm (4 inch) tumor within eight days, and (ii) virtually none of the patients showed any of the "side effects" frequently encountered with oral vitamin/mineral application such as nausea, diarrhea, abdominal discomfort, possible aggravation of ulcer symptoms, and sometimes even vomiting. After several cancer patients were successfully treated at the Integrated Medical Center in Northern Virginia from April to July 1998, from mid–1998 until mid–2003, government agencies and "law enforcement" in the U.S.A. virtually completely suppressed the use of **the enhanced high–pH cancer therapy** by LSU/ULS, and this treatment **can now only be offered offshore** and far removed from these agencies.

TABLE I: RESULTS OF THE LSU (now ULS) CANCER TREATMENT OF 97 PATIENTS WITH 100 CANCERS TREATED FROM 1980 THROUGH 1987

		Survival Times					
Type of Cancer	Total # Patients	Up to 3 Weeks[5]	Up to 3 Month[5]	Up to 1 Years[5]	Up to 3 Years	Up to 5 years[4]	Over 5 Years
Lung[1]	18	2	1	1+1[3]	2+1[3]	2+2[3]	6[1]
Lymphoma[1]	13	1	1	2+1[3]	1+1[3]	1	5[1]
Liver	12	2	2	1	1	1[3]	5
Pancreas[2]	11	2	1	1[3]	1	1	5[2]
Breast	9	1	1	1	1+1[3]		4
Prostate	8	1	1	1[3]	1		4
Colon	6		1	1[3]	1[3]		3
Uterine/Cervix	6	1	1		1	1[3]	2
Brain	4		1		1[3]	1[3]	1
Melanoma	3			1	1		1
Ovary	2						1
Stomach[2]	2		1		1[2]		
Sarcomas	2	1			1		
Kidney	2					1	
Bladder	1			1			
Adrenal	1						1
Total	100[1,2]	11	11	6+4[3]	9+5[3]	5+5[3]	38

[1] Two patients had both lung cancer and lymphoma. [2] One patient had both stomach and pancreas cancer.
[3] Patients who died from causes unrelated to cancer. [4] **All patients in this column are NCI 5 year "cured".**
[5] These 3 columns virtually never appear in cancer statistics & the "adjusted cure rate" would be **63%** (v.38%)

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RESULTS WITH THE LSU/ULS TREATMENT PROGRAM FOR CANCER
(broken down into the most frequent types/locations of cancers treated)

1. Lung Cancers

Of the 18 lung cancers described in this study (of a total of >100), 14 were connected to active smoking, two to passive smoking, one to radon exposure in the home, and one to cadmium exposure at the workplace. Asbestos may have been a factor in one of the active smokers, radon in the home in one of the passive smokers.

Beta-carotene, vitamin A, selenium, and vitamin E from green and yellow vegetables are now recognized as clearly preventative of lung cancer. These vegetables were conspicuously absent from the diet of most of our lung cancer patients. Instead, most of them were eating a meat and potato diet before they started the LSU cancer treatment program.

Histologically, 4 patients had epidermoid cancers, 3 had adenocarcinomas, 8 had small cell carcinomas, 2 had large cell carcinomas, and in 2 patients the histologic type was unknown; two of the small cell carcinoma patients also had a lymphoma.

All patients had received the full course of orthodox treatment: 6 had surgical resections (3 of the epidermoid-, and one each of the adeno-, small cell-, and large cell carcinomas). All patients had received chemotherapy, and the 6 surgical patients also had received radiation.

At the beginning of the treatment, four of the patients were dying on a stretcher, four could walk only with sistance, six were given a prognosis of less than 6 months of survival, and in 4, the prognosis was unknown.

The 2 patients with unknown histology who came in dying on a stretcher nevertheless survived 13 and 20 days respectively. The third of the dying patients, with an epidermoid cancer, survived almost 3 months until he died from internal bleeding from an extremely low platelet count. The fourth of the dying patients survived over 5 years and was well in July 1992; he had a small cell carcinoma that generally has less than 1% chance of 5 year survival (less than 0.01% according to Arlin J. Brown).

One of the two small cell carcinoma patients who also had a lymphoma is alive and well without any sign of cancer over 10 years after he was barely able to walk into the office with assistance. He is now in excellent health and successfully runs a medical equipment company. The other unfortunately died in a hit-and-run car accident 10 months beyond his given life expectancy and without any sign of cancer at autopsy. One of the adenocarcinoma patients who came in, walking with assistance, responded well for about 2 weeks, then continuously deteriorated, and died after 4 months. The fourth walk-assist patient, with a large cell cancer was treated 4 times and died after 1 year and 8 months. Of the 6 patients who were given fewer than 6 months to live, one epidermoid cancer patient died from cardiac failure after 3 years and 4 months, one of the small cell cancer patients with terminal emphysema died from a combination of pulmonary failure and bronchopneumonia; one patient with adenocarcinoma received 6 treatment series and died from his cancer after 3 years and 8 months; one small cell cancer patient died after 2 years 5 months, one after 4 years 1 month, one epidermoid cancer patient died after 3 years 3 months. One of the factors in the deaths of these patients may have been that at the time of their treatments, the LSU mental reconditioning program (MRP) was far less veloped. By using the full, presently available LSU MRP, perhaps at least two, maybe even four of these patient uld have been helped. Of the lung cancer patients who survived over five years, four had a small cell cancer, one had a large cell, and one had an epidermoid cancer.

2. Lymphomas

Of the 13 lymphomas described in this study (of a total of >60), 9 were lymphocytic (3 males had AIDS, one male had severe rheumatoid arthritis, and one was a Klinefelter syndrome; 4 were females), one female had Hodgkin lymphoma, one male had a T-cell lymphoma, and in 2 males, the histology was not determined. Three patients were dying, 4 needed ambulatory assistance partially because of their enormous tumors, and 3 were given less than a year to live.

One of the dying patients with lymphoma of unknown histology died after 17 days from cardiac toxicity of chemotherapy. Another of them, an AIDS patient, died after 7 weeks from aplastic anemia from combined chemotherapies for infections and the lymphoma, given to the patient prior to his coming to LSU. No signs of lymphoma were detected at time of death. One 37 year old dying woman has survived over 10 years without any sign of recurrence after only one series of the LSU treatment.

Of the 4 patients who needed assistance with walking, one AIDS patient is alive and well for over 8 years, has turned HIV negative at the end of one treatment series and his T4 cell count rose from 124 with a T4/T8 ratio of 0.36 to between 1,100 and 1,300 with a T4/T8 ratio between 1.5 and 1.8 for the last 4 years. Within one month, his nodal lymphomas disappeared and none of his previous CNS involvement was detected anymore on a CAT scan.

One patient had a huge hemispheric protrusion of his abdomen, very similar to a patient described in *Pharmacol. Biochem. Behav.*, Vol. 21, Suppl. 1, pp. 11-13, 1984. His total tumor mass was estimated to be about 37 kg

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with about 40 liters of ascites. Within 3 weeks both tumor and ascites were reduced to approximately one half, within 2 months there was only a slight enlargement of the spleen of about 5 cm. The patient survived for over five years without any sign of tumor recurrence. The two patients who had both lymphoma and lung cancer were already discussed under 1.; one of them is alive and well, the other died 10 months after treatment in a hit-and-run accident. He had shown no signs of cancer at autopsy.

One of the 3 patients who were given less than a year to live, unexpectedly died from a heart attack 10 months after initial treatment. Another died after 3 years and 7 months and did not respond to treatments, except for the initial series. The third patient survived for over 5 years without sign of tumor recurrence.

The woman with Hodgkin lymphoma died from aplastic anemia, a complication of her previously received chemotherapy, 1 year and 2 months after treatment onset. The patient with the T-cell lymphoma had come all the way from Osaka, Japan and seemed to respond well to the first treatment series. He returned 5 months later, showed barely any response to the treatment, and died 11 months after the initial visit. Language problems may have been a contributing factor to his death, since we were not sure, whether he and his family had completely understood our instructions.

3. Liver Cancers

Primary hepatocellular carcinoma (HCC) or malignant hepatoma is one of the most common malignancies in the world and it is estimated to be responsible for up to 1,300,000 deaths every year. In portions of Africa and Asia, HCC is the most common malignant tumor. It occurs infrequently in the U.S., North and South America, and Europe where it accounts for about 2% of the malignancies. The incidence of HCC is especially high in China, Taiwan, Mozambique, and Singapore. Risk factors of HCC include chronic toxic hepatic injury (20 to 60% in N&S America), cirrhosis (60 to 90% worldwide), chronic hepatitis B infection (20 to 90% worldwide), aflatoxin (especially in Africa and Asia, e.g. from peanut oil), alcoholism, chronic hepatic outflow obstruction (CHOO; 20% in South Africa, 60+% in Japan), male gender (5:1 in high incidence areas, 2:1 in low incidence areas), Asian or Black ancestry (or rather dietary habits).

Of the 12 patients listed as having liver cancer (of a total of >50), 8 had primary HCC, 3 had extensive liver metastasis from an occult primary malignancy (OPM), and one patient had intrahepatic biliary cancer (IHBC). The 8 patients with HCC had elevated alpha fetoprotein (AFP) and reduction of AFP below 100 mg/mL was interpreted as an indication of tumor disappearance. Using a cutoff for serum levels of 10 ng/mL, AFP is sensitive for HCC in 70 to 90%. Patients with cirrhosis and chronic hepatitis tend to have elevated AFP levels of usually under 200 ng/mL. Levels of 400 to 1,000 ng/mL are diagnostic for HCC. AFP is also elevated in yolk sac tumors and in a high proportion of other germ cell tumors.

The patient with IHBC and the 3 patients with liver metastasis from OPM had elevated carcinoembryonic antigen (CEA) in the range of 55 to 185 ng/mL at their admission to the LSU cancer treatment program. No colo-rectal cancer or other primary malignancy was ever found. Elevated CEA levels are found in patients with gastrointestinal, pancreatic, breast, lung, thyroid medullary, and genitourinary carcinomas, as well as in benign disorders including inflammatory bowel disease, cirrhosis of the liver, pancreatitis, and pneumonia. Normal values for CEA are up to 2.5 ng/mL, in smokers up to 5.0 ng/mL. Benign disorders seldom elevate the CEA level above 10 ng/mL. Reduction of CEA levels below 5 ng/mL was interpreted as an indication of tumor disappearance.

Of the 12 liver cancer patients, 3 were dying, 3 needed assistance when walking, and 4 were given life expectancies of less than 6 months. 9 had undergone surgery, including the 3 OPM and the IHBC patients; 5 had suffered radiation treatment, and all 12 had been exposed no massive chemotherapy.

One female HCC patient, a 32-year-old fitness instructor, had been first seen in the office of a world famous diet doctor in New York City, where she almost died on the table from an imbalanced vitamin-mineral IV. Through almost a miracle she made it to Washington, D.C., lying on a stretcher in the station wagon driven by her husband. Within 2 weeks her massively enlarged liver that had extended over 14 cm below the normal in a scalloped curve that filled about two-thirds of her abdomen, had returned to normal. Her AFP test came down from 2,420 ng/L to 120 ng/mL within 24 weeks. She was well until about 4 years later when she died in a car crash. Unfortunately, the diet doctor never referred any other cancer patient to the LSU clinics.

Four more of the HCC patients, and one of the OPM patients, responded very well and survived over 8 years after their initial treatment without signs of recurrence, with AFP and CEA below the cutoff points of 100 ng/mL and 5.0 ng/mL respectively. One HCC patient died from the side effects of chemotherapy within 2 weeks, another within 2 months; one OPM patient shared the same fate after fewer than 3 months. The IHCP survived 2 years and 4 months, after responding moderately well to 3 courses of the LSU cancer treatment.

4. Pancreas Cancer

The tumor-associated carbohydrate antigen, CA 19-9, detects about 80% of all pancreatic cancers correctly, compared with 8% of patients with pancreatitis and 1% false positive normal patients. The pancreatic adenocarcinoma

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glycoprotein, DU-PAN-2,. detects up to 55% of all pancreatic cancers, though in may also be elevated in patients with biliary cirrhosis, gastric cancer, and biliary cancer.

In all of our 11 pancreatic cancer patients(of a total of >50), either CA 19-9, DU-PAN-2, or both markers were elevated to a range of 850 to 950 U/mL for CA 19-9, and 300 to 1,200 U/mL for DU-PAN-2 at admission, and reductions of serum levels below 70 or 120 U/mL, respectively, were considered as evidence of disappearance of the tumor. CA 19-9 antigen (detectable by a murine IgG1 monoclonal antibody against a human colon carcinoma cell line) is elevated in 55 to 90% of stomach cancers, 80% of pancreatic cancers, and about 95% of colorectal cancers; in advanced pancreatic cancers it is elevated in 80-90%. In benign disorders including acute pancreatic, hepatobiliary disease, and inflammatory bowel disease, CA 19-9 usually does not exceed 100 U/mL. Normal values of CA 19-9 are up to 36 U/mL. DU-PAN-2 is a mucin-type glycoprotein antigen selected for reactivity against human pancreatic carcinoma cells (detectable by murine monoclomal antibodies). Increased levels occur in many diseases of the liver and hepatobiliary tree including primary biliary cirrhosis, sclerosing cholangitis, hepatitis, cirrhosis, and benign hepatomas, and usually do not exceed 200 U/mL. DU-PAN-2 may also be elevated in biliary and gastric cancer, and in primary hepatocellular carcinoma (HCC). Normal DU-PAN-2 values are up to 60 U/mL.

Histologically 10 of the 11 patients had an adenocarcinoma of the pancreas, one had an intrapancreatic bile duct carcinoma (IPDC) that was diagnosed intraoperatively. One patient had both stomach and pancreatic cancer. Eight of the patients had undergone resections and/or exploratory surgery, 10 had suffered from radiation, and all 11 had been given massive doses of chemotherapy. At the onset of the LSU treatment, one patient was dying, 3 needed walking assistance, and 6 were given fewer than 6 months to live.

Two patients died from the side effects of chemotherapy within less than 3 weeks including the patient with IPDC. One other succumbed from chemotherapy side effects after 10 weeks. One patient died after about 10 months from an internal bleeding probably not related to cancer. The patient with stomach and pancreatic cancer did not respond well to 3 treatment courses. Nevertheless, they prolonged his life from an expected less than one month to 1 year and 7 months. One patient died after 3 years and 2 months, another after 3 years and 11 months. Nevertheless, the treatment had extended their life expectancy of less than 6 months. Four of the 11 patients survived more than 5 years which compares favorably with a reported 5-year survival rate of pancreas cancer patients of 3% (or less than 0.01% according to Arlin J. Brown).

5. Breast Cancer

Six of the nine breast cancer patients (of a total of >40), who are discussed in this report were terminal with widespread metastatic disease, one of them dying, two of them needing walking assistance, and another three with a life expectancy of less than 6 months.

In all cases, any detectable primary tumors or metastatic skin tumors either disappeared within 2 weeks or turned from hard, knobby, scalloped, infiltrative cancerous growths into much smaller well-defined, round, and much softer benign cysts with a smooth surface.

Unfortunately, two months after treatment onset, one patient died of cardiac failure from doxorubicin toxicity, and one patient died from acute pericarditis-myocarditis from cyclophosphamide less than 3 weeks after treatment was started. One patient responded well to the first treatment course, but had a recurrence after 3 months, and died from pneumonitis. It is possible that an ill-advised treatment course with bleomycin may have contributed to her demise.

One patient, a former heavy smoker aged 57 when her treatment began, died after 2 years and 11 months from a myocardial infarction. 5-fluorouracil treatment may also have contributed to her premature death. Another patient who responded poorly to the treatment nevertheless survived 2 years and 2 months, more than 2 years longer than she expected before she started the LSU treatment. The remaining 4 patients survived over 5 years without any sign of recurrence.

6. Prostate Cancers

Six of the 8 prostate cancer patients in this study (of a total of >40), had extensive metastatic disease, one of them was dying, two needed assistance with walking, and 4 were given less than 6 months to live. All patients showed elevated levels of prostatic specific antigen (PSA) that ranged from 35 to 235 ng/mL at admission (Normal PSA < 4.0 ng/mL). In benign prostatic hypertrophy (BPH), PSA levels <25 ng/mL are seen. PSA is false negative in about 15% of the prostate cancers. The cutoff point for the disappearance of the cancer was set at 10 ng/mL.

Very similar to the results in breast cancer patients, all palpable infiltrating tumor masses in all patients either disappeared or turned into benign, well-defined, cystic tumors of much smaller size.

The dying patient succumbed to the side-effects of his chemotherapy 20 days after the beginning of his treatment. One of the severely debilitated patients died after 9 weeks also as a consequence of his chemotherapy. Two patients only partially responded to the treatment. One of these died in a horseback riding accident, the other died after 4 treatment courses 2 years and 5 months after he started the LSU cancer treatment. He had survived almost 2 years longer than was originally expected.

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Four patients survived at least 5 years, two of them needed only one treatment course, one of them needed two, and the fourth needed four treatment courses. Their PSA levels were maintained below 10 ng/mL after their treatments were completed.

7. Colorectal Cancers

Of the 6 patients in this study with colorectal cancers (of a total of >50), all had elevated values of carcinoembryonic antigen (CEA) in the range of 80 to 280 ng/mL, indicative of widespread metastatic disease; all of them had undergone surgical resections, 4 with colostomy, and 2 without colostomy. All 6 had received a full course of chemotherapy with 5-fluorouracil (5-FU) and a variety of other chemotherapeutics. Two of the patients received radiation therapy.

The response of these patients to the LSU treatment program was not as impressive as for instance, in the case of liver cancer patients. Only the 2 patients without colostomy survived more than five years after 2 and 3 LSU treatment courses respectively. In both cases, the CEA was maintained below 5.0 ng/mL.

One of the colostomy patients died from a heart attack after a good initial response to the treatment in the 11th week of his treatment. 5-FU-induced myocardial ischemia may have been a contributing factor. Another of the colostomy patients apparently died from a barbiturate overdose, possibly a suicide attempt. It should be noted that over 35 of the colostomy patients were lost in the follow-up.

The two patients who had suffered abdominal radiation had severe problems with adhesions and fistulas. Both had severe diarrhea at admission that was controlled with diet within about 2 to 3 weeks. Though both had a life expectancy of less than 3 months at the time of admission, they survived for 2 years and 7 months, and 3 years and 3 months, respectively. Their CEA levels returned to below 5.0 ng/mL after 3 months and stayed there until their deaths.

8. Uterine Cervical Cancers

All 6 patients in this study (of a total of>30) had undergone radical hysterectomies and pelvic lymph-adenectomies, multiple radiation treatments, and full courses of chemotherapy (4 patients received a combination of doxorubicin and methotrexate; 4 patients received mitomycine, vincristine, and bleomycin; one patient had been given both combinations).

One patient died after 2 years and 20 months after undergoing 4 courses of the LSU treatment. Originally she was given less than 3 months to live. One patient fell down a flight of stars, fractured her neck and died with hours. She had survived 3 years and 5 months. Her original life expectancy was less than one year. Two patients survived 5 years and had no indication of tumor recurrence on CAT scans and NMR imaging.

For the normalization of abnormal Papanicolaou (PAP) smears [Group 2: Infections; Group 4: squamous cell CA; Group 5: adenocarcinoma; Group 6: nonepithelial malignancy] and even of Stage O (*Carcinoma in situ*) through Stage IA2 (strictly confined to cervix; depth: ≤ 5 mm, spread: ≤ 7 mm), cervical cancers, topical application of folic acid in conjunction with vaginal ozone application has been found virtually 100% effectivein about 30 patients. Vaginal ozone applications are also an effective prevention of cervical cancers since it removes HPV and other pathogens that are causing chronic cervicitis that may turn malignant.

9. Brain Cancers

All 4 brain cancer patients (of a total of about 15) had highly malignant extensive glioblastomas. All 4 had undergone surgery and radiation, as well as glucocorticoid therapy. Two of the patients were unconscious at admission. The two conscious patients complained about headaches, especially in the morning, loss of appetite, nausea, loss of concentration, reduced mental capacity, and increased sleepiness. In both, personality changes were clearly evident.

After treatment onset both unconscious patients regained consciousness within 3 days and were able to say simple sentences within 5 and 8 days respectively. One of these patients suddenly deteriorated in the 4th week, possibly from malnutrition. His sister, who supervised his feeding, had failed to properly follow our instructions. When we found out that there was a problem, the patient was already beyond recovery. The other patient recovered well enough to return to his job as a real estate broker, and has survived 5 years without sign of recurrence.

Both of the two conscious patients had a lethal car accident; one about 2-1/2 years, the other about 3-1/2 years after their treatments. Both accidents may have been related to personality and psychomotor changes caused by their original tumors.

10. Melanomas

The three patients with melanoma in this study (of a total of about 12) all had widespread metastatic disease. They all responded well to the first course of treatment though less favorably to further treatment courses. One of the

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patients died after 11 months. She had originally been given less than one month to live. Another patient who had been given less than 6 months to live survived 2 years and 10 months. One of the patients, a black woman who had undergone 5 courses of treatment, survived 5 years without sign of malignancy.

11. **Other Cancers**

The number of the 10 remaining tumors in this study (of a total remaining of >80), two **ovarian cancers**, two **stomach cancers** (one of which was combined with a pancreatic cancer; see under 4.), one **osteosarcoma**, one **soft tissue sarcoma**, two **kidney cancers**, one **bladder cancer**, and one **adrenal cancer**, is too small to allow any clear judgment of the effectiveness of the LSU treatment in these specific cancers.

In all cases, a prompt response was seen in the first treatment course. One kidney cancer patient died after 20 days as a consequence of his chemotherapy. The other kidney cancer patient responded moderately well to the LSU treatment and died after 4 years and one month (well over 5 years after his original diagnosis & thus "cured" according to NCI statistics,).The stomach cancer patient who also had pancreas cancer is described above under 4.-He died after 1 year and 3 months. The other-stomach cancer patient responded moderately well to consecutive LSU treatments and died after 4 years and 2 months (rather than after less than one year ; & would also be listed by NCI as"cured").One ovarian cancer patient responded well and survived over 5 years. The other responded moderately well to consecutive LSU treatments and survived 3 years and 10 months.The bladder cancer patient did not respond well and died after 11-1/2 months (rather than after less than 1 month). The adrenal cancer did well, needed only one LSU treatment course, and survived over 5 years without sign of recurrence.

12. **The 200 Plus Cancers Treated from 1987 through 2003**

The following are only general remarks since on 2 May 1992, U.S Government Agents simultaneously broke into three locations where the originals and two copies of some 3000 patient records treated by LSU from 1980 through 1992, including about 650 cancer patients, about 180 AIDS patients, about 80 multiple sclerosis patients, and over 2000 patients with different conditions that were the data basis for the 2d ed. of the Ozone Book that for reasons beyond the control of the authors took until the year 2004 to be finally completed.

Again, we see a prevalence of **"incurable" cancers** (a) which have **0.0% success rate and thus should NOT be treated conventionally** at all, including, **small cell lung, pancreas, & esophagus, mesotheliomas, acute adult leukemias**, and **all cancers with widespread metastasis**; (b) malignancies where **conventional treatment in almost all cases shortens the life span**, including, **stomach, brain, liver, & most ovarian cancers, multiple myeloma & chronic adult leukemias**, as well as large (>10 cm = >2") **fast growing cancers with lymph-node metastasis**; (c) cancers with the highest incidence (in the USA & Western Europe), including, (female) breast, prostate, lungs[see (a)], & colon, where with early detection there is about 50% 5-year survival in breast, of 60% in prostate, & about 25% in colon cancers, that drops precipitously to some 10% if (b) & 1.0% if (a), *supra*, conditions are present; (d) other cancers including non-Hodgkin lymphomas, cancers of the urinary bladder & kidneys, rectum, (epi/naso)pharynx & oral cavity, endometrium & uterine cervix, & melanomas of the skin, rectovaginal cancer, larynx & thyroid cancer, Ewing sarcoma, etc. [which includes all 20 most frequent cancers in Thailand]. The **estimated overall 5-year survival rate of all of these cancer patients**, almost all of them terminal **with** widespread metastasis [see (a)] & [seeking ou treatment only] after all conventional treatments had been exhausted, was **~40%**, which increased to **~50%** if they survived the first 3 weeks after-treatment onset, & to **~60%** if they survived 3 months after treatment onset, even more, **~80%**, if they had a chance to have follow-up treatments at LSU, which was denied to virtually all patients after 17 July 1998 & until mid-2003, and many of which would be alive today; and while the **estimated 5 year survival of untreated** [with conventional methods: surgery &/or radiation &/or chemotherapy, etc.] **patients was about 95%** if they kept in touch with LSU/ULS, had a purpose to their lives with goals they absolutely needed to achieve, no matter what, meticulously maintained their alkalinizing blood-type-specific supplementation/diet/lifestyle, & balanced mind/body/spirit as practitioners of Taoist Energy Healing, Silva Mind Control, & Neurolinguistic Programming (NLP).

Why is it essential that you stay in touch with us after completion of your initial treatment? Because we will use EVERY METHOD AVAILABLE to get & keep you well

These methods, **individually tailored to your specific needs**, may include but are not limited to the following:

1. **Herbal Electron Donors & Propagermanium** (both for treatment & maintenance): The most effective herbal electron donors that restore the body to an alkaline balance can be found in plants containing high amounts of **germanium** (Ge).

Medicinal plants that reputedly have anticancer activity and that contain high amounts of **Ge** include shelf fungus (*Trametes cinnabarina*; 800-2000 ppm), Ginseng (*Panax ginseng*; 250-350 Korean < 4000ppm), garlic (*Allium sativum*; 750 ppm), dāng-shēn/sansukon root (*Codonopsis pilosula*; 260 ppm), sushi (*Angelica pubescens*; 260 ppm), Bandai moss (260 ppm), Japanese waternut (*Trapa japonica*: 240 ppm), Comfrey (*Symphytum officinale*; 150 ppm), boxthorn seed (Lycium chinense; 125 ppm), wisteria knob/gall (*Wisteria floribunda*; 110 ppm), pearl barley (fructus coicis lacryma-jobi; 75 ppm), etc.

Based on this concept, Kazuhiko Asai synthesized numerous non-toxic Ge compounds, most notably, **propagermanium** or bis-carboxyethyl Ge sesquioxide [$O_3(Ge.CH_2.CH_2.COOH)_2$], which has been found effective in the prevention and treatment of numerous cancers and their metastases including cancers of the lungs, prostate, breast, liver, kidney, brain tumors, lymphomas and leukemias, and sarcomas such

KATHLEEN PRESTON MEMORIAL HEALTH CENTRE

PATIENT INFORMATION SHEET

By initialising at the end of this line, I, _____, acknowledge that I read & fully understand the 6 pages of this Patient Information Sheet & the 4 pages of Appendices thereof _____.

The Kathy Preston Memorial Health Centre and all staff involved in the running of the health centre, including doctors and nurses, are available during the treatment of all patients at the clinic. Patients have these staff at their disposal during their treatment and for their wellbeing. Any issues, concerns, or problems that arise during treatment can & will be dealt with by staff at the clinic, and they are most happy to assist patients with any queries.

We will use EVERY AVAILABLE METHOD to get & keep you well and these methods are based on over 50 years of research and over 35 years of actual clinical experience with the enhanced high pH therapy, oxidative therapies, Hematoxilin-DMSO, and virtually all other therapies offered anywhere on Earth. We recommend that you have ONE family member accompany you at all times during your stay with us; if you have more family members/ friends with you, only ONE of them, best your spouse, can attend the actual I.V. treatments.

Almost all patients treated at our clinic are terminal an have exhausted all methods of orthodox medicine, i.e., rgery, radiation, and chemotherapy. Virtually all patients have **"incurable" cancers**, i.e., (a) which have **0.0% success rate and thus should NOT be treated conventionally** at all, including, **small cell lung, pancreas, & esophagus, mesotheliomas, acute adult leukemias**, and **all cancers with widespread metastasis**; (b) malignancies where **conventional treatment in almost all cases shortens the life span**, including, **stomach, brain, liver**, & **most ovarian cancers, multiple myeloma & chronic adult leukemias**, as well as large (>10 cm = >2") **fast growing cancers with lymph node metastasis**; (c) cancers with the highest incidence (in the USA, Australia, & Western Europe), including, (female) breast, prostate, lungs[see (a)], & colon, where with early detection there is about 50% 5-year survival in breast, of 60% in prostate, & about 25% in colon cancers, that drops precipitously to some 10% if (b) & 1.0% if (a), *supra*, conditions are present; (d) other cancers including non-Hodgkin lymphomas, cancers of the urinary bladder & kidneys, rectum, (epi/naso)pharynx & oral cavity, endometrium & uterine cervix, & melanomas of the skin, rectovaginal cancer, larynx & thyroid cancer, Ewing sarcoma, etc. [which includes all 20 most frequent cancers in Thailand & SE Asia]. The **estimated overall 5-year survival rate of all of these cancer patients**, almost all of them terminal **with** widespread metastasis [see (a)] & [seeking our treatment only] after all conventional treatments had been exhausted, was **~40%**, which increased to **~50%** if they survived the first 3 weeks after treatment onset, & to **~60%** if they survived 3 months after treatment onset, even more, **~80%**, if they had a chance to have follow-up treatments at LSU. The **estimated 5 year survival rate of untreated** [with conventional methods: surgery &/or radiation &/or chemotherapy, etc.] **patients was about 95%** if (1) **they kept in touch with LSU/ULS**, (2) **had a purpose to their lives with goals they absolutely needed to achieve, no matter what**, (3) meticulously maintained their alkalinizing blood-type-specific supplementation, diet, lifestyle, & balanced mind/ body/spirit as practitioners of Taoist Energy Healing, Silva Mind Control, & Neurolinguistic Programming (NLP).

With our unique THREE-WEEK PRE- and THREE-MONTH POST-TREATMENT PROGRAM, provided that: (1) you closely follow the program; (2) you MUST live to achieve your purpose in life; (3) you DO NOT RETURN to your old destructive habits, false friends, unhealthy diet & lifestyle; and (4) you LET GO OF ALL "LOSSES" you may have suffered, and all of which CO-CAUSED YOUR CANCER, or other degenerative disease, to begin with, THE SUCCESS OF OUR TREATMENT IS ENTIRELY UP TO YOU and may approach 100%, barring late complications of chemotherapy, etc.

WAIT at least THREE WEEKS, in case of tumours in the chest cavity, within the skull, & certain bone metastasis, SIX to SIXTEEN WEEKS before any imaging (X-rays, scans, etc.) are performed to evaluate post-treatment results, as it takes at least that long to restructure the space left after treatment has destroyed all cancer cells and the "cysts" found by inexperienced radiologists are virtually always harmless fluid build-ups in the space previously occupied by the tumour. Ideally, do the imaging by enrolling as a "NEW PATIENT" to get an unbiased opinion, as our results are entirely outside the range of experience of virtually any radiologist. Also, DO NOT TAKE ANY CHEMOTHERAPY or RADIATION offered by well-meaning oncologists for these cysts since the cancer is not there anymore. Thus, any chemo or radiation offered by well-meaning oncologists for these cysts will not only have no effects whatsoever, but will needlessly destroy your health. Note also that it may take up to THREE WEEKS after the cancer has disappeared, for cancer markers to disappear from the blood.

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ULTIMATE EFFECTIVE HEALTH CARE AT THE KATHLEEN PRESTON MEMORIAL RESORT: Since September 2004, by integrating a comprehensive before and after care system for all patients, by far THE MOST EFFECTIVE ACUTE & LONGTERM HEALTH CARE available to all of humanity has finally been realized. Thus, even most dying terminal patients may be restored to permanent wellness, to the degree to and for as long as they are willing to follow the program. The PRE & POST TREATMENT SYSTEM is an integral part of our therapy and you should follow it for at least one year or, preferably, for the rest of your life. Following this System gives you not only the **highest success rates in permanently overcoming cancer** but also greatly **enhances your overall health, happiness, vigor, and longevity.**

Key factors of our Program are:

(1) **Blood-Type- specific nutrition** which, in cases of terminal or unconscious patients who cannot be adequately nourished by mouth, may have to be applied by **nasogastric tube**. Each patient will receive a specific diet sheet according to his/her blood type & the condition treated.

(2) **Pre- and Post-Treatment Packs** where the former, ideally, are applied for three weeks before the I.V. treatment is started, and where the latter is generally recommended for three months but should be part of a lifelong program in conjunction with blood-type specific diet & exercise.

(3) **Enhanced High pH Treatment of Cancer** or any other **Intravenous (I.V.)Program** that usually is applied for **twelve (12) consecutive days**, but may be shortened to eight or four days. **For maximum effectiveness & minimum patient discomfort his requires the insertion of a PICC-line or of a CVA-ort such as the ones commonly used for chemotherapy.** Most treatments take 3 to 6 hours and consist o. I.V. ozone follow d by a mineral. & a vitamin I.V. drip:

(a) **High-Dose Direct-I.V. Ozone:** The primary reason for this treatment is to homeopathically reverse any causes of the degenerative condition & to remove any cellular imprints of drug toxicity. For all other effects of ozone you may consult Dr Sartori's comprehensive book on "Ozone".

(b) **Mineral-I.V.:** Contains for cancer patients the **High pH minerals** cesium (Cs) or rubidium and a mixture of essential minerals individually tailored to the specific needs of the patient.

(c) **Vitamin I.V.**: Contains a mixture of essential vitamins individually tailored to the specific needs of the patient to optimally enhance the **High pH minerals**. For specific information regarding individual vitamins minerals, please consult Dr Sartori's "Cancer" books & cancer articles.

(4) **BALANCING MIND-BODY-SPIRIT as practitioners of Taoist Energy Healing, Silva Mind Control, Neurolinguistic Programming (NLP), & Emotional Freedom Techniques (EFT):** All of our patients are greatly encouraged to spend at least one week each to learn Taoist Energy Healing, Silva Mind Control, and Neurolinguistic Programming (NLP).

IF YOU COMPLETELY (and as long as you) FOLLOW OUR PROGRAM YOU HAVE AN EXCELLENT CHANCE OF PERMANENT RECOVERY no matter what kind or stage of cancer you have, be **"incurable"** , i. e., (a) **having a 0.0% success rate and thus should NOT be treated conventionally** at al' including, **small cell lung, pancreas, & esophagus, mesotheliomas, acute adult leukemias**, and **all cancers with widespread metastasis**; or (b) malignancies where **conventional treatment in almost all cases shortens the life span**, including, **stomach, brain, liver**, & **most ovarian cancers, multiple myeloma** & **chronic adult leukemias**, as well as large (>10 cm = >2") **fast growing cancers with lymph node metastasis**; or (c) or any of the cancers with the highest incidence (in the USA & Western Europe), including, (female) breast, prostate, lungs[see (a)], & colon, where with early detection there is about 50% 5-year survival in breast, of 60% in prostate, & about 25% in colon cancers, that drops precipitously to some 10% if (b) & 1.0% if (a), *supra*, conditions are present; (d) other cancers including non-Hodgkin lymphomas, cancers of the urinary bladder & kidneys, rectum, (epi/naso)pharynx & oral cavity, endometrium & uterine cervix, & melanomas of the skin, rectovaginal cancer, larynx & thyroid cancer, Ewing sarcoma, etc.

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es chondro- and osteosarcomas. The recommended dosage for prevention is 100 to 200 mg/day and for treatment 1000 to 4000 mg/day for a 60 kg patient. Except for a Herxheimer-type "healing crisis" reaction, no other adverse effects have been observed with this compound. If no effect is seen, the treatment should be discontinued after 60 days.

2. Other **Proven Effective Herbal Combinations: Herbal treatments of cancer** which were used worldwide since time immemorial include: **Shark cartilage,** Resistocell®, the **thymus** preparations Thymex L® and TFZ-Thymomodulin®, **colostrum-derived transfer factor (TF)** according to **H. Hugh Fudenberg**, Dr. Nieper's **natural anticancer substances,** and **herbal cancer treatments** such as compounded Hoksey [*Trifolium pratense, Rhammus cathartica, Berberis vulgaris, Arctium lappa, Stillingia sylvatica, Rhammus purshiana* or *Cascara amarga (Sweetia panamensis), Glycyrrhiza glabra, Zanthoxylum clava-herculis*], compounded Echinacea [*Echinacea* spp, *Ceanothus americanus, Baptisia tinctoria, Thuja occidentalis, Stillingia sylvatica, Iris versicolor, Zanthoxylum clava-herculis*], Folia *Thujae occidentalis* (fresh), Radix *Astragali membranacei* (Huáng Qí), Radix *Rumicis crispi* (fresh), and Renée Caisse's Essiac compound [*Rumex acetosella, Arctium lappa* (fresh root), *Ulmus rubra, Rheum palmatum* (root), etc.], PDR Cancer Formula [*Larrea divaricata* (folia), *Sanguinaria canadensis* (radix), *Trifolium pratense* (flores), *Arcticum lappa* (radix); *Echinacea purpurea* (radix), *Hydrastis canadensis* (radix); *Symphytum officinale* (folia), *Eleutherococcus senticosus* (radix; eventually folia, radix, and flores), *Chelidonium maius,* combined with *Artemisia absinthium, Yucca* spp, and *Commiphora molmol* (gum), *C. abyssinica* (myrrh), or *C. opobalsamum* (bdellium-oleoresin)], Laetrile® *et al.* mandelonitriles, immunostimulating mushroom extracts from *Grifola frondosa* (maitake), *Ganoderma lucidum* (reishi), and *Lentinus edodes* (shiitake), combined with herbs for specific cancers; e.g., herba *Hedyotis diffusae* (bái huā shé cǎo) combined with herba *Scutellariae barbatae* (bàn zhī lián) for stomach, esophageal, & colon cancers , & the latter alone for lung cancers, & tuber *Dioscoreae bulbiferae* (huáng yào zǐ) for thyroid cancer & endemic goiter, and, especially, **colostrum, bovine tracheal cartilage,**and **Nature's Blessing.**

3. **WILL TO LIVE - MENTAL RECONDITIONING:** What **virtually all cancer survivors, particularly** the ones that had been **undergoing conventional therapies, have in common** is that **they had a purpose to their lives with goals they absolutely needed to achieve, no matter what.** If counseling is successful in restructuring an individual's outlook on life along those lines considerable life extensions beyond all expectations can be achieved after conventional therapies, while **with the enhanced high pH therapy, the success is virtually guaranteed,** provided that the patient has survived the first three months after the treatment started, and that they followed the programs outlined under 4. & 5., *infra*. Conventional cancer treatment attempts, particularly surgery, that may in many cases frustrate all efforts to restore the will to live include colostomies, crippling lung resections, amputations of limbs, especially in children, cosmetically poor results after head, neck, & breast surgery &/or radiation. The same applies to paralysis after collapse of vertebrae from metastasis or from brain malignancies.

4. **DIET & LIFESTYLE: Meticulously maintaining their prescribed alkalinizing blood type specific diet, supplementation, exercise program,** and **lifestyle is as essential** as mental reconditioning [see 3.] and energy balancing [see 5.]. **Individualized supplementation** may include maintenance doses of cesium & rubidium, potassium & magnesium salts, Wobemugos, bromelain, papain, superoxide dismutase (SOD), & other enzymes, coenzyme Q10, vitamin A & beta-carotene, selenium & vitamin E, vitamin C, quercetin, & isoflavones, lycopene, N-acetyl cystein (NAC), pycnogenol, d-limonene, curcumin, alpha lipoic acid, inositol, methylsulfonylmethane (MSM), ellagic acid & graviola (*Annona muricata*), Primal Defense, Nature's Blessing, green tea, olive leaf extract, echinacea, garlic, parsley, Korean ginseng, apricot pits, wheat grass, chlorella, cod & shark liver oils, contortrostatin, carrot & cabbage juices, mogu (Kompucha) tea, regular escargots & soy bean products for blood type As & ABs, and over 20 other cancer fighting foods accordig to your blood type & individually tailored to specific needs. The blood type specific diet & exercise program follows largely the one outlined in Dr. Peter J. D'Adamo's book "Live Right Fo(u)r Your Type", modified & amplified based on our own research including avoidance of sugar & fructose (& all refined carbohydrates) by all types, particularly Os & Bs, avoidance of cow's milk, particularly Os & As, avoidance of the foods shown harmful for all types including pork, etc., as well as identifying the specific requirements for Type A2, a combination of A1 & O features.

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6. **ULTIMATE EFFECTIVE HEALTH CARE AT THE KATHLEEN PRESTON MEMORIAL RESORT: Since September 2004, by integrating a comprehensive before and after care system for all patients, by far THE MOST EFFECTIVE ACUTE & LONGTERM HEALTH CARE available to all of humanity has finally been realized. Thus, even most dying terminal patients may be restored to permanent wellness, to the degree to and for as long as they are willing to follow the program. The PRE & POST TREATMENT SYSTEM is an integral part of our therapy and you should follow it for at least one year** or, preferably, for the rest of your life. Following this System gives you not only the **highest success rates in permanently overcoming cancer** but also greatly **enhances your overall health, happiness, vigor, and longevity.**

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   Medicinal plants that reputedly have anticancer activity and that contain high amounts of **Ge** include shelf fungus (*Trametes cinnabarina*; 800-2000 ppm), Ginseng (*Panax ginseng*; 250-350 Korean < 4000ppm), garlic (*Allium sativum*; 750 ppm), dāng-shēn/sansukon root (*Codonopsis pilosula*; 260 ppm), sushi (*Angelica pubescens*; 260 ppm), Bandai moss (260 ppm), Japanese waternut (*Trapa japonica*: 240 ppm), Comfrey (*Symphytum officinale*; 150 ppm), boxthorn seed (Lycium chinense; 125 ppm), wisteria knob/gall (*Wisteria floribunda*; 110 ppm), pearl barley (fructus coicis lacryma-jobi; 75 ppm), etc.

   Based on this concept, Kazuhiko Asai synthesized numerous non-toxic Ge compounds, most notably, **propagermanium** or bis-carboxyethyl Ge sesquioxide [$O_3(Ge.CH_2.CH_2.COOH)_2$], which has been found effective in the prevention and treatment of numerous cancers and their metastases including cancers of the lungs, prostate, breast, liver, kidney, brain tumors, lymphomas and leukemias, and sarcomas such as chondro- and osteosarcomas. The recommended dosage for prevention is 100 to 200 mg/day and for treatment 1000 to 4000 mg/day for a 60 kg patient. Except for a Herxheimer-type "healing crisis" reaction, no other adverse effects have been observed with this compound. If no effect is seen, the treatment should be discontinued after 60 days.

2. Other **Proven Effective Herbal Combinations: Herbal treatments of cancer** which were used worldwide since time immemorial include: **Shark cartilage,** Resistocell®, the **thymus** preparations Thymex L® and TFZ-Thymomodulin®, **colostrum-derived transfer factor (TF)** according to **H. Hugh Fudenberg**, Dr. Nieper's **natural anticancer substances**, and **herbal cancer treatments** such as compounded Hoksey [*Trifolium pratense, Rhammus cathartica, Berberis vulgaris, Arctium lappa, Stillingia sylvatica, Rhammus purshiana* or *Cascara amarga (Sweetia panamensis), Glycyrrhiza glabra, Zanthoxylum clava-herculis*], compounded Echinacea [*Echinacea* spp, *Ceanothus americanus, Baptisia tinctoria, Thuja occidentalis, Stillingia sylvatica, Iris versicolor, Zanthoxylum clava-herculis*], Folia *Thujae occidentalis* (fresh), Radix *Astragali membranacei* (Huáng Qí), Radix *Rumicis crispi* (fresh), and Renèe Caisse's Essiac compound [*Rumex acetosella, Arctium lappa* (fresh root), *Ulmus rubra, Rheum palmatum* (root), etc.], PDR Cancer Formula [*Larrea divaricata* (folia), *Sanguinaria canadensis* (radix), *Trifolium pratense* (flores), *Arcticum lappa* (radix); *Echinacea purpurea* (radix), *Hydrastis canadensis* (radix); *Symphytum officinale* (folia), *Eleutherococcus senticosus* (radix; eventually folia, radix, and flores), *Chelidonium majus*, combined with *Artemisia absinthium, Yucca* spp, and *Commiphora molmol* (gum), *C. abyssinica* (myrrh), or C. *opobalsamum* (bdellium-oleoresin)], Laetrile® *et al.* mandelonitriles, immunostimulating mushroom extracts from *Grifola frondosa* (maitake), *Ganoderma lucidum* (reishi), and *Lentinus edodes* (shiitake), combined with herbs for specific cancers; e.g., herba *Hedyotis diffusae* (bái huā shé cǎo) combined with herba *Scutellariae barbatae* (bàn zhī lián) for stomach, esophageal, & colon cancers , & the latter alone for lung cancers, & tuber *Dioscoreae bulbiferae* (huáng yào zǐ) for thyroid cancer & endemic goiter, and, especially, **colostrum, bovine tracheal cartilage,** and **Nature's Blessing.**

3. **WILL TO LIVE - MENTAL RECONDITIONING:** What **virtually all cancer survivors, particularly** the ones that had been **undergoing conventional therapies, have in common** is that **they had a purpose to their lives with goals they absolutely needed to achieve, no matter what.** If counseling is successful in restructuring an individual's outlook on life along those lines considerable life extensions beyond all expectations can be achieved after conventional therapies, while **with the enhanced high pH therapy, the success is virtually guaranteed,** provided that the patient has survived the first three months after the treatment started, and that they followed the programs outlined under 4. & 5., *infra*. Conventional cancer treatment attempts, particularly surgery, that may in many cases frustrate all efforts to restore the will to live include colostomies, crippling lung resections, amputations of limbs, especially in children, cosmetically poor results after head, neck, & breast surgery &/or radiation. The same applies to paralysis after collapse of vertebrae from metastasis or from brain malignancies.

4. **DIET & LIFESTYLE: Meticulously maintaining their prescribed alkalinizing blood type specific diet supplementation, exercise program,** and **lifestyle is as essential** as mental reconditioning [see 3.] and energy balancing [see 5.]. **Individualized supplementation** may include maintenance doses of cesium & rubidium, potassium & magnesium salts, Wobenugos, bromelain, papain, superoxide dismutase (SOD), & other enzymes, coenzyme Q10, vitamin A & beta-carotene, selenium & vitamin E, vitamin C, quercetin, & isoflavones, lycopene, N-acetyl cystein (NAC), pycnogenol, d-limonene, curcumin, alpha lipoic acid, inositol, methylsulfonylmethane (MSM), ellagic acid & graviola (*Annona muricata*), Primal Defense, Nature's Blessing, green tea, olive leaf extract, echinacea, garlic, parsley, Korean ginseng, apricot pits, wheat grass, chlorella, cod & shark liver oils, contortrostatin, carrot & cabbage juices, mogu (Kompucha) tea, regular escargots & soy bean products for blood type As & ABs, and over 20 other cancer fighting foods accordig to your blood type & individually tailored to specific needs. The blood type specific diet & exercise program follows largely the one outlined in Dr. Peter J. D'Adamo's book "Live Right Fo(u)r Your Type", modified & amplified based on our own research including avoidance of sugar & fructose (& all refined carbohydrates) by all types, particularly Os & Bs, avoidance of cow's milk, particularly Os & As, avoidance of the foods shown harmful for all types including pork, etc., as well as identifying the specific requirements for Type A2, a combination of A1 & O features.

5. **BALANCING MIND-BODY-SPIRIT as practitioners of Taoist Energy Healing, Silva Mind Control, Neurolinguistic Programming (NLP), & Emotional Freedom Techniques (EFT):** All of our patients are greatly encouraged to spend at least one week each to learn Taoist Energy Healing, Silva Mind Control, and Neurolinguistic Programming (NLP). If these techniques are practiced for at least one half hour a day, your expanding wellness, abiding happiness, success in all your aspirations, limitless energy & vigor, as well as longevity is virtually guaranteed after a year of practice and as long as you maintain it faithfully. Until these "exercises" became an integral part of one's life this may require one to two hours of practice a day & 2-4 hours on weekends including solo & dual energy balancing, physical, mind, & spiritual exercises. The Path may seem arduous, but the rewards are so great that, once experienced, you simple cannot do without them.

EXPRESS DETECTIVE SERVICE

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6. **ULTIMATE EFFECTIVE HEALTH CARE AT THE KATHLEEN PRESTON MEMORIAL RESORT: Since September 2004, by integrating a comprehensive before and after care system for all patients, by far THE MOST EFFECTIVE ACUTE & LONGTERM HEALTH CARE available to all of humanity was finally realized. Thus, even most dying terminal patients achieve permanent wellness, to the degree to and for as long as they are willing to follow the program. The PRE & POST TREATMENT SYSTEM is an integral part of our therapy and you should follow it for at least one year** or, preferably, for the rest of your life. Following this System gives you not only the **highest success rates in permanently overcoming cancer** but also greatly **enhances your overall health, happiness, vigour, and longevity.**

Why is UPFRONT PAYMENT of the FEES ESSENTIAL for the SUCCESS of the treatment?
Over 30 years of personal experience combined with the wisdom accumulated in alternative medical facilities all over the world made it crystal clear that, **in terminal dieing patients, it is absolutely essential to pay the full fee for their entire treatment up front.** This is the only way to assure:
(1) **Total commitment of the patient AND his/her family to complete the ENTIRE treatment;**
(2) **Most effective programming of your subconscious for a successful outcome of the treatment;**
(3) **Minimum intrusion of "Second Thoughts" in patients and their families**, often occurring even after little discomfort of the patient during the treatment, and often reinforced by their families who rather spend the money on themselves, that (a) it is their time to leave this world, or (b) they may end up in a wheelchair or in other ways crippled though almost all patients undergoing our full treatment course end up well, or (c) any of 1001 rationalizations, oftentimes entirely outside reason, to discontinue treatment;
(4) **Maximum all-out effort of the patient and his/her family to make the treatment a success** as almost all patients we lose have not been adequately feed or properly cared for by their families who often simply seem to be unable to carry out simple & most explicit instructions;
(5) **Motivation to continue on the program for the rest of their lives.**

Note: Dr. Sartori is available for consultations, in conjunction with your personal health care provider, about **all aspects of Alternative Medicines for any type of medical condition**, particularly **cancer, heart** and **vascular disease, diabetes** and its complications **(angiopathy, retinopathy, etc.), rheumatoid arthritis (RA)** and **systemic lupus erythematosus (SLE), asthma** and **allergies, alcoholism** and **drug** (and other) **addictions, general revitalization** and **rejuvenation, impotence** and other **sexual dysfunctions, immune system disorders** including **chronic fatigue immunodeficiency syndrome (CFIDS)** and **AIDS, Alzheimer disease** and **schizophrenias, multiple sclerosis (MS)** and other neurological diseases, any type of acute and chronic **toxicity/poisoning from drugs/ environment/asbestos, aluminium/heavy metal toxicity, lung diseases** including **cancer, pneumonias, emphysema,** and **sarcoidosis**, acute and chronic **infectious diseases, hepatitis** of all types, **vaginal yeast infections** and other urogenital problems, etc., on a case to case and fee for service basis.

There are effective treatments for virtually any condition where standard orthodox approaches have virtually nothing to offer except temporary symptomatic relief while the underlying disease progresses relentlessly. Besides cancer these include RA & SLE and virtually all other conditions with immune system involvement. Through a vast worldwide network of like-minded practitioners, effective treatments can be found for virtually any "incurable" health problem, i.e., that either requires permanent lifelong medication or by its nature causes premature death or permanent progressive invalidity. Examples are myasthenia gravis where I.V. ozone, a special nutritional & herbal regimen, and, above all, homeopathy will result in most patients living virtually normal lives; or massive disabling elephantiasis that is often curable with acupuncture; or muscular dystrophy that may be reversed with ozone, homeopathy, acupuncture, special nutrients, and Taoist energy exercises. The universally beneficial effect of high dose direct I.V. ozone, since there was no other comprehensive source available, made Dr. Sartori write a book on **"Ozone, the Eternal Purifier..."** This book is by far the most complete listing of applications of ozone ever compiled and, at the same time, provides information about a wealth of effective empirical ("proven by experience") modalities for most major degenerative disease including AIDS, cancer, COPD, pulmonary sarcoidosis, acute and chronic infections, MS, ALS, collagen diseases including RA, SLE, even Paget disease of bone, cataracts, and many others.

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FOLLOW THE WELLNESS PRINCIPLES FROM NOW ON OUT

Modelled after Jack Canfield's 64 Success Principles in "*The Success Principles*", HarperCollins, N. Y., 2005

1. **Take 100% Responsibility for Your Life and realize that YOU are, ultimately, the Cause and the CURE of Your Illness. By meticulously following all of our instructions and, above all, continuously living The Wellness Principles, YOU WILL GET WELL in due time.**
2. **Let Go of Your Past as YOU HAVE ONLY THE BRIGHTEST LIMITLESS FUTURE YOU CAN IMAGINE. There are absolutely no limits to your growth in any area of your life.** Whereas Jack Canfield's has spelled out the 64 Success Principles or "How to get from where you are to where you want to be" in all area of your life, in his book "*The Success Principles*", *v.s.*, we provide you here "The Wellness Principles" or "How to return your body, mind, soul, and spirit to the highest level of functioning no matter how far gone you were". In our 2-page pamphlet , "Sedona Method – Letting Go" you learn all the essentials of this 2nd Principle. For most cancer patients, this letting go involves **dealing with a loss** that somehow co-caused the cancer, or with their **inability to express hostility**, or **despair & hopelessness.** Thus, LET GO &: (a) **REFRAME ALL LOSES INTO OPPORTUNITIES, thus** -- Loss of your beloved spouse is an opportunity to **create a memorial** for her/him. -- Loss of a family member is an opportunity to replace her/him **enhancing their importance.**
   -- Loss of a girlfriend/boyfriend is an opportunity to **find someone even better suited for you.**
   -- Loss of your job/business is an opportunity to **find/create the ideal job/business** for yourself.
   -- Loss of your houseboat/plane/car... is an opportunity to **get what you really want.**
   -- Your cancer or degenerative disease is an opportunity to **find a path to permanent wellness.**
   (b) **Learn to assert yourself in every area of your life** and that **you don't have to let yourself be terrorized by other people's expectations of you** and that **you can say NO to all things that are against your health, happiness or success in all areas of your life**
   (c) Realize that **there is NEVER A CAUSE for despair& hopelessness**, and **NEVER GIVE UP ON YOUR HOPES & DREAMS, including Your Dream of Permanent Wellness**
3. **Decide what You Want & FIRMLY BELIEVE It's Possible to get well NO MATTER HOW FAR YOU ARE GONE as hundreds of our patients were only days away from dying and RECOVERED within a few days. Say & visualize: "I am proudly celebrating my victory over my cancer [, etc.] and feel better than ever before in my life".**
4. **SEE What You Want and Get What You See from now on and for he rest of your life.** This is perhaps the most important principle when undergoing any intensive therapies such as the Enhanced High pH Therapy or High-Dose I.V. Ozone. The evening before and before & during every treatment visualize & affirm: **"I'm peacefully relaxing while the healing energy from my I.V. flows into me". "I'm feeling better & better ...". "My cancer, my pain, my nausea, my ... has disappeared". "I am feeling happy, strong, full of energy ...".** At bedtime after treatments visualize & affirm: **"I am waking up refreshed, full of energy, & move like a 20 yo".** From now on out for the rest of your life affirm: **"I am getting better & better every day in every way".**
5. **KEEP DOING WHAT WORKS for the rest of your life.** This includes at least the following:
   (1) **Blood-type specific diet modified for your condition**
   (2) **Blood-type specific exercise modified for your condition**
   (3) **Pre- and Post-Treatment Packs and vitamin-mineral-herbal supplementation**
   (4) **Make sure your entire family / ALL your friends support you in your Quest for Wellness,** & as hard as it may be in the beginning, **BREAK UP WITH EVERYONE WHO DOES NOT. Note: Anyone who does not, in the long run, will be destructive in other areas of your life too.**
   (5) Make learning & practicing **Taoist Techniques, Silva Mind Control, Neuro-Linguistic Programming, Emotive Control Techniques, The Sedona Method**, and, above all, Jack Canfield's **64 Success Principles,** a life-long ongoing project to get "better & better every day in every way". **Note: Continuing Improvement in All Areas of your life raises your level of consciousness and energy over time to such levels that the result is Total Wellness, Serenity, & Bliss.** This evolution was perhaps best expressed by David R. Hawkins in his book **"Power vs Force"**(1998).
6. **BELIEVE & ACT ALWAYS AS IF IT WERE IMPOSSIBLE TO FAIL** since to fly as fast as thought & to be anywhere there is begins with knowing **YOU HAVE ALREADY ARRIVED.**
7. **KNOW that YOU CAN LIVE A FULL COMPLETE LIFE ACHIEVING ALL OF YOUR GOALS and REALIZING YOUR WILDEST MOST OUTRAGEOUS DREAMS.**

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ARE THERE ANY *ADVERSE EFFECTS* TO OUR CANCER TREATMENT?

Unlike conventional or orthodox Cancer Treatments that have PROVEN and, in most cases, very severe adverse effects that are summarized in Appendix II, the Enhanced High pH Therapy and all the other methods used at the KPMHC have minimal, if any, physical side effects. Almost all discomfort encountered by the patient is linked to elimination of the broken down tumour mass. Another strictly subjective phenomenon is the "homeopathic effect" of direct I.V. ozone.

1. **Cesium & the other ingredients of the high pH therapy, in over 700 cases treated by Dr Sartori and over 10,000 cases of self-treatment have NONE of the adverse effects listed in Appendix II. There are four reported cases of cardiac arrhythmias due to failure to add potassium. Note also that all the adverse effects of hormone treatments of prostate & testicular cancers and breast & ovarian cancers** [not mentioned in Appendix II] **are never encountered with any of our treatments. On the contrary, with our treatments, your sexual functioning, in most cases, is restored to that of your "glory days".** If this is one of your concerns, make sure to let us know so we can address it. **The almost universal, and often extreme, fatigue from conventional therapy is indicative of destruction of normal tissues and usually lasts for weeks if not months. Fatigue with cesium therapy, is usually mild, limited to at most two to four hours right after the I.V. and is, in fact a sign that cancers are turned to normal tissues which requires enormous energy. While severe nausea & vomiting is found with almost all chemotherapeutic agents and may last over to six months after use, it is mild and lasts usually less then one half to at most perhaps four hours with cesium. These symptoms allow us, in conjunction with numbness around the mouth, to adjust the dosage for the next I.V. application of cesium.**
2. **Symptoms linked to elimination of the broken down tumour mass with any of our therapies include diarrhea, sweating with body odor, productive cough with halitosis, copious often cloudy and sometimes malodorous urine.**
3. **Direct I.V. Ozone brings about a "healing crisis" that simulates milder versions of any hidden, but still significant, disease processes that have not been completely resolved, including allergies, old drug toxicities, environmental pollution, old viral, bacterial or fungal infections, even physical traumas, migraines, and other conditions. After the "healing crisis" is brought about by the ozone administration, these conditions are resolved (analogous to the mechanism of action of homeopathic remedies) and people reach a new level of wellbeing that was unattainable before. Note that these healing crises may be quite uncomfortable but, according to a study by the University of Innsbruck, Austria, there is less then one chance in one million for I.V. ozone applications to cause any serious side effects.** Further ozone effects are explained in **Appendix I.**
4. **Symptoms from Oral Supplementation: One of the main reasons we recommend our 12-day intensive I.V. treatment is to assure that patients get all the ingredients of the high pH therapy into their bodies. Many times, cancer patients get discouraged when there is some nausea or diarrhea or other symptoms with oral supplementation. Also, oral supplementation may be too slow to fully control your cancer especially if you are unable to take higher doses of cesium. Oral intake usually does not remove the causes of cancer or other degenerative disease, nor does it effectively remove cellular imprints of toxic drugs that may cause late complications of chemotherapy** [see Appendix II], **as does I.V. ozone.**
5. **Symptoms from Pre- & Post-Treatment Packs: These are specially designed to minimize any symptoms if applied according to our instructions. If there are any problems please consult with us and we will adjust the dosage for best results.**
6. **Symptoms from prior Chemotherapy or Radiation:** As listed in more detail in Appendix II, **many patients may suffer from long-term effects of chemotherapy or radiation** that may make him/her believe they were caused by our treatments, most notably, **sustained nausea & vomiting. Almost all non-hormonal anticancer drugs show dose-limiting** (1) **bone marrow depression** or (2) **delayed leukopenia & thrombopenia, which may also occur after radiation.** Other long-term effects include (3) **Pneumonitis & pulmonary fibrosis,** (4) **Renal damage,** (5) **Stomatitis & oral ulcerations,** (6) **Cardiotoxicity** (7) **Hemorrhagic cystitis,** (8) **Teratogenicity** (9) **CNS depression,** (10) **Hemorrhagic diathesis,** (11) **Peripheral neuropathy,** (13) **Mucositis.** Of these, **cardiotoxicity** from **dauno- & doxorubicin,** a cumulative, dose-dependent **cardiomyopathy /CHF** that may be delayed for years, unfortunately, **caused the death, from fulminant intractable CHF, of several of our patients** that were otherwise responding well to our treatment.

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INDEMNITY

KATHLEEN PRESTON MEMORIAL HEALTH CENTRE (KPMHC)

I, (patient's name) _____ state and declare that, in conjunction with my treatment at the Health Centre by Dr H. Sartori, Dr Alex Boyd, and Registered Nurse Simone Phasey and Merrilee Baker, I indemnify the above named from any action relating to my treatment. I also indemnify the Health Centre, any other persons or employees of the clinic and the technician, Keith Preston, from any action relating to my treatment.

I for myself, do hereby release Dr H. Sartori, Dr Alex Boyd, Registered Nurse Simone Phasey and Merrilee Baker, technician Keith Preston and any other persons or employees from all such actions, proceedings, claims and demands for damages, costs and benefits as aforesaid and I do further agree to indemnify and keep indemnified Dr Sartori, Dr Alex Boyd, Registered Nurse Simone Phasey and Merilee Baker, technician Keith Preston and any other staff member against the said actions, proceedings, claims, demands for damages and costs as related in any way, shape, or form to my treatment at KPMHC.

I for myself, herewith state that I have completely and truthfully filled out the ADDENDUM (pages 1 to 6) to this INDEMNITY FORM relating to my medical history and medications, as well as my present state of health. I will not hold KPMHC or any other persons or employees of the clinic and the technician, Keith Preston, responsible for any complications arising from any disclosed/known or undisclosed/unknown condition related or unrelated to the one I am here to seek relief from.

I for myself, herewith state that I will take full responsibility for following instructions given to me to the best of my ability and will not take any steps against KMMHC if, in case of repeated non-compliance, my health has been compromised to the point that continuation of the treatment may present excessive risk and thus, for the time being, my treatments need to be discontinued until the underlying problem is corrected.

Any and all potential effects of the treatments I may receive at KPMHC, as stated in the "Patient Information Sheet"["PIS"], have been explained to me in full and I completely and freely accept any and all of the risks involved that, in rare instances, may include death, and I fully indemnify KPMHC and all its personnel and consultants from any adverse outcome whatsoever in conjunction with any of the treatments I may receive here. Almost all of these adverse reactions, though, are unrelated to the treatments and caused by prior chemotherapy, prescription or OTC drugs, or even violent flashbacks/fugue states/anxiety attacks, e.g., from stimulants or hallucinogens, and I clearly understand that Non-Disclosure of such use may result in Forfeiture of Payments made to KPMHC [See Note re Upfront Payment on pg. 4 of the "PIS"].

Lastly, I state that I will wait at least three weeks, in case of tumours in the chest cavity and skull, six to 16 weeks before any imaging (X rays, scans, etc.) to evaluate post-treatment results are performed, as it takes at least that long to restructure the space left after treatment has destroyed all cancer cells and the "cysts" found by inexperienced radiologists are virtually always harmless fluid build-ups in the space previously occupied by the tumour, and that I WILL NOT TAKE ANY CHEMOTHERAPY or RADIATION offered by well-meaning oncologists for these cysts since the cancer is not there anymore (unless there is conclusive proof of malignancy and I therefore choose these treatments).

Signature of patient: _____ **Date:** _____

In the presence of (Name of Witness): _____

Signature of Witness: _____

Address of Witness: _____

_____

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ADDENDUM TO INDEMNITY FORM
KATHLEEN PRESTON MEMORIAL HEALTH CENTRE

I, (patient's name) SANDRA LOUISE MCCARTY herewith state under penalty of perjury that to the best of my knowledge, information and belief, prior to starting any of the modalities at the Kathy Preston Memorial Health Centre, I have received the following COMPLETE LIST of treatments for my condition.

A. SURGERY

I have undergone ALL of the following surgical procedures.

Date	Procedure	Result
1975	GALL BLADDER	
1994	MASECTOMY	LEFT BREAST & GLANDS
1997	BREAST RECONSTRUCTION	

B. RADIATION

I have undergone the following radiation treatments:

Date	Type & Dose of Radiation	Result
1994	LEFT BREAST & GLANDS	

C. CHEMOTHERAPY

I have received the following chemotherapies:

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Sue Carty

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Date	Type & Dose of Chemotherapy	Result
1994 - 1995		
2002-2003	TAXOL	
2004-2005	N/	

D. PAIN MEDICATION

I was given the following pain mediations:

a. Narcotic analgesics such as morphine, codeine etc.

From	To	Time of Med	Name & Amount of drug	Result

b. Non-Narcotic analgesics

From	To	Time of Med	Name & Amount of drug	Result

b. Non-Narcotic analgesics (continued)

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D. OTHER MEDICATIONS

List all other medication you have been using for the last 5 years.

From	To	Time of Med	Type of Medication	Result
OCCASIONALLY			SERAPAX	
C I H			ZANTAC	
OCCASIONALLY			MILANTA	
FEB 05	—	APRIL 05	FLUID TABLETS	

E. Alcohol – Smoking – Street Drugs

List all alcohol, smoking, and street drugs used throughout your entire life.

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a. Alcohol

From (Yr)	To (Yr)	Type of Alcohol	Problems[2]
		N/A	

b. Smoking

From (Yr)	To (Yr)	Type of "Smokes"	Problems[2]
1968	199? 2003	Ampule	

c. Street Drugs

From (Yr)	To (Yr)	Type of Drug	Problems[2]

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F. ALTERNATIVE CANCER TREATMENTS RECEIVED

From	To	Type of Treatment
		NIL TO DARWIN 2 WEEKS AGO

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G. ALL MEDICATIONS/ALTERNATIVE TREATMENTS PRESENTLY TAKING

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1. _____
2. _____
3. _____

21

4. _____
5. _____
6. _____
7.. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

I (patient's name) _____, herewith state under penalty of perjury that the foregoing lists are COMPLETE to the best of my knowledge, information and belief and furthermore PROMISE that I will ADD any items to this list if and as soon as I become aware of any omissions.

Signature of patient: _____

Date: _____

Signature of Witness: _____

Date: _____

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KEITH
898 31029

SANDRA McCARTY - NUTRITIONAL SUPPLEMENT REGIME

1/05/2005

7.30 AM	9.00 AM	12 NOON	3pm	6:00 PM	9:00 PM
	Breakfast	Lunch		Dinner	
L-Lysine x 2	Revenol x 2	Revenol x 2	L-Lysine x 2	Revenol x 2	L-Lysine x 2
	Cas. Rev x 2	Cas.Rev x 2		Cas.Rev x2	
	Orachel x 5			Orachel x 5	
	Chelamin x 1	Chelamin x 1		Chelamin x 1	
	B.Carotenx3	B.Carotenx3		B.Carotenx3	
	Melatoninx6	Melatoninx6		Melatoninx6	
	CoQ10 x 2			CoQ10 x 2	
	Rubid 1 tsp	Rubid x 1tsp		Rubid x 1tsp	AFTER FOOD
	Cesium x 4	Cesium x 4		Cesium x 4	AFTER FOOD
	Oxy x 2	Oxy x2		Oxy x 2	

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Appendix II

Appendix II ***Exhibit List***

Exhibit/ Volume	*1*	*Sandra McCarty*
	2	*Pia Bosso*
	3	*Sandra Kokalis*
	4	*Deborah Gruber*
	5	*Carmelo Vinciullo*
	6	*Daryl Green*
	7	*Antonio Ranieri*
	8a	*General Information KPMHC/ PERTH*
	8b	*General Information KPMHC/ PERTH*
	9	*General Information KPMHC/ PERTH 2*
	10	*Kathleen Preston and Lesley Bramston*
	11	*General Information KPMHC/ Darwin*
	12	*Other patients*
	13	*Documents seized DARWIN (Saxby Road)*
	14	*Documents seized DARWIN (Jacomb Place)*
	15	*Sartori's lap top*
	16	*Sourcing of substance (1)*
	17	*Sourcing of substances (2)*
	18	*CIS information Sartori*
	19	*Paul Rana*
	20	*Paul Rana*
	21	*Expert Reports – pre inquest*
	22	*Photographs WA Police*
	23	*Bank Accounts*
Exhibit:	*24*	*Kathleen Preston Memorial Health Centre, Indemnity Sheet (Vinciullo)*
	25	*Copy of notes written by Carmelo Vinciullo*
	26	*Emails from Sartori to Mr McCarty*
	27	*Gadgets – Magnetic Pads*
	28	*Extracts taken from Mr McCarty's diary from 29 April to 19 May*
	29	*Report Mr van Hazel dated 28 October 2010*
	30	*7/ 52 Record*
	31	*Ms Young's receipt summaries copy*
	32	*Ms Sindholt's remaining recipes*

	33	*Copy of picture of commode chair*
	34	*KPMH record copies by Ms Baker*
	35	*Copies of Ms Bakers notes*
	36	*Volume 1/13 page 23 Indemnity information (McCarty's)*
	37	*Black folder - Sartori copies of patients*
	38a	*Bundle of documents – 2004 by Ultra Life Science*
	38b	*Nutrients + Cancer an introduction to Caesium therapy highlighted*
	38c	*Nutrients on Cancer*
	38d	*Literature summary and Critique*
	38e	*Extract list*
	38f	*Summary of patients of Sartori*
	39	*Statement – Mr Lawson to Ms Kemp dated 3 January 2011*
	40	*Letter Dr Stephen Proud to Mr Lawson dated 9 August 2011*
	41	*Letter from Dr Wilson dated 30 August 2011*
	42	*Two cheques (copies) commonwealth Bank – Palmerston Branch*
	43	*KPMHC – records highlighted by Ms Phasey*
	44	*Bundle of documents with brochure*
	45	*Download from computer profile Ms Firth*
	46	*Email Dr Joyce to Dr Kemp dated 7 January 2011*
	47	*Email Dr Kemp to Dr Joyce dated 22 September 2011*
	48	*Royal Darwin Clinical Practice Manual Page 10-1 Peripherally Inserted Central Catheter (PICC) management*