MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Investigation into the death of Margaret Joyce Binns

Ruling No 1

Background

1. On 8 January 2020 Mrs Binns died at the Launceston General Hospital ('LGH') whilst she was an inpatient at that facility. A medical certificate certifying her death ('MCCD') was issued by Dr Renshaw who was at that time the Executive Director of Medical Services ('EDMS') – North. Dr Renshaw is a medical practitioner, and his responsibilities included clinical leadership and governance at the LGH. The MCCD identified the cause of Mrs Binns' death as an acute subarachnoid haemorrhage resulting from a subarachnoid aneurysm on a background of hypertension.

2. On 20 February 2024 the Tasmanian Health Service announced a review into reportable deaths and death reporting processes in Tasmanian public hospitals, including the LGH and convened a panel to undertake that review. The panel was chaired by Adjunct Professor Debora Picone AO, and members, Adjunct Professor Karen Crawshaw PSM, Ms Ann Keenan and Associate Professor Amanda Walker ('the panel'). The panel chair and members are respected experts in the fields of public and health administration, law, nursing and medicine. Their final report was issued on 26 June 2024.[1] One of the recommendations included in the report was that several deaths at the LGH, being deaths that appeared to be reportable deaths and in respect of which Dr Renshaw had issued an MCCD, be reported to the coroner. Mrs Binns was one of these deaths and was reported by the Department of Health to the coroner because of the review and the panel's recommendation.

3. The Department of Health now submit through its counsel, Ms Chen, that its review panel were in error identifying Mrs Binns' death as a reportable death and that I do not have jurisdiction to investigate Mrs Binns' death nor comment on the MCCD.

[1] Exhibit C9 – Final Report of the Independent Review Reportable Deaths and Death Reporting Processes in Tasmanian Public Hospitals.

4. The interested parties in this matter, the Department of Health through Ms Chen and Dr Renshaw through his counsel provided written submissions and were heard as to the issue of jurisdiction.

Mrs Binns

5. Mrs Binns was 82 years of age when she died and had been enjoying good health and quality of life, other than a history of hypertension. On 6 January 2020 she was in the kitchen of her home when she fell to the floor striking her head. She was conveyed to the LGH by ambulance and underwent a CT scan which identified she had suffered a moderate to large left frontal-temporal-parietal subdural haematoma with associated subarachnoid haemorrhage and midline shift and an undisplaced transverse fracture in the right petrous temporal bone.[2] Due to the extent and nature of the head injury and her family's understanding of her wishes, she was provided with comfort care and died. Whilst her death was a natural consequence of the subdural haematoma and subarachnoid haemorrhage it was unclear whether the haematoma or haemorrhage had been caused by the fall, and as such was unnatural, unexpected, and resulted directly from an accident or injury, or was a spontaneous bleed without traumatic origin and of a natural cause. If it was found to be of a natural cause what that cause was, aneurism for example, was unknown and the death remained unexpected.

The jurisdiction of a coroner and consideration of the *Coroners Act* 1995 (Tas)

6. The jurisdiction of a coroner in Tasmania is derived wholly from the *Coroners Act* 1995 (Tas) ('the Act'). There is no common law source of jurisdiction. The nature and limits of the jurisdiction is to be determined by a consideration of its statutory source, specifically the language used in the Act informed, where appropriate, by the Act's purpose and context.[3]

7. The Act creates a framework by which the public can have confidence in and be potentially protected by the independent judicial scrutiny of specified categories of deaths that occur in this State. Those categories of deaths identified as requiring such scrutiny are defined in the Act as reportable deaths,[4] and include deaths that are or maybe unexpected, unnatural, violent, accidental, associated with medical procedures or employment, occur during a period of detention or mandated care or the cause of which is unknown. It is an offence for any person

[2] Exhibit C4 – Launceston General Hospital ('LGH') medical record p23-24.
[3] *Acts Interpretation Act* 1931 (Tas), s 8A.
[4] *Coroners Act* 1995 (Tas) (the Act), s 3.

who holds a reasonable belief that a death is a reportable death not to report the death, as soon as possible to a coroner or police officer.[5]

8. A coroner's jurisdiction extends to investigating a death it if "*appears*" it "*maybe*" a reportable death.[6] A reportable death includes a death that "*appears*" to have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury.[7] When considering the nature and extent of jurisdiction vested in a coroner by s 21 of the Act the words used in the Act are to be interpreted broadly and construed "*with all the amplitude that the ordinary meaning of its words admits*".[8] The language used in the Act is wide. Jurisdiction is enlivened by the appearance of reportability of the death and the possibility of the death being a reportable death. To be a reportable death the death need only appear to be unexpected, unnatural or violent. The Act does not demand certainty regarding the reportability of the death to invoke jurisdiction.[9] The use of the words "*may be*" and "*appears*" in s 21 and "*appears*" again in the s 3 definition of reportable death sets a low threshold for the invoking of a coroner's jurisdiction to investigate a death. This is in line with the beneficial purpose of the Act and the protective role of the coroner.

9. Counsel for the Department of Health recognise that the use of the word *"maybe*" in s 21 of the Act reflects a circumstance where a coroner is "*not yet satisfied that a death is reportable*"[10] yet submit, contrary to the language used in s 21 of the Act, that for jurisdiction to arise the death must, as a jurisdictional fact, be found to be a reportable death.[11] Counsel rely on the formulation of what was the jurisdictional fact in *Saraf & Anor v Johns* [2008] SASC 16 per Debelle J at [9], a case involving the South Australian *Coroners Act* 2003, for this submission.

10. The question that arose in *Saraf* was whether a coroner in South Australia jurisdiction had, in the circumstances that arose in that case, to conduct an inquest. Debelle J held that the coroner's jurisdiction to conduct an inquest did not arise if the death was not a reportable death based on a proper construction

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[5] The Act, s 19.
[6] The Act, s 21.
[7] The Act, s 3.
[8] *Roy Morgan Research Centre Pty Ltd v Commissioner of State Revenue (Vic)* [2001] 207 CLR 72, [9], [11]; *Hossain v Minister for Immigration and Border Protection* (2018) 264 CLR 123, [22]-[25].
[9] Contrast this with the *Coroners Act* 2003 (SA) where jurisdiction is in the Coroner's Court to hold inquests into the events prescribed (s 13). Events that can be subject of inquest include a reportable death (s 21) and a reportable death is, inter alia, a death by unexpected, unnatural unusual violent or unknown cause (s 3).
[10] Paragraph 16 of the written submissions received from the Department of Health.
[11] Paragraph 17 of the written submissions received from the Department of Health.

of the South Australian Act and identified an "*unfortunate circularity*" that a coroner may require an inquest to determine, as a jurisdictional fact, if the death is reportable only to find, following inquest, that it was not. Debelle J observed that there was a fundamental difference between the *Coroners Act* in South Australia and that in Victoria, New South Wales, Western Australia and Australian Capital Territory (I add Tasmania to that list).

11. In South Australia the jurisdiction of a coroner arises upon a conclusion, as an objective fact, that the cause of death is of a kind that is prescribed/reportable. In contrast the other States referred to, and Tasmania, require only the appearance and/or possibility of a reportable death to invoke jurisdiction. Debelle J recognised that if the South Australian Act was amended to replicate that of the other states it "*might be possible to avoid arid questions as to whether the coroner's court did in fact have jurisdiction to conduct an inquest*".[12] This reflects the significance of the broad language adopted in s 21 of the Tasmanian Act, and the consequential breadth of the jurisdiction of a coroner in this state to investigate deaths. Noting that the South Australian statutory framework, for the reason I have set out, bears little resemblance to that operating in Tasmania, the decision of the South Australian Supreme Court in *Saraf* is not binding on me nor is it persuasive regarding the issue of jurisdiction of a Tasmanian coroner.

12. Similar provisions to ss 3 and 21 of the Act existed in the Victorian *Coroners Act* 1985, ss 3 and 15, the predecessor to the *Coroners Act* 2008 (Vic). In the context of an application for an inquest to be held under the *Coroners Act* 1985 (Vic), the Court of Appeal of Victoria observed that:

> "*Any death that is reported to a coroner is presumably one that the coroner has both jurisdiction and a duty to investigate to some extent because, until some investigation is made, it would necessarily appear to the coroner that the death 'may be' a 'reportable death' by definition."*.[13]

13. The trigger for jurisdiction is inexorably linked to the appearance of the reportability of a death. The word "*reportable*" implies that it is at the time when a death is reported that jurisdiction must exist. The use of the word "*appears*" also suggests that it is at the time the death is reported or before the investigation commences that jurisdiction is vested, rather than after or during an investigation

[12] *Saraf & Anor v Johns* [2008] SASC 16, [43].
[13] *Clancy v West* [1996] VicRp 92.

when the reportability of the death is informed by the investigation and becomes known.

14. The power to investigate includes the power to conduct an inquest. An inquest is one of the tools of investigation available to a coroner as part of an investigation.[14] Once a coroner investigates a death that appears to may be a reportable death, whether by inquest or not, the coroner must, where possible, make findings regarding the death.[15] The coroner also must, where appropriate, make recommendations regarding the death[16] and may comment on any matter connected with the death.[17] Section 28 is not a provision of jurisdiction but creates duties and powers in a coroner to do certain things once the coroner has exercised the jurisdiction to investigate a death. The duty and/or power does not discriminate by the length of the investigation nor whether the investigation has revealed a death to be an unnatural death before the power and/or duty arises.

15. The Act does not include a requirement of a coroner to cease an investigation without findings in the event a death is shown, after investigation, to not be a reportable death. This is to be compared to other statutory regimes, for example Victoria where a coroner must cease an investigation upon finding a death is not reportable[18] and Western Australia where a coroner is not required to investigate or continue to investigate a reportable death determined to be due to natural causes and which was reportable solely as it appeared unexpected.[19] These statutory provisions, occurring as they do in frameworks where, as in Tasmania, the jurisdiction of a coroner is broad and arises on the appearance of a reportable death, reflect that jurisdiction arises and vests in a coroner at the time a death that appears may be reportable is reported.

16. There is nothing in the language used in the Act nor its beneficial purpose which operates to prevent the making of findings, recommendations and comment under s 28 in circumstances where, following investigation, a death is found to have been a natural death. Preventing a coroner who, after investigation, finds a death to be natural from making findings, recommendations and/or comment, could frustrate the beneficial purpose of the Act and calls for, as in Victoria, clear statutory provision for the cessation of the investigation. The finding, of a natural

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[14] The Act, Part 5 outlines the investigatory powers and functions of a coroner including the holding of an inquest, ss 24-27.
[15] The Act, s 28(1).
[16] The Act, s 28(2).
[17] The Act, s 28(3).
[18] *Coroners Act* 2008 (Vic), s 16(3).
[19] *Coroners Act* 1996 (WA), s 19A.

death does not automatically preclude the presence of matters connected with that death that deserve comment to prevent future deaths, or which are relevant to the administration of justice.

17. The extent to which the coroner can use the powers of inquest, findings, recommendation and comments are not at large but are limited by questions of desirability, possibility, appropriateness and connection to the death. The circumstances of the death inform the availability of these powers. In some cases, a coroner investigating a death revealed to be natural may find it undesirable to hold an inquest, or inappropriate to comment or make recommendations. A coroner cannot exercise their powers of investigation without fetter.

18. The scheme of the Act, the triggering of jurisdiction to investigate by the appearance of a reportable death and the obligation and powers under s 28 accruing upon investigation, in the absence of clear language to the contrary, causes me to conclude that a coroner's jurisdiction is enlivened under s 21 upon the appearance that a death may be a reportable death at the time it is reported. If, after investigation, the death, is found to be outside the definition of a reportable death a coroner retains the power and duty to make findings, recommendations and/or comments where such findings, recommendations and comments are within the parameters of s 28 of the Act.

Was Mrs Binn's death a reportable death?

19. Mrs Binns' death was the subject of review by the panel and was assessed by the panel to be reportable. The LGH medical records of Mrs Binns' inpatient period from 6 to 8 January 2020, including the Tasmanian Ambulance Service report of their attendance at her home on 6 January 2020, and the results of the CT scan of 6 January 2020 and its addendum, reveal that Mrs Binns had previously been well, enjoyed a good quality of life, experienced an "absence episode", fell onto the floor of her kitchen on 6 January 2020 and had a subdural haematoma, subarachnoid haemorrhage with midline shift and undisplaced fracture of the right petrous bone.[20] Due to these matters the death, when it was reported, had the appearance of being a reportable death giving rise to a jurisdiction to investigate and a power to make findings under s 28 of the Act.

[20] The petrous is part of the temporal bone and is located at the base of the skull.

20. Having jurisdiction I commenced an investigation regarding Mrs Binns' death. As part of the investigation the LGH medical records, an affidavit of Mr Binns and a medical report of Dr Anthony Bell MB BS MD FRACP FCICM, medical advisor to the coroner,[21] were obtained. Dr Bell reviewed the medical records and concluded that the CT scan did not show evidence of a ruptured aneurysm nor trauma as a cause of the subarachnoid haemorrhage and, the history of Mrs Binns becoming vacant preceding the fall, "*strongly suggested*"[22] the subarachnoid bleed caused the fall rather than being caused by the fall. Mr Binns was not present in the kitchen at the time of Mrs Binns' fall. Whilst Dr Bell's opinion is compelling, the source of the history of Mrs Binns becoming "vacant" appears to be a third hand account from a person who was present with Mrs Binns in the kitchen when she fell. Considering these matters Mrs Binns' death retains the appearance of a death that may be unexpected and the cause of the subarachnoid haemorrhage remains unknown and would be appropriately further investigated by obtaining, at least the evidence of the person who was present when Mrs Binns fell.

Ruling

21. I find that at the time Mrs Binns' death was reported by the Department of Health as recommended by the review panel the death appeared to be a death that may be a reportable death and I had jurisdiction to investigate it. Having investigated Mrs Binns' death, I have a power and/or duty to make findings, comments, and/or recommendations where such findings, comments and recommendations come within the relevant limits of s 28 of the Act.

22. I further find that once invested with jurisdiction at the time Mrs Binns' death was reported I remain vested with jurisdiction until the conclusion of the investigation and the making of findings. The nature, duration and extent of the investigation will be informed by the nature and circumstances of the death as it is revealed by the investigation.

23. If I am wrong to find that, having been vested with jurisdiction to investigate Mrs Binns' death when it was reported I retain jurisdiction until the conclusion of that investigation, I find that, as Mrs Binns' death continues to have the appearance of a reportable death, being apparently unexpected and, the cause of the subarachnoid haemorrhage remaining unknown, I continue to have jurisdiction.

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[21] Exhibit C7 – Report of Dr Bell.
[22] Exhibit C7 – Report of Dr Bell p3.

Submission on the power to comment

24. In this ruling I have addressed the first limb of the Department of Health's submissions and found that it appeared Mrs Binns' death may be a reportable death and I have jurisdiction to investigate the death under s 21 of the Act. The second limb of the Department of Health's submissions was that I do not have jurisdiction to make comment on the MCCD.

25. The exercise of the duties and powers given by s 28 of the Act, including the power to comment, as I have found earlier in this ruling, is not a matter of jurisdiction. The nature of the jurisdiction afforded by s 21 of the Act is to investigate a death that appears reportable. Because I have jurisdiction and once I have investigated Mrs Binns' death, I may, within the limits placed on my power to do so, make comment.[23] The fetter on my exercise of that power is that any comment made must be connected to the death of Mrs Binns.

26. In this respect, counsel for the Department of Health relies upon *Saraf and Another v Johns*,[24] where the court also considered the exercise of the power to make recommendations regarding the medical certification of a death by a South Australian coroner. The court's review of the coroner's recommendations was not a question of jurisdiction but of whether the exercise of the coroner's power fell within its statutory limits. Similarly, my ability to comment on the MCCD is to be determined by its connection to Mrs Binns' death. I do not resolve that question in this ruling as it may be informed by the investigation and evidence received relating to Mrs Binns' death. There will be a point at which the question of what comment may be made regarding Mrs Binns' death will be raised and an opportunity, in the interests of fairness, will at that time be provided to the interested parties to make submissions as to the exercise of that power.

Dated: 18 August 2026 at Hobart, in the State of Tasmania.

Leigh Mackey
Coroner

[23] The Act, s 28(3).
[24] [2008] SASC 166.