CORONERS ACT, 2003

SOUTH *AUSTRALIA*

RULING OF CORONER IN THE COURSE OF INQUEST

An Inquiry taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, concerning Christopher McRae, Johanna Pinxteren, Bronte Ormond Higham and Carol Anne Bairnsfather.

1.1. This is an inquest into the cause and circumstances of the deaths of four individuals. They are as follows:

- Johanna Pinxteren aged 76 years who died on 23 June 2015
- Christopher McRae aged 67 years who died on 22 November 2015
- Bronte Ormond Higham aged 68 years who died on 7 August 2016
- Carol Anne Bairnsfather aged 70 years who died on 17 February 2017

1.2. The cause of Mrs Pinxteren's death was e-coli bacteraemia secondary to refractory acute myeloid leukaemia (AML). She was originally diagnosed with AML in November 2014 at the age of 75. She was treated at the Royal Adelaide Hospital (the RAH). Mrs Pinxteren's death was not the subject of a notification pursuant to section 28(1) of the Coroners Act 2003 (the Act).

1.3. The cause of Mr McRae's death was AML. He was originally diagnosed with AML in May 2014 at the age of 66. He was treated at the RAH. Mr McRae's death was not the subject of a notification pursuant to section 28(1) of the Act.

1.4. The cause of Mr Higham's death was AML. He was originally diagnosed with AML in November 2014 at the age of 66. He was treated at the Flinders Medical Centre (the FMC). Mr Higham's death was the subject of a notification pursuant to section 28(1) of the Act. A certificate of a doctor certifying cause of death was not provided to the Registrar of Births, Deaths and Marriages (the Registrar) pursuant to

section 36(3) of the Births, Deaths and Marriages Registration Act 1996 (the BDM Act)[1]. Pursuant to the definition of *'reportable death'* within section 3 of the Coroners Act the lack of such a certificate meant that Mr Higham's death was a reportable death by reason of that lack[2], thereby enlivening the State Coroner's powers in respect of that death.

1.5. The cause of Mrs Bairnsfather's death was AML. She was originally diagnosed with AML in October 2014 at the age of 68. She was treated at the RAH. Mrs Bairnsfather's death was the subject of a notification pursuant to section 28(1) of the Act. A certificate of a doctor certifying cause of death was not provided to the Registrar pursuant to section 36(3) of the BDM Act[3]. Pursuant to the definition of *'reportable death'* within section 3 of the Act the lack of such a certificate meant that Mrs Bairnsfather's death was a reportable death by reason of that lack, thereby enlivening the State Coroner's powers in respect of that death.

1.6. The evidence in the inquest has been finalised and in the normal course of events the next step would be to proceed to final submissions in relation to the issue concerning the Court's ultimate findings as to the cause and circumstances of these deaths.

1.7. A submission has been made on behalf of certain represented entities in the inquest (the Doctors, including a Dr R to whom I will later refer) that the deaths of Mrs Pinxteren and Mr McRae are not reportable deaths as defined by the Act and that the Coroners Court has had no jurisdiction to conduct an inquest into the cause and circumstances of those deaths. In relation to the deaths of Mr Higham and Mrs Bairnsfather it is submitted on behalf of the Doctors that while it is conceded that these deaths are reportable deaths for the reasons identified in paras 1.4 and 1.5 above, it would be unlawful for this inquest to proceed to finality in respect of those deaths and to deliver findings in relation to the cause and circumstances of those deaths. The Doctors are represented by Mr Trim QC and Mr Besanko of counsel. Their submissions have been supported by Ms Cliff on behalf of Dr B (to whom I will later refer) and Dr G. The submissions are opposed by Mr Griffin QC on behalf of families of the deceased as well as other individuals whom he represents in these proceedings. The submissions are also opposed by the Crown Solicitor Mr Wait SC on behalf of the Minister for Health and Wellbeing. Counsel Assisting, Ms Kereru,

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1 Exhibit C58, Document 10
2 See item (h) in the definition of 'reportable death' and note 1 thereto

has submitted that Mr Trim's submissions should be rejected and that the Court should find that it has jurisdiction in relation to all four deaths. She contends that there is no impediment to the Court proceeding to finality in respect of all four deaths.

1.8. The following facts are recited by way of background and appear not to be the subject of controversy.

1.9. All four deceased persons are said to have died of or from the complications of AML.

1.10. All four deceased persons had been accurately diagnosed as suffering from AML. An individual patient's prognosis may be affected by a number of factors. These include the age and performance status of the patient at the time of diagnosis, the presence or otherwise of predisposing myelodysplasia, medical and psychological co-morbidities, the presence of significant extramedullary disease and cytogenetic risk. The presence or absence of prognostic factors such as these are known to possibly affect treatment outcomes.

1.11. Following diagnosis all four deceased persons were treated by way of chemotherapy. In the first instance the chemotherapy in respect of each patient was delivered by way of what is known as induction therapy. In each instance complete remission was induced in the patient. Following the achievement of complete remission all four persons underwent what is known as consolidation chemotherapy the purpose of which I shall briefly explain in a moment.

1.12. The durations of the remission in each instance varied, but in due course all four patients experienced a relapse of AML and then underwent varying regimes of further treatment. Ultimately, however, they succumbed to the disease.

1.13. There is no suggestion other than that each of the four deceased persons had received induction therapy that was in correct accordance with chemotherapy protocols as they existed at the time of their treatment.

1.14. I now turn to the question of the consolidation chemotherapy. It was explained to the Court that even with complete remission of AML, a majority of patients who receive no further treatment will subsequently relapse due to residual disease which cannot be detected within the body. However, in order to reduce the likelihood of relapse

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[3] Exhibit C58, Document 10

occurring, consolidation chemotherapy is offered and administered to the patient as soon as possible after the achievement of complete remission. The evidence before the Court is that the idea underlying consolidation is to 'consolidate' remission by way of the administration of further courses of chemotherapy, the purpose being to gradually eradicate the leukaemic cells in the body or to or diminish the number of cells to a level that the body's own immune system can control and, perhaps, to provide a cure for the patient. In essence the purpose of consolidation is to reduce residual disease, to reduce the likelihood of relapse, to prolong remission and possibly to effect a cure.

1.15. There are a number of differing consolidation therapy protocols that dictate the nature of the chemotherapy administration regime in an individual patient. The evidence is that the consolidation therapy pertaining to the four deceased persons is usually administered in two separate rounds of chemotherapy, each round being administered over three alternate days. The four deceased persons underwent consolidation therapy after the achievement of complete remission in each case. Mr McRae and Mr Higham underwent two rounds of consolidation therapy. Mrs Pinxteren underwent one round of consolidation therapy. She relapsed before a second round could be administered. Mrs Bairnsfather underwent one round of consolidation therapy. A differing regime of treatment was undertaken instead of a second round in her case.

1.16. It is asserted that the consolidation therapy in the case of each deceased person miscarried because it was undertaken not in accordance with the consolidation therapy protocol that was pertinent to, and had been clinically determined to dictate the appropriate consolidation therapy for, those persons. What happened was that the first round of consolidation therapy in each case involved the provision of once daily administrations of chemotherapy over three alternate days when the protocol called for administration twice daily over three alternate days. The miscarriage of treatment is said to be the result of an error that was contained within the written protocol pertaining to the consolidation treatment for these patients. The error is said to be due to the inclusion of the word 'ONCE' instead of the word 'twice', or the expression 'bd' which is well understood medical terminology indicating twice daily administration. It had been the intention that the protocol should specify twice daily administration. The circumstances in which this error occurred have been the subject of detailed inquiry during the course of the inquest. The circumstances do not need to

be discussed exhaustively here except to say that the evidence is that the error originated within the Haematology Department at the RAH and was replicated at the FMC which had adopted the erroneous RAH protocol and that there is an issue as to whether the root cause of the error at each hospital was poor clinical governance at either or both hospitals. As indicated earlier, Mr Higham was treated at the FMC. A second round of what is said to be the same erroneous consolidation therapy was administered to Mr McRae at the RAH and to Mr Higham at the FMC.

1.17. The four deceased individuals are said not to be the only persons who received consolidation chemotherapy for AML that was not in accordance with the correct protocol for administration. Six other patients who have survived also underwent consolidation chemotherapy that was delivered pursuant to the terms of the erroneously worded protocol. Two of those additional patients underwent their treatment at the RAH. Four of them underwent their treatment at the FMC. In all a total of ten patients are said to have been the subject of the erroneous administration of consolidation chemotherapy for AML pursuant to the same erroneous protocol. Four of them have died. As indicated, this inquest relates to those four persons. In due course the protocol error was discovered in circumstances that I will describe.

1.18. The evidence is that the protocol error was discovered and appreciated for what it was at the RAH no later than Monday 19 January 2015. It was discovered as the result of a prescription discrepancy in the consolidation chemotherapy for a patient at the RAH wherein one doctor had prescribed once daily therapy but another more senior doctor, correctly, had prescribed twice daily. The discrepancy had been identified by a pharmacist on Friday 16 January. If the identification of the discrepancy had led in turn to the detection of the protocol error on that Friday, the suggestion would be that the underdosing of Mrs Pinxteren in respect of her third alternate daily administration of therapy on Saturday 17 January at the RAH should and probably would have been avoided.

1.19. Similarly the suggestion would be that if adequate procedures had been in place for the reporting of adverse incidents and for the communication of the detection of an error on Friday 16 January 2015 to FMC on that day, the underdosing of Mr Higham on 18 January (and possibly 16 January) should have been avoided.

1.20. A surviving patient, Mr Andrew Knox, had been treated at the FMC. A body of evidence relating to Mr Knox has been admitted at the inquest over objection by Mr Trim QC. I overruled that objection and delivered written reasons. The circumstances surrounding the treatment of Mr Knox are unique in that Mr Knox was the only patient who was treated in accordance with the erroneous protocol after the error had been identified at the RAH no later than 19 January 2015.

1.21. On Tuesday 20 January 2015 an email was sent to a large distribution list within 'Health' that included haematology clinicians at both the RAH and the FMC[4]. On my count the email was sent to forty individuals, nine of whom are identifiably haematology consultants some of whom worked at both hospitals. The email advised that the protocol called for twice daily administration of consolidation therapy. The email did not make specific reference to the fact that this new requirement had been initiated as the result of the detection of an error in the protocol. It did not state whether or not some patients had already been treated pursuant to the erroneous protocol. The email did not cause the erroneous protocol in use at the FMC to be immediately amended.

1.22. A haematology consultant at the FMC, Dr R, has given evidence to the effect that if the email had specifically identified that the change to twice daily administration was as the result of the detection of an error in the protocol at the RAH, he might have reviewed Mr Knox's prescription of consolidation therapy that was scheduled to commence on 22 January when he saw Mr Knox on 24 January[5].

1.23. On Thursday 22 January 2015 Mr Knox commenced his second round of consolidation therapy in accordance with the erroneous protocol notwithstanding that the error had been discovered at the RAH no later than Monday 19 January and in spite of the fact that the email specifying twice daily administration had gone out including to haematology clinicians at the FMC where Mr Knox underwent his second round of consolidation therapy. He received only once daily administration when it should have been twice daily. This occurred on each of his alternate daily administrations on 22, 24 and 26 January 2015.

[4] Exhibit C38, page 82
[5] Transcript, page 1200 - it would also follow that Dr R might have reviewed Mr Knox's prescription when he also saw Mr Knox on 22 January

1.24. There is material to suggest that the consultant haematologist who was instrumental in the introduction of the incorrect protocol at the FMC, Dr B, was the doctor at the FMC who was instrumental in the prescription of Mr Knox's erroneous second round of consolidation therapy administered after 19 January 2015. Dr B's electronic signature appears on that prescription[6] and Dr B had been a recipient of the email of 20 January 2015.

1.25. As things transpired, on Monday 19 January 2015 at the RAH one of the affected surviving patient's second round of consolidation therapy had been commenced and it involved the correct twice daily administration, the first round having been administered to her in December only once daily. The correct twice daily administration in this patient was due to the discovery of the error at the RAH. The evidence is that Mr Knox at FMC, later in the same week, was not so fortunate. There is evidence to suggest that the error was not ultimately identified at the FMC until several days after the completion of Mr Knox's erroneous consolidation therapy. Therefore, the integrity of and compliance with adverse incident reporting and management processes across the South Australian public health system are appropriate issues for investigation. It would be idle to investigate these issues in the abstract. It is relevant to enquire whether any irregularities in this regard had been sufficiently serious as to have generated patient consequences in the context of the protocol error under discussion. The evidence regarding Mr Knox's circumstances is capable of affording an instance of such consequences having been generated.

1.26. The evidence is that the consolidation chemotherapy regimen that was utilised in respect of the affected patients, namely once daily administration on days 1, 3 and 5 instead of twice daily on days 1, 3 and 5, is not a recognised regimen of administration and is not reflected in any of the protocols that have been admitted in evidence in the inquest. Much evidence of an expert nature has been given in relation to the value of consolidation therapy, particularly in the aged patient, its efficacy and in respect of the frequency of dosage and other related matters.

1.27. There are a number of issues that the Court has investigated in respect of the cause and circumstances of the deaths of the four individuals. These include:

a) Whether the consolidation therapy that was administered not in accordance with the correct protocol for administration contributed or may have contributed in any

[6] Exhibit C43, page 75

way to the death of each individual or to the death of any of those individuals. In this regard one issue that is appropriate for investigation is whether or not the period of complete remission following induction therapy in each or any of these cases was not as long as it might have been if consolidation therapy had been administered in accordance with the correct protocol. That question in turn is relevant to the question as to whether the longevity of any of the four individuals was not as long as it might have been if consolidation therapy had been administered in accordance with the correct protocol.

b) Intrinsically enmeshed with a) above is the more general question as to whether consolidation therapy that is not in accordance with the correct protocol would or could compromise the treatment of a patient or would or could lead to a shorter period of remission or of longevity than otherwise would have been the case if the correct protocol had been adhered to. This is an issue that is divorced from a consideration of any particular deceased person's treatment.

c) Whether further clinical measures taken following the discovery that consolidation therapy had not been administered in accordance with the correct protocol had any positive effect on the longevity of either the period of remission or the life of the patient in each or any of the instances.

d) Whether the root cause of the protocol error at the RAH and the FMC and the consequent erroneous administration of consolidation therapy was poor clinical governance at either or at both hospitals.

e) Whether there were any irregularities in the integrity of or compliance with adverse incident reporting processes across the South Australian public health system and whether they had been sufficiently serious to have generated patient consequences in the context of the protocol error under discussion.

1.28. It appears to be common ground in this inquest that all of the deceased persons received consolidation chemotherapy that did not accord with the correct and intended protocol. This fact in each case forms part of the general circumstances in which those four persons ultimately died, and that would be so regardless of whether or not it can be positively demonstrated that the underdosing had an effect on the length of their remission or on their longevity. The fact that the underdosing occurred is plainly a circumstance of the deaths of these patients.

1.29. On 7 July 2016 an inquest into the deaths of Mrs Pinxteren and Mr McRae commenced. At that time out of the ten persons who were said to have been underdosed, Mrs Pinxteren and Mr McRae were the only two persons who had died. Counsel assisting Ms Kereru delivered an opening address to the Court. The inquest was then adjourned.

1.30. On 7 August 2016 Mr Higham died. Mr Higham's death was notified pursuant to section 28(1) of the Act by way of a *'Death Report to Coroner - Medical Practitioners Deposition'* dated 7 August 2016[7]. The notifying medical practitioner is said within this proforma document to be a Paul Kleinig, a Registrar at the Repatriation General Hospital where Mr Higham died. The stated reason for Mr Higham's death being notified was '*POTENTIALLY A RESULT OF CHEMOTHERAPY UNDERDOSE*'. The suggested cause of death was stated in the document as '*RELAPSED ACUTE MYELOID LEUKAEMIA*'. A number of matters were identified in the document as issues that might be addressed at an autopsy. In a section of the document which seeks information relating to whether concerns as to the cause of death or the medical treatment have been expressed there is an entry which states, *'MULTIPLE AS A CONSEQUENCE OF THE UNDERDOSING'*.

1.31. A post mortem examination including a full autopsy was conducted in respect of Mr Higham's remains. The post mortem report of Dr Neil Langlois, a forensic pathologist, expresses the cause of death as '*Acute myeloid leukaemia*'[8].

1.32. On 8 August 2016 at a sitting of this Court I announced that the inquest would be expanded to include an investigation into the cause and circumstances of the death of Mr Higham[9].

1.33. On 17 February 2017 Mrs Bairnsfather died. Mrs Bairnsfather's death was notified pursuant to section 28(1) of the Act by way of a *'Death Report to Coroner - Medical Practitioners Deposition'* dated 17 February 2017[10]. The notifying medical practitioner is said to be a Sreecanth Raja, a resident medical officer at the Royal Adelaide Hospital where Mrs Bairnsfather died. The stated reason for Mrs Bairnsfather's death being notified is '*Incorrect dosing of Cytarabine chemotherapy due to incorrect protocol in October 2016*'. The cause of death as

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[7] Exhibit C58, Document 2
[8] Exhibit C58, Document 3
[9] Transcript, pages 24-26

expressed in the document is *'Refractory Acute Myeloid Leukaemia'*. The report did not refer to any issues that might be addressed at an autopsy.

1.34. A review of Mrs Bairnsfather's clinical circumstances was sought from Dr Langlois to whom I have already referred. Dr Langlois provided an opinion, without conducting an autopsy, that Mrs Bairnsfather's suggested cause of death was acute myeloid leukaemia[11].

1.35. On 21 February 2017 at a sitting of this Court I announced that an inquiry into the cause and circumstances of the death of Mrs Bairnsfather would be joined to the then current proceeding[12].

1.36. Thus the Court's inquiries into the cause and circumstances of the deaths of Mr Higham and Mrs Bairnsfather were joined to an already existing inquest into the cause and circumstances of the deaths of Mrs Pinxteren and Mr McRae.

1.37. On Friday 29 May 2017 at a sitting of the Court counsel assisting Ms Kereru informed the Court that the family of Mrs Bairnsfather had contacted the Court and had recounted difficulties that they were experiencing in relation to the administration of Mrs Bairnsfather's estate. It was suggested that if a preliminary finding as to the cause of her death was made by the Court it would assist with the administration of that estate[13]. I agreed to this suggestion, and for the sake of consistency I agreed to take the same course in respect of Mr Higham[14]. No objection was raised by any represented entity in respect of this course of action. I indicated that I was satisfied on the balance of probabilities that the causes of death of both Mr Higham and Mrs Bairnsfather were AML in each case and I so found. A sealed record of those findings were prepared by the Court[15]. In due course death certificates were issued by the Registrar in respect of the causes of death of Mr Higham and Mrs Bairnsfather[16]. I should point out here that these certificates are not the certificates referred to in the definition of reportable death in section 3 of the Act. They are not certificates prepared by a doctor. Rather, they are certificates issued by the Registrar pursuant to the BDM Act. No-one has suggested that the issuing of these certificates, relating

[10] Exhibit C58, Document 1
[11] Exhibit C58, Document 4
[12] Transcript, pages 47-54
[13] Document 5, Transcript, pages 315-
[14] My understanding was that certificates as to cause of death had been already issued by the Registrar of Births, Deaths and Marriages in respect of the deaths of Mrs Pinxteren and Mr McRae
[15] Exhibit C58, Documents 6 and 7

simply as they do to cause of death and not to the circumstances of death, in any way removes the Court's jurisdiction to hear inquests relating to their deaths or that the Court is in any sense functus officio. It still remains for the Court to deliver its findings in relation to the circumstances of the deaths of both Mr Higham and Mrs Bairnsfather and in relation to matters that are relevant to the causes of their deaths.

1.38. This ruling relates to the submissions that have been made by Mr Trim QC in relation to the Court's jurisdiction to hold inquests, or to proceed with the inquest as the case may be, in relation to the four deceased persons. In respect of all four deaths he argues that at this stage of the Court's inquiry the Court cannot find that any of the deaths were caused by the treatment they received in the consolidation phase of their chemotherapy or that this treatment caused them to die sooner than they otherwise would have. Further, he argues that there is no basis upon which it could be concluded that the treatment caused the deaths in the sense that had they not received the treatment they would not have died at all or would have lived longer than they did. However, the real gravamen of the submission it is that the evidence, and in particular the expert evidence adduced in this case, establishes that it is simply not possible to conclude one way or the other whether the treatment received by each of the deceased persons meant that they died sooner than they would have had they received treatment in accordance with the intended protocol. Mr Trim QC argues that this would mean that in the case of Mrs Pinxteren and Mr McRae their deaths are not reportable deaths and that this Court therefore does not have the power or jurisdiction to deliver its findings as to the cause and circumstances of their deaths. I do not understand Mr Trim QC to be arguing that even if on the evidence such a causal connection could be drawn in relation to those deaths, the deaths would still not be reportable deaths. Mr Trim's submission that neither Mrs Pinxteren's nor Mr McRae's deaths are reportable deaths is countered by others who argue that this is not the time for the Court's consideration to be given to the causation issue that Mr Trim has raised and that the time at which the Court's jurisdiction was enlivened, and when the question of whether the reportable deaths was a live issue, was no later than the commencement of the inquest.

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[16] Exhibit C58, Documents 8 and 9

1.39. In the cases of Mr Higham and Mrs Bairnsfather Mr Trim QC further submits that although their deaths are reportable by virtue of the absence of doctor's certificates as to cause of death pursuant to section 36(3) of the BDM Act, the inquest insofar as it relates to these deaths should not proceed for reasons of a technical nature that concern alleged improper joinder with the inquiry into the deaths of Mrs Pinxteren and Mr McRae and other matters. Other entities counter this submission.

1.40. For reasons that follow I have rejected Mr Trim's submissions. I have determined that there is no impediment to the Court proceeding to finality in respect of the inquest as it relates to those four individuals and that the Court is at liberty to, indeed must, deliver findings into the cause and circumstances of those deaths. I have found that all four deaths were reportable deaths as defined in the Act in that they can properly be characterised as deaths from an unknown, unnatural or unusual cause. The deaths of Mr Higham and Mrs Bairnsfather are reportable deaths also by reason of the matters identified in paragraphs 1.4 and 1.5 herein.

1.41. I here refer to certain provisions of the Act and of the BDM Act insofar as they are relevant to the issues under discussion.

1.42. The Act draws a distinction between the State Coroner on the one hand and the Coroner's Court on the other. This is evident from provisions such as section 7 of the Act which sets out the functions of the State Coroner, one of those functions being to administer the Coroners Court[17].

1.43. The definition of 'reportable death' in section 3 of the Act relevantly includes:

> 'the State death (other than a State death to which subsection (2) applies) of a person—
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> (a) by unexpected, unnatural, unusual, violent or unknown cause; or
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> (c) in custody; or
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> (h) where no certificate as to the cause of death[1] has been given to the Registrar of Births, Deaths and Marriages; or
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> Note -
>
> 1 See section 36(3) of the Births, Deaths and Marriages Registration Act 1996'.'

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[17] Section 7(1)(a)

1.44. Sections 28(1) and (2) of the Act are set out as follows:

> '(1) A person must, immediately after becoming aware of a death that is or may be a reportable death, notify the State Coroner or (except in the case of a death in custody) a police officer of the death, unless the person believes on reasonable grounds that the death has already been reported, or that the State Coroner is otherwise aware of the death.
>
> (2) The person notifying the State Coroner must –
>
> (a) give the State Coroner or police officer any information that the person has in relation to the death; and
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> (b) if the person is a medical practitioner who was responsible for the medical care of the dead person prior to death or who examined the body of the person after death – give his or her opinion as to the cause of death.

The obligation to notify a death to the State Coroner is placed upon medical practitioners who have become aware of the death. It is noteworthy that the obligation to notify the State Coroner exists in respect of a death that is a reportable death or *'may be'* a reportable death. Sections 28(1) and (2) of the Act should be read in conjunction with section 36 of the BDM Act which is as follows:

> '(1) A doctor who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death, must, within 48 hours after the death, give written notice of the death to the Registrar, including the particulars required by regulation.
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> Maximum penalty: $1 250.
>
> (2) However, a doctor—
>
> (a) need not give a notice under this section if another doctor has given the required notice; and
>
> (b) must not give a notice under this section if the State Coroner or a police officer is required to be notified of the death under the Coroners Act 2003.
>
> Maximum penalty: $1 250.
>
> (3) When notice of a death is given, the doctor must also give a certificate in a form approved by the Registrar, certifying the cause of death, to—
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> (a) the Registrar; and
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> (b) the funeral director or other person who will be arranging for the disposal of the human remains.
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> Maximum penalty: $1 250.
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> (4) If a child is still-born, the child's death is not to be notified under this section1.
>
> Note—
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> 1 In the case of a still-birth notice must be given to the Registrar under section 12.'

1.45. Section 36 of the BDM Act obliges the doctor when giving written notice of the death to the Registrar to give a certificate certifying the cause of death to the Registrar[18]. Section 36(2) prohibits a doctor from giving notice under section 36 if the State Coroner or a police officer is required to be notified of the death under the Act. The practical effect of section 36 is that when a doctor, pursuant to section 28(1) of the Act, notifies a death that may be a reportable death, the doctor is precluded from issuing a certificate as to the cause of death under section 36(3) of the BDM Act. Thus, when a doctor notifies the State Coroner of a death that *may be* a reportable death, in effect the State Coroner is being notified of a death that *is in fact and in law* a reportable death by virtue of the absence of a certificate as to cause of death pursuant to section 36(3) of the BDM Act. This is because under item (h) of the definition of reportable death the lack of a certificate pursuant to section 36(3) of the BDM Act renders the death a reportable death in and of itself. This in fact is the case with the deaths of Mr Higham and Mrs Bairnsfather.

1.46. Section 13 of the Act describes the jurisdiction of the Coroner's Court.

> 'The jurisdiction of the Coroner's Court is to hold inquests in order to ascertain the cause or circumstances of the events prescribed by or under this Act or any other Act'.

One such event over which the Coroner's Court might exercise its jurisdiction under the Act is a reportable death as defined in section 3. I agree with Mr Wait SC, the Crown Solicitor, that whether the death is a reportable death is a jurisdictional fact. The question becomes at what point that is to be assessed, whether at this very late stage of the proceedings or at the outset when jurisdiction is embraced by the Court.

1.47. Under section 14 of the Act the Coroner's Court is to be constituted of a 'coroner' which is defined in section 3 to mean the State Coroner, a Deputy State Coroner or any other coroner appointed under Part 2 of the Act. In this inquest the Court is constituted by a Deputy State Coroner.

1.48. Section 21 of the Act sets out the circumstances in which an inquest is mandatory. I set out section 21 immediately below:

> '(1) The Coroner's Court must hold an inquest to ascertain the cause or circumstances of the following events:
>
> (a) a death in custody;

[18] Section 36(3)

(b) if the State Coroner considers it necessary or desirable to do so, or the Attorney-General so directs—

(i) any other reportable death or a death that would, but for section 3(2), have been a reportable death; or

(ii) the disappearance from any place of a person ordinarily resident in the State; or

(iii) the disappearance from, or within, the State of any person; or

(iv) a fire or accident that causes injury to person or property;

(c) any other event if so required under some other Act.

(2) However, if a person has been charged in criminal proceedings with causing the event that is, or is to be, the subject of an inquest, the Court may not commence or proceed further with the inquest until the criminal proceedings have been disposed of, withdrawn or permanently stayed.

(3) An inquest may be held to ascertain the cause or circumstances of more than one event.'

1.49. There are three circumstances in which an inquest is mandatory, namely where the death is a death in custody, where the State Coroner considers it necessary or desirable for the Court to hold an inquest into the cause or circumstances of the event in question or where the Attorney-General so directs. It is not the Coroner's Court that decides whether an inquest is necessary or desirable or whether its continuation, depending upon what view it takes of the facts, is necessary or desirable. The Court does not continually assess and re-assess issues of necessity or desirability during the course of an inquest. Nor does it pause to consider those issues before it decides whether or not to deliver its findings.

1.50. Section 21(3) of the Act states that an inquest may be held to ascertain the cause or circumstances of more than one event. The word 'event' takes its colour from the use of the same word in its plural sense within the first line of section 21(1) of the Act. Although the terms of section 21(3) suggests that an inquiry into the cause and circumstances of more than one event gives rise to the one single inquest, there is really nothing substantially different from the Court conducting a number of concurrent inquests into multiple events, adducing the one body of evidence that is admitted in respect of all events. If there is any difference it is a matter of form and not substance.

1.51. Section 24 of the Act sets out the principles governing inquests:

'In holding an inquest, the Coroner's Court—

(a) is not bound by the rules of evidence and may inform itself on any matter as it thinks fit; and

(b) must act according to equity, good conscience and the substantial merits of the case, without regard to technicalities and legal forms.'

1.52. Section 25 of the Act relates to the findings of the Coroner's Court. I set out section 25(1) and 25(2):

> '(1) The Coroner's Court must, as soon as practicable after the completion of an inquest, give its findings in writing setting out as far as has been ascertained the cause and circumstances of the event that was the subject of the inquest.
>
> (2) The Court may add to its findings any recommendation that might, in the opinion of the Court, prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest.'

1.53. Section 29 of the Act is set out:

> 'If the State Coroner is notified under this Act of a reportable death, a finding as to the cause of the death must be made –
>
> (a) if an inquest is held into the death – by the Coroner's Court;
>
> (b) in any other case – by the State Coroner.'

1.54. It will be observed that section 25(1) of the Act mandates the Coroner's Court to give its findings in writing setting out as far as has been ascertained the cause and circumstances of the event that was the subject of the inquest and to do so after the completion of the inquest. That mandatory obligation is to be contrasted with what is a discretion within section 25(2) of the Act to add recommendations to the Court's findings. I note that there is no express power within the Act to abandon an inquest once started. If an inquest could be abandoned without the delivery of findings, the result would be incongruent with the Court's duty to make a finding as to cause of death pursuant to section 25 of the Act, and in cases in which the death has been notified to the State Coroner under the Act, with its duty pursuant to section 29(a) of the Act.

1.55. The recommendation power contained within section 25(2) of the Act is a power dependent upon the Court delivering its findings as to cause and circumstances. It is a power to make recommendations that might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest. This does not mean that it must be shown that the recommended measure as crafted by the

Court would necessarily have prevented the death the subject of the inquest. Rather, it is a recommendation designed to prevent, or reduce the likelihood of, a recurrence of a similar event in the future. Justice Debelle in **Saraf & Anor v Johns** (2008) 101 SASR 87 at [37] indicated that a death similar to the death that was the subject of the inquest could be a *'death in like circumstances'* to those in which the particular deceased died, or a future *'death from the same or like causes'* to those from which the deceased died. The power of recommendation would not require an exact replication of the circumstances of the subject death to be within the court's contemplation before a recommendation could validly be made. Thus, if a medical misadventure is identified in the course of an inquest, the Court might add a recommendation to its findings that is crafted to prevent, or reduce the likelihood of, a death resulting from that misadventure recurring and may do so even if the Court was not necessarily satisfied that the recommendation would have prevented the death under investigation. To my mind, this proposition is not inconsistent with the plain wording of section 25(2) nor with what fell from Debelle J in **Saraf**. So, in a case where at the conclusion of an inquest a causal link between medical misadventure and a death could not be shown, this fact would not prevent the Court from making a recommendation that might prevent a future death in which the misadventure might have a causal link. What this demonstrates is that there is an important public benefit in the Coroner's Court delivering its findings even if at the end of an inquest the evidence might throw a different light on the question of causation from what may have been understood at the commencement of an inquest.

1.56. It is worthwhile reciting what fell from the Full Court of the Supreme Court of South Australia in **Barrett v Coroners Court of South Australia**[19] regarding the public interest to be served by the conduct of inquests by the Coroner. In the judgment of Justice Peek at [123] his Honour stated:

> '.. the ambit of the jurisdiction invested in any court by the relevant enabling statute should generally be construed broadly.'

Justice White stated as follows at [40]:

> '.. it is appropriate to bear in mind the public interest served by the conduct of inquests by the Coroner. The purposes of a coronial inquiry have been said to include the determination of the medical cause of death; the advancement of medical knowledge; the investigation of deaths to allay suspicions; recommendations to avoid future fatalities;

[19] Barrett v Coroner's Court Of South Australia [2010] 108 SASR 568

and the monitoring of death investigation systems. The importance and value of these purposes suggests that the jurisdiction of the Coroner's Court should not be construed narrowly.' [20]

1.57. I also refer to the judgment of the Full Court of the Supreme Court in **WRB Transport & ORS v Chivell** [1998] SASC S7002 in which Justice Lander stated at [31]:

> 'In my opinion, the jurisdiction given by the Act to the coroner is quite extensive. It is not limited, as suggested, to a particular inquiry into the direct cause of death of the deceased. The coroner has a jurisdiction and, indeed, an obligation to inquire into all facts which may have operated to cause the death of the deceased and as well to inquire into the wider circumstances surrounding the death of the deceased'.

1.58. The Full Court in **WRB Transport** was dealing with the repealed Coroners Act of 1975, but in my opinion there is no distinction to be drawn between the terms of that legislation and the current Act. I note Lander J's dictum that a coronial inquiry is one that inquires into all facts which may have operated to *cause the death*. Moreover, in so saying, His Honour draws a distinction between cause of death and circumstances of death, a matter over which the Coroner's Court also has a power of inquiry. Clearly then, an inquiry into all facts which may have operated to cause the death would not be limited to those facts which are anatomically connected with the cause of death. Indeed, at [20] Lander J stated:

> 'In determining those events which may be said to give rise to the cause of the death, the Coroner is not limited by concepts such as 'direct cause', 'direct or natural cause', 'proximate cause' or the 'real or effective cause'.

And His Honour further stated at [21]:

> 'The Coroner, therefore, has to carry out an inquiry into the facts surrounding the death of the deceased to determine what, as a matter of common sense, has been the cause of that person's death. The inquiry will not be limited to those facts which are immediately proximate in time to the deceased's death. Some of the events immediately proximate in time to the death of the deceased will be relevant to determine the cause of death of the deceased. But there will be other facts less proximate in time which will be seen to operate, in some fact situations, as a cause of the death of the deceased'.

1.59. Thus, cause of death is not confined to a consideration of what the anatomical cause of death was. Common sense has to be brought to bear on the question as to what caused a death. There may be many elements in the cause of a death. In my view it

[20] Paragraph 40

can rightly be argued that even though a natural anatomical cause of death such as AML is known, there may be other elements associated with its cause that are unknown. One such unknown element is whether or not the death may have been contributed to by incompetently delivered medical intervention, or put in another way, whether the death may have been prevented by medical intervention if it had been competently delivered and not incompetently delivered[21].

1.60. The authors of '*Death Investigation and the Coroner's Inquest*'[22], a work by Freckleton and Ranson, deal with the issue of what may constitute an unnatural death for the purposes of coronial jurisdiction. The authors suggest that as a matter of law, in England and Wales, it is apparent that '*unnatural death*' is a broader expression than '*death from unnatural causes*'[23]:

> '….where neglect is a cause or contributory cause of death, that results in an unnatural death for this purpose, even if the underlying cause of death is otherwise natural. Moreover, the same is apparently true 'whenever a wholly unexpected death, albeit from natural causes, results from some culpable human failure'. So a culpable failure to prevent death from natural causes is an unnatural death; but a non-culpable failure is not. Medical treatment for a non-potentially fatal condition but which causes death will continue to be unnatural. Again, death from natural disease transmitted unnaturally (e.g. deliberately or by reason of work) is unnatural.'

The above citation is taken from the 12th edition of *Jervis on the Office and Duties of Coroners*. I am not certain that this passage supports the contention that an unnatural death is different from a death from an unnatural cause, but the authorities cited in Jervis and by Freckleton and Ranson are worth examining.

1.61. Freckleton and Ranson refer to two English cases decided by the Court of Appeal of England and Wales. It is the second of these cases that is of particular relevance here. That case is **R (Touche) v Inner North London Coroner** [2001] QB 1206. There is little doubt that this case is authority for the proposition that cases involving a wholly unexpected death from natural causes which would not have occurred but for some culpable human failure could rightly be regarded as an unnatural death[24]. His Lordship there appears to have regarded a case involving a wholly unexpected death from natural causes which would not have occurred but for some culpable human failure as judiciable by a coroner regardless of whether it could be characterised as

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22 Oxford University Press, 2006 edition, Freckleton and Ranson,

23 Page 164 of the text

24 Paragraph [46]

'neglect', a matter separately identified within the English coronial legislation. At [43] Simon Brown LJ refers to wider policy considerations that would support such an approach. He states:

> 'Such deaths prompt understandable public concern and surely no small part of the Coroners function is to carry out an appropriate investigation to allay such concern.'

It is informative that his Lordship refers to the allaying of public concern. This suggests that the identification of medical error or other culpable human failure is not necessarily the sole underlying basis for the coroner to assume jurisdiction in cases of this nature. The coroner's function where such an allegation is made is not only to identify such a failure if it exists, but to establish whether or not it has contributed to a death, and even where it has not contributed, to report that in order to allay public concern. In **Barrett** White J referred to the same consideration as being a key function of the coronial jurisdiction in this State.

1.62. Touche involved the death of a woman who, following the delivery of healthy twins, was the subject of inadequate post-partum blood pressure monitoring. The question for a coroner was whether this had contributed to her death from what was essentially a stroke, which on the face of it would be a natural death or indeed a natural cause of death. The issue was whether adequate monitoring would have alerted practitioners to the woman's catastrophic high blood pressure and whether appropriate corrective treatment would have prevented her death. The judgment of the Court of Appeal was that the coroner was obliged to conduct an inquest into the woman's death.

1.63. The **Touche** case was referred to in a subsequent decision of the Queen's Bench Division of the England and Wales High Court of Justice in the case of **Bicknall v H.M. Coroner for Birmingham/Solihull** [2007] EWHC 2547 (Admin). This was the judgment of Mr Justice McCombe. His Lordship at [24] refers to that part of the judgment of Simon Brown LJ in **Touche** to which I have referred above. In the **Bicknall** case the Court was persuaded that the particular death could be judiciable by the coroner on the basis that the deceased's death from an outwardly natural cause was caused or contributed to by excessive doses of an antipsychotic drug coupled with the restrictive effect of a particular chair and the possible failure to give adequate antibiotic treatment once pneumonia had set in[25]. Such a combination of circumstances gave rise to a '*reasonable cause to suspect*' that the deceased had died

an unnatural death. His Lordship appears to have come to that conclusion regardless of whether the death could be said to have also arisen from '*neglect*'.

1.64. In my opinion, the English cases can be taken as authority to support the proposition that an outwardly natural death that has been contributed to by medical error can be viewed as an unnatural death, or put in another way, a death from an unnatural cause. I do not see anything in those judgments that would support the contention that an unnatural death is materially different from a death from an unnatural cause, a distinction articulated by Freckleton and Ranson. Moreover, insofar as the English authorities identify a need for a death in these circumstances to be 'wholly unexpected' before they can be characterised as unnatural, this is another way of saying that the occurrence of the death was outside of expectations having regard to the possible beneficial effects of appropriate medical treatment. The expression also begs the question, wholly unexpected by whom? That said, in the English coronial jurisdiction the issue of unexpectedness is not a question that has to be positively answered before an inquest can be held. As seen from both the **Touche** case and the **Bicknall** case this is because the coronial jurisdiction in England and Wales is activated by '*reasonable cause to suspect*' that the deceased had died an unnatural death. This would mean that for coronial powers of inquest to be enlivened in that jurisdiction, one would not need conclusive proof at the outset of the coronial inquiry that the death was wholly unexpected or was due to human failure or was both. All that would be required would be a reasonable suspicion of the same even though those issues might be surrounded in some uncertainty. That reasonable suspicion then forms the basis for a forensic inquiry to be undertaken into whether in fact the death was of a character that would render it unnatural. The English legislation is couched in such a way as to ensure that the coronial jurisdiction is not self-defeated by an unnecessary insistence that before coronial jurisdiction is engaged it must be shown that a death was unnatural on a balance of probabilities, the very issue that an inquest is intended to address for the public benefit. As will be seen this approach would align with the suggested approach of Mr Wait SC on behalf of the Minister for Health and Wellbeing in relation to the engagement of coronial jurisdiction in this State. It would obviously be a much more pragmatic and sensible approach to the question of the manner in which the coronial jurisdiction in this State could be enlivened. This approach would also align with equivalent legislation in Victoria. The Victorian

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[25] Paragraph [27]

Coroners Act 2008 is an example wherein *'reportable death'* is defined as a death *'that appears to have been unexpected, unnatural, etc'*.[26]

1.65. In addition, to my mind a death from an outwardly natural cause could also be regarded as a death from an unusual cause where the death has been preceded by medical treatment that has been designed to arrest the disease from which the deceased ultimately succumbs but which has miscarried. In such a case, the character of the cause of death as being usual or unusual has to be evaluated against the fact that there is a question mark as to whether the cause of death may have been arrested by medical treatment that was administered competently as opposed to incompetently.

1.66. Mr Trim QC argues that it is now incumbent upon this Court at this time, the evidence having been completed, to revisit the question as to whether or not the deaths of the four individuals concerned are reportable deaths. Mr Trim QC contends that this assessment must be made by a consideration of the body of evidence that deals with the issue as to whether the chemotherapy protocol error caused or contributed to the deaths of any of these individuals. That would naturally involve a careful assessment of all of the relevant evidence that has been placed before this Court in respect of that issue and to make findings accordingly and to make them to the civil standard of proof. Mr Trim QC contends that at this juncture I must find a jurisdictional fact proven on the balance of probabilities. He seems to suggest that this exercise would supplant any previous assessment, legitimate or otherwise, that the Court had jurisdiction. He relies on the judgment of Justice Debelle in **Saraf** to support this proposition. I will deal with **Saraf** later in this ruling. I would observe here that such an assessment and such findings based on the evidence led in this inquiry at this stage would involve an assessment of and the delivery of findings in respect of the very issues that this inquest set out to investigate. Such an exercise would be akin to the exercise that Mr Wait SC identified in his submissions and described as absurd, namely that of the Court setting itself on a course that could culminate in the Court thwarting its own jurisdiction in a case where, say, the Court is conducting an inquest into an unknown cause of death only to find that the cause is indeed established during the course of the inquest, thereby robbing the Court of its jurisdiction to make that very finding. To my mind an intrinsically more preferable view is that a death takes on its character as a reportable death at the time the death is reported and certainly no later than the time at which an inquest commences or is contemplated.

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[26] Section 4(2)

1.67. Mr Trim QC argues that the Court cannot find that the cause of death was unknown because in each instance it is known that it was AML. He also argues that the deaths cannot be shown to have been unexpected, unusual or unnatural. He bases those submissions on a consideration of the evidence that has been heard in this inquest, not on a consideration on what the position was when the inquest commenced.

1.68. Mr Trim QC argues that at this stage of the proceedings the Court must be satisfied that there is a demonstrable causal connection between the chemotherapy error and the deaths before the Court is seized of jurisdiction. Otherwise, the Court would have no jurisdiction on the basis that it is not conducting an inquest into a reportable death. I do not accept the submission that there has to be such a demonstrated causal connection between error and death before the death can be characterised as a reportable death so as to provide this Court with jurisdiction to hold an inquest. To my mind the Court's jurisdiction is enlivened simply on the basis that there has been an error and there has been a death. The very nature of the inquest is to enquire whether there is that causal connection. It is a legitimate line of inquiry to be undertaken to serve the public benefits described by White J in **Barrett**. Not only is it legitimate to inquire into that issue, it is legitimate for the Court to report its findings in respect of that line of inquiry.

1.69. For reasons that will become apparent, I also reject Mr Trim's contention that the time for the Court to consider whether it has jurisdiction is now, that is to say at the conclusion of the evidence that has been taken at the inquest.

1.70. Mr Trim also argues in his written submission at [87] that to the extent that the Court was satisfied that an inquest into the deaths of Mrs Pinxteren and Mr McRae should take place prior to 7 July 2016, that was erroneous since one of the jurisdictional facts that was required to be in existence *'appears not to have been found to have been in existence at the time the decision was made to proceed with the inquest……. and in any event was not in existence, having regard to the evidence'*. He argues that this means that the inquest was improperly constituted in the sense that the Court did not have jurisdiction to proceed and exercise the powers that were exercised. If this submission when properly understood means that the evidence adduced in this inquest can in some manner now be assigned to the occasion at which the inquest was commenced or to when the decision was made to conduct the inquest, and that this would now invalidate what had been a valid and proper decision based on the

available information at the time, thereby re-writing history, this submission has to be roundly rejected.

1.71. In his written submission Mr Wait SC, counsel for the Minister for Health and Wellbeing who is the Crown Solicitor and Crown Advocate, argues that there is no reason to construe the Act as permitting the Court, from time to time, to revisit its decision to hold an inquest. Mr Wait SC advocates a construction of the Act that would see the question of the Court's jurisdiction being answered at an early point in time when the inquest is decided to be held and then embarked upon and not at the stage when the evidence that has been adduced in the inquest is all in. Mr Wait SC also invites the Court to distinguish, and indeed not follow, the decision of the Supreme Court in **Saraf** insofar as that decision is authority to the contrary. I have accepted those submissions and that invitation. Mr Wait SC further argues that the notion that the Court can revisit the decision to hold the inquest cannot be correct having regard to a number of adverse consequences if that was the case. First, if the Court was obliged to revisit its original decision to hold an inquest on the assumption that the Court has made that decision, it would mean in effect that the jurisdiction of the Court to conduct an inquest would wax and wane depending on the weight of evidence before the Court at any one point in time. Second, it would cause confusion, fragmentation, delay and additional expense to an inquest as parties, or the Court on its own motion, seek to test jurisdiction. Third, it would lead to the absurd result that an inquest into the death of unknown cause would be incapable of completion because in ascertaining the cause of death (the very purpose of the exercise of jurisdiction) the death would cease to be '*unknown*' and the Court would have thwarted its own jurisdiction to give findings. To my mind, there is much force in those submissions.

1.72. An example more aligned with the present case and which also illustrates the degree of absurdity to which the Crown Solicitor refers is afforded by the following. An elderly woman is admitted to hospital and is diagnosed as suffering from sepsis. In order to treat that condition intravenous antibiotics are prescribed by an Emergency Department medical practitioner, Dr X. However, instead of IV antibiotics being administered, saline solution is administered in error. The identified cause of the error is egregious miscommunication to the nursing staff of what is required and a lack of appropriate clinical supervision within the ED. The patient dies. Dr X immediately issues a certificate pursuant to section 36(3) of the BDM Act certifying that the cause of death is sepsis due to a urinary tract infection. He furnishes it to the

Registrar. At that time the position is unclear as to whether or not proper antibiotic treatment would have prevented the woman's death. A root cause analysis is undertaken. In some medical quarters within the hospital it is believed that antibiotic medication probably would have prevented the death, whereas in other quarters the opinion is that it would not have prevented the death. The validity of either opinion is not settled. Another more senior doctor, Doctor Y, appropriately decides to notify the State Coroner of the death as he believes it is or may be a reportable death. I do not believe it could seriously be contended that at that point in time this was not a reportable death so as to preclude the Coroner's Court from commencing an inquest to ascertain the cause and circumstances of that death. In such a case the uncertainty surrounding the contribution to the cause of death occasioned by the incorrect administration of saline renders it as a reportable death, at least on the basis that there is an important element in respect of the cause of the deceased's death that is unknown, namely whether the error contributed to the death, or put in another way, whether treatment in accordance with what had been recommended and prescribed might have prevented it. Similarly, the death would be from an unusual and unnatural cause because it occurred in circumstances in which the deceased's medical treatment miscarried and there is a question as to whether proper medical treatment would have prevented it. All of those questions are not ones that can be answered definitively at that stage. In the ensuing inquest which is conducted in the hope of answering those questions, independent expert medical opinion diverges as to whether the death was contributed to by the error and whether with proper antibiotic therapy it would have been prevented. The coroner conducting the inquest is unable to find on the balance of probabilities that the error contributed to the death or that appropriate antibiotics would have prevented the death or have prolonged the deceased's life. So he refuses jurisdiction. During the course of the inquest, however, the coroner is satisfied that a medication administration error had occurred and that by crafting a suitable recommendation a similar death in the future might be prevented. He is precluded from making that recommendation because he has refused jurisdiction.

1.73. To suggest that in that example the Coroner's Court would be precluded from making any findings as to the cause and circumstances of the death and from making any recommendations that might prevent a similar death in the future would be to articulate an astonishing and most unsatisfying outcome and would frustrate the very purpose of the Act. Let us take the instant example further. At the instigation of the deceased's family the Court's refusal of jurisdiction becomes the subject of review in

a higher court. The higher court quashes the coroner's decision to refuse jurisdiction on the basis that it is unreasonable or has failed to take into account a factual matter of some importance, as a result of which the case is sent back to the Coroners Court for the presiding coroner's further consideration. The coroner reconsiders his original findings on the question of jurisdiction and then, on reconsidered factual findings that are different from what the coroner had originally found, finds jurisdiction and delivers the Court's finding as to that and then, assuming no review of that decision, ultimately delivers the finding into the cause and circumstances of the death. There would now be two or possibly three sets of factual findings, at least two of which would necessarily conflict with each other. And yet they have been made by the same Court presided over by the same coroner and based on the same evidence. Meanwhile, the expense occasioned by what has taken place so far in the proceedings has reached unaffordable proportions. Furthermore, there would always be the possibility that the second amended set of findings following the review of the first could also be the subject of further review, and so on. To describe this possibly self-perpetuating forensic process as unedifying would be an understatement and it would bring the administration of justice insofar as it relates to the coronial jurisdiction into disrepute. What would be a far more preferable and sensible course, and one that would be in accordance with the purposes of the Act, would be for the coroner at the conclusion of the inquest and in the usual way to deliver the findings of the Court relating to the cause and circumstances of the death whatever those findings are and to make the recommendation that might prevent a future death from the same error. The delivery of either finding, whether it drew the causal connection between the error and the death or not, would be as much in the public interest as the other. In this regard it will be recalled that it is said that one of the purposes of the coronial jurisdiction is to allay suspicion. If the coroner's finding is that no connection has been established, the suspicion that there was a connection has been allayed. This example illustrates the validity of Mr Wait's submission that the question of jurisdiction is not a matter that is visited or revisited at this stage of coronial proceedings.

1.74. To take another example. The Coroners Court has jurisdiction pursuant to section 13 of the Act to hold an inquest in order to ascertain the cause or circumstances of the disappearance of a person[27]. A person ordinarily resident in this State disappears in that he suddenly and unexpectedly fails to attend his workplace and his usual haunts and has not seen at his known place of living for some time. He is not seen for many

[27] Section 21(1)(b)(ii)(iii)

months and his bank accounts are untouched. It is believed that the person has disappeared and fears as to his welfare are entertained by his family and by police. The Coroner's Court, armed with its undoubted jurisdiction to do so, commences an inquest to ascertain the cause or circumstances of the person's disappearance. During the course of the inquest the person's whereabouts are unexpectedly established. It is revealed that for his own reasons he had simply elected to remain incommunicado. There is no longer a disappearance. In such a situation would the Coroners Court no longer have jurisdiction thereby preventing it from delivering its findings into the cause and circumstances of the person's original disappearance? Would the proceedings to that point be viewed as an inquest into whether the Court had jurisdiction to hold an inquest?[28] The answers to both questions are, of course not. What this example illustrates is that the Court's jurisdiction to hold that inquest was a matter that had to be examined at the commencement of the inquest, namely by reference to the fact that at that stage the person in question had been the subject of a disappearance. More generally, what it also illustrates is that the event over which the Coroners Court has jurisdiction takes its character from the circumstances of the event when examined at the time an inquest is commenced, not at its conclusion.

1.75. In his written reply Mr Trim QC appears to contend at [4] that I, or in my capacity as the presiding coroner in these proceedings, do not appear to have formed a view that the deaths of Mr McRae or Mrs Pinxteren were reportable deaths at the time the decision was made to proceed with the inquest, or at least any such decision is not reflected in the transcript. Having regard to Mr Trim's principal contention that one must examine the question of reportable death at this stage of the proceedings I am not certain that I understand this submission. I think Mr Trim QC is arguing that if the Crown Solicitor's contention is correct, namely that one must examine that issue at the commencement of the inquest, in each and every inquest what would be required at that early juncture is a formal, enunciated, reasoned and reviewable determination by the Court that the deaths were reportable deaths and that this is absent in this case. I reject that submission. The submission again graphically illustrates how unwieldy the coronial process would become if such a technical requirement existed. Parliament could not have intended such a process to occur in relation to proceedings that are meant to be remedial and be conducted with informality. True it is that an initial inquiry as to jurisdiction was undertaken in **Barrett**, but the inquiry there was not in relation to whether there was a reportable

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[28] As will be seen, this is the circularity of reasoning identified by Justice Debelle in **Saraf & Anor v Johns** at [9]

death. The issue was whether there had in fact been a death of a person at all, the core fundamental requirement for the coronial process to be engaged.

1.76. I turn now to the decision of Justice Debelle in **Saraf** upon which Mr Trim QC relies. This Court does not consider itself bound by that decision. Firstly, the decision can be distinguished. Debelle J did not expressly deal with the situation in which at the outset of the inquest the death in question could appropriately have been characterised as a reportable death and whether the inquest could have legitimately proceeded to the Court's ultimate findings for that reason, the approach contended for by the Crown Solicitor. Rather, His Honour's conclusion that the deceased's death had not been from an unusual cause is consistent with a view that the death in that case had not been a reportable death from the beginning and that the evidence adduced at the inquest confirmed that view of the matter. His Honour concluded that there was no evidence to support the Coroner's Court's conclusion at the end of the inquest that the deceased's death may have been caused by the position in which she had been found and for that reason it could not be said that she had died from an unusual cause, a conclusion that arguably had been available from the outset. Therefore, the **Saraf** decision does not contradict the Crown Solicitor's submission that one must examine the issue as to whether the death is a reportable death at the time an inquest into the cause and circumstances of that death is embarked upon, not at the conclusion of the evidence adduced at that inquest.

1.77. Secondly, and in any event, the ratio decidendi of **Saraf** is not that this Court must examine the evidence at the conclusion of the inquest and that if the Court is not satisfied that the death is a reportable death it must not deliver any findings as to cause and circumstances. It is true that the application of this proposition resulted in Debelle J holding that the death had not been a reportable death on the basis of unusual cause, but that proposition is not the ratio of the case because the proposition was not the basis upon which the case was decided. In the event His Honour did not hold that the death had not been a reportable death. His Honour found that the death was a reportable death on a basis other than that advanced by the State Coroner. Debelle J held that the Coroner's Court had jurisdiction on the basis that the inquest had not established a cause of death and for that reason the death in question had an unknown cause and was therefore a reportable death.

1.78. It is a worthwhile exercise taking His Honour's analysis in **Saraf** to its inevitable conclusion. If at the conclusion of the **Saraf** inquest the coroner had in fact found a

cause of death, Justice Debelle would inevitably have held that the Coroner's Court had no jurisdiction to conduct the inquest which would thereby have precluded that Court from delivering its finding as to cause of death. It is to be acknowledged that in those circumstances the State Coroner could have directed correction of the Register of deaths pursuant to section 35 of the BDM Act, but such a frustrating forensic outcome simply could not be right.

1.79. For all of the above reasons in my opinion this Court is not bound by the **Saraf** decision. Mr Trim QC in his written reply appears not to contend otherwise but suggests that what fell from Justice Debelle is highly persuasive obiter dicta[29]. I have decided that I will not follow what is dicta. I am not persuaded that it is correct. In particular, there is one matter within the **Saraf** judgment that, with respect, renders His Honour's dictum difficult to support. At para [9] of the judgment in **Saraf** His Honour has referred to the unavoidable *'unfortunate circularity'* occasioned by the Coroner's Court needing to conduct an inquest in order to determine whether or not it has jurisdiction to conduct the inquest. No doubt His Honour is correct when he identified this element of circularity, but I do not accept that it is unavoidable. The circularity is all the more stark when it is considered that in reality what is being contended is that the Court has to conduct an inquest and make findings on the balance of probabilities as to the cause of a death in order to have jurisdiction to conduct an inquest and make the exact same findings to the same standard of proof as to the cause of the death. Moreover, insofar as the circumstances of the death would shed light on its characterisation as a reportable death, the same dual processes would have to be undertaken in relation to that issue as well. And, of course, as already observed, there is the potential that the Coroner's Court may have to deliver inconsistent findings at the two different stages of this dual process depending on intervention by a higher court on review. Yet the circularity that His Honour has identified would cease to operate if the analysis contended by Mr Wait SC is to be preferred. To my mind, Parliament could not have intended such a fragmented, unwieldy and unnecessary construction that the **Saraf** construction is, particularly in a statute that is meant to serve the beneficial purposes identified by White J in **Barrett** at [40]. In addition, if the Court was precluded from making findings pursuant to section 25 of the Act merely because at the conclusion of the inquest it cannot be shown on the evidence that the death was a reportable death when judged at that

[29] Written Submissions in Reply on the Question of Jurisdiction – page 9 at 13.6

juncture, the inquest would have counted for nought and any benefit that may have been derived from the Court's investigation of the circumstances of the death that would otherwise be reflected in useful, informed and evidence based recommendations for change would be lost. Accordingly, I am persuaded by Mr Wait SC that **Saraf** should not be followed.

1.80. There is one other matter concerning the judgment in **Saraf** that I should deal with. His Honour Justice Debelle indicated at paragraph [11] that he did not agree with the submission of the Solicitor-General that it was appropriate to adopt a purposive construction of both section 21 of the Act and of the definition of '*reportable death*' such that, by necessary implication, the definition in paragraph (a) would read as if the phrase '*which appears to be*' was inserted at the beginning of paragraph (a). If that submission was accepted, para (a) would be read in effect as follows:

> (a) Which appears to be by unexpected, unnatural, unusual, violent or unknown cause …

1.81. It is not necessary to discuss the reasons underlying His Honour's disagreement with that submission. In my view it is not necessary on the construction suggested by the Crown Solicitor in this case for those words to be impliedly imported into the definition of reportable death. If the characterisation of a death as a reportable death has to be examined at the outset of the inquest and not at the end of the evidence adduced in the inquest, it would not be necessary to imply any further words in the nature of '*what appears to be*' or '*reasonable suspicion of*' or some such formula. In my view it is not necessary to imply those words because the characterisation of a death as a reportable death has to be examined at the outset of the inquest and not at the end of the evidence adduced at that inquest. If I am wrong about that, I would unhesitatingly recommend that the definition of reportable death within section 3 of the Act be amended to read as the then Solicitor-General in **Saraf** argued, thereby aligning the South Australian definition with that of Victoria as seen earlier.

1.82. Mr Wait SC has argued that at the outset of this inquest each of these deaths could have been characterised as deaths from an unknown cause and that this would render each of them a reportable death at that point in time. Mr Wait SC argues this notwithstanding the fact that the anatomical cause of death did not then and does not now appear to be the subject of any debate in that in each case the anatomical cause of death was AML. However, he argues that that is not the end of the matter as there were certain elements that went to the wider notion of the cause of their deaths that

were at that point in time unknown. I agree with that submission. In my view the Court has had jurisdiction, and still retains jurisdiction, to conduct this inquest in relation to all four deaths because they were reportable deaths on the basis that the causes of the deaths are unknown, unknown in the sense that there are certain important elements adhering to the causes of their deaths that are unknown. Although the anatomical causes of death were known at the beginning of this inquest, what was not known in each case about the cause in its wider sense was whether the chemotherapy protocol error had contributed to that cause. Firstly, did the therapy provide the efficacy that it was intended or expected to provide to the patients? Secondly, could the deaths have been prevented, or may the patients' longevity have been greater, may their periods of remission been greater if the error had not occurred? Could the protocol error rightly be viewed as a matter that contributed to the cause of their deaths? These are all considerations that pertain to the issue of cause of death. Indeed, these are still matters for this Court to determine, not on the question of jurisdiction, but in the context of its findings in relation to the cause and circumstances of the deceased's deaths. I agree with the submission of Mr Wait SC that given those unknown elements, the causes of the deaths of each of the deceased persons could rightly be characterised as unknown such that they were and still are reportable deaths. An inquest was therefore appropriate to inquire into the question as to whether or not those unknown elements could be elucidated one way or the other. I reject the contention that to characterise a death of this nature as being from an unknown cause would be to place an unreasonable burden on medical practitioners who have duties to notify the coroner pursuant to section 28(1) of the Act.

1.83. In addition, in my opinion the deaths are reportable deaths because they are from an unusual or unnatural cause. The undisputed facts are that the deceased died of a disease which properly administered chemotherapy was designed to treat if not cure. The other incontrovertible fact is that each of the deceased persons were delivered chemotherapy other than with the intended frequency of administration. Indeed, the evidence is that the regimen of administration, delivered in error, was one which is not known to clinical practice. Those facts have remained unaltered since these proceedings began. What has been debated are issues including whether the reduced and erroneous frequency of chemotherapy administration can be shown to have affected its efficacy. Another issue that this Court has had to deal with is the possible effect of such underdosing in terms of the patient's longevity of remission and indeed

of their lives. These inquiries have duly been forensically undertaken. No decision has yet to be made on those issues.

1.84. To my mind, applying the construction of the Act that Mr Wait SC urges upon me which I accept, the inquest into each of these four deaths to ascertain the cause and circumstances has involved an inquiry into deaths from an unknown cause. In addition, it has involved an inquiry into deaths from an unnatural cause or unusual cause. Accordingly, this Court has and always has had jurisdiction to hold this inquest as it relates to all four deceased individuals on the basis that each death was and still is a reportable death.

1.85. I agree with Mr Wait's submission that once the decision to hold an inquest has been made, the Court must proceed to complete it pursuant to section 25 of the Act. On the assumption that what these proceedings have constituted has been an inquest, and not some form of hybrid voir dire of an inquest as the suggestion seems to be, this Court is obliged to deliver its findings into those causes and circumstances.

1.86. I now deal with the submissions of Mr Trim QC relating to the Court's jurisdiction in respect of the deaths of Mr Higham and Mrs Bairnsfather. In his submission to the Court Mr Trim QC has indicated that in relation to Mr Higham and Mrs Bairnsfather he accepts that no doctors' certificates were issued as contemplated within the definition of reportable death in the Act and that these two deaths are reportable deaths by reason of sub paragraph (h) within that definition. He concedes that the notification to the State Coroner by the medical practitioner in each instance was appropriate. I agree with those concessions. However, Mr Trim QC argues that if the inquest as it relates to the deaths of Mrs Pinxteren and Mr McRae was not properly constituted due to a failure of jurisdiction, this infects whatever occurred next and that the addition to the inquest of inquiries into the deaths of Mr Higham and Mrs Bairnsfather was 'beyond power', cannot be severed from what has been the one inquest into all four deaths and that therefore the inquest as it relates to those two deaths cannot proceed. He argues that in those circumstances it matters not that the deaths of either Mr Higham or Mrs Bairnsfather are reportable deaths on another proper basis. Secondly, he argues that due to a number of differing considerations it is no longer necessary or desirable for the inquest into the cause and circumstances of the deaths of Mr Higham and Mrs Bairnsfather to be held. This latter submission can be dismissed immediately because the question of necessity and desirability under

section 21 of the Act is clearly not a matter for the Court. Thirdly, Mr Trim QC invites the Court to infer that the deaths of Mr Higham and Mrs Bairnsfather were notified pursuant to section 28(1) of the Act only because this Court was holding an inquest into the deaths of Mrs Pinxteren and Mr McRae. This submission can also be immediately be rejected on the basis that it is unsupported by evidence and is inconsistent with Mr Trim's concession that these deaths were rightly notified on the basis that they may have been reportable deaths. The motivation of those persons notifying the deaths can hardly be a relevant consideration if there was a legal obligation upon those persons to notify them.

1.87. I reject all of those submissions in their entirety. Firstly, even if this Court found that the Court had no jurisdiction to enquire into the cause and circumstances of the deaths of Mrs Pinxteren and Mr McRae on the basis that their deaths were not reportable deaths, there is no basis to conclude that the inquests in respect of Mr Higham and Mrs Bairnsfather were not properly joined to the already existing inquiry or that they could not be severed from the inquiries relating to Mrs Pinxteren and Mr McRae. To test this proposition, if the inquest into the deaths of Mr Higham and Mrs Bairnsfather could not be properly severed, there would be nothing to prevent a wholly separate inquest into their deaths immediately being recommenced and the evidence that this Court has already heard in respect of their deaths, insofar as it is relevant, being re-adduced. In this regard section 24(a) of the Act would enable this Court to re-adduce that evidence on the basis that it may inform itself on any matter as it thinks fit. There would be no prejudice to anyone in doing so. The fact that this Court would be entitled to lawfully conduct a reconstituted inquest in this regard means that any objection that Mr Trim QC has raised in terms of an inability to sever the inquiry into the deaths of Mr Higham and Mrs Bairnsfather would involve a cosmetic issue only and would therefore be more a matter of form than substance. In this regard it has to be borne in mind that this Court is bound by section 24(b) of the Act to act according to equity, good conscience and the substantial merits of the case and without regard to technicalities and legal forms. It would be a technicality of the highest order for an objection to be raised and upheld simply on the basis that severance could not be achieved simply due to the erroneous inclusion of an inquiry into a matter that was not a reportable death. Moreover, when considering the cause and circumstances of the deaths of Mr Higham and Mrs Bairnsfather some might seek to argue that the causes and circumstances of the deaths of Mrs Pinxteren and Mr McRae would be relevant in any event. I have not heard argument on that issue so I pass no comment.

1.88. There is one further matter I should mention in connection with the inquest as it relates to the deaths of Mr Higham and Mrs Bairnsfather. In his oral submission before the Court Mr Trim QC acknowledged, correctly in my view, that it was appropriate for the notifying medical practitioners in the cases of Mr Higham and Mrs Bairnsfather to have notified those deaths pursuant to section 28(1) of the Act because they *may* have been reportable deaths[30]. He also acknowledged that they may have been reportable deaths for the reasons that both practitioners identified in their respective reports, namely the chemotherapy underdosing[31]. This then raises a question as to whether the earlier deaths of Mrs Pinxteren and Mr McRae, arising as they both did on a background of the same chemotherapy underdosing, should also have been notified on precisely the same basis that the deaths of Mr Higham and Mrs Bairnsfather were later notified. Mr Trim QC suggested that the answer to that question was no. Frankly, having regard to Mr Trim's concession that the deaths of Mr Higham and Mrs Bairnsfather were appropriately notified, I do not understand the reasoning behind that answer. Not only were the notifications of those deaths appropriate, the terms of section 28(1) of the Act mandated their notification. If the deaths of Mrs Pinxteren and Mr McRae should also have been notified pursuant to section 28(1), it would also bring into question the appropriateness of the doctors' certificates pursuant to section 36(3) of the BDM Act having been issued. This is so because as already observed, section 36(2)(b) states that a doctor must not give a notice under section 36(3) if the State Coroner is required to be notified of the death under the Coroners Act 2003. This would also bring into question whether those certificates are valid or were indeed a nullity. If so, it would mean that the deaths of Mrs Pinxteren and Mr McRae are also reportable on the basis that there were no valid certificates furnished to the Registrar pursuant to section 36(3) of the BDM Act. This point has not been argued before me. However, I do not need to decide this point because I have found that the deaths of Mrs Pinxteren and Mr McRae were reportable for the reasons I have identified.

1.89. Finally, if I am wrong to hold that the deaths of Mrs Pinxteren and Mr McRae are reportable deaths on the bases identified above, I would reserve the right to consider the issue as to whether those deaths were reportable on the basis of the evidence relating to the issue of causation that the Court has heard during this inquiry. This would accord with the course that Mr Trim QC has argued the Court should undertake

[30] Transcript, page 3037
[31] Transcript, page 3038

at this stage of the proceedings. I am not prepared to take that course at this stage of the proceedings for the following reasons:

i. I have ruled that this Court has jurisdiction in relation to all four deaths for the reasons set out above, reasons which do not depend upon the Court's findings in relation to the question of causation. In my opinion, the Court does not need to make any such findings at this stage;

ii. In any event two of the deaths, namely those of Mr Higham and Mrs Bairnsfather, are undoubtedly reportable deaths on an entirely different basis, namely the lack of certificates pursuant to section 36(3) of the BDM Act. It is worthwhile observing here that this would mean that a severed inquest into the cause and circumstances of their deaths would involve a full analysis of the circumstances in which the error in the relevant protocol was brought into existence and how it became the basis for erroneous administration of consolidation therapy at both the RAH and the FMC, remembering that Mrs Bairnsfather was treated at the RAH and Mr Higham was treated at the FMC. Mr Knox was also treated at the FMC. If the inquest was altered by the severance of the inquiry into deaths of Mr Higham and Mrs Bairnsfather from that of Mrs Pinxteren and Mr McRae, the resulting inquest would bear a very strong resemblance to the inquest that has been heard to date and the findings of the Court would reflect that;

iii. In any event even if the inquest as it relates to Mr Higham and Mrs Bairnsfather was severed, there would still remain an issue as to whether the evidence relating to the cause and circumstances surrounding the other two deaths was nevertheless relevant;

iv. At this stage I have not heard submissions on the question of causation from Mr Bonig who is counsel for certain represented entities and who did not want to be heard on the issue of jurisdiction. For similar reasons I have not heard from Mr Tilley who represents Dr T and Mrs T, the latter of whom is said to have played a role of an administrative nature in the wrongful inclusion of the word 'once' instead of the word 'twice' in the incorrect chemotherapy protocol and who for that reason could be expected to have a strong interest in the outcome of these proceedings particularly as it relates to the issue of causation. In relation to the question of causation I have not heard from

counsel who represents the Minister for Health and Wellbeing. Mr Wait SC, the Crown Solicitor, did not address the Court in relation to this issue;

v. While there remains any possibility that the factual findings that this Court would make on the question of causation would have to be revised following any review of this ruling, it would be undesirable for the Court to make any such findings at this stage.

1.90. The conclusion of the Court is that all four deaths that are the subject of this inquest are reportable deaths and for that reason the Court has jurisdiction to hold an inquest into the cause and circumstances of all four deaths. The Court must therefore deliver findings in relation to the same.

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 1st day of June, 2018.

____

Deputy State Coroner

Inquest Number 42/2016 (1188/2016, 1189/2016, 1488/2016 and 0295/2017)