IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2011 4738

In the matter of the death of Delta Diawo Poke
Ruling on application by interested parties for Coroner to recuse herself

Background

1. Delta Diawo Poke (Mrs Poke) died on 18 December 2011, aged 42.
2. On 10 December 2011, Mrs Poke attended the Croydon Day Surgery (now known as the Marie Stopes Clinic and owned by Marie Stopes International Australia) located at 411 Dorset Road, Croydon and was booked in for a three day procedure to commence on 12 December 2011 for a second trimester termination of pregnancy, at 21-22 weeks gestation.
3. At 7.00am on 13 December 2011, Mrs Poke presented at the clinic for her first procedure involving an anaesthetic. It appears from the treating medical staff statements and medical records that no problems were noted on this day.
4. On 14 December 2011, Mrs Poke presented to the Croydon Day Surgery for the final procedure during which it appears she suffered a cardiac arrest. It is the events of this day that are the subject of my coronial investigation.

Purpose of a coronial investigation

5. Mrs Poke's death was reported to the Coroners Court of Victoria (CCOV) in accordance with the *Coroners Act 2008* (Vic) (the Act).
6. I commenced my coronial investigation shortly thereafter. It is important to clarify the purpose of a coronial investigation into a reportable death[1] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[2] In the context of a coronial investigation, it is the medical cause of death which is important (including, where possible, the mode or mechanism of death) and the context or

1 *The Coroners Act 2008* requires certain deaths to be reported to the Coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, a 'reportable death' is defined in section 4 of the Act.

2 Section 67(1) of the *Coroners Act 2008*.

background and surrounding circumstances of the death sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[3]

7. The broader purpose of a coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the *prevention* role.

8. Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health and safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health and safety or the administration of justice.[4] These are effectively the vehicles by which the prevention role may be advanced.[5]

9. It is <u>not</u> the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

10. The coronial jurisdiction, being inquisitorial and not adversarial, is not concerned with blameworthiness. It is about finding, where possible, ways to prevent further like deaths in the future.

11. Coroners are also not bound by the rules of evidence and may be informed and conduct an inquest in any manner that the Coroner reasonably thinks fit.[6]

12. Whilst the circumstances of Mrs Poke's death do not warrant a mandatory inquest, I have determined that a discretionary inquest is warranted to assist me with making my statutory findings, in particular the circumstances in which her death occurred.

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3 This is the effect of the authorities- see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

4 See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

5 See also sections 73(1) and 72(5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

6 The Act, section 62.

Notification of the AHPRA's investigation into the circumstances of Mrs Poke's death

13. On 5 January 2012, the Australian Health Practitioner Regulation Agency (AHPRA) sent a letter to the CCOV advising that is was investigating three medical practitioners employed by the Croydon Day Surgery and advised that they had gathered information from nursing and medical staff that would assist me with my investigation into Mrs Poke's death.

Form 4 requests

14. As a result of receiving the letter from the AHPRA I formed the opinion that the AHPRA ***may*** have documents relevant to my investigation. Consequently, I exercised my coercive powers pursuant to section 42 of the Act to request information from the AHPRA as follows:

    a. a Form 4 dated 8 November 2013 which requested the AHPRA to produce all documents, including statements and records of conversations, relating to the AHPRA's investigation into the care of Mrs Poke provided by registered medical and/or allied health practitioners at the Croydon Day Surgery in December 2011 (**First Form 4**); and

    b. a Form 4 dated 18 March 2014 that requested the AHPRA to provide a statement regarding investigations of medical practitioners at the Croydon Day Surgery following the death of Mrs Poke, including how the matter was reported to the AHPRA, the investigative process undertaken by the AHPRA so far and the future anticipated course of the investigation (**Second Form 4**).

AHPRA documents already contained in the coronial brief

15. I note that prior to the First and Second Form 4 requests the Coroner's Investigator, Detective Senior Constable (DSC) Corin, was provided with a number of the AHPRA documents that are contained at pages 259-300 of the coronial brief.

16. Whilst the origin of these documents was initially unclear, a letter received from the AHPRA dated 31 July 2014 suggests that DSC Corin obtained these documents from Marie Stopes International Australia and not the AHPRA.

17. The coronial brief was distributed to interested parties on 19 November 2013, 2 April 2014 and 11 April 2014.

Directions hearing on 25 March 2014

18. On 25 March 2014, I conducted a directions hearing which involved, amongst other things, discussions in relation to the First and Second Form 4 requests.

19. At this hearing, the AHPRA provided me with documents in response to the First Form 4 request.

20. I understand that the AHPRA provided the documents to me because they considered them to fall within section 216(2)(c) of the *Health Practitioner Regulation National Law 2009* (the National Law) in that they were required or permitted by law.

21. I was also advised by the AHPRA that amongst the documents provided to me were documents that were obtained using its coercive powers.

22. Whilst I received these documents from the AHPRA, I wish to make it clear that they have never formed part of the coronial brief, nor have they been copied or distributed to any interested parties.

Response to Second Form 4 request

23. On 1 April 2014, in response to the Second Form 4 request, the AHPRA provided me with a statement of the AHPRA investigator Ms Fiona Sinnamon dated 27 March 2014. I have advised all interested parties that this statement will be included as part of the coronial brief.

Directions hearing on 10 April 2014

24. On 10 April 2014, I conducted a further directions hearing to hear submissions from interested parties in relation to the documents provided to me by the AHPRA pursuant to both Form 4 requests.

25. The interested parties present at this directions hearing were as follows:

    a. the AHPRA, represented by Ms Sara Hinchey of Counsel;

    b. Dr Schulberg and Dr McAllister, represented by Mr Tim McEvoy of Counsel; and

    c. Marie Stopes International Australia, represented by Mr Michael Regos, Partner at DLA Piper Australia.

26. Leading Senior Constable Tania Cristiano, of the Police Coronial Support Unit, was Counsel assisting me.

27. Mr McEvoy provided written submissions dated 10 April 2014 and also made oral submissions regarding the AHPRA documents.

28. Mr McEvoy submitted that the documents I requested were documents created in the context of immediate action taken and investigations conducted by the AHPRA pursuant to divisions 7 and 8 of Part 8 of the National Law, particularly sections 155-167.

29. In essence, Mr McEvoy submitted that my coercive powers under section 42 of the Act were fettered and that they must be exercised in a manner, which is not inconsistent with any common law rights that have not been excluded or modified by any applicable statute.

30. Mr McEvoy submitted that the AHPRA in its investigations also exercised coercive power pursuant to section 5 of the National Law, which deals with the power of investigators and creates offences for failing to produce information or attend before investigators.

31. While I had regard to section 7 of the Act, which provides that it is the intention of Parliament that a Coroner should liaise with other investigative authorities, official bodies or statutory officers to avoid unnecessary duplication of inquiries and investigations and to expedite the investigation of deaths, I ultimately agreed with Mr McEvoy that the interviews conducted by the AHPRA were conducted for a different purpose and in a different statutory context to that in which the Coroner operates.

32. I also agreed with Mr McEvoy's submissions that there is a public interest in the AHPRA being able to discharge its statutory functions without medical and allied health practitioners fearing that statements or submissions they make to the AHPRA in the context of the AHPRA's exercise of its regulatory function may be produced to a Coroner at inquest and disclosed to interested parties.

33. I note that there have been no applications pursuant to section 10 of the *Open Courts Act 2013* (Vic) for a suppression order in relation to any of the AHPRA documents provided.

Ruling dated 11 April 2014

34. On 11 April 2014 I ruled as follows:

Documents obtained by the AHPRA using its coercive powers

a. In relation to documents provided to me by the AHPRA in response to my First Form 4 request dated 8 November 2013 and obtained under its coercive powers, I accepted the submissions of Mr McEvoy and directed that they be returned to the AHPRA having not been copied or disseminated to any other person. This means that these documents were not included in the coronial brief.

Documents obtained by the AHPRA - not coercively obtained

b. In relation to the non coercively obtained documents provided to me by the AHPRA in response to my First Form 4 request dated 8 November 2013, I also returned these documents to the AHPRA not having copied or disseminated them to any other person. In doing so I considered whether there was sufficient public interest to include these documents in the coronial brief and ruled that in the absence of having heard any evidence from the potential witnesses in this matter, I was unable to determine whether the potential benefit of including these documents in the coronial brief outweighed the potential prejudice to the doctors concerned and the ability of the AHPRA to exercise its statutory functions.

c. I did, however, state that the probative value of the non coercively obtained documents might need to be reconsidered if my coronial investigation is hampered in any way from receiving matters relevant to Mrs Poke's death.

d. I ruled that the statement of Ms Sinnamon in response to my Second Form 4 dated 18 March 2014 was relevant to my investigation and that it would be included in the coronial brief.

Letter dated 13 May 2014

35. On 13 May 2014, Ms Lara Larking, Partner at TressCox Lawyers wrote to the CCOV on behalf of her client, Dr McAllister, asking that I excuse myself from the investigation into the death of Mrs Poke and that another Coroner be appointed.

36. The letter explained that this request was based on a view taken that it appeared that I was familiar with at least some of the material provided by the AHPRA, and that it seemed likely that I had read and considered documents which have now been excluded from the inquest.

37. The letter also informed me that this request was supported by the solicitors representing Dr Mark Schulberg.

Letter dated 16 May 2013

38. On 16 May 2013, the Coroner's solicitor sent a letter to Ms Larking, attaching transcript of the directions hearing on 10 April 2014. The Coroner's solicitor informed Ms Larking that at that stage, I was not inclined to entertain an application to excuse myself on the basis of the content of the letter dated 13 May 2014, but that in the interests of natural justice, I was prepared to accept fully particularised written submissions in relation to any application their client wished to make for me to excuse myself by 20 May 2014.

39. By email dated 19 May 2014, the applicants were granted an extension until 21 May 2014 to provide written submissions to support their application.

Submissions dated 21 May 2014

40. On 21 May 2014, I received the submissions of Drs McAllister and Schulberg dated same.

41. The submissions alleged that I had viewed at least some of the material provided by the AHPRA and that by doing so, an apprehension of bias has arisen.

42. I agree with submissions of Counsel on behalf of Drs McAllister and Schulberg that in order to disqualify a Judge from sitting, it is not necessary to show that the Judge is in fact biased. It is sufficient to show a reasonable apprehension of bias.[7]

43. In support of their application, both doctors relied upon the specific category of apprehended bias of disqualification by extraneous information.[8]

44. When considering the application, I have had regard to the principles as stated by the High Court in *R v Watson; ex parte Armstrong*[9] which have been

7 *R v Watson; ex parte Armstrong* (1976) 136 CLR 248, 258.

8 *Webb v R* (1994) 181 CLR 41, 74 per Deane J; *Ebner v Official Trustee* (2000) 205 CLR 337, 348.

slightly modified by the Court in *Livesay v New South Wales Bar Association*[10] as follows:

> ... a Judge should not sit to hear a case if in all the circumstances the parties or the public might entertain a reasonable apprehension that he might not bring an impartial and unprejudiced mind to the resolution of the question involved in it.

45. I note that in the High Court decision of *Ebner v Official Trustee in Bankruptcy* (2000) 205 CLR 337, Gleeson CJ, McHugh, Gummow and Hayne JJ stated that the applicable principle requires two steps:

> First, it requires the identification of what it is said might lead a judge (or juror) to decide a case other than on its legal and factual merits. The second step is no less important. There must be an articulation of the logical connection between the matter and the feared deviation from the course of deciding the case on its merits. The bare assertion that a judge (or juror) has an "interest" in litigation, or an interest in a party to it, will be of no assistance until the nature of the interest, and the asserted connection with the possibility of departure from impartial decision making, is articulated. Only then can the reasonableness of the asserted apprehension of bias be assessed.[11]

46. Counsel on behalf of Drs McAllister and Schulberg submitted apprehended bias of disqualification by extraneous information had arisen by virtue of my having viewed the material (or part thereof) provided by the AHPRA, having had regard to it for the purpose of making a ruling in relation to it.

47. Counsel also submitted that as a consequence I should disqualify myself from continuing the inquest as I now have knowledge of prejudicial but inadmissible material that may cause a reasonable informed member of the public to form the view that I might not bring an impartial mind to the questions I have to decide.

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9 (1976) CLR 248, 262.

10 (1983) 151 CLR 288, 294.

11 (2000) 205 LR 337m 345

48. It was also submitted that whilst I indicated that I do not intend to rely on this material, the mind of the Judge is not relevant, rather what is important is the *impression* that may be given to the fair-minded lay observer.[12]

49. I note that the outline of submissions on behalf of Drs Schulberg and McAllister dated 21 May 2014 also referred to a request to exclude the AHPRA material contained at pages 259-300 of the coronial brief and potential further submissions on this point (at paragraph 20).

50. In an email dated 30 July 2014, the Coroner's solicitor requested that Mr Chris Spain, legal representative for Drs Schulberg and McAllister, advise by the close of business on 6 August 2014 whether further submissions would be made in relation to paragraph 20 of the outline for submissions dated 21 May 2014.

51. No further written submissions in relation to paragraph 20 of the outline for submissions dated 21 May 2014 were received by the CCOV and in the absence of hearing from all interested parties on this point, I will not rule on the matter at this stage.

Email dated 30 July 2014

52. The Coroner's solicitor sent an email on 30 July 2014 to all the interested parties advising that, amongst other things, the CCOV would be briefing Counsel to assist me at the directions hearing on 11 August 2014.

Submissions dated 31 July 2014

53. Supplementary submissions of Drs McAllister and Schulberg dated 31 July 2014 were received. These submissions appear to relate to the transcript of proceedings of the directions hearing on 25 March 2014 and referred to a "regime" and a "two-step process" that Counsel appears to consider that I have committed myself to by virtue of a comment made by Counsel acting on behalf of the AHPRA.[13]

54. The supplementary submissions refer to an alleged departure from the "regime." As the material produced pursuant to the First Form 4 was returned

12 *Ebner v Official Trustee* (2000) 205 CLR 337, 344 [6].

13 T11.24-26.

to the AHPRA on 11 April 2014 not having been copied or disseminated, I do not consider that I need to make a ruling on this point.

Directions hearing 11 August 2014

55. On 11 August 2014, I conducted a directions hearing for the sole purpose of hearing oral submissions from Counsel for the doctors. I note that no other interested parties attended this hearing.

56. I will not summarise these submissions save to say that they were not inconsistent with the written submissions previously provided to me.

The questions I have to decide

57. I agree that a judicial officer should not sit to hear a case if in all the circumstances the parties or the public might entertain a reasonable apprehension that he or she might not bring an impartial and unprejudiced mind to the resolution of the ***question*** involved in it.

58. It is important to be clear about what the 'question' or 'questions' I as the Coroner investigating the circumstances of Mrs Poke's death must, where possible, decide.

59. As previously stated section 67 of the Act provides a mandatory statutory obligation for the Coroner to find, if possible, the identity of the deceased, medical cause of the death and the circumstances in which the death occurred. A Coroner's role is also to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice.[14]

60. Coroners also have an important prevention function to make recommendations, where possible, to prevent similar deaths. Whether a doctor is fit to be registered is not a function, or 'question' a Coroner must decide. This is the statutory role of the AHPRA.

61. It is also not part of a Coroner's function to apportion blame for a death. Nor is it a function of a Coroner to review decisions by other bodies, such as the AHPRA.

14 *Coroners Act 2008* (Vic), Preamble and s 1.

Ruling

62. Having considered all of the submissions, both written and oral, in relation to the doctors' application and having considered the series of decisions which enunciate the test to be applied in Australia in determining whether a Judge is disqualified by reason of the appearance of bias (which, in the present case, was said to take the form of prejudgment) I rule that a fair-minded lay observer would not reasonably apprehend that I might not bring an impartial and unprejudiced mind to the resolution of the questions I must decide, namely finding the identity of the deceased, the medical cause of death and the circumstances within which the death occurred.

63. I note that this test is an objective one where the lay-minded observer must appreciate all the decisions that a Coroner must decide when investigating a reportable death. The High Court decision of *Webb v R*[15] provides that a fair-minded observer is someone with knowledge of the particular facts of the matter rather than broad general knowledge:

> It is plain from the law that the circumstances of each case are all important and that judges should not too readily respond to protests advanced on the basis that they may not be able to discharge their judicial duties properly in a particular matter before them. The reasonable apprehension of bias, which is the core of the test, turns very much upon the adjective 'reasonable'. It is not enough that there be some apprehension to some uninformed and uninstructed person. It must be a reasonable apprehension and it must be an apprehension which would be apparent to or entertained by a reasonable person with a full comprehension of the circumstances of the case.[16]

64. Reasonableness of any suggested apprehension of bias must be considered in light of ordinary judicial practice and procedure, the nature of the functions performed by the decision-maker and the statutory context. Notably in relation to the role of a Coroner, regard must be had to its inquisitorial nature and the statutory departures from the judicial paradigm.[17]

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15 *Webb v R* (1994) HCA 30.

16 As per Street CJ, with Yeldham and Finlay JJ agreeing in *R v George & Ors* (1987) 9 NSWLR 527.

17 *Victoria Police Special Operations Group Operators 16,34,41 and 64 v Coroners Court of Victoria* [2013] VSC 246.

65. I am not satisfied that Counsel appearing on behalf of Drs McAllister and Schulberg has particularised how it is that my receiving the AHPRA documents pursuant to the First Form 4 request, and then not relying upon them, results in apprehended bias for the statutory findings I must make.

66. I do not consider that Counsel appearing on behalf of Drs Schulberg and McAllister have firmly established a logical connection between the ground asserted and the feared deviation from the course of my fulfilling my statutory role.[18]

67. I am persuaded by the comments in *O'Sullivan v. Medical Tribunal of New South Wales*[19] where Basten JA, with whom Tobias and Hodgson JJA agreed said:

> *[42] Applying this test,* ***the fair-minded observer should also be understood to know that judicial officers rule on the admissibility of evidence on a daily basis, and are assumed to be able to put out of their minds irrelevant or prejudicial material which is excluded.*** *At one stage senior counsel for the practitioner sought to press a claim that the judicial member should also be disqualified.* ***However, if that were correct, it is difficult to see how a judge could rule in the course of a trial on the inadmissibility of disputed prejudicial material without rendering herself liable to disqualification if the matter were excluded. Such an approach would be inconsistent with the daily practice of the administration of justice.*** *That submission should be rejected*
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> (emphasis added).

68. Accordingly, the application to recuse myself is refused and I will remain the investigating Coroner in relation to the death of Mrs Poke.

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18 *Ebner v. Official Trustee in Bankruptcy* (2000) 205 CLR 337, at 345, per Gleeson CJ, Gummow and Hayne JJ; *British American Tobacco Australia Services Limited v Laurie* [2011] HCA 2, (2011) 242 CLR 283, per French CJ at [44]-[45], Gummow J at [71]-[71], in the context of judicial conduct, but broadly applicable.

19 [2008] NSWCA 374.

Signature:

AUDREY JAMIESON
CORONER
Date: **14 August 2014**