MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (With Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Simon Cooper, Coroner, having investigated the death of Pamela Diane McCall with an inquest held at Hobart in Tasmania make the following findings.

Hearing Dates

21 and 22 March 2017, at Hobart in Tasmania

Representation

Counsel Assisting the Coroner: Ms Allison Shand
Counsel for Ms J Tan: Mr AB Walker
Dr S Bennett – self-represented

Introduction

1. Ms Pamela Diane McCall died in the Royal Hobart Hospital, Hobart, Tasmania on 12 February 2013.

2. The *Coroners Act* 1995 (the '*Act*') provides that a death is reportable to the coroner if, *inter alia*, the death is one of a person that occurred in Tasmania, and that death is "unexpected, unnatural or violent" (see section 3).

3. Section 19 of the *Act* creates an obligation upon any person who becomes aware of what is suspected to be a reportable death to report that fact to the coroner.

4. The circumstances of Ms McCall's death were such that pursuant to section 19 of the *Act* the fact of Ms McCall's death was reported to the Coronial Division of the Magistrates Court of Tasmania. This was so because her death was both unexpected and unnatural.

5. The *Act* provides that where a death has been reported to a coroner then she or he has jurisdiction to investigate that death.

6. Section 24 (2) of the *Act* provides that where a coroner has jurisdiction to investigate a death he or she may hold an inquest (other than a mandatory inquest which is dealt with in section 24 (1)) where it is considered desirable to do so. The facts surrounding Ms McCall's death that emerged as a consequence of the investigation, especially that it was apparent her death was due to mixed prescription drug toxicity, such drugs having been prescribed for her over a lengthy period of time by her partner Stephen Bennett, a general practitioner, led me to conclude that it was desirable to hold an inquest. The *Act* defines an inquest as being a public hearing.

7. Although a judicial officer, the coroner exercises a very different role to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and to make findings with respect to that death. This process requires the making of various findings, but without apportioning legal or moral blame (see *R v Tennent; ex parte Jaeger* [2000] TASSC 64, per Cox CJ at paragraph 7).

8. One matter that the *Act* requires a finding to be made about is how death occurred (section 28 (1) (b)). It is well settled that this phrase involves the application of the ordinary concepts of legal causation. Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28 (1) (b) upon the coroner.

9. In addition to being required to make findings pursuant to section 28 (1) of the *Act* a coroner is empowered, in appropriate cases, to make 'recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate' (section 28 (2)) and to 'comment on any matter connected with the death including public health or safety or the administration of justice' (section 28 (3)).

Application for suppression

10. During closing submissions Dr Bennett applied for an order suppressing publication. As best I could understand the application, an order was sought pursuant to section 57 of the *Act* forbidding publication of any details of the inquest, Dr Bennett submitting that I was required to apply some type of public benefit test, and that this test would be met by the

granting of the order. This application was then varied by Dr Bennett to be, as I understood it, an application that this finding be de-identified before publication. The first application was entirely misconceived and the second is refused. The reasons for refusing the application are as follows.

11. Relevantly Section 57 provides:

> *"57. Restriction on publication of reports*
>
> *(1) A coroner may order that a report of an inquest or a report of any part of the proceedings of, or any evidence given at, an inquest not be published if the coroner reasonably believes that –*
>
> > *(a) it would be likely to prejudice the fair trial of a person; or*
> >
> > *(b) it would be contrary to the administration of justice, national security or personal security; or*
> >
> > *(c) it would involve the disclosure of details of sensitive personal matters including, if the senior next of kin of the deceased has so requested, the name of the deceased."*

12. Subsections (2) and (3) deal with the consequences of breaches of an order and are not relevant to the present application.

13. Also of importance is section 51 of the *Act*, which provides that a coroner holding an inquest is not bound by the rules of evidence.

14. Finally, I observe as has already been mentioned, the definition of "inquest" in section 3 of the *Act* is 'a **public inquiry** that is held by a coroner in respect of a death, fire or explosion'. [Emphasis added]

15. The fundamental rule is that the administration of justice is open to public scrutiny and comment. That this is the general rule has been the case since at least *Scott v Scott* (1913) AC 417.

16. In *R v Matterson and anor ex parte Moles* (No. 2) [1993] TASSC 75 Underwood J (as he then was) said, at par 6, that "any application to suppress from public scrutiny either a

part or the whole of a judicial proceeding is a fundamental concern to the court". His Honour pointed out that so fundamental is the court's concern that, whilst the consent of all parties to an order is relevant, it is not decisive. Although his Honour was dealing with the now repealed *Coroners Act* 1957, the principles to be taken from his judgment are applicable to this case. His Honour referred to *Scott v Scott* [*supra*] and referred with approval to the speech of Lord Shaw at page 477 of that report wherein his Lordship referred in turn to Bentham, who emphasised the fundamental importance to justice of publicity, Bentham describing it as 'the very soul of justice'.

17. Section 57 provides a statutory power to depart from the general position (there is of course no common law power – see section 4 of the *Act*). However, the fundamental position is that inquests are public and are to be conducted in the full glare of public scrutiny. This is a position not to be departed from without compelling reason. Neither section 57 (1) (a) or (b) are conceivably relevant and so a consideration then of section 57 (1) (c) needs to be undertaken to determine whether that section provides any proper basis to suppress details.

18. That provision is broad in its terms dealing with, as it does, 'sensitive personal details'. However the cases cited above make it clear there must be something more than just a request; it is necessary that there be a cogent reason advanced why the normal position that justice should be administered openly should be departed from. In this case no compelling reason, nor indeed any reason, has been identified by Dr Bennett, other than the amorphous concept of privacy, as a basis for making the order sought. There is no basis to supress any details of the evidence at the inquest, nor to de-identify this finding.

Ms McCall's background

19. Ms McCall was born on 15 April 1967 and at the time of her death she was aged 45. She was the mother of two adult children from a previous marriage, Scott and Kate. The evidence suggests that her earlier marriage was unhappy and that she is likely to have been a victim of domestic violence.

20. Her relationship with her children was at times strained and there was at the time of her death something in the nature of an estrangement between her and Scott. The details of that estrangement and the reason for it are unnecessary to canvass in the context of this

inquiry, but it is sufficient to say that the evidence suggests that it caused Ms McCall a good deal of upset.

21. Ms McCall spent much of her working life as a medical receptionist. Between 1988 and 2006 she was employed as a receptionist at the Clarence Community Health Centre. Whilst working there she met Dr Stephen Bennett who worked as a medical practitioner in the same practice.

22. In about August 1999, Ms McCall and Dr Bennett commenced a relationship. Some years later, in approximately 2008, Ms McCall moved in with Dr Bennett at his home at 89 Jubilee Road, South Hobart. Thereafter Ms McCall and Dr Bennett lived in a *de facto* relationship until her death.

Ms McCall's medical history

23. A considerable amount of evidence was before the Court in relation to Ms McCall's health and medical history. Dr Jennifer Skeat, a general practitioner, treated Ms McCall between 1993 and 2012. A report written by her was tendered in evidence[1] and she also gave evidence at the inquest. Dr Skeat said in her report that at "the time of her first consultations, 25/02/1994 [sic] Ms McCall was stressed due to personal problems, largely related to her unhappy marriage to her first husband Richard McCall … By 1995 she had separated from [her husband] but their interactions, despite the separation, continued to be a source of extreme anxiety and concern. Richard committed suicide in the late 1990s and Pam required support and counselling during this time."

24. Dr Skeat described Ms McCall as a very private person who at no point discussed any personal issues with her. She said in her report she was aware at some point that Ms McCall had moved away from Richmond where she had been living and that she had a new partner. When she gave evidence at the inquest Dr Skeat acknowledged that she was aware that Ms McCall was in a relationship with Dr Bennett.

25. Dr Skeat in her report went on to detail the nature of the consultations between 1996 and 2012 that Ms McCall had with her (or colleagues at the practice). They involved obstetrical matters, pneumonia, treatment for recurring focal migraines (which included a

[1] Exhibit C10

referral to a physician Dr Simon Bower at the Royal Hobart Hospital in 1995), and lower back pain (which involved referral to Dr Andrew Hunn, a neurosurgeon, and Dr Robert Patton, a pain specialist).

26. Dr Skeat also recounted work-related difficulties experienced by Ms McCall. She said that she understood "Ms McCall had an unsatisfactory relationship with her immediate superior after… Management changes at Clarence Health Centre and she became unhappy in her work environment". She noted that Ms McCall frequently presented with a migraine, always wearing dark glasses in the surgery during consultation. She said in her report that she often appeared to be unhappy. Dr Skeat said there was an open invitation to Ms McCall to discuss issues of concern and consider antidepressant medication or counselling but that she never accepted the offer. She reiterated that this was the case when she gave evidence at the inquest. Ms McCall was last seen at Dr Skeat's surgery by a colleague on 4 December 2012 when she was treated for a migraine.

27. The evidence was that Ms McCall had for many years been prescribed a beta blocker, propranolol, (also known by the brand name 'deralin'), to treat focal migraines, and panadeine forte for back pain. Those drugs had first been prescribed for Ms McCall by Dr Skeat. During 2008 Dr Bennett started writing prescriptions for Ms McCall, rather than Dr Skeat. Dr Bennett did not tell Dr Skeat he was doing this. Indeed, he did not initiate any contact with Dr Skeat, at all, in relation to his prescribing propranolol and panadeine forte for Ms McCall.

28. It is apparent from screen shots of text messages that passed between Dr Bennett and Ms McCall that the prescribing was done somewhat informally. On occasions Ms McCall seems to have requested 'scripts' from Dr Bennett by text message, and Dr Bennett apparently complied with those requests[2].

29. Dr Bennett kept records at his practice in relation to at least some of his prescribing of drugs for Ms McCall between December 2008 and February 2013. Those records were tendered[3]. The records show that for the period they were kept Dr Bennett wrote 60 prescriptions for Ms McCall. Most, but not all of those prescriptions, were for propranolol and panadeine forte. At least one (1) prescription was also written by Dr Bennett for the anti-

[2] See Exhibit C44, photographs 57 and 58
[3] Exhibit C59

biotic cephalexin. In addition to those prescriptions recorded in the records, Dr Bennett agreed he wrote handwritten prescriptions on occasions, which were not recorded and the number of which he was unsure about.

30. In the same period he wrote a number of medical certificates for Ms McCall, provided her with a letter dealing with her medication (for the purpose of overseas travel), and referred her for pathology testing. All of this occurred without Dr Bennett making Dr Skeat aware that he was doing it; although he claimed that at all relevant times Dr Skeat was Ms McCall's treating general practitioner. All this occurred without Dr Bennett ever conducting a formal consultation upon Ms McCall, without ever examining her physically and without ever seeing her in his professional rooms.

31. In respect of the drugs, Dr Bennett agreed he was the only doctor prescribing that medication, that panadeine forte was potentially addictive and that a level of care was needed to attend the prescribing of it. At no stage did Dr Bennett refer Ms McCall for any investigation and, aside from receiving some records from Dr Skeat, did nothing it would seem to satisfy himself that the medication in general and the doses in particular were appropriate. He agreed that there was no urgency about any of the prescriptions he wrote.

32. Dr Bennett tendered records from Relationships Australia[4] indicating that just before Christmas 2012 Ms McCall made an appointment for counselling with Relationships Australia. Dr Skeat said in her evidence that Ms McCall needed psychological assistance and had for a considerable period of time. She knew nothing however about the appointment. Dr Bennett said that as the appointment approached Ms McCall became "stressed and anxious" and as a consequence he advised her to re-schedule the appointment until "after things had settled down" (although what those 'things' were was not clear). Dr Bennett did not advise Dr Skeat about the appointment Ms McCall made with Relationships Australia, his advice to postpone it or the fact that Ms McCall did postpone it.

Events leading up to 10 February 2013

33. The events leading up to Ms McCall's overdose of drugs and alcohol on Sunday 10 February 2013 appear unremarkable. She spent time over the Australia Day long weekend

[4] Exhibit C63

with her daughter who said in her affidavit[5] that whilst she and her mother "never had the super close mother-daughter relationship" they certainly got along and spent time together, particularly in the two years leading up to her death. Kate McCall said in that affidavit that the last time she saw her mother (before seeing her for the last time in the Royal Hobart Hospital immediately prior to her death) was on Tuesday, 5 February 2013. She visited Ms McCall and Dr Bennett, and stayed for an hour or so. She described her mother and Dr Bennett as both seeming fine and happy, and noticed nothing out of the ordinary.

34. On 6 February at about 11.00am Ms McCall had an appointment with a friend, Ms Margaret Kingston, who, as was normal, did a manicure and pedicure upon her. Ms Kingston described Ms McCall as being happy on that day.

35. Affidavits were tendered from work colleagues Diane Lyons and Brent Wickham. In her affidavit[6] Ms Lyons described Ms McCall as seeming "happy and fine" in the week prior to her death. Conversely, Mr Wickham in his affidavit[7] said "I never noticed her so down in spirits as I did the week prior to death". Dr Bennett apparently did not notice anything 'wrong' with Ms McCall either.

36. I note too that Kate McCall, Ms Kingston, and Ms Lyons all described Ms McCall and Dr Bennett's relationship in positive terms.

37. Although the issue of workplace bullying was one expressly raised for consideration at the inquest by Dr Bennett it was ultimately an issue he did not seek to pursue. Accordingly, no witnesses from Ms McCall's workplace were actually called to give evidence (at Dr Bennett's request). Affidavits however were tendered from a number of work colleagues including Kimbra Lynd, Mark Upton, and Andrew Rushton as well as Brent Wickham and Diane Lyons, who have already been mentioned. The picture that emerges from the material from her co-workers is of a person deeply unhappy in her place of employment. The records make it quite clear that Ms McCall had a significant amount of sick leave both with and without certificates. It was noted by one manager to be considered "higher than average". A number of those certificates were supplied by Dr Bennett. At the time of her death she was on pre-arranged annual leave from work.

[5] Exhibit C28
[6] Exhibit C33
[7] Exhibit C32

Ms McCall's overdose, hospitalisation and subsequent death

38. Dr Bennett said that he and Ms McCall met at the Hobart docks on Friday 8 February after work. The biennial Wooden Boat Festival was being conducted over that weekend. Dr Bennett described Ms McCall as being happy that evening. Saturday was spent partly going for a drive, part at the festival, and having dinner. Again Dr Bennett describes Ms McCall as not giving any hint of her intentions or that she was in any mental distress.

39. The issue of the movements of both Dr Bennett and Ms McCall on Sunday 10 February 2013 was the subject of careful investigation and consideration. As a result of the evidence tendered at the inquest I make the following findings.

40. Early on the morning of Sunday 10 February, at about dawn (or as he subsequently told police, between 5.30am and 5.45am) Dr Bennett made his way alone to the dock area of Hobart with a view to taking photographs of boats in the Wooden Boat Festival. He sent a text message to Ms McCall at 7.14am and then returned home.

41. After walking their dog Max and taking a coffee to Ms McCall, who was still in bed, Dr Bennett had breakfast whilst Ms McCall showered. Dr Bennett gave evidence that the original intention of the couple was to make their way to the Wooden Boat Festival together. However, apparently Ms McCall was not ready to leave when Dr Bennett wished to (she was still in the shower), and so Dr Bennett made his own way to the Wooden Boat Festival. Thereafter an exchange of text messages took place between Dr Bennett and Ms McCall. The call charge records of the mobile telephones used by Dr Bennett and Ms McCall were tendered in evidence[8]. Photographs of messages on both mobile telephones were also in evidence[9].

42. Dr Bennett gave evidence that he spent the balance of the day at the Wooden Boat Festival. When interviewed on video by police on 13 February 2013 (the day after Ms McCall's death in the Royal Hobart Hospital) he told police that after 10.57am "I didn't send any more messages". He said he was busy at the festival and that he stayed there all day. However call charge records for both Dr Bennett and Ms McCall's mobile telephones show that at 10.18.40am a second text message was sent from Ms McCall's phone to Dr Bennett's and at 3.09.13pm a message was sent from Dr Bennett's phone to Ms McCall's phone. Both

[8] Exhibit C46 and C47
[9] Exhibit C44, photograph 64

messages were no longer on either telephone when they were examined and photographed by police forensic officers. The only logical conclusion is the messages were deleted by someone before the telephones were handed to police. Dr Bennett agreed that he had access to both his phone and Ms McCall's phone after her death (indeed it was he that provided them to police for subsequent examination and photographing). He denied any knowledge of the messages and denied deleting them. I do not accept his denial. However, in the absence of the messages themselves, or some evidence as to their content, it is impossible to take the issue any further.

43. Evidence was led from a pharmacist, Ms Jacqueline Tan, employed at the Chemist Warehouse in Murray Street, who served Ms McCall later in the morning at that pharmacy on 10 February 2013. In addition to Ms Tan's affidavit[10] and her oral evidence at the inquest, CCTV footage downloaded from cameras in the pharmacy was also tendered[11]. That CCTV footage clearly showed Ms McCall being served by Ms Tan at about 12.40pm at the pharmacy in Murray Street. During that transaction Ms McCall had a prescription, written for her by Dr Stephen Bennett, filled. The prescription was for a propranolol. Ms McCall asked Ms Tan to fill all three repeats left on the prescription. The prescription was tendered[12]. It had been written on 6 April 2012 and thus had a little less than two months left until it expired. Ms McCall requested that all three repeats be filled because according to Ms Tan, who impressed as a careful and accurate witness, there had been difficulty filling prescriptions for that product in the past. Ms Tan said that this accorded with her knowledge of the product. As a result, Ms Tan supplied to Ms McCall three bottles of propranolol each containing 100 40mg tablets. No criticism should be made of Ms Tan. It is clear that she discharged her duty in respect of the prescriptions appropriately. The CCTV footage tendered supports Ms Tan's evidence, which I accept, as to what transpired between her and Ms McCall.

44. Nothing more is known of Ms McCall's movements after she left Chemist Warehouse in Murray Street at approximately 12.40pm. Certainly she must have made her way to the home she shared with Dr Bennett in Jubilee Road, South Hobart. She also changed her clothing, as the clothing she was found in at about 7.00pm by Dr Bennett was different to that she is seen wearing in the CCTV footage at Chemist Warehouse. And at some stage she took a quantity of propranolol and paracetamol as well as almost certainly consuming some alcohol. She slipped into unconsciousness and a coma.

[10] Exhibit C13
[11] Exhibit C64
[12] Exhibit C14

45. Dr Bennett made his way home from the Wooden Boat Festival, stopping only at a shop in South Hobart to buy some cherries. He arrived home close to 7.00pm to find Ms McCall unconscious on their bed. He said he noticed an open propranolol bottle and a wine glass near the bed. Dr Bennett removed Ms McCall's jewellery and phoned 000 at 7.13pm and an ambulance responded quickly, with paramedic Zachary Morgan arriving at 7.22pm. Paramedic Morgan commenced treating Ms McCall and as he did so he spoke to Dr Bennett who was present. Mr Morgan gave evidence, not challenged or disputed by Dr Bennett, that Dr Bennett told him that he had left the house that morning after an argument.

46. Mr Morgan called for assistance which arrived shortly after at 7.29pm. Attempts to stabilise Ms McCall were continued, but were unsuccessful and so she was transported to the Royal Hobart Hospital by ambulance. Dr Bennett did not travel in the ambulance with her but made his way to the RHH in his own vehicle, stopping at his professional rooms on the way.

47. Unfortunately for the subsequent investigation, Ambulance Tasmania did not notify Tasmania Police of their attendance on Ms McCall. The failure to advise Tasmania Police meant that what may have been a crime scene went unsecured and unexamined for several days. It is recognised that the primary role of attending ambulance officers at any incident is to provide care to a patient and that they are not investigators, but the failure to report apparent suicide attempts which have critical and ultimately fatal results makes any investigation, whether it be criminal or coronial, very difficult. The failure to report to police in this case is by no means an isolated incident. It is an issue that needs to be addressed.

48. Ms McCall was treated at the RHH but sadly nothing could be done for her and so, after consultation with those close to her, a decision was made to withdraw artificial support and just after 2.00pm on Tuesday 12 February 2013 Ms McCall died. Only after her death were police notified.

49. The matter was also reported to the Coroner. An investigation commenced immediately. Forensic and CIB officers attended 89 Jubilee Road the following day. The scene was examined and photographs taken. Dr Bennett showed investigators the bed where he found Ms McCall, a wine glass he had found near her and some medication. Unfortunately the wine glass had been washed by Dr Bennett who had also shredded some documentation. Mobile telephones were taken possession of and examined. Text messages on those phones were photographed.

50. Later the same day Dr Bennett was interviewed by police. That interview was video recorded. The video was tendered at the inquest and played. In a wide-ranging interview Dr Bennett told police that he wrote a prescription when Ms McCall's 'Dove' facial cream ran out. He also told police that if Ms McCall increased her dose he would have been aware and he would have told her that she had to go and see her own doctor (presumably Dr Skeat)[13]. However, there is no evidence this ever occurred and if it did Dr Skeat was unaware of it.

51. Dr Bennett in an affidavit objected, as Ms McCall's senior next of kin, to the conducting of an autopsy but one was ultimately carried out by Dr Donald Ritchey, forensic pathologist. Dr Ritchey found no signs of violence at autopsy and his opinion was, which I accept, that the cause of Ms McCall's death was mixed drug and alcohol toxicity. He said in his evidence at the inquest that the drug of most significance in her death was propranolol which impacted on her heart so as to cause major, irreversible organ failure. That drug was prescribed for her by Dr Bennett.

Section 28 findings

52. The following findings are made pursuant to section 28 of the *Coroners Act* 1995:

(a) The identity of the deceased is Pamela Diane McCall;
(b) How Ms McCall died is addressed in detail in these findings;
(c) The cause of Ms McCall's death was mixed drug and alcohol toxicity;
(d) Ms McCall died in the Royal Hobart Hospital on 12 February 2013; and
(e) Because the *Births, Deaths and Marriages Registration Act* 1999 provides no guidance as to the particulars required to register a death under that *Act*, something which has been commented upon several times in the past, I am unable to make any finding under s28 (1) (e) of the *Act*.

Conclusion

53. The circumstances of Ms McCall's death do not require me to make any recommendations. I do however **comment** that steps need to be taken by Ambulance Tasmania, in consultation with the Tasmania Police Service, to ensure the development of

[13] See Exhibit C52

reporting guidelines to ensure the timely involvement of Tasmania Police at the scene of any likely suspicious death or anticipated suspicious death.

54. I direct that a copy of this finding be sent to the Australian Health Practitioner Regulatory Agency.

55. I express my particular thanks to Ms Shand, counsel assisting, and commend Senior Constable Pretyman for her extremely professional investigation.

56. I extend my condolences to the family and loved ones of Ms McCall on their loss.

Dated: 8 May 2017 at Hobart in the State of Tasmania.

Simon Cooper
Coroner