IN THE SUPREME COURT OF VICTORIA
AT MELBOURNE
COMMON LAW DIVISION
JUDICIAL REVIEW AND APPEALS LIST

Not Restricted

S ECI 2023 03164

SEAN RUNACRES — Appellant

v

THE CORONERS COURT OF VICTORIA — Respondent

and

AUNTY DONNA NELSON — Intervenors

JAMES LEONARD ('PERCY') LOVETT

JUDGE:	Quigley J
WHERE HELD:	Melbourne
DATE OF HEARING:	31 October and 1 November 2023
DATE OF JUDGMENT:	11 June 2024
CASE MAY BE CITED AS:	Runacres v The Coroners Court of Victoria
MEDIUM NEUTRAL CITATION:	[2024] VSC 304

CORONERS COURT — Inquest — Appeal on a question of law — Findings as to circumstances in which death occurred — Whether finding open — Whether coroner failed to apply *Briginshaw* standard to the evidence — Legal unreasonableness — Whether findings against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made the findings — Role of the Coroner — Duty to make findings — No right of appeal against recommendations or comments — Statutory finding distinguished from consideration of evidence before the Coroner — Coroners findings upheld — *Coroners Act 2008* (Vic) ss 4, 14, 15, 57, 62, 67, 72, 83, 87 — *Briginshaw v Briginshaw* (1938) 60 CLR 336, *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223, *Minister for Immigration and Citizenship v Li* (2013) 249 CLR 332, *Minister for Immigration and Border Protection v SZVFW* (2018) 264 CLR 541, *Minister for Immigration and Border Protection v Stretton* (2016) 237 FCR 1, *Minister for Immigration v Eden* (2016) 240 FCR 158.

PRACTICE AND PROCEDURE — Application to intervene in appeal — Interested parties before the Coroner — Leave granted in accordance with order 9 of the *Supreme Court (General Civil Procedure) Rules 2015* (Vic) — *Bauer Media Pty Ltd v Wilson* [2018] VSCA 68 considerations applied.

APPEARANCES:	Counsel	Solicitors
For the Appellant	Mr C Winneke KC Ms B Myers	Kennedys Law
For the Respondent	Mr R Ajzensztat	Coroners Court of Victoria (In-house Legal Service)
For the Intervenors	Ms S Gold Ms S Wallace	Robinson Gill Lawyers Victorian Aboriginal Legal Service

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HER HONOUR:

INTRODUCTION

1 On 30 January 2023, Coroner Simon McGregor (the 'Coroner') published his findings into the death with inquest into the passing of Veronica Marie Nelson ('Coroner's Report' or 'Report').[1]

2 Veronica,[2] a proud Gunditjmara, Dja Dja Wurrung, Wiradjuri and Yorta Yorta woman, passed away whilst in the State's custody on 2 January 2020 at the Dame Phyllis Frost Centre ('DPFC').

3 The Coroner found that Veronica died of complications of withdrawal from chronic opiate use and Wilkie Syndrome in the setting of malnutrition.[3] Veronica was 37 years old at the time of her death. She had been remanded in custody at the time of her passing, having been refused bail for relatively minor, non-violent offences.

4 Veronica's death constituted a 'reportable death' pursuant to s 4 of the *Coroners Act 2008* (Vic) ('Coroners Act').[4]

5 In accordance with s 67 of the Coroners Act, the Coroner made a large number of statutory findings across a range of matters connected with Veronica's death, including adverse findings as to her medical assessment and care, and the underlying processes and policies relevant to her care whilst she was at DPFC. Whilst the Coroner made a number of adverse findings against the corrections and clinical staff at DPFC who dealt with Veronica,[5] he also made specific adverse findings against certain individuals, including the appellant.

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1 Inquest into the Passing of Veronica Nelson (Amended pursuant to Section 76 of the *Coroners Act 2008* on 24 August 2023), 30 January 2023 (Proceeding COR 2020 0021, Coroners Court of Victoria) exhibited in Court Book (filed 30 October 2023 in S ECI 2023 03164, Supreme Court of Victoria) ('Court Book'), 11806.

2 Veronica's family requested that the deceased be referred to by her first name and this was adopted throughout the trial of this proceeding by all parties.

3 Coroner's Report, 73 [213].

4 Coroners Act ss 4(1), (2)(a), (2)(c).

5 I note that adverse findings and comments in respect of the circumstances of Veronica's death were not limited to the period she was in custody at DPFC.

6 By this appeal, the appellant, Dr Sean Runacres, seeks to quash certain adverse findings made against him by the Coroner with respect to the circumstances of Veronica's death. The findings as to identity and medical cause of death are not disputed.

7 At the time of Veronica's death, the appellant, a registered medical doctor, was employed by Correct Care Australasia ('CCA'), the private entity which provided primary health services at DPFC. Dr Runacres conducted the initial medical assessment — referred to as the 'reception medical assessment' (the 'RMA') — of Veronica upon her arrival at DPFC on 31 December 2019. Shortly after completing this task, Dr Runacres left DPFC for the day. He had no further direct involvement with Veronica's care. What followed was, as the Coroner found, a series of failures in Veronica's medical care, ultimately leading to her death some 36 hours later.

APPEAL AGAINST A CORONER'S FINDINGS

The task of a coroner

8 Coroners are required to investigate a 'reportable death'.[6] Veronica's death was a 'reportable death' as it was unexpected, and occurred in Victoria where she was in custody.[7]

9 Under s 67 of the Coroners Act, the task imposed on a coroner investigating a reportable death is to make findings as to:

(a) the identity of the deceased;[8]

(b) the cause of the death;[9] and

(c) the circumstances in which the death occurred.[10]

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6 Coroners Act ss 14, 15.
7 Coroners Act ss 4(1), (2)(a), (2)(c).
8 Coroners Act s 67(1)(a).
9 Coroners Act s 67(1)(b).
10 Coroners Act s 67(1)(c).

10 Coroners are also empowered to:

(a) make comment on any matter connected with the death under investigation;[11] and

(b) make recommendations on any matter connected with the death.[12]

11 Whilst the Coroner has a mandatory obligation to make findings under s 67(1) if it is possible to do so,[13] there is no corresponding mandatory obligation on a coroner to make comments or recommendations.

12 As noted in the Coroner's Report,[14] the broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through investigation findings and by the making of recommendations — generally referred to as the coroner's prevention role.

Standing and subject matter of an appeal

13 This appeal is brought under s 83(2) of the Coroners Act which provides that 'an interested party may appeal against the findings of a coroner in respect of a death or fire after an inquest to the Trial Division of the Supreme Court constituted by a single judge.'

14 As such, the appeal is limited to the *findings* of the Coroner. There is no right of appeal against a coroner's comments or recommendations made in respect of a death.

15 The appellant is an interested party for the purposes of the Coroners Act because the Coroner granted him leave to appear as an interested party at the Inquest under s 56 of the Coroners Act.[15]

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11 Coroners Act s 67(3).
12 Coroners Act s 72(2).
13 See *Priest v West* (2012) 40 VR 521, [4] (Maxwell P and Harper JA).
14 See Coroner's Report, 34 [102].
15 Coroner's Report, 47 [139.7].

The nature of an appeal

16 Subject to s 87A of the Coroners Act, an appeal against a coroner's findings can be brought only on a question of law.[16]

17 In order to succeed in an appeal under s 87 of the Coroners Act, an applicant must identify an error of law in the Coroner's findings.

18 Section 87(1A) of the Coroners Act relevantly provides:

> An appeal on a question of law includes an appeal on the grounds that the finding which is appealed is against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made the finding.

Relief

19 The relevant relief that may be ordered by the Supreme Court in respect of this appeal is set out in s 87(4) which provides that:

> Subject to section 88, after hearing and determining the appeal, the Supreme Court may make any order that it thinks appropriate, including an order remitting the matter for re-hearing to the Coroners Court with or without any direction in law.

20 By his notice of appeal,[17] orders are sought by the appellant quashing certain findings made against him by the Coroner in relation to the circumstances of Veronica's death,[18] specifically:

(a) At [528] of the findings, that the appellant did not physically examine Veronica on 31 December 2019;

(b) At [520] of the findings, that the appellant recorded Veronica's weight inaccurately in the Medical Assessment Form (the 'MAF'); and

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16 Coroners Act s 87(1).

17 Notice of Appeal (filed 17 July 2023 in S ECI 2023 03164, Supreme Court of Victoria).

18 The Coroner's findings are set out in pages 67–290 of the Coroner's Report and collated in Appendix B.

(c) At [541] of the findings, that the appellant set in motion a chain of events in which Veronica's medical treatment and care was inadequate in an ongoing way.

21 The appeal primarily challenges the above findings of the Coroner on the basis that:

(a) the Coroner failed to correctly apply the relevant evidentiary standard, being the *Briginshaw v Briginshaw*[19] standard, in weighing all available evidence; and/or

(b) the findings are wrong in law in that they are against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made them.

22 There is a question in this appeal as to whether the matter raised in [541] of the Coroner's Report amounts to a statutory finding which is capable of being appealed. This is dealt with at [321]–[326] below.

THE RESPONDENT PARTIES

Coroners Court of Victoria

23 The respondent to the appeal, the Coroners Court of Victoria (the 'CCV') made submissions consistent with the principles set out in *R v Australian Broadcasting Tribunal; Ex parte Hardiman*.[20]

24 CCV's submissions[21] identified the relevant provisions of the Coroners Act and usefully set out a roadmap to the relevant documents.[22] It did not make submissions on the merits of the appeal.

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19 (1938) 60 CLR 336 ('*Briginshaw*').

20 (1980) 144 CLR 13 ('*Hardiman*').

21 Outline of Submissions on behalf of the Coroners Court of Victoria (filed 5 October 2023 in S ECI 2023 03164, Supreme Court of Victoria).

22 The material which was before the Coroner and which might be relevant to this appeal was extensive. The affidavit of CCV's Principal In-House Solicitor, Ms Samantha Brown, exhibited the relevant material, which of itself ran to over 12,000 pages.

Intervenors

25 By summons filed 4 October 2023, an application was made to intervene in the appeal on behalf of Aunty Donna Nelson, Veronica's mother, and James Leonard ('Percy') Lovett, Veronica's longtime partner.[23] Both Aunty Donna and Mr Lovett were interested parties in the proceeding before the Coroner.[24]

26 The application to intervene was not opposed by the appellant nor the respondent.

27 Applying the intervenor principles in *Bauer Media Pty Ltd v Wilson*,[25] I was satisfied that it was in the interests of justice to join the intervenors as parties to the appeal. I did so on the basis that they had a considerable interest in the proceedings as senior next of kin and as persons who participated fully in the Coroner's inquest, being separately represented, cross examining witnesses and having made submissions to the Coroner specifically with respect to the appellant.

28 I was of the view that their contribution as intervenors would be useful and different from the contribution of other parties and that their participation would not unreasonably interfere with the conduct of the proceeding. Given the *Hardiman* position of CCV, the intervenors' ability to act as contradictor and bring to bear a useful and constructive contribution was an important consideration.

29 Written and oral submissions were made on the intervenors' behalf on the merits of the appeal.[26] The emphasis of the intervenors' submissions was that there was no error by the Coroner in his findings, that he had correctly applied the *Briginshaw* test and that he had the benefit of seeing and hearing the whole of the evidence, thus allowing

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23 The Intervenors sought to make their application pursuant to r 64.10 of the *Supreme Court (General Civil Procedure) Rules 2015* (Vic) ('Rules'). Judicial Registrar Keith made orders on 4 October 2023 adjourning the application to intervene to the hearing of the appeal on 31 October 2023. The 'other matters' recorded that the Intervenors were to forthwith apply to intervene in the appeal by filing a summons and a supporting affidavit. The Affidavit of Ali Besiroglu (filed 4 October 2023 in S ECI 2023 03164, Supreme Court of Victoria) set out the factors relevant to the application to intervene.

24 Coroner's Report, 47 [139].

25 [2018] VSCA 68.

26 Submissions of Interveners (filed 4 October 2023 in S ECI 2023 03164, Supreme Court of Victoria); Transcript of the Proceedings (Supreme Court of Victoria, Quigley J, 31 October – 1 November 2023), 70–104 ('Trial Transcript').

him to make his own assessment of the veracity and reliability of the individual witnesses.

BACKGROUND AND SCOPE OF THE CORONER'S REPORT

30 The procedural history to this matter, which was not contested, was set out in the affidavit of Samantha Brown, Principal In-house Solicitor at CCV filed on behalf of the respondent.[27] Exhibit 'SB-1' to her affidavit produced a bundle exhibit of the relevant documents, including the Coroner's Report.

31 The documents held by CCV for the investigation and inquest are voluminous and only those parts which were deemed necessary for the purpose of this appeal were provided in the Court Book, which of itself ran to over 12,000 pages.

Scope of the Inquest

32 The extent of a coroner's powers are not free ranging and must be sufficiently connected with the death being investigated. The process by which the Coroner developed and finalised the scope of the investigation included consultation with interested parties.

33 The scope included:[28]

(a) the circumstances of Veronica's arrest and charge on 30 December 2019 by Victoria Police;

(b) the circumstances of Veronica's remand in custody and the application for bail made on 31 December 2019, including:

(i) the operation of the *Bail Act 1977* (Vic);

(ii) her appearance without legal representation; and

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27 Affidavit of Samantha Brown (filed 9 September 2023 in S ECI 2023 03164, Supreme Court of Victoria).

28 See Coroner's Report, 45–6 [138].

(iii) what Aboriginal and legal support services were offered and/or available to her at the Magistrates Court of Victoria;

(c) whether Veronica received adequate medical assessment, treatment and care while on remand at DPFC, in particular:

(i) whether there was adequate monitoring and observation of her;

(ii) why she was transferred to the Yarra Unit at DPFC;

(iii) whether there was an appropriate health management response provided to her;

(iv) whether there was an appropriate escalation of care response provided to her;

(v) whether the medical assessment, treatment and care was adequate for her as a woman with health issues including a drug dependency; and

(vi) the response of DPFC staff members immediately following the discovery of her body on 2 January 2020;

(d) the relevance of her Aboriginality, drug use and criminal antecedents to the decisions made in relation to her arrest on 30 December 2019 to her death on 2 January 2020;

(e) whether her treatment from the time of her arrest on 30 December 2019 to her death on 2 January 2020 was culturally competent;

(f) whether her death was preventable; and

(g) identification of any prevention opportunities.

Interested parties and witnesses

34 In the course of the investigation, the Coroner granted leave for 17 applicants (including the appellant) to appear as 'interested parties' in accordance with s 56 of the Coroners Act.[29]

35 The Coroner heard oral evidence from 19 witnesses (including the appellant) regarding the factual circumstances surrounding Veronica's death.[30] He also heard from five other witnesses who gave evidence speaking to the systems involved in Veronica's treatment whilst in custody.[31]

36 Section 57 of the Coroners Act permits a witness to object to giving evidence, or evidence on a particular matter, at an inquest on the grounds that the evidence may tend to prove the witness has committed an offence or is liable to a civil penalty. If the coroner determines that there are reasonable grounds for such an objection, the coroner must cause the witness to be given a certificate under s 57 of the Coroners Act. The effect of the certificate is that in any proceeding in a court[32] the evidence and any information, document or thing obtained as a direct or indirect consequence of the person having given evidence cannot be used against the person.[33]

37 The Coroner was satisfied that a certificate be granted to a number of witnesses, including the appellant.[34]

38 The inquest also received two tranches of concurrent expert evidence.[35] One tranche was relevant to medical questions and issues (the 'Medical Conclave')[36] and the other

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29 Coroner's Report, 47–8 [139].

30 Coroner's Report, 48–9 [142].

31 Coroner's Report, 49–50 [143]–[146]. These included the DPFC Governor Tracey Jones, CCA Chief Medical Officer Dr Foti Blaher, CCA Deputy CEO and Chief Nursing Officer Christine Fuller, forensic pathologist Dr Yeliena Baber and cultural expert Aunty Vickie Roach.

32 Or a proceeding before any person or body authorised by a law of Victoria or by consent of the parties to hear, receive and examine evidence.

33 Coroners Act s 57(7). The privilege granted by s 57(7) does not apply to a criminal proceeding in respect of the falsity of the evidence.

34 Eight witnesses were granted a certificate under s 57 of the Coroners Act. See Coroner's Report, 51–2 [150].

35 Coroner's Report, 52–64 [152]–[178].

36 The Medical Conclave comprised 13 expert witnesses, each of whom provided expert reports. See Coroner's Report, 53–5 [157]–[158].

in relation to administration of justice issues (the 'Administration of Justice Conclave').[37]

39 The Coroner conducted a view of the reception area, medical centre and Cell 40 of the Yarra Unit at DPFC.[38] The extensive evidence before the Coroner included the court file, coronial brief, inclusive of the materials sought, obtained and received by CCV throughout the investigation and inquest, and the evidence adduced during the inquest as well as written submissions of counsel.[39]

Draft Findings

40 After the conclusion of the evidence, on 30 May 2022 CCV circulated to the interested parties the Coroner's draft findings and recommendations ('Draft Findings')[40] and set a timetable for submissions in response.[41]

41 Dr Runacres was represented during the inquest by the legal practitioners acting for his employer, CCA, up until the time when the Draft Findings were presented to the participating parties. Leave was thereafter granted for him to be separately represented given the serious allegations made against him in the Draft Findings.

Runacres' Response to the Draft Findings

42 In November 2022, written submissions were made to the Coroner on the appellant's behalf responding to the:[42]

(a) Draft Findings;

(b) final submissions made by Counsel Assisting dated 6 September 2022; and

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37 The Administration of Justice Conclave comprised 10 expert witnesses, each of whom provided expert reports or outline of opinion. See Coroner's Report, 55–6 [159]–[160].

38 Coroner's Report, 64–5 [179]–[181]. A plan of the locations was also part of the evidence before the Coroner and relied upon before the Court in this proceeding.

39 Coroner's Report, 65 [182].

40 Draft Key Findings and Recommendations, Court Book, 11198.

41 Email from S Brown dated 30 May 2022 re Inquest into the passing of Veronica Nelson COR 20/21 - Draft Findings (including attachments), Court Book, 11197.

42 Submissions on Behalf of Doctor Sean Runacres (An Interested Party) (filed in COR 2020 0021, dated 21 November 2022) ('Dr Runacres' Submissions to the Coroner'), Court Book, 11753–805. The submissions focussed on draft findings 15–17 and 22–3 insofar as they related to Dr Runacres.

(c) submissions of interested parties insofar as they related to Dr Runacres specifically and the care he provided to Veronica on 31 December 2019.

43 The submissions addressed, in particular, the allegations that:[43]

(a) Dr Runacres did not conduct a physical examination of Veronica but falsely recorded an entry suggesting that he did;

(b) it was not conveyed to Dr Runacres and/or that he did not reasonably believe that Veronica weighed 40.7 kg at the time he assessed her but falsely recorded an entry suggesting that was her weight; and

(c) Dr Runacres' professional management of Veronica so far departed from what could have been expected of a medical practitioner with his training and experience that he can be found to have contributed to her death.

Revisions made in response to Runacres' Submissions to the Coroner

44 As previously noted, the Coroner published his final Report containing his statutory findings and recommendations on 30 January 2023.

45 The ultimate findings which relate to the appellant in the Coroner's Report are notably different to the draft versions of the findings which were set out in the Draft Findings.

46 In the Coroner's Report, there is no direct allegation or finding of falsity in the medical record as to the recording of Veronica's weight in the terms used in the Draft Findings (as set out at [43(b)] above). The relevant comparison is the finding at [520] of the Coroner's Report.[44]

47 Similarly, the draft finding that the appellant did not conduct a physical examination of Veronica but *falsely* recorded an entry suggesting he did (as set out at [43(a)] above)

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43 Dr Runacres' Submissions to the Coroner, Court Book, 11756 [10].

44 This finding is also repeated at Item 20 in Appendix B of the Coroner's Report.

is not contained in the final Coroner's Report. The relevant comparison is at [528] of the Coroner's Report.[45]

48 In terms of the finding that Dr Runacres' professional management of Veronica departed from the expected professional standards such that he contributed to her death, no direct allegation of this severity is found in the Coroner's Report. The closest finding in the Coroner's Report is at [540], which is not a finding challenged in this appeal save by reference to the failure to physically examine Veronica which is repeated in part of the finding at [528] of the Coroner's Report.

49 There is a finding at [542] of the Coroner's Report which, whilst not specifically naming the appellant, would likely include him (and others) by reference to the timing of when the Coroner found Veronica should have been transferred to hospital. This is described as an 'ongoing failure' which is said to have causally contributed to her death. The finding at [542] is not a finding challenged in this appeal.

50 What is challenged is the Coroner's observation at [541] (which has no equivalent finding in the Summary of Findings in Appendix B of the Coroner's Report) that makes reference to the appellant's 'failure to properly utilise' the opportunity in the RMA which 'set in motion a chain of events in which [Veronica's] medical treatment and care was inadequate in an ongoing way.'

THE CORONER'S FINDINGS

51 As noted above, the Coroner set out in Appendix B to his Report a summary of his statutory findings.

52 The findings challenged by the appellant are not the entirety of the adverse findings or observations made about his conduct and involvement in Veronica's medical assessment and care.

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45 This finding is also repeated at Item 21 in Appendix B of the Coroner's Report.

53 The appellant seeks to set aside the three specific following findings found at [528], [520] and [541] of the Coroner's Report and, if set aside, make consequential amendments to other paragraphs of the Report.

Finding at [528] of the Coroner's Report

54 The first finding challenged is at [528] of the Coroner's Report and is recorded as Item 21 in Appendix B of the Coroner's Report:

> On the basis of the evidence canvassed above, I find that a physical examination of Veronica was not conducted on 31 December 2019, although three examinations were recorded as having been undertaken in the MAF and Initial Appointment Notes by Dr Runacres.

55 If this finding is set aside, consequential amendments were also sought to [540] and [696] of the Coroner's Report which are said to be dependent on it (footnotes omitted):[46]

> [540] I find Dr Runacres' medical assessment and treatment of Veronica on 31 December 2019 was inadequate. Dr Runacres failure to physically examine Veronica, plan her ongoing care and maintain accurate records are significant departures from reasonable standards of care and diligence expected in medical practice.
>
> […]
>
> [696] Dr Runacres said that he did not take care to ensure that these notes were accurate because he did not believe that other staff would ever look at them. He left notes in error on Veronica's file, often failing to update pre-populated material. He also recorded an inaccurate weight in Veronica's MAF and recorded physical examinations that were not performed. Some of these errors were critical in Veronica's care – particularly the incorrect recording of her weight – as they were relied upon by Dr Brown.

46 The first is listed as a finding at Item 22 in Appendix B. The latter is not listed in Appendix B.

Finding at [520] of the Coroner's Report

56 The second finding challenged is at [520] of the Coroner's Report and is recorded as Item 20 in Appendix B:

> On the basis of Dr Baber's[47] evidence, I find that Veronica weighed around 33kg at the time of her reception medical assessment and that the weight recorded by Dr Runacres in the MAF was inaccurate.[48]

57 If this finding is set aside, a consequential amendment was also sought to the finding at [696] of the Coroner's Report (set out at [55] above) which is said to be dependent on it.

Finding at [541] of the Coroner's Report

58 The third finding sought to be challenged is at [541] of the Coroner's Report (footnotes omitted):

> Dr Runacres was the health professional responsible for identifying at reception whether Veronica was fit to be held in an unobserved cell. The reception medical assessment is to be a comprehensive health assessment and offered the best opportunity in the prison reception process for the extent of Veronica's unwellness to be identified, recorded, treated and escalated. Dr Runacres' failure to properly utilise this opportunity set in motion a chain of events in which her medical treatment and care was inadequate in an ongoing way.[49]

59 There is no corresponding Item listed in the Summary of Findings in Appendix B which refers to this paragraph of the Coroner's Report as a 'finding'.

THE GROUNDS OF APPEAL

60 The notice of appeal raises six questions of law or alleged errors by the Coroner in his assessment of the evidence upon which he made the specific findings challenged by appellant. In particular:

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47 Forensic Pathologist, Dr Yeliena Baber ('Dr Baber') gave expert evidence about the medical cause of Veronica's passing.

48 Grounds 4 and 5 relate to this finding.

49 Ground 6 relates to this finding.

(a) whether the Coroner erred in finding that it was 'not open' to him to reach his conclusion at [526] of the Report.[50]

(b) in reaching his findings at [528] and [520], whether the Coroner failed to apply the *Briginshaw* standard in weighing all available evidence, bearing in mind the gravity of that finding against the appellant and the inherent unlikelihood of the conduct found;[51] and

(c) whether the findings at [528], [520] and [541] are wrong in law in that they are 'against the evidence and the weight of the evidence' to the extent that no reasonable coroner could have made it.[52]

61 Each question of law has a corresponding Ground of review.

Ground 1

62 Ground 1 (and the corresponding Question 1) relates to whether the Coroner erred in law in determining at [526] of the Report that it was 'not open' to him to find that the appellant could have conducted physical examinations of Veronica in the reception cell.

63 This statement at [526] of the Coroner's Report is not identified by the notice of appeal as a 'finding' subject to appeal. However, it appears to be a conclusion on the evidence upon which the appealed finding at [528] is based.

64 The particulars alleged that:

(a) the Coroner based his determination on the appellant's evidence;[53]

(b) the Coroner earlier found that the appellant was an unreliable witness;[54]

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50 Ground 1.
51 Grounds 2 and 4.
52 Grounds 3, 5 and 6.
53 Coroner's Report, [526].
54 Coroner's Report, [495].

(c) however, the CCTV footage was capable of supporting an inference that physical examinations could have been performed in the reception medical cell; and

(d) the Coroner did not consider the other relevant evidence, including the CCTV evidence in addition to the appellant's evidence, and so failed to weigh all available evidence prior to reaching this determination.

Ground 2

65 Ground 2 (and the corresponding Question 2) relates to whether, in finding the appellant did not physically examine Veronica on 31 December 2019 at [528] of the Report, the Coroner failed to apply the *Briginshaw* standard in weighing all available evidence, bearing in mind the gravity of the finding against the appellant and the inherent unlikelihood of the conduct found.

66 The particulars allege that, in addition to those matters set out under Ground 1, the finding that the appellant did not physically examine Veronica on 31 December 2019 is inherently unlikely and is not supported by evidence commensurate with the gravity of allegation. The finding was said to be based on inexact proofs, indefinite testimony and/or indirect inferences:

(a) the appellant's notations in the JCare system ('JCare')[55] corroborate the fact that physical examinations were conducted as noted. That there were other inaccuracies in the JCare notes is not sufficient evidence from which to infer the entries concerning the examinations were also inaccurate;

(b) the appellant gave clear evidence that he does not make up data recorded in medical records;[56]

(c) Nurse Stephanie Hills ('RN Hills') gave evidence that she could not recall any time in the 60 or 70 shifts she had worked with Dr Runacres at the DPFC that

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55 Being the Justice Health medical record which in December 2019 was an electronic record.

56 Coroner's Report, [524]; Transcript of Proceedings, *Inquest into the Passing of Veronica Nelson* (Coroners Court of Victoria, Coroner McGregor, 26 April – 27 May 2022), 1020 ('Inquest Transcript').

he had made entries in the form without conducting the corresponding examination;[57] and

(d) the Coroner accepted that the dispute between RN Hills and Dr Runacres was significant and 'central' to the findings about the appellant's care and treatment of Veronica and his role, if any, in her passing,[58] that RN Hills' evidence was inaccurate in several important respects,[59] and that these inaccuracies ought to have led the Coroner to view RN Hills' evidence as inexact, and to treat it with caution, particularly given the centrality of the dispute between RN Hills and Dr Runacres to the Coroner's ultimate findings.

67 The particulars also allege that underpinning the challenged finding is an implicit finding that Dr Runacres falsified the notes in the JCare records in relation to physical examinations. Individually and in combination, these findings are likely to have an extremely deleterious effect upon Dr Runacres' professional standing, reputation and employment prospects. These findings demanded evidence of such weight, cogency and clarity that were commensurate with their gravity and that the evidence was not of sufficient weight, cogency and clarity to permit the Coroner to find that the appellant did not conduct a physical examination of Veronica.

68 The particulars further allege that the Coroner should have but failed to consider the submission made on behalf of the appellant that no motive or reason was advanced to explain why the appellant would have failed to conduct an examination and contemporaneously falsified records to make it appear that he had done so and that the Coroner failed to give sufficient weight to the presumption of Dr Runacres' innocence.

Ground 3

69 Ground 3 (and the corresponding Question 3) relates to whether the finding that the appellant did not physically examine Veronica on 31 December 2019 at [528] of the

57 Inquest Transcript, 661, 676–77.
58 Coroner's Report, [443].
59 Coroner's Report, [477].

Report is wrong in law in that it is against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made it.

70 To support this ground the appellant relied on the particulars set out in respect of Grounds 1 and 2.

Ground 4

71 Ground 4 (and the corresponding Question 4) relates to whether, in finding that the appellant inaccurately recorded the weight of Veronica in the MAF at [520] of the Report, the Coroner failed to apply the *Briginshaw* standard in weighing all available evidence, bearing in mind the gravity of the finding against the appellant and the inherent unlikelihood of the conduct found.

72 The particulars in support of this ground were:

(a) the Coroner accepted the evidence of RN Hills that Veronica was not weighed during the RMA and that there was no evidence that another person weighed Veronica;[60]

(b) the Coroner accepted Dr Baber's evidence that Veronica weighed around 33 kgs at the time of her RMA;[61]

(c) accordingly, the Coroner's finding amounts to an implicit finding that the appellant falsified the weight recorded in the MAF which is a serious adverse finding based on inexact proofs, indefinite testimony and/or indirect inferences. As against this, the following evidence supports a contrary view:

(i) the existence of a note in the MAF supports an inference that Veronica was in fact weighed at some point before or during her RMA;

60 Coroner's Report, [519].
61 Coroner's Report, [520].

(ii) the appellant gave clear evidence that he does not make up data entered into medical records;[62]

(iii) RN Hills gave evidence that despite having worked together with Dr Runacres on over 60 or 70 shifts at DPFC, she could not recall an instance of Dr Runacres making entries in the form without having performed the corresponding examination;[63]

(iv) apart from the appellant's notes, there was no other objective evidence before the Coroner about Veronica's actual weight at the time of her RMA;

(v) the Coroner did not address the evidence that Veronica might have lost 5 kg of fluid from her stomach and bladder, which Dr Baber testified was theoretically possible, though not very likely,[64] and there was no further expert evidence before the Coroner on this point;

(vi) the evidence from RN Hills that Veronica was not weighed during the RMA is not capable of establishing the proposition that she was not weighed at any other time during her stay at DPFC;

(vii) the CCTV evidence did not capture all of Veronica's movements while at DPFC so could not support a conclusion that she was not weighed at any other time; and

(viii) the Coroner accepted that the dispute between Dr Runacres and RN Hills was significant and 'central' to the findings about the appellant's care and treatment of Veronica, and his role, if any, in her passing. The Coroner accepted there were inaccuracies in RN Hills' evidence in several important respects.[65] These inaccuracies ought to have led the Coroner to view RN Hills' evidence as inexact, and to treat

62 Coroner's Report, [524].
63 Inquest Transcript, 661, 676–7.
64 Inquest Transcript, 2079.
65 Coroner's Report, [477.1], [477.2].

it with caution, particularly given the centrality of the dispute between RN Hills and Dr Runacres to the Coroner's ultimate findings.

(d) The finding is likely to have an extremely deleterious effect upon Dr Runacres' professional standing, reputation and employment prospects and required evidence of such weight, cogency and clarity which was commensurate to its gravity. The evidence was not of sufficient weight, cogency or clarity to permit the Coroner to find that Dr Runacres falsely recorded Veronica's weight.

(e) The Coroner should have, but failed to consider the submission that no reason or motive was advanced to explain why the appellant would have falsely recorded Veronica's weight.

(f) In making this finding, the Coroner did not give sufficient weight to the presumption of innocence.

Ground 5

73 Ground 5 (and the corresponding Question 5) relates to whether the finding that the appellant inaccurately recorded the weight of Veronica in the MAF at [520] of the Report is wrong in law in that it is against the evidence and the weight of the evidence to such an extent that no reasonable Coroner could have made it.

74 The appellant adopted the particulars for Ground 4 in support of Ground 5.

Ground 6

75 Ground 6 (and the corresponding Question 6) relates to whether the finding at [541] of the Report that the appellant set in motion a chain of event which Veronica's medical treatment and care was inadequate in an ongoing way, is wrong in law in that it is against the evidence and the weight of the evidence to such an extent that no reasonable Coroner could have made it.

76 In support of this ground, the appellant argued that:

(a) the decisions and conduct of others involved in Veronica's medical treatment and care after the RMA were made independently of the appellant's management which was not a relevant cause of such decisions and conduct;

(b) Dr Runacres was not responsible for Veronica's care after the RMA, was not made aware of her deterioration subsequent to her RMA and had no opportunity to provide further care in light of the change to her presentation;

(c) the Coroner's findings at [645] of the Report in relation to the systematic failings of CCA, Corrections Victoria ('CV'), and Justice Health and the manner in which those failings causally contributed to Veronica's death is inconsistent with the finding that it was his care and conduct which set in motion the chain of events in which Veronica's care and treatment was inadequate in an ongoing way; and

(d) this was a serious adverse finding which is based on inexact proofs, indefinite testimony and/or indirect inferences.

SUBMISSIONS

Appellant's submissions

77 The appellant made oral and written submissions consistent with the particulars of the grounds set out above.

78 At trial, parts of the CCTV footage were played to the Court which showed Veronica's arrival at DPFC, her entry into the reception cell, her moving towards a shower cubicle and emerging in a prison tracksuit, her movement towards the medical treatment rooms (in part) and footage of her in the medical holding cell.[66]

[66] Affidavit of Mia Campbell (filed 17 July 2023 in S ECI 2023 03164, Supreme Court of Victoria) ('Affidavit of M Campbell'), Exhibit MC3 enclosing CCTV footage marked 'CCTV C300', 'CCTV C318', 'CCTV C319', 'CCTV C321'.

79 The appellant accepted that, in order to succeed in this appeal under s 87 of the Coroners Act, an error of law in the Coroner's findings must be identified.

80 It was also accepted that all coronial findings 'must be made based on proof of relevant facts on the balance of probabilities and in determining those matters the principles enunciated in *Briginshaw* apply.'[67]

81 The appellant accepted that the Coroner may make findings that are dependent on drawing inferences. It was argued that before any inference can be accepted, it must be the more probable inference drawn from the whole of the evidence. A more probable inference must be more than an inference of equal degree of probability with other inferences so as to avoid guesswork or conjecture.[68]

82 The appellant accepted that other findings adverse to his interest were appropriate and are not challenged by him.[69] He does not, for example, challenge the more general finding of inaccurate record keeping or the more generally directed adverse findings as to the inadequacy of assessment and care, and systemic and entrenched adverse processes and attitudes towards prisoners' care in the context of opioid addiction. He challenges the direct criticism of specific aspects of his own assessment and care of Veronica.

83 There are adverse observations made regarding the appellant's assessment and care at [539] of the Coroner's Report which states that, based on the evidence, he was satisfied that:

(a) Dr Runacres' RMA of Veronica was not comprehensive and his records of it were inaccurate;

(b) Dr Runacres provided no plan for Veronica's ongoing management and ought to have done so; and

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67 *Mortimer v Coroners Court of Victoria* [2022] VSC 437, [89] citing *Re State Coroner; Ex parte Minister for Health* (2009) 261 ALR 152 and *Briginshaw*.

68 *Lithgow City Council v Jackson* [2011] HCA 36, [93]–[94] (per Crennan J).

69 For example, the finding that Veronica should have been transferred to hospital at Coroner's Report, [542], [778] which is listed as Item 23 in Appendix B. See Trial Transcript, 9–10.

(c) Veronica was so unwell at the time of her RMA and her presentation warranted transfer to hospital.

84 The Coroner's finding at [540] refers to his conclusion that the appellant did not physically examine Veronica as one of the reasons why he formed the view that his medical assessment and treatment of Veronica on 31 December 2019 was inadequate. The finding that no physical examination was undertaken is found at [528] and the accuracy of recording Veronica's weight at [520]. I have understood the challenge to [540] is only to that part which would be consequentially affected by the quashing of the finding at [528], being the reference to no physical examination being undertaken.

85 At [542], which is not subject to challenge, the appellant would be included in the group of CCA staff members against which adverse comments and findings are made in respect of the failure to transfer Veronica to hospital and that the ongoing failure causally contributed to her death.

86 At [696], which is challenged as associated with the finding at [528] insofar as it refers to notations recorded relating to physical examinations not performed and the recording of an inaccurate weight, the Coroner notes that, in the context of a finding at [700], the medical records maintained by CCA staff were incomplete and in parts inaccurate and misleading concerning Veronica's medical history and clinical presentation whilst at DPFC between 31 December 2019 and 2 January 2020.

87 In respect of Dr Runacres specifically, the Coroner goes on to say at [696], noting that this paragraph is also challenged as a consequence of the challenge to the finding at [528] (footnotes omitted):[70]

> Dr Runacres said that he did not take care to ensure that his notes were accurate because he did not believe that other staff would ever look at them. He left notes in error on Veronica's file, often failing to update pre-populated material. He also recorded an inaccurate weight in Veronica's MAF and recorded physical examinations that were not performed. Some of these errors were critical in Veronica's care - particularly the incorrect recording of her weight – as they were relied upon by Dr Brown.

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70 Coroner's Report, 241.

88 The observations on the evidence which led to the finding by the Coroner that Veronica's death was preventable includes commentary adverse to Dr Runacres as it is based on the evidence accepted by the Coroner that Veronica's death or condition could have been addressed and corrected upon transfer to hospital where she would have received intravenous fluids and electrolyte replacement. The Coroner accepted that Veronica's death was preventable, and on the balance of probabilities would have been prevented if she had been transferred to hospital at any time between her arrest and her passing.[71]

89 As noted above, the focus of the appellant's submission was on the application of the *Briginshaw* standard to the evidence before the Coroner.

90 The rules of evidence do not apply to inquests.[72] The appellant submitted that that does not displace the common law requirement that 'information on which a court or tribunal may act, however obtained, must form a proper basis for the decision.'[73] Such information can only form the proper basis for a decision if it is 'logically probative, reliable and relevant and the parties have been given an adequate opportunity to comment on it.'[74]

91 The appellant accepted that the ultimate findings of the investigation and the inquest are quintessentially matters for the Coroner and that an error of law will not result from a finding of fact about a matter upon which reasonable minds might have differed after examining all the available evidence.[75]

92 Additionally, it was accepted by the appellant that the weight accorded to relevant factors in reaching an evidentiary conclusion is not ordinarily an error of law, nor is the relative weight given to various parts of the evidence.

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71 Coroner's Report, [827]–[831].

72 Coroners Act s 62.

73 *R v Deputy Industrial Industries Commissioner; Ex parte Moore* [1965] 1 QB 456, 476; *Wajnberg v Raynor and Melbourne and Metropolitan Board of Works* [1971] VR 665, 678–9; *Secretary, Department of Human Services v Sanding* (2000) 36 VR 221.

74 *R v Deputy Industrial Industries Commissioner; Ex parte Moore* [1965] 1 QB 456, 476; *Wajnberg v Raynor and Melbourne and Metropolitan Board of Works* [1971] VR 665, 678–9; *Secretary, Department of Human Services v Sanding* (2000) 36 VR 221.

75 *Thales v Australia Limited v The Coroners Court of Victoria* [2011] VSC 133, [59].

93 An error based on a conclusion not reasonably open to the decision maker is a species of error specifically contemplated under s 87(1A) of the Coroners Act, which provides:

> An appeal on a question of law includes an appeal on the grounds that the finding which is appealed is against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made the finding.

94 I observe that the submission about the weight and reliability of the evidence and the application of the *Briginshaw* standard was also submitted to the Coroner in response to the Draft Findings. I have the benefit of the detailed submissions made on Dr Runacres' behalf to the Coroner on the Draft Findings. Given the modification made to the Draft Findings and the discussion of matters raised on the appellant's behalf throughout the Coroner's Report, I discern that the Coroner's consideration of these matters has been incorporated into his reasoning recorded in the Coroner's Report.

Intervenors' submissions

95 The Intervenor's submissions can be summarised as set out below:

(a) Dr Runacres was represented during the investigation and at the inquest by way of employer and later independently.

(b) The appeal re-agitates matters of fact properly considered and determined by the Coroner in the first instance.

(c) Unlike this Court, the Coroner has the advantages of observing each witness give *viva voce* evidence, including the appellant and RN Hills and was thus best placed to assess the reliability and credibility of the witnesses who appeared and to consider the conflicting evidence.

(d) The Coroner's findings contain extensive analysis and comparison between conflicting evidence of Dr Runacres and RN Hills.

(e) In his oral evidence, Dr Runacres steadfastly maintained he had no recollection of Veronica and prepared his statement and gave his oral evidence relying only

on his notes. That concession was an important factor in which to consider the rest of his evidence, and consequently its reliability or otherwise.

(f) Dr Runacres' reliance on his notes then and now provide a questionable evidentiary foundation.

(g) It was not in dispute, nor could it be disputed, that the notes contained multiple inaccuracies. Reference was made to the Inquest Transcript.[76]

(h) The inaccuracies and shortcomings of Dr Runacres' notes are compounded by the failure of Dr Runacres to note basic matters regarding Veronica's medical history, including the recurrent vomiting and evident malnutrition.

(i) Dr Runacres 'remarkably' gave evidence that he did not consider the notes would be read by other medical practitioners as an excuse for his errors or the incompleteness of the notes.[77]

(j) The evidence of Dr Runacres was negatively contrasted with that of RN Hills. RN Hills' evidence was that she remembered Veronica and what occurred during Dr Runacres' medical consultation, she was a relevant eyewitness who was present at that consultation and she did not suffer the same memory recall issues as Dr Runacres. It was submitted that this is a fundamental tool of assessing reliability. She was subject to robust cross-examination and demonstrated that she was a reliable witness.

(k) RN Hills' evidence before the Coroner was that she made notes after Veronica's passing which were subsequently lost. This evidence was accepted by the Coroner.

(l) The Coroner's assessment of RN Hills' oral evidence was that it was 'spontaneous and appeared to come from genuine memory and recollection'.[78]

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76 1071–2.
77 Inquest Transcript, 982, 985.
78 Coroner's Report, [464].

In the circumstances, based on the evidence that the Coroner saw and heard, he was entitled to come to that conclusion.

(m) With respect to Dr Runacres' evidence, the Coroner concluded at [493]–[495]:

> In fact, I find his inability to provide any evidence of independent recollection to be extremely convenient, given the competing accounts of other DPFC staff members and objective evidence indicating Veronica was very unwell at that time. His evidence on this point was uncorroborated, and at times self-serving and implausible.
>
> I also note, that on his own account, Dr Runacres' evidence was wholly reconstructed from his notes (which he ultimately admitted were unreliable) and retrospectively reviewed CCTV footage (which prompted no recollection).
>
> On the weight of the available evidence, I am satisfied that Dr Runacres was an unreliable witness. To the extent there is inconsistency, I prefer the evidence of RN Hills.

(n) The intervenors' submissions criticised the appellant's submissions as failing to grapple with what was said to be this essential finding, accepting the evidence of RN Hills over that of Dr Runacres. This central finding, based on the evidence, was open to the Coroner and he provided reasoning based on the evidence as to his conclusions.

(o) Further, the appellant's submissions ignore the fact that Dr Runacres himself did not give evidence that he actually did weigh or conduct a physical examination of Veronica (or even may have done these things) otherwise than in the presence of RN Hills.

(p) The only evidence that Dr Runacres weighed Veronica or conducted any physical examination of her at all were his clinical notes, the veracity and reliability of which were reasonably rejected by the Coroner and ultimately accepted by the appellant in his evidence as unreliable.

(q) In the context of finding that the JCare notes were inaccurate, and once the Coroner accepted that RN Hills was a credible and truthful witness, it was open and logical for the Coroner to conclude that Dr Runacres' evidence was untrustworthy and his medical treatment of Veronica inadequate.

(r) Careful analysis demonstrates the Coroner properly considered all matters and once the evidence demonstrated that the appellant's account was predicated on clinical notes that he himself accepted were unreliable, the Coroner was entitled to reject the appellant's evidence as unreliable. The Coroner also had other cogent, reliable evidence, primarily from RN Hills, which undermined that of Dr Runacres. In those circumstances, the Coroner was entitled to make findings that he did to the standard he did.

(s) The Court should be clear to identify that which is proper comment by the Coroner as opposed to a finding.

LEGAL PRINCIPLES TO BE APPLIED TO THE EVIDENCE

Briginshaw standard

96 The parties all referred to and relied on the applicability of the principles in *Briginshaw*. They differ as to the result that the application of what has come to be referred to as the '*Briginshaw* standard' means to the evidence in this proceeding.

97 It is non-controversial that all coronial findings must be made on proof of relevant facts on the balance of probabilities, and in determining those matters the principles enunciated in *Briginshaw* apply.[79]

98 The Coroner summarised the key facets of the *Briginshaw* test at [118] of his Report (footnotes omitted):

> Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demand a weight of evidence commensurate with the gravity of the facts sought to be proved. Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence. What must be given to the presumption of innocence.

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79 *Mortimer v Coroners Court of Victoria* [2022] VSC 437, [89] citing *Re State Coroner; Ex parte Minister for Health* (2009) 261 ALR 152 and *Briginshaw*.

99 The appellant noted that, at [119] and [443] of the Coroner's Report, the Coroner acknowledged that standard and said that he had paid due regard to it in reaching adverse findings against individuals.

100 Notwithstanding the statement, the appellant argues that the evidence in respect of the findings at [520] and [528] of the Report[80] was 'not sufficiently clear or cogent to enable such satisfaction under the heightened standard of proof'.[81]

101 The intervenors argued that the Coroner recognised that the *Briginshaw* standard of proof applied to adverse findings, including those made against the appellant, but that this did not displace the civil standard of proof, being the balance of probabilities explained by Justice Gordon in *Re Day*:[82]

> This does it does mean that the standard of persuasion is any higher than the balance of probabilities. It does mean that the nature of the issue necessarily affects the process by which the reasonable satisfaction is reached.
>
> […]
>
> The tribunal must feel an actual persuasion of the occurrence or existence of a fact before it can be found. Where direct proof is not available and satisfaction of the civil standard depends on inference, "there must be something more than mere conjecture, guesswork or surmise" – there must be more than "conflicting inferences of equal degrees of probability so that the choice between them is [a] mere matter of conjecture". An inference will be no more than conjecture unless some fact is found which positively suggests, or provides a reason in the circumstances particular to the case, that a specific event happened or a specific state of affairs existed.

102 I am satisfied that the Coroner well understood the task of weighing the evidence that he was required to undertake. This does not mean that he must be satisfied that all the evidence be one way. In any contest of evidence there will be evidence of greater or lesser relevance, objectivity and persuasion. The Coroner had the benefit of observing all of the key witnesses, reference to the relevant documents and extensive submissions on behalf of the interested parties on the cogency and reliability of the evidence. Ultimately, the finding of facts and the statutory findings as to

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80 Being the complaint under Grounds 2 and 4.

81 Amended Appellant's Outline of Submissions (filed 26 September 2023 in S ECI 2023 03164, Supreme Court of Victoria), [11] 9 ('Appellant's Amended Submissions').

82 [2017] HCA 2, [15], [18] (footnotes omitted).

circumstances of death which is in issue here are matters of which he needed to be satisfied. He expressly said that he was so satisfied and that he formed the view in accordance with the *Briginshaw* standard where his findings adversely affected a party.

103 Where the Coroner drew inferences, I am of the view that those inferences were soundly based. By and large, the submission which suggested that alternatives were not considered and were open and possible, in my view, were speculative. In particular the suggestion by the appellant that the physical examination could have occurred in the reception cell in one minute and 34 seconds is itself one example of unacceptable speculation. The suggestion that Veronica could legitimately lose almost 19% of her body weight in 36 hours is another.

104 I return to this issue below where each of the appellant's grounds is considered.

Legal unreasonableness

105 As noted above, this appeal is confined to a question of law though the findings challenged by the appellant are based on findings of fact. On one view, the basis of the appeal could be characterised as a challenge to the facts found and as a consequence there would be no appeal jurisdiction enlivened.

106 However, the grounds raise the question of the process by which the Coroner formed his view of the facts. Section 87(1A) of the Coroners Act provides that a question of law includes 'an appeal on the grounds that the finding which is appealed against is against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made the finding'.

107 The amended explanatory memorandum to the bill for the *Justice Legislation Miscellaneous Amendment Act 2018* (Vic) which inserted subsection (1A) to s 87 explained that the purpose for adding this new subsection was to:

> clarify that an appeal on a question of law includes an appeal on the ground that a coroner's finding is against the evidence and the weight of evidence to such an extent that no reasonable coroner could have made the finding. This wording is intended to reflect the concept of "*Wednesbury* unreasonableness"

> and does not seek to expand or otherwise alter the scope of appeal rights under Part 7 of the **Coroners Act 2008**. Such appeals remain limited to an appeal on a question of law.

108 Thus, the task for the Court on appeal is to consider the evidence before the Coroner and his conclusions and determine whether the Coroner's findings under challenge are 'against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made the finding'. This task is not one which empowers the Court to substitute the Coroner's findings with its own view of the evidence. That would be to stray into an impermissible merits review.[83]

109 The explanatory material clarifies that an appeal on a question of law may be brought on grounds consistent with the principles embodied in the concept of *Wednesbury* unreasonableness.[84] As such, the Coroners Act suggests the bar is a high one.

110 The earlier observations of the *Wednesbury* unreasonableness concept were expressed in terms that required the decision to be 'manifestly unreasonable',[85] one so devoid of any plausible justification that no reasonable person could have reached it. The decision would be unlawful as an unreasonable exercise of legislative power.[86] Unreasonableness can be made out, or a decision properly classified as manifestly unreasonable, because it defies comprehension, it is obvious that the decision maker acted perversely, or that there was manifest illogicality in arriving at the decision. This includes there being illogical findings or inferences of fact unsupported by probative material or logical grounds.[87] The Court will intervene where there is an absence of any foundation in fact for the fulfillment of the conditions upon which the existence of the power depends.

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83 *Minister for Immigration and Citizenship v Li* (2013) 249 CLR 332, [66] (Hayne, Kiefel and Bell JJ); *Minister for Immigration and Border Protection v Stretton* (2016) 237 FCR 1, [8], [12] (Allsop CJ), [58] (Griffiths J); *Minister for Immigration v Eden* (2016) 240 FCR 158, [59].

84 Being the formulation of the administrative law standard of 'unreasonableness' enunciated in *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223 ('*Wednesbury*').

85 *Minister for Aboriginal Affairs v Peko-Wallsend Ltd* (1986) 162 CLR 24, 41 (per Mason J).

86 See *Li*, [26], [29] (French CJ), [63] (Hayne, Kiefel and Bell JJ) and [88] (Gageler J); *Eden*, [58]; *Stretton*, [4] (Allsop CJ), [53] (Griffiths J).

87 *East Melbourne Group Inc v Minister for Planning* (2008) 23 VR 605, [183]–[184].

111 The contemporary principles applicable to legal unreasonableness under Australian law are those discussed by the High Court in *Minister for Immigration and Citizenship v Li* ('*Li*')[88] and more recently in *Minister for Immigration and Border Protection v SZVFW* ('*SZVFW*').[89] In *Li*, the High Court said that legal unreasonableness in Australia is not confined to *Wednesbury* unreasonableness, being a concept which encapsulates what is in effect an 'irrational if not bizarre decision'.[90] The modern exposition of the legal unreasonableness concept distilled in *Li* captures a decision or conclusion 'which lacks evident and intelligible justification.'[91] This exposition was reiterated in *SZVFW*.[92]

112 In *Minister for Immigration v Eden* ('*Eden*')[93] the Full Court of the Federal Court considered the relevant principles in relation to legal unreasonableness.[94] The principles were the subject of a detailed analysis in an earlier decision of that Court in *Minister for Immigration and Border Protection v Stretton*.[95] In *Eden*, the Court's summary of the principles were set out in a few short propositions at [58]–[65] and, insofar as they can be applied to the concept of unreasonableness in s 87 of the Coroners Act, I observe that there is a clear legislative intention that in undertaking the assessment of the evidence in order to make statutory findings, a coroner must exercise the power reasonably.

113 The appellant has framed his grounds of review in respect of unreasonableness[96] in terms akin to the *Wednesbury* unreasonableness standard. This is appropriate given the test reflected in the wording of s 87(1A). However, in my view, the use of the word 'includes' in s 87(1A) contemplates that an appeal on a question of law brought on grounds of unreasonableness is not necessarily limited to the *Wednesbury* standard. As such, in this decision I have had regard to both the *Wednesbury* standard and the

88 (2013) 249 CLR 332.
89 (2018) 264 CLR 541.
90 *Li*, [68] (per Hayne, Kiefel and Bell JJ).
91 *Li*, [76] (per Hayne, Kiefel and Bell JJ).
92 *SZVFW*, [10] (Kiefel CJ), [82] (Nettle and Gordon JJ).
93 (2016) 240 FCR 158.
94 The relevant principles were also recently summarised by Harris J in *Wilks v Psychology Board of Australia* [2024] VSC 2.
95 (2016) 237 FCR 1.
96 Grounds 3, 5 and 6.

contemporary exposition in *Li*. However, for the reasons at [284], [315] and [325] the distinction is ultimately not material in this appeal.

114 It is important to bear in mind, as I described at [8] above, the task of the Coroner was not to find guilt or blame in a civil or criminal sense, but to make findings as to the factual circumstances of the death. I note that this task is done in a context where parties giving evidence may be subject to the privilege against incrimination provided by s 57.[97]

115 The power being exercised by the Coroner in the investigation of a reportable death is the power to make findings under s 67(1). The Coroner is also empowered to make comments and recommendations.[98] The Coroners Act provides a number of powers to aid the investigation.[99]

116 By s 62(1) of the Coroners Act, a coroner holding an inquest is not bound by the rules of evidence.[100] There are a number of other tribunals which, by their statutory mandate, are similarly not bound by the rules of evidence and may inform themselves as they see fit. The construction of s 62(1) must accord with the rules of statutory interpretation including that the starting point is the text of the provision considered in light of its context and purpose,[101] and in interpreting the relevant legislation the Coroners Act must be read as a whole.[102]

117 CCV submitted that the context of the Coroners Act is important, as a coroner who holds an inquest into a death is required not only to make findings under s 67(1), but when investigating the death must do everything possible to enable the required findings to be made. The scope of an investigation is broad and the inquisitorial function of an inquest is an important consideration. It is not an adversarial process,

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97 Discussed at [36] above.
98 Discussed at [10] above.
99 These include those in ss 25, 28, 32, 33, 36, 39 and 42.
100 *Priest v West* (2012) 40 VR 521, [5].
101 *SAS Trustee Corporation v Miles* (2018) 265 CLR 137, [20]; *Project Blue Sky Inc v Australian Broadcasting Corporation* (1998) 194 CLR 355, [69]; *SZTAL v Minister for Immigration and Border Protection* (2017) 262 CLR 362, [14].
102 *Thales Australia Ltd v Coroners Court of Victoria* [2011] VSC 133, [69].

the duty of the coroner being to find the cause of death and all that they can about the circumstances surrounding the death.[103]

118 In determining whether the findings adverse to the appellant made by the Coroner were lawfully made and within power and not conclusions which are affected by legal unreasonableness, the task of the Coroner prescribed by the Coroners Act must be borne in mind and the evidentiary principles of *Briginshaw* seen in that context.

CORONER'S ANALYSIS

Coroner's approach to making findings and comments

119 In setting out the task ahead of the Coroner, the Coroner's Report outlined the jurisdiction and purpose of the coronial investigation, the task he identified in making findings pursuant to s 67(1) of the Coroners Act and the process engaged in setting the scope of the investigation.[104]

120 The Coroner noted that the circumstances surrounding a death can include several important categories in relation to a person's involvement:[105]

(a) courses of action that person undertook;

(b) any relevant normal practices in that person's profession or party's industry; and

(c) the likelihood that various courses of action, including the one taken, could have prevented the death.

121 The Coroner commented that questions about a person or a party's 'culpability', in a context where coroners do not assign fault or blame, will necessarily be addressed in

103 *Priest v West* (2012) 40 VR 521, [167]–[169] (Tate JA).
104 Coroner's Report, 33–46.
105 Coroner's Report, 36 [108].

comments regarding the relationship between the person or party's course of action and either of the latter two categories above.[106] The Coroner stressed that:[107]

> coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including a finding or comment or any statement that a person is, or may be, guilty of an offence.

Findings as to circumstances of death

122 The Coroner said that circumstances of the death do not refer to the entire narrative culminating in the death, but rather those circumstances which are sufficiently proximate and causally relevant to the death.[108] The findings as to circumstances will necessarily include findings as to which events caused others, in what combination they played this causative role, and to what degree.

123 He said that the standard for making a finding that matters are 'connected with' the death for the purposes of the power to make comments or recommendations is not the same as the standard of proximate connection required for a finding as to the circumstances of death. He referred to *Thales Australia Limited v The Coroners Court* ('*Thales*')[109] in which Justice Beach said there was no warrant for reading 'connected with' as meaning only 'directly connected with', and that the range of matters connected with a death, for the purpose of comments or recommendations, can be 'diverse'.

124 The Coroner observed that on most questions, and in relation to most matters about which he is obliged to make findings, the Medical Conclave and the Administration of Justice Conclave resolved to unanimous opinions. On a small number of matters,

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106 Coroner's Report, 36 [109].

107 Coroner's Report, 37 [112] (footnote omitted). The Coroner acknowledged a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death, referring to ss 69(2) and 49(1) of the Coroners Act.

108 Coroner's Report, 37 [114].

109 [2011] VSC 133, [75]. In this decision, Beach J adopted the interpretation of Muir J in *Doomadgee v Clements* [2006] 2 Qd R 352, [33].

the Medical Conclave formed a majority view and the nature and number of any dissenting views was identified.

125 Of relevance are the Coroner's comments in response to final submissions that urged the Coroner to be cautious before adopting unequivocal opinions of the Medical Conclave.[110] The Coroner said that he had to be satisfied on each of these matters to the requisite standard of proof. He said that he had considered the Medical Conclave's evidence in the context of the material they had before them which was necessarily more limited than the evidence upon which he could make his findings. He also stated that he bore in mind that the experts did not have the benefit of assessing Veronica in person and he said he had regard to the acknowledgement by the Medical Conclave that a custodial setting created additional burdens in the provision of clinical care when formulating the findings relevant to individual CCA clinicians.

Standard of proof

126 The Coroner acknowledged that the level at which he is required to be satisfied by the evidence before him was on the balance of probabilities in accordance with the *Briginshaw* principles. As previously noted,[111] the applicability of the *Briginshaw* standard was agreed between the parties. The Coroner expressly noted that he achieved this degree of satisfaction in his findings:[112]

> Where I have arrived at an adverse finding or comment in relation to an individual or entity, I have been satisfied that the appropriate standard of proof has been met.

127 The Coroner said that the strength of evidence necessary to prove relevant facts varied according to the nature of the facts and circumstances in which they are sought to be proved. He said that the effect of *Briginshaw* and similar authorities is that the coroner should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that the individual or

110 Coroner's Report, 64 [177]–[178].
111 See [96]–[97] above.
112 Coroner's Report, 39 [119].

entity caused or contributed to the death.[113] He accepted that proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demanded a weight of evidence commensurate with the gravity of the facts sought to be proved.[114] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of the presumption of innocence.[115]

128 The parties agreed that this recitation of the law was not in issue. However, what was in issue was its application to the facts and circumstances before the Coroner and his conclusions in respect of Dr Runacres.

Adverse comments about professionals

129 In respect of adverse comments about professionals, the Coroner acknowledged that determining that a person in their professional capacity has contributed to the death of another person is a serious conclusion for a coroner to reach.[116]

130 Reference was made to the earlier authorities of *Secretary, Department of Health & Community Services v Gurvich*[117] and *Chief Commissioner of Police v Hallenstein*[118] where the standard of proof was considered in the context of s 19(1)(e) of the now repealed *Coroners Act 1985* (Vic) (the '1985 Act'). The Coroner noted that under the current Coroners Act, the question of a person's contribution to a death is a matter for comment rather than findings into circumstances.[119] It would be a comment, either:

(a) that a person's course of action departed from normal professional practices; or

113 Coroner's Report, 38 [117].
114 Coroner's Report, 38 [118], citing *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw*.
115 *Briginshaw v Briginshaw* (1938) 60 CLR 336, 362–3 (Dixon J).
116 Coroner's Report, 39 [120].
117 [1995] 2 VR 69, 74.
118 [1996] 2 VR 1, 19.
119 Coroner's Report, 40 [122].

(b) that there was another course of action available which would have been more likely to prevent death, or less likely to cause it.

131 A comment of the second type, he said, 'does not necessarily imply that the person had enough information to recognise that this other course would have been more appropriate'.[120]

132 The purpose of making comments is directed towards identifying prevention opportunities and that it is particularly important to be able to make comments where systemic prevention opportunities exist that might relate to practices across the profession rather than a single practitioner.[121]

133 The Coroner recognised that a comment that a practitioner had another course of action available to them which had a higher probability of preventing the death or a lower probability of causing the death, is an adverse one and is one in which the standard of proof is heightened in accordance with *Briginshaw*.[122] This is not to the degree required to justify a finding of negligence as would have been appropriate for findings under s 19(1)(e) of the 1985 Act.

134 He commented that 'as this is an objective issue, it is not appropriate to shun the benefit of hindsight when addressing it.'[123] He said it was important that a coroner is able to identify opportunities to prevent a death even if they were not apparent at the time and that this is central to a coroner's death prevention function.

135 He considered that normal professional practices will be a factor in considering whether a practitioner had enough information to recognise a better course of action. Where he proposed to make a specific comment that a health practitioner's conduct was substandard for their profession, the heightened standard of probability and the heightened wariness of hindsight was applied. He said the same heightened standards must also apply to any notification or recommendation to a regulatory or professional

120 Coroner's Report, 40 [123].
121 Coroner's Report, 40 [124].
122 Coroner's Report, 41 [125].
123 Coroner's Report, 41 [125].

body that a practitioner's conduct should be reviewed and possibly be made the subject of disciplinary action.[124]

Coroner's ultimate findings

136 The Coroner's Report traversed a wide range of matters including, amongst other matters, consideration of the factors that lead to Veronica's incarceration in the first place and the practical implications of the 2018 changes to the *Bail Act 1977* (Vic) and whether resulting effects had been congruent with the stated aims of the amendments. He considered the limitations of the criminal justice system which had allowed Veronica to appear unrepresented at her bail hearing and whether her Aboriginality and medical history were adequately accounted for by the institutions making decisions in relation to her.

137 He considered the extent to which stigma associated with Veronica's Aboriginality, opioid dependency and criminal antecedents influenced the decisions that were made in relation to her care and management inside the prison. He noted the investigation posed some concerning questions about the operation of the custodial healthcare in Victoria and the adequacy of reviews of Aboriginal deaths in custody.

138 The structure of the Coroner's Report was by reference to the decisions made in each of the locations, stages or events which preceded Veronica's death. This traversed from her arrest and processing at Melbourne West Police Station, the bail application decisions and processes at the Melbourne Custody Centre and the Melbourne Magistrates Court, the absence of drug and alcohol support services and the absence of cultural support, through to her time at DPFC.

139 Self-evidently, the focus of the submissions in this proceeding on behalf of the appellant relate to the specific findings he challenged and the period of time he had direct contact with Veronica (though not exclusively).

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124 Coroner's Report, 41 [127]–[128].

140 It is, in my view, necessary to put the challenged findings into this context. When the Coroner's Report and findings as to Veronica's medical assessment and care is considered, there is a clear overlap between the systemic failings and the actions of a range of individuals, including the appellant. Having read the Coroner's Report as a whole, I am of the view that the challenged findings cannot be considered in a temporal bubble. It is relevant to consider the whole of the trajectory from Veronica's reception at DPFC because part of the rationale of the Coroner's findings against the appellant involves the systems in place and the treatment of Veronica whilst in custody at DPFC, not just the limited, but crucial short period where the appellant was directly involved with her medical assessment and care. In particular, the challenged 'finding' at [541] needs to be seen in this context.

Assessment and care at DPFC

141 The Coroner's Report noted the Facility and Policy Framework[125] and that at all relevant times, CCA was the primary healthcare provider to prisoners at DPFC, with CCA employing health practitioners and administrative staff to provide those services. DPFC and the Medical Centre[126] are co-located, the Medical Centre being staffed 24 hours a day by custodial and clinical staff. Apart from clinical and treatment rooms, there are two 'holding' cells and three 'ward' cells. Wards 1 and 2 may be used for medical observations. A decision to transfer a prisoner to an external health facility for ongoing care is a clinical decision made by CCA.

142 Minimum standards for healthcare are established by the Justice Health Quality Framework ('JHQF') with a principle of 'equivalence of care', being that people in custody have the right to receive health services equivalent to those available in the community through the public health system.

143 As noted at [7], the RMA is the initial medical assessment conducted when a prisoner arrives at DPFC. Significantly, the Coroner said the JHQF emphasises the importance

125 Coroner's Report, 140–1 [395]–[400].

126 The Coroner noted that the health facility at DPFC is a 'Health Centre', however at the inquest, witnesses predominately referred to the facility as the 'Medical Centre', therefore, he adopted this term in his findings. See Coroner's Report, 5 [17].

of the RMA as 'it is at this time that the health profile of the prisoner is identified and healthcare treatment and planning commenced.'[127] Following this assessment, a prisoner is liable to be locked in a cell overnight without any independent means of obtaining medical assistance as they would if they were in the community. Instead, they are reliant on an intercom system to alert a prison officer ('PO').

144 The JHQF sets out some minimum requirements for a RMA and all health assessments are documented in a prisoner's health record on the JCare system and used to inform all future assessments.[128]

145 As a consequence of the standards required by the JHQF and the contractual agreement with the State, the CCA's policies require that all patients are provided with a comprehensive health assessment upon their reception. A full medical assessment is conducted at this health assessment including a physical examination, the assessment of a patient's urgent physical needs, treatment planned, and patients cared for in a culturally sensitive manner (including referrals to Aboriginal Welfare Officers and health workers where appropriate or requested).[129]

146 The MAF sets out what investigations are required for a comprehensive medical assessment. They include:[130]

(a) standard nursing observations;

(b) a physical examination requiring an assessment of heart, lungs, abdomen;

(c) inspection of teeth;

(d) enquiries about past medical history, chronic health conditions, medical history, allergies, immunisations, and any blood borne history;

127 Coroner's Report, 142 [402].
128 Coroner's Report, 142 [403].
129 Coroner's Report, 143–4.
130 Coroner's Report, 144–5.

(e) enquiries in relation to drug and alcohol history, and drug-related risk-taking behaviours;

(f) enquiries about smoking; and

(g) enquiries in relation to STI history, sexual and reproductive health.

147 Based on the polices outlined above, the Coroner said he must have regard to those polices and, in assessing the adequacy of Veronica's RMA, noted:[131]

(a) Veronica was an Aboriginal person who had no contact with any Aboriginal person since her arrest;

(b) a completed medical assessment amounted to a 'medical clearance' for fitness to be isolated in a locked cell; and

(c) the JCare electronic file was the system by which medical staff recorded and accessed medical information about a patient for the purposes of ongoing review and treatment.

148 The Victorian Opioid Substitution Therapy Guidelines were in operation at the time of Veronica's reception at DPFC. In accordance with CCA's Opioid Substitution Program Policy made to implement these guidelines, Veronica was prescribed a standard withdrawal pack. The pack contained suggested doses of suboxone. As the Coroner noted, the CCA doctors appear to have understood the policy not to allow for clinical judgement or discretion when prescribing and effectively it was a 'one size fits all' package with set dosages of pharmacotherapy regardless of a prisoner's level of opioid dependence or the severity of withdrawal symptoms.

149 On the basis of the Medical Conclave's evidence, the Coroner critiqued this treatment approach as inadequate to address the severity of Veronica's withdrawal while also acknowledging the obligation for CCA staff to implement the policy.[132]

131 Coroner's Report, 145.
132 Coroner's Report, 146–7.

Reception medical assessment

150 The Coroner deals with this evidence at [419]–[554] of the Coroner's Report.

151 The appellant was the rostered medical officer at the time of Veronica's arrival at DPFC and was responsible for conducting the RMA. The key evidence before the Coroner with regard to the RMA came from the evidence given by Dr Runacres himself and the contradictory evidence given by RN Hills. In addition, CCTV evidence and the documentary evidence of Veronica's medical assessment and records were available to the Coroner, as was the report of the Medical Conclave and the evidence of the autopsy pathologists.

GROUNDS 1 TO 3: PHYSICAL EXAMINATION

152 Grounds 1 to 3 of the notice of appeal (and corresponding Questions 1 to 3) relate to the finding at [528] of the Coroner's Report that the appellant did not conduct a physical examination of Veronica, although three examinations were recorded by the appellant in Veronica's medical record.

153 This finding involved several evidentiary conclusions being whether a physical examination took place in the reception holding cell or elsewhere and the recording of results.

154 The first opportunity for physical examinations to occur was in a one minute and 34 second interaction between Dr Runacres and Veronica in holding cell 2 ('HC2').

155 The second opportunity for a physical examination to have taken place was during the more formal assessment, which was to be conducted in the medical centre and lasted around 13 minutes.

156 Ground 1 relates specifically to the first question of whether a physical examination *could* have taken place in HC2.

157 Grounds 2 and 3 are more broadly based and cover the whole of the period relating to the RMA process.

What physical examinations were required to be undertaken?

158 As noted at [146(b)] above, the physical examinations which Dr Runacres was required to undertake comprised an assessment of the heart, lungs and abdomen. This comprises one component of the full RMA which is intended to be a comprehensive health assessment.

What physical examinations were recorded as having been undertaken?

159 The following physical examinations were recorded in the MAF and Initial Appointment Notes as having been undertaken:[133]

(a) 'HSDNM';[134]

(b) 'Chest clear good a/e to bases';[135] and

(c) 'Abdo SNT'.[136]

Ground 1: Did a physical examination take place in HC2?

160 This first Ground relates to the conclusion at [526] of the Coroner's Report that it was 'not open' to the Coroner to find that Dr Runacres could have conducted physical examinations while in HC2, being the reception cell Veronica was held in when she first arrived at DPFC.

161 The appealed finding at [528], that a physical examination on Veronica was not conducted on 31 December 2019, is based in part on this conclusion at [526].

CCTV footage evidence

162 It is evident from the Coroner's Report that he considered the CCTV footage. He referred to it in the course of his various references to the evidence. He also made

133 Coroner's Report, 151 [429], 186 [521].
134 An abbreviation used by Dr Runacres to indicate 'heart sounds dual no murmur'.
135 An abbreviation used by Dr Runacres to indicate the chest was clear and there was good air entry to the base of the lungs.
136 An abbreviation used by Dr Runacres to indicate the abdomen is soft and not tender.

observations about it in answer to the criticism made by the submission on behalf of the appellant.[137]

163 Part of the CCTV footage was played to the Court in this appeal to support the appellant's submissions that the view of the evidence taken by the Coroner was unreasonable and to support the contention that the Coroner was wrong in finding it was 'not open' to him to make a finding that a physical examination took place in HC2.

164 The appellant's submissions were that on the basis of this CCTV footage, it was quite conceivable that he conducted the physical examinations which he recorded in his JCare notes in Holding Cell 1 ('HC1') shortly prior to escorting Veronica to the Medical Treatment Room.[138]

165 The CCTV footage shows as follows:

(a) At 4:35pm on 31 December 2019, Veronica arrived at DPFC. The CCTV footage shows her exiting a prison van and entering the building with what appears to be a sick bag in her left hand, with an item of clothing tucked under her left arm. She enters HC2. A few seconds later she returns to the van, collects a water bottle and then drops the water bottle and the sick bag into a rubbish bin. It appears from the footage that she has been sick.

(b) At 4:36:50pm, Veronica returns to HC2. A nurse appears to speak to her very briefly (about 15 seconds).

(c) Between 4:43:23pm and 4:45:05pm, a nurse and a PO speak to another prisoner who is in the adjacent HC1.

(d) At 4:48pm, Dr Runacres approaches HC1 holding a stethoscope. He is accompanied by a female PO and an ununiformed woman. The door is opened

137 See Coroner's Report, 164–8.

138 Trial Transcript, 30, lines 9–30. This CCTV footage was specifically raised before the Coroner. See Appellant's Amended Submissions, [25].

for him. He enters and appears to interact with the prisoner in HC1. He can be seen placing the stethoscope over his ears.

(e) At 4:50:00pm, Dr Runacres walks away from the HC1 door and speaks to the female PO and the second ununiformed woman outside the door of the shower room. He leaves the screen at 4:52:47pm.

(f) At 4:58:17pm, a female PO approaches HC2 holding a plastic cup of blue fluid. She speaks to Veronica through the cell door of HC2.

(g) At 4:59:09pm, the female PO places the cup of fluid in the shower room nearby. At 4:59:25pm, a different female PO places a bundle of clothing in the shower room.

(h) At 5:05:00pm, a PO opens the door to HC2. At 5:05:14pm, Veronica exits HC2 carrying what appears to be a sweater in her right hand. She appears to be slightly unsteady on her feet but walks independently.

(i) At 5:07:07pm, Veronica enters the shower room.

(j) At 5:09:28pm, the door to the shower room is opened and Veronica can be seen putting on long pants while seated inside the room. She is escorted by two female POs back to HC2. Her hair appears to be tucked into her prison sweater.

(k) At 5:10:32pm, a PO approaches the HC2 cell with a cup of yellow tinted fluid, and the PO passes the cup through the open door. At 5:11:16pm, while the HC2 door is closed, the PO appears to spray air freshener or disinfectant in the hallway outside HC2.

(l) At 5:15:11pm, a female PO approaches HC2. At 5:15:14pm, Dr Runacres enters the hallway outside HC1 and HC2. He stands away from the door and watches the PO speak to Veronica. He is holding stethoscope in his left hand.

(m) At 5:17:03pm, Dr Runacres enters HC2, still holding the stethoscope in his left hand. Between 5:17:03pm and 5:18:42pm, Dr Runacres remains inside HC2 while a female PO watches from outside the open door of HC2 and a male PO stands near the door to the outdoor driveway. At 5:18:42pm, Dr Runacres leaves HC2, holding the stethoscope folded in his left hand.

166 It was submitted on the appellant's behalf that this aspect of the footage above was a crucial piece of evidence which was 'fairly central to this appeal'.[139] The CCTV footage, it was submitted, appears to show Dr Runacres going into HC2 holding a stethoscope. When he entered HC2, the stethoscope was dangling at full length. When he comes out of HC2, the stethoscope is being held in a different way. There was a female PO standing immediately outside HC2 looking in. There was another male PO standing near the door who is at times looking in and at other times turned away. It was submitted that this is a critical piece of evidence because, as had been submitted to the Coroner, there was clearly an opportunity for Dr Runacres to carry out examinations of the sort he claimed he carried out, the results of which he entered into Veronica's medical records.[140] Dr Runacres was in the cell without RN Hills. It was submitted that he had a stethoscope with him and he was in the cell for more than enough time to use the stethoscope to listen to Veronica's heart and lungs and more than enough time to have her abdomen examined.

167 It was submitted that the presence of a female PO means that it would have been appropriate for Dr Runacres to conduct an examination of a female prisoner.[141] It was submitted that those examinations could conceivably have occurred and indeed probably did occur in that interaction. Whilst Dr Runacres could not recall what he did in the cell at the time, he gave evidence to the Coroner that he was conducting a component of the formal medical assessment. The transcript of the evidence before the Coroner was relied on in this appeal.[142]

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139 Trial Transcript, 20, lines 2–4.
140 Trial Transcript, 20, 25–6.
141 Trial Transcript, 41, lines 3–11.
142 Trial Transcript, 30, lines 2–8.

168 It was also submitted that there was no attempt made by the Coroner to reconcile the oral evidence with the above portion of the CCTV footage nor any evident engagement with that evidence and the available inferences that flow from it.[143]

Coroner's analysis

169 At [526] of the Coroner's Report, the Coroner found that it was 'not open' to him to find that 'Dr Runacres could have conducted physical examinations while in the reception cell.'

170 The Coroner made this finding in response to the submission made to him that 'there was sufficient time for a physical examination to have been conducted by Dr Runacres when he attended HC2 holding a stethoscope at 5:17pm.'[144]

171 He rejected this submission, notwithstanding reference to the CCTV footage, on the following basis:

(a) Dr Runacres' own evidence that he would 'never touch a female patient for any reason without a female nurse present'[145] and the CCTV footage showed no female nurse was present at 5:17pm; and

(b) Dr Runacres' evidence that he was only in the cell with Veronica for one minute and 34 seconds and had accepted that not 'very much'[146] could have occurred in that time.

172 I note the language used by the Coroner that it was 'not open' to him to make the finding. This observation was challenged as incorrect on the basis of there being evidence of the possibility that physical examinations were conduced in HC2.

173 I do not accept that the use of the language here is that the Coroner meant 'not open' in the sense of there being *no* contrary evidence but that it was shorthand for him

143 Appellant's Amended Submissions, [32].

144 The Coroner cited the CCTV footage 'Extract 008' which is exhibited Exhibit SB-1 of the Affidavit of S Brown. This is a portion of the CCTV Footage entitled 'C300' enclosed in Court Book, 387 between 5:16:57pm and 5:18:54pm which was shown to the Court at trial.

145 Coroner's Report, 187 [525] citing Dr Runacres' evidence at Inquest Transcript, 1092, lines 7–11.

146 Coroner's Report, 187 [525] citing Dr Runacres' evidence at Inquest Transcript, 1092, lines 28–9.

expressing that he was not satisfied on that evidence that physical examinations took place. In other words, I take the use of this phraseology as meaning that was his conclusion on the evidence as a matter of persuasion, not that there was no possible evidence to the contrary.

174 The Coroner clearly sets out the alternative conclusion but rejects it. The words 'not open' cannot be considered in isolation but as a continuum of the whole of the section of the Report which deals with the competing evidence about the probability that a physical examination (of the nature and extent required) occurred in the initial RMA.

175 In my view, whilst the alternative conclusion on the evidence — that physical examinations *did* occur during this interaction — is theoretically possible, the contrary evidence (including Dr Runacres' own evidence), and the period of time that Dr Runacres was in the cell makes this conclusion unconvincing, even speculative. Therefore, I am not satisfied that the Coroner erred in law in finding that it was not open to him to find that Dr Runacres conducted physical examinations while in the reception cell.

176 I am fortified in this conclusion when considered in context of other evidence before the Coroner that:

(a) Dr Runacres did not give positive evidence that he did in fact conduct the RMA in HC2 (or anywhere else);

(b) his evidence was entirely reconstructed from his notes (which he ultimately conceded he did not take care to ensure were accurate),[147] he had no independent recollection of any interaction with Veronica (even after retrospective review of the CCTV footage)[148] and he could not say what he did do in HC2; and

147 Coroner's Report, 177 [494], 186–7 [524].
148 Coroner's Report, 177 [494], citing Inquest Transcript, 978.

(c) there was no direct evidence from any other witness who said Dr Runacres did in fact undertake the physical assessment in HC2.

177 The contrary finding is not assisted by the Coroner's observations that:

(a) the RMA is intended to be a comprehensive health assessment which offered the best opportunity in the prison reception process for the extent of Veronica's unwellness to be identified, recorded, treated and escalated; and

(b) overall, the appellant was an 'unreliable witness'.[149]

178 That such a foundational component of the assessment could be undertaken in one minute and 34 seconds (which is the time shown on the CCTV footage) is of itself inherently unlikely and illogical.

179 I am not persuaded that Ground 1 is made out.

Grounds 2 and 3: Did the physical examinations take place elsewhere?

180 At [528] of the Coroner's Report, the Coroner records that:

> On the basis of the evidence canvassed above, I find that a physical examination of Veronica was not conducted on 31 December 2019, although three examinations were recorded as having been undertaken in the MAF and Initial Appointment Notes by Dr Runacres.

181 He also referred to Dr Runacres' failure to conduct a physical examination at [540] and [541] of the Coroner's Report.

182 Grounds 2 and 3 (and corresponding Questions 2 and 3) allege:

(a) a failure of the Coroner to properly apply the *Briginshaw* standard to the evidence, bearing in mind the gravity of the finding and the inherent unlikelihood of the conduct found; and

149 Coroner's Report, 177 [495].

(b) that the finding was against the evidence and weight of the evidence such that no reasonable coroner could have made it.

CCTV footage evidence

183 In addition to the matters described at [165] above, the CCTV footage also shows as set out below.

(a) At 5:19:39pm, a female PO is talking to a prisoner in HC1.

(b) As 5:20:53pm, the same PO approaches HC2 with a second female PO.

(c) At 5:21:00pm, Dr Runacres approaches HC2. A third female PO stands next to him. One of the POs, Veronica and Dr Runacres (in that order) leave HC2 and walk south, then turn right at the open door underneath the position where the CCTV camera is located.[150] The footage records a portion of the walk from the holding cell to the medical centre. She walks unassisted though with a stilted gait.

184 After this time, the PO, Veronica and Dr Runacres make their way to the treatment room, where they are met by RN Hills, traversing a corridor roughly three times longer than the previous hallway. None of this is captured by any CCTV footage.[151]

Conflict of evidence

185 The submissions made on appeal raised similar complaints about the cogency of the evidence (in accordance with the *Briginshaw* standard), as were made before the Coroner in response to the initially drafted findings. Criticism of the reliability of the evidence was based on:

(a) the conflict of evidence between Dr Runacres and RN Hills;

150 Trial Transcript, 21, lines 10–31.
151 Coroner's Report, 164 [467]; Trial Transcript, 57, lines 10–21.

(b) the reliability of RN Hills' evidence based on alleged internal and external inconsistencies (including the CCTV footage and other witnesses); and

(c) the allegation of personal motivations for RN Hills' portrayal of Dr Runacres, which were addressed in the Coroner's Report and raised in this appeal.

186 I have reviewed the Coroner's Report, the relevant transcript references referred to by the parties and their submissions in forming the view that there was a sufficient basis for the Coroner to form his view in accordance with the *Briginshaw* standard in finding that the appellant did not conduct the physical examinations required of him.

187 In addition, there is the separate specific finding that the appellant did not accurately record Veronica's weight.[152] I note that the evidentiary observations he made in relation to whether the physical examinations took place overlaps with the evidence about whether the weight recorded by Dr Runacres was accurate (or whether she was weighed at all).

188 It was submitted by the appellant that in balancing all of the evidence before the Coroner, the Coroner failed to give appropriate regard to a number of matters in the appellant's favour. It was submitted that the gravity of these adverse findings and the likelihood that such findings would have a deleterious effect on his professional reputation, standing and employment prospects were such that these findings demanded evidence of commensurate weight, cogency and clarity.

189 I am not satisfied that these matters, in isolation or combination, justify a different conclusion on the evidence to undermine the Coroner's finding at [528].

190 Each issue in relation to the evidence challenged will be addressed in turn. In respect of each issue, I am satisfied that the conclusions are borne out by the evidence and that he did not err in his approach.

152 Being the finding appealed under Grounds 4 and 5 dealt with at [286]–[316] below.

Accuracy of Dr Runacres' medical notes

191 It was submitted by the appellant that the fact notations had been made in the medical notes corroborates the likelihood that the physical examinations actually took place.

192 The Coroner was not satisfied that the entries in Veronica's medical records were accurate, noting that Dr Runacres ultimately admitted they were unreliable.[153] Some of the pre-populated entries remained untouched.[154]

193 The Medical Conclave also unanimously held concerns that Dr Runacres' notation was 'inadequate and at times inaccurate'.[155]

194 Dr Runacres argued that the fact that there were inaccuracies in the medical notes was not sufficient evidence to infer that the physical examinations did not take place.

195 Dr Runacres gave evidence that he 'does not make up data'[156] and that RN Hills gave evidence that in the 60 to –70 shifts they had worked together she had not known Dr Runacres to make entries without undertaking the corresponding examinations.[157] However, given the inaccuracies evident in the medical record, this denial seems feeble.

196 In my view, the fact that some notations were entered into the medical record does not change the balance of the weight of the evidence (as discussed below) in support of the adverse view. It, in effect, begs the question rather than answers it.

197 In my view, it was open to the Coroner to form the view that, in terms of an inference to be drawn that a physical examination did not take place, the evidentiary effect of leaving a pre-populated but inaccurate entry in the medical record has the same effect as a false entry. In fact, both types of entry are false entries, and in my view the

153 Coroner's Report, 177 [494].

154 See Coroner's Report, 152 [430]–[432]. During the inquest, it was established that parts of the standard template used for the MAF contain pre-filled answers which record that the patient is in good health (for example, 'looked generally well', 'alert, not drowsy' and 'not toxic looking'). These entries remain in the form and will form part of the patient's record unless the clinician alters them.

155 Coroner's Report, 191 [536.1].

156 Coroner's Report, 186–7 [524]; Inquest Transcript, 1020.

157 Inquest Transcript, 661, 676–7.

unchanged re-populated entries lends weight to the inference that a physical examination did not occur, to the extent that the record is shown to be unreliable and should not be preferred in circumstances where there is other credible evidence that the examinations did not take place.

198 The other matters raised in Grounds 2 and 3 involve the conflict of evidence between the appellant and RN Hills.

Conflict of evidence between RN Hills and Dr Runacres

199 RN Hills and Dr Runacres undertook Veronica's RMA together. One of the key tasks before the Coroner was to resolve the discrepancies between the competing testimonial evidence of RN Hills and Dr Runacres as to whether the physical examinations were undertaken.

200 The Coroner considered the significant discrepancies raised with him in making his findings in relation to Dr Runacres' assessment, care and treatment of Veronica as well as his role in her passing.[158] The assessment of the Coroner's approach to dealing with the evidence of these two key witnesses is an important factor in the determination of this appeal.

201 RN Hills gave evidence that during the RMA:[159]

(a) Veronica was not weighed because she was unable to walk to the scales;[160]

(b) there was no assessment of Veronica's lungs or heart with the use of the stethoscope, nor was there any assessment of Veronica's abdomen;[161]

(c) Veronica was not asked to lie down to be physically examined at any stage;[162]

(d) there was no assessment of Veronica's teeth;[163]

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158 See Coroner's Report, 154, [442]–[443].
159 Coroner's Report, 155–6 [444]–[445].
160 Inquest Transcript, 670.
161 Inquest Transcript, 675–6.
162 Inquest Transcript, 676.
163 Inquest Transcript, 674.

(e) there was no physical examination of Veronica's heart, chest or lungs (as is documented in the Initial Appointment Notes);[164]

(f) Veronica's drug use was not specifically discussed in the consultation;[165]

(g) there was no examination of Veronica's pupils to see whether they were dilated;[166]

(h) Dr Runacres did not move from his chair during the assessment;[167]

(i) Veronica was complaining of vomiting and stomach pain, had vomit in her hair and on her clothes;[168]

(j) Veronica was too unwell to sit upright in her chair and instead draped over the right-hand side of it;[169] and

(k) Veronica was incoherent and fading in and out of consciousness and was not alert or orientated.[170]

202 Dr Runacres denied RH Hills' assertions and maintained that Veronica was not unwell during his assessment of her. He called RN Hills 'a liar'.[171]

203 Dr Runacres' counsel submitted to the Coroner and to me that the evidence of RN Hills should be treated with caution and that her credibility and reliability should be doubted because:

(a) RN Hills' evidence about the severity of Veronica's clinical presentation conflicted with other evidence, including the CCTV footage;

(b) RN Hills' evidence was internally inconsistent;

164 Inquest Transcript, 676.
165 Inquest Transcript, 680.
166 Inquest Transcript, 686.
167 Inquest Transcript, 686.
168 Inquest Transcript, 690.
169 Inquest Transcript, 671.
170 Inquest Transcript, 692.
171 Coroner's Report, 157 [446]; Inquest Transcript, 999, lines 9–10.

(c) RN Hills did not conduct herself in a manner consistent with someone who held the concerns for Veronica that she outlined in her evidence;

(d) there was a strained personal relationship between RN Hills and Dr Runacres which may have influenced the way she portrayed him;

(e) RN Hills' statement was taken 22 months after Veronica's passing and was drafted over a period of six months, giving her time to reconsider her narrative and change parts of it; and

(f) RN Hills' notes on Veronica which she made on or around 4 January 2020 were unable to be located and interested parties did not have an opportunity to see them.

204 The Coroner dealt with the inconsistencies and the criticisms of RN Hills' evidence at [449]–[495] of the Coroner's Report.

Conflict of evidence regarding Veronica's clinical presentation

205 Counsel for Dr Runacres submitted that the Coroner should have doubts about RN Hills' credibility and reliability because her evidence did not align with other evidence, including the CCTV footage of Veronica. In particular, it was submitted that the CCTV footage of Veronica:

(a) walking along the corridor to the Medical Centre[172] is inconsistent with RN Hills' evidence that Veronica had an unsteady gait and required assistance as she walked along that corridor;

(b) standing to have her photo taken at 5:52pm[173] is inconsistent with RN Hills' evidence that Veronica was unable to stand and walk to the scales during the medical assessment;

172 As described at [183] above.
173 As shown in CCTV extract '014' enclosed in Exhibit SB-1 to the Affidavit of S Brown.

(c) being collected from HC2 by Dr Runacres does not appear to show vomit on Veronica's clothing[174] and is therefore inconsistent with RN Hills' evidence that Veronica presented to the clinical treatment room with vomit in her hair and clothes; and

(d) having medications administered by RN Hills following the medical consultation[175] is inconsistent with RN Hills' evidence about the extent of Veronica's physical unwellness during the assessment.

206 Some of these portions of CCTV footage were shown to the Court at the hearing.

207 The Coroner set out his observations of the sequence of events from the CCTV footage and his view of the effect of the submissions on his assessment of the CCTV footage as follows:

(a) He noted that, when Veronica walked down the hallway between the reception centre and the medical centre with a PO and Dr Runacres, there is no CCTV footage available for the length of the corridor which is roughly three times longer than the part of the corridor observable in the CCTV footage.

(b) The Coroner did not accept the submission that it can be determined from the brief, low quality CCTV footage at 'CCTV 009' whether Veronica had vomit in her hair or her clothes at the time she was taken from a cell in the reception centre. She had a blanket draped over her shoulders and her long hair appeared to be tucked inside the neckline of her top.

(c) At 5:37pm, immediately following her RMA, Veronica was placed in a Medical Centre Cell.[176] She sat down on the bed, removed her shoes and laid down on the bed in the recovery position. Two minutes later at 5:39pm, she projectile vomited onto the floor of the cell.[177]

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174 As shown in CCTV extract '009' enclosed in Exhibit SB-1 to the Affidavit of S Brown.
175 CCTV extract '016' enclosed in Exhibit SB-1 to the Affidavit of S Brown.
176 CCTV extract '009B' enclosed in Exhibit SB-1 to the Affidavit of S Brown.
177 CCTV extract '010' enclosed in Exhibit SB-1 to the Affidavit of S Brown.

(d) Veronica remained lying in the recovery position on the bed. She did not sit up to take the clean vomit bag delivered by a PO at 5:42pm[178] nor did she sit up to take the paper towels delivered by a PO at 5:45pm.[179]

(e) At 5:48pm, Veronica sat up as Registered Psychiatric Nurse Bester Chisvo ('RPN Chisvo') entered the cell to assess her. She used the paper towel to clean the vomit on the floor while remaining seated. She lay down again 50 seconds later.[180]

(f) Veronica remained lying down until a PO entered the cell requesting she stand so a photo could be taken. She stood and walked to the end of the bed before returning to the bed and lying down. She was on her feet for about 50 seconds.[181]

(g) At 6:03pm, Veronica was still lying down and called prison staff via the intercom to ask for water and was told 'there is a cup in there and you just need to get up and use the tap yourself.' She remained lying down following receipt of this information.[182]

208 The Coroner concluded that he was not persuaded that the available CCTV footage as described above is irreconcilable with the evidence that Veronica had an unsteady gait and was unable to stand and walk to the scales during the assessment. He was satisfied that Veronica appears in this footage to be very unwell and only stood when required to do so.[183]

209 The Coroner referred to CCTV footage at 6:08pm[184] which depicts RN Hills and Prison Officer Hermans ('PO Hermans') entering the cell to administer medication to Veronica. Veronica sat up for about one minute and 45 seconds before lying down again. She appears to be told to sit up and do so for a further 30 seconds before laying

178 CCTV extract '011' enclosed in Exhibit SB-1 to the Affidavit of S Brown.
179 CCTV extract '012' enclosed in Exhibit SB-1 to the Affidavit of S Brown.
180 CCTV extract '013' enclosed in Exhibit SB-1 to the Affidavit of S Brown.
181 CCTV extract '014' enclosed in Exhibit SB-1 to the Affidavit of S Brown.
182 Audio extract '015' enclosed in Exhibit SB-1 to the Affidavit of S Brown.
183 Coroner's Report, 166 [469].
184 CCTV extract '016' enclosed in Exhibit SB-1 to the Affidavit of S Brown.

down again. During this interaction and after the medication is administered, Veronica tried three times to drink from her cup but was stopped by RN Hills or PO Hermans. Once the staff left, Veronica drank from her cup without sitting up.

210 The Coroner observed that, comparing this interaction with RN Hills' recollection of Veronica's presentation during the RMA, RN Hills observed that Veronica:[185]

(a) had vomit in her hair and clothes which was presumably also present in the 6:08pm footage given that she had projectile vomited 30 minutes earlier;[186]

(b) was complaining of vomiting and stomach pain which is unable to be refuted in the absence of footage with audio;

(c) was too unwell to sit up in her chair and draped over it during the 15 minute assessment which is not inconsistent with Veronica's keenness to lie down after less than two minutes sitting up in the 6:08pm footage and her failure to stand and retrieve water in the 6:03pm footage; and

(d) was incoherent, fading in and out of consciousness, not alert and not orientated, a description not inconsistent with Veronica's apparent difficulty following instructions not to drink water immediately following administration of the medication but which cannot otherwise be refuted without the capture of audio.

211 The Coroner recorded that RN Hills' evidence, when shown the 6:08pm footage was that 'at that point she was presenting the same as during the health assessment'. Whilst the Coroner observed that it was impossible now to determine with precision whether RN Hills was referring to the same particular point in time as Dr Runacres was referring to in his evidence with respect to the CCTV footage, the Coroner was not persuaded by the submission that CCTV footage relating to the 6:08pm interaction

185 Coroner's Report, 167 [471].
186 CCTV extract '010' enclosed in Exhibit SB-1 to the Affidavit of S Brown.

was inconsistent with RN Hills' evidence that Veronica was presenting at this time in the same manner as she says she was during the RMA.

Internal inconsistencies in RN Hills' evidence

212 The following matters were highlighted in the submissions to the Coroner on behalf of Dr Runacres:[187]

(a) in oral evidence, RN Hills first said she met Dr Runacres for the assessment outside the clinical room before saying later she could not recall whether he was already sitting at his desk or he was sitting at his desk when Veronica came in;

(b) in oral evidence, RN Hills first stated that Veronica's opioid use was discussed at some point before later denying that Veronica was asked about her drug use or withdrawal symptoms; and

(c) RN Hills' evidence was inconsistent and erroneous about the administration of Veronica's medication, the time of RN Hills' departure from DPFC, the nature of the handover she provided and her claim that she continued to monitor Veronica after Dr Runacres' departure.

213 The Coroner rejected these submissions on the basis that the evidence needed to be considered more broadly and in context. He stated the following points:[188]

(a) It is clear from the transcript, and in the broader context of evidence about Dr Runacres' seated position in the clinical room that she was not providing the evidence about where she met Dr Runacres. Rather, she was detailing where each party was in relation to the others.

(b) Likewise, she first gave evidence that she believed opioid use was discussed at some point whilst being shown an exhibit of the part of the MAF where opioid use was noted. On the same page of the transcript of evidence, while she was

187 Coroner's Report, 168–9 [474].
188 Coroner's Report, 169–70 [475].

being shown the drug and alcohol history section of the MAF, she stated that the details entered by Dr Runacres were incorrect and the specific matters they relate to were not discussed. The Coroner said her evidence was consistent that the specifics of Veronica's last drug use and withdrawal symptoms were not discussed by Dr Runacres.

214 The Coroner concluded that the evidence about these matters, when considered in context, was not inconsistent.[189]

215 As to the allegation that RN Hills' evidence was inconsistent and erroneous about the administration of Veronica's medication, the time of her own departure from DPFC, the nature of the handover and her continued monitoring of Veronica, the Coroner accepted the following points:[190]

(a) RN Hills was mistaken about the time at which she left DPFC and the number of times she administered medication to Veronica. However, he did not consider those errors to have any meaningful impact on his overall assessment of credibility and reliability. He commented that 'she conceded the errors without recanting other evidence and this on my view engenders confidence in her as a witness.'

(b) In her oral evidence, RN Hills accepted she could not have handed over to the night nurse Registered Nurse Atheana George ('RN George') because their shifts did not overlap. She had qualified her evidence by saying she could not recall to whom she handed over before agreeing it must have been RN George. The Coroner accepted that it was not clear who the handover was conducted with or whether she conducted handover at all but did not consider this rendered the whole of the evidence unreliable or incredible.

(c) In relation to the evidence of how busy RN Hills said she was late in her shift being inconsistent with her continuing to monitor Veronica, the Coroner

189 Coroner's Report, 170 [476].
190 Coroner's Report, 170–1 [477].

observed that the nurses' station in the Medical Centre is directly opposite the cell in which Veronica was accommodated and its front wall is transparent. Visually observing Veronica from outside the cell would be possible even if RN Hills was occupied with the tasks she identified. Indeed, other evidence suggested a nurse in the station would only have to stand up to see into the cell in which Veronica was placed. Accordingly, the Coroner did not attach much weight to the submission and said that he did not 'take matters very far'.[191]

Inconsistencies regarding RN Hills' stated degree of concern for Veronica

216 Counsel for Dr Runacres submitted that RN Hills' evidence about the degree of concern she held for Veronica was effectively undermined by the fact she left work at 7:30pm and did not escalate Veronica's care. She conceded that she left work half an hour early at 7:30pm.

217 The Coroner did not consider that her decision to leave work early after an understaffed 12 hour shift with no break undermined RN Hills' evidence that she found Veronica's presentation 'very concerning' and thought her to be sick enough to warrant transfer to hospital.

218 RN Hills was challenged that she could have contacted the on-call medical officer before the end of her shift. Her answer was that Veronica had been reviewed by Dr Runacres and he had overridden her suggestion to send Veronica to hospital.

219 The Coroner also noted that when RN Hills was leaving for the day, Veronica would have appeared to have been sleeping under her blankets for the past hour.

220 Veronica had called via the intercom three times in that hour, but as the Coroner explained, those calls went to the officer's post in the Medical Centre and there was no process in place to relay those calls to the clinical staff. He was satisfied that RN Hills sought to escalate Veronica's care initially by suggesting to Dr Runacres that she should be transferred to hospital, then by discussing with RPN Chisvo that

191 Coroner's Report, 171–2 [478].

Veronica stay in the Medical Centre overnight and writing a direction in the nursing daily handover book. The decision to keep Veronica overnight in the Medical Centre was indicative of an unusual or abnormal degree of concern. This was particularly so when the evidence of others (including Dr Runacres) was that this was not where a prisoner would usually stay overnight.

221 The Coroner rejected the submission that RN Hills' actions did not reflect her stated level of concern.

RN Hills' motivation to negatively portray Dr Runacres

222 RN Hills' evidence was that there was particular animosity between herself and Dr Runacres stemming from an incident (the details of which were undisclosed) which had occurred a few months before Veronica's passing. She also said that there was a clear hierarchy between Dr Runacres and how he responded to the nurses at DPFC.

223 Dr Runacres gave evidence of a fractious relationship between himself and RN Hills, that he did not trust her and that he had written to CCA indicating he did not wish to work with her. He gave evidence of two episodes of which he was critical of her.

224 The Coroner discussed his view of this submission.[192] The Coroner observed that there was 'a strained relationship between the pair'. He referred to Dr Runacres repeatedly calling RN Hills 'a liar' and that Dr Runacres had no faith in her professionally. He contrasted Dr Runacres' description of the relationship with that of RN Hills by saying that she 'was much more professional when discussing the relationship' and that she 'resisted the opportunity to criticise him if she could not do so honestly' and that she was 'restrained' when invited to discuss their relationship.

225 The Coroner concluded that 'there is simply no evidentiary basis for me to conclude that their strained relationship coloured RN Hills' evidence about Dr Runacres.'[193]

192 Coroner's Report, 175 [488].
193 Coroner's Report, 175 [488].

Differences between RN Hills' draft and signed statement

226 Counsel for Dr Runacres noted that RN Hills' statement was taken 22 months after Veronica's passing and was drafted over a period of six months, giving her time to reconsider her narrative and change parts of it. Counsel identified seven differences between RN Hills' draft statement of 21 October 2021 and the statement ultimately provided to the inquest on 19 April 2022, and criticised her evidence on the basis that it may have been affected by hindsight given the amendments made to the draft and the fact that she received unspecified documents from the DPFC Medical Centre on 28 March 2022.

227 The Coroner rejected this criticism for the reasons set out below.[194]

(a) RN Hills only requested access to documents when lawyers for CCA who acted for Dr Runacres at that time notified her that she would be required to make a statement to the Coroner. The CCA lawyers offered to seek instructions to provide her with relevant medical records to help refresh her memory. She requested copies of the records on 16 December 2021 but received them three months later on 28 March 2022. She provided her statement the following day.

(b) All clinicians who provided statements were assisted by the notes in the JCare file. RN Hills did not have access to the file at the time she commenced her draft statement and had no opportunity to review records until after the offer made by CCA's lawyers roughly two years later.

(c) She was not to be criticised for the delay in the provision of the statement or the period over which she was initially drafted and reviewed. The Coroner said that he was satisfied that she sought to assist any investigation into Veronica's passing from the moment she learned of it.

194 Coroner's Report, 158–60, [451]–[454].

(d) The identified differences between her draft and final statements were not considered to be changes of 'any moment.' None of the variations substantively changed the meaning of her evidence. The Coroner considered the changes to be standard variations that one might expect in a drafting phase when reviewing a document drafted by a lawyer and then reviewed and signed by the person providing the evidence. It was not uncommon to see minor variations between other drafted final statements provided to the investigation.

228 Rather than consider these complaints as a basis upon which the Coroner should find the evidence unreliable or a basis upon which he should find the evidence has shifted over time, the Coroner said '[o]n the contrary, RN Hills' evidence has remained consistent in its most crucial respects.'[195]

RN Hills' missing notes and the purported disadvantage to other parties

229 RN Hills gave evidence that she wrote her own 'reflection' of Veronica's RMA on or around 4 January 2020 and later referred to these notes during a conversation with her lawyer. The notes had been lost and were unable to be produced to the inquest which meant that interested parties did not have an opportunity to see them.[196]

230 The Coroner considered that it was unfortunate that parties were unable to view the notes, but that this was not a material unfairness and any unfairness arising from unavailability of notes must be in part attributable to CCA.

231 The Coroner referred to the absence of a statement being obtained from RN Hills in January 2020, when statements from all staff who had any interaction with Veronica between 31 December 2019 and 2 January 2020, had been sought, except from RN Hills.

232 There was a dispute about how this came about with an allegation that CCA executive management had a preference for not obtaining a statement from RN Hills. RN Hills gave evidence that she tried to provide a statement on two occasions but it was not

195 Coroner's Report, 160 [455].
196 Coroner's Report, 160–3 [456]–[465].

accepted. The relevant officer gave evidence that he recalled meeting with RN Hills, that she expressed concern about Veronica's health at the time of the assessment and he confirmed that RN Hills told him that she felt that Veronica needed to be transferred to hospital at the time of the RMA.[197]

233 The Coroner determined that her statement should not be strengthened by the purported existence of contemporaneous notes. He concluded that no additional weight should be given to any aspect of her evidence insofar as it was suggested that evidence is derived from contemporaneous notes.

234 The Coroner commented that RN Hills' oral evidence:[198]

> was spontaneous and appeared to come from genuine memory and recollection. She could recall most details of the assessment and described events consistently with her statement. RN Hills also took responsibility for her failures; she acknowledged that she failed to document her concerns in detail and that she did not send Veronica to hospital although it was within her power to do so.

235 The Coroner said that he was satisfied that she sought to assist any investigation into Veronica's passing from the moment she was advised of it. The absence of her notes is not suggestive of a desire on the part of RN Hills to withhold information.[199]

Dr Runacres' reliability as a witness

236 A key issue for the Coroner in resolving the competing evidence given by Dr Runacres and RN Hills was Dr Runacres' (un)reliability as a witness.

237 In defence of the evidence given by Dr Runacres, it was submitted to the Coroner that Dr Runacres should not be criticised for his lack of memory and that he had no independent recollection of Veronica, his evidence being reconstructed from notes. This was put forward on several bases:[200]

(a) the events were more than two years prior to his oral evidence;

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197 Coroner's Report, 161–3 [460]–[465].
198 Coroner's Report, 162 [464] (footnotes omitted).
199 Coroner's Report, 162 [463].
200 Coroner's Report, 175–6 [489].

(b) it was human experience for people to have different capacities to recall events;

(c) a witness who is not comfortable giving evidence without a clear recollection or support from contemporaneous documents was not an unreliable witness, but to the contrary; and

(d) Dr Runacres had provided an explanation that might account for his lack of recall.[201]

238 The Coroner rejected this submission about Dr Runacres in somewhat damning terms, observing that:[202]

(a) it was unclear when Dr Runacres heard of Veronica's passing but accepted it may have been the next time he worked at the prison, possibly within weeks;

(b) Dr Runacres recalled a meeting with Dr Blaher to discuss Veronica's cause of death after the autopsy report was available. This meeting did not 'spark any recollection or curiosity';[203]

(c) Dr Runacres' review of the CCTV footage and his notes did not prompt any memory either;[204]

(d) while at DPFC, Veronica had interactions with several CV and CCA staff, all of whom were able to give oral evidence at the inquest of their recollections, some independently and some only with the assistance of their notes and CCTV footage;[205]

201 Coroner's Report, 176 [489.4] citing Inquest Transcript 1070, lines 14–23.
202 Coroner's Report, 176–7 [490]–[495].
203 Inquest Transcript, 1066.
204 Inquest Transcript, 980–1, 888.
205 Coroner's Report, 176 [492] referring to the following witnesses as examples: Leanne Enever, Leanne Reid, Christine Fenech, Stephanie Hills, Bester Chisvo, Mark Minett, Alison Brown, Justin Urch, Michelle Reeve, Karen Heath, Tracey Brown and Atheana George.

(e) Dr Runacres was the only DPFC staff member who maintained that Veronica was not unwell, the Coroner viewing his evidence on this point being 'uncorroborated, and at times self-serving and implausible';[206] and

(f) on Dr Runacres' own account, his evidence was wholly reconstructed from his notes (which he ultimately admitted were unreliable),[207] and retrospective review of the CCTV footage promoted no recollection.[208]

239 The Coroner contrasted his observations of Dr Runacres with others, in particular RPN Chisvo who assessed Veronica for roughly three minutes (contrasting the time spent by Dr Runacres, who spent the most time of any DPFC staff interacting with Veronica — over 13 minutes) and said of RPN Chisvo's evidence that she was 'a very impressive witness who gave honest, considered and forthright evidence to which I attach significant weight'.[209]

240 In rejecting Counsel's submission to the Coroner that Dr Runacres should be considered a reliable witness, the Coroner said:[210]

> In fact, I find his inability to provide any evidence of independent recollections to be extremely convenient, given the competing accounts of other DPFC staff members and the objective evidence indicating Veronica was very unwell at that time. His evidence on this point was uncorroborated, and at time self serving and implausible.

241 He went on to say that on the weight of the available evidence, he was satisfied that Dr Runacres was an unreliable witness and to the extent there is inconsistency, he preferred the evidence of RN Hills.

242 This conclusion as to reliability and preference of evidence which was made adverse to Dr Runacres is compelling. It also assists in influencing my view that the findings which the Coroner made were open to him and that they were findings not tainted by

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206 Coroner's Report, 177 [493] citing Inquest Transcript, 996–8. Dr Runacres' evidence about Veronica's clinical presentation was given in reliance on the CCTV footage and pre-populated notes which he had left unchanged which said that Veronica was 'alert not drowsy' and 'not toxic looking'.

207 Coroner's Report, 177 [494] citing Inquest Transcript, 1066, 1069. Dr Runacres also states that his notes contained errors and inaccuracies at Inquest Transcript, 997.

208 Coroner's Report, 177 [494] citing Inquest Transcript, 978.

209 Coroner's Report, 176–7, [492].

210 Coroner's Report, 177 [493], citing Inquest Transcript 1066–9.

unreasonableness nor inconsistent with a proper and competent view of the evidence on the *Briginshaw* standard.

243 Having made his assessment of the competing evidence between Dr Runacres and RN Hills, the Coroner then dealt with his findings about Veronica's health at the time of the RMA and, in particular, his findings as to whether Veronica was weighed and whether there was a physical assessment undertaken by Dr Runacres.

Coroner's findings

244 In light of the competing evidence (weighed in accordance with the considerations set out above), the Coroner proceeded to make findings as to:

(a) Veronica's clinical presentation at the time of her RMA;

(b) the decision not to transfer Veronica to hospital; and

(c) Dr Runacres' treatment and care of Veronica.

245 These findings, although not subject to appeal, are relevant to the overall context in which the Coroner made his finding that physical examinations were not conducted by Dr Runacres.

Veronica's clinical presentation at the time of her RMA

246 The Coroner concluded that the combined weight of the evidence of RN Hills and RPN Chisvo,[211] and non-medical but experienced POs, PO Watts[212] and PO Hermans[213], Senior Prison Officer Christine Fenech ('SPO Fenech')[214] combined with the CCTV footage led to the conclusion that at the time of her RMA, Veronica was very unwell.[215]

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211 Coroner's Report, 182–3 [510]–[511].
212 Coroner's Report, 182 [507].
213 Coroner's Report, 182 [508].
214 Coroner's Report, 181 [506].
215 Coroner's Report, 183 [512].

247 These witnesses variously described Veronica's presentation as 'very sick, shaking and could not stop vomiting consistently', 'extremely ill, vomiting and quite weak, though she was able to talk and stand'. PO Watts recalled being shocked at Veronica's emaciation. SPO Fenech noted 'how small, frail and unwell' Veronica appeared.

248 Supervisor Reid (who saw Veronica *prior* to her medical assessment)[216] said that:

(a) Veronica was unable to complete the formal prison reception because she was too unwell;

(b) Veronica had one of the worst cases of withdrawal she had ever seen;

(c) Veronica looked, 'very, very underweight, very lethargic' and was stooped over in what looked like stomach pain;

(d) Veronica was not engaging with staff much because she was unwell; and

(e) 'everybody could see' that 'Veronica was so unwell'.

249 Whist these officers are not medically trained, the Coroner observed that they are lay people who regularly worked in a custodial setting and were seemingly concerned about Veronica's health compared to other new receptions. However, he appropriately gave greater weight to the observations of RN Hills and RPN Chisvo as they are registered nurses.[217]

250 RPN Chisvo conducted a psychiatric assessment in the cell 10 minutes after the RMA and said Veronica was actively vomiting and that she observed during that assessment that Veronica was visibly struggling to sit on her bed and reported feeling 'horrible' and 'uncomfortable'. Veronica told her she could not sit up because she was not feeling well, that she preferred to lay down, and that she was 'closing her eyes and not fully oriented' so RPN Chisvo scheduled a follow up review when she was 'fully oriented and alert'.[218]

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216 Coroner's Report, 181 [505].
217 Coroner's Report, 182 [510].
218 Coroner's Report, 182–3 [510].

251 RPN Chisvo and RN Hills agreed that Veronica should stay in the Medical Centre overnight, which suggested to the Coroner that this indicated an unusual degree of sickness.[219]

252 This evidence was directly contrary to that of Dr Runacres, who said that Veronica was not very sick at the time of her medical assessment. He conceded that she was vomiting, withdrawing from heroin and said that 'I'm sure that's incredibly uncomfortable, but that's not very sick'.[220]

253 He reiterated this when viewing the CCTV footage and later evidence where he commented that he was not concerned with Veronica's presentation: 'I saw somebody who was withdrawing from heroin that needed management of that and that I provided that management.'[221]

254 The Coroner noted that Dr Runacres recorded Veronica's 'EJustice M Rating' as 'M3' at the time of her reception, which means he did not consider Veronica's opioid dependence to be a serious medical condition or one requiring ongoing treatment.[222] This rating indicates the prisoner had a 'known or suspected medical condition/symptoms requiring appointment' and not the higher ratings of 'M2' ('medical condition requiring regular or ongoing treatment') or 'M1' ('serous medical condition/symptoms requiring immediate assessment/treatment'.)[223]

255 The Coroner noted what he considered to be an important distinction made here as between being *sick* and *someone who is withdrawing from heroin*. The Coroner's Report makes a number of observations and findings about the standard treatment of prisoners suffering from drug or alcohol substance issues and withdrawal management and, in particular, the impact drug use stigma had on the quality of care Veronica received whilst at DPFC.[224]

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219 Coroner's Report, 183 [511].
220 Coroner's Report, 178 [497] citing Inquest Transcript, 1050.
221 Coroner's Report, 178 [498.2] citing Inquest Transcript 1086.
222 Coroner's Report, 179 [500].
223 Coroner's Report, 179 [500].
224 See Coroner's Report, 178–81 [499]–[503].

256 I consider the Coroner's conclusion that Veronica was very unwell at the time of her RMA to be relevant context to the findings made by the Coroner which are the subject of this appeal. This is particularly so with regard to the conclusion that Dr Runacres started the 'chain of events' at [541] of the Report. It is also important to provide the context and the significance of the other findings challenged.

257 Whilst there are clearly systemic failure of operations and policies at play, it is not possible to draw a bright line between these systemic or policy failures and the overlap with the actions of individuals in this coronial investigation. Consequently, it is necessary to look at the evidence beyond just that of the competing evidence of Dr Runacres and RN Hills and limited CCTV footage relied upon in the hearing. To do so would be to artificially exclude surrounding corroborative or contrary evidence and context.

258 Whilst Veronica's unwellness is not a specific finding challenged, I do not think that it can be ignored when the whole of the evidence in relation to Dr Runacres is considered. Of itself it tends to demonstrate an attitude and course of conduct which was cavalier rather than caring.

The decision to not transfer Veronica to hospital

259 Similarly to the Coroner's findings as to Veronica's clinical presentation, relevant context to the appealed findings is provided by the Coroner's findings in relation to the decision not to transfer Veronica to hospital.

260 The Coroner considered the evidence of RN Hills that she expressed concerns about Veronica's presentation and told him she thought that Veronica should be transferred to the hospital but Dr Runacres did not agree.[225]

261 Dr Runacres did not recall whether RN Hills suggested that Veronica should go to hospital but accepted it may have occurred and there was a great possibility that Veronica would have lived if he had followed RN Hills' advice. Dr Runacres' evidence

225 Coroner's Report, 188–9.

was that he did not consider it necessary to transfer Veronica to hospital before the medication prescribed had been administered. Dr Runacres, relying on his notes, maintained that Veronica was well enough to be moved to the main part of the prison and did not need to go to hospital.[226]

262 The Coroner was satisfied that RN Hills attempted to advocate for Veronica to be transferred to hospital and that, based on the advice of the Medical Conclave, it was reasonable to have done so.[227]

Dr Runacres' treatment and care of Veronica

263 The Coroner's Report also sets out the Coroner's observations, conclusions and formal findings on Dr Runacres' treatment and care of Veronica.[228]

264 The Coroner set out that, in making findings about the adequacy of Dr Runacres' RMA, he had regard to matters including:[229]

(a) the additional burdens on medical professionals practising in the custodial setting;

(b) the assumption that health practitioners go to work with the intention to do good and not harm;

(c) the fact that the severe deterioration in Veronica's condition cannot of itself render an otherwise adequate assessment inadequate; and

(d) the standard of proof required to make adverse findings about a professional's conduct.

265 The Coroner acknowledged that he received extensive submissions on behalf of Dr Runacres and his employer CCA opposing any finding that would suggest inadequacy of care and treatment of Veronica.

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226 Coroner's Report, 189 [531] citing Inquest Transcript 1100–1101, 1124, 1049–59, 1003.
227 Coroner's Report, 189 [532].
228 Coroner's Report, 190–4 [533]–[542].
229 Coroner's Report, 190 [533].

266 The submissions proceeded on the basis that his Initial Appointment Notes and MAF were accurate and that a physical examination was performed. These submissions referred to expert evidence which also relied on the same assumptions.

267 The Coroner considered the Medical Conclave's opinion and observed that it saw the case for Dr Runacres' proficiency of service at its highest because they were not in receipt of adverse material which went to Dr Runacres' credibility and reliability, assumed the MAF and Initial Appointment Notes were accurate, the physical examinations had been conducted and that Veronica's weight was correctly recorded at 40.7 kg.

268 The Coroner noted that notwithstanding the Medical Conclave saw Dr Runacres' conduct at its highest, when asked to provide an opinion about the adequacy of the RMA, the Medical Conclave unanimously held the following concerns:[230]

(a) his notation was inadequate and at times inaccurate;

(b) he took an inadequate history, and in particular, failed to make enquiries of Veronica's previous vomiting;

(c) he failed to conduct a cultural assessment;

(d) he failed to acknowledge Veronica's frailty;

(e) he failed to make a forward plan for her management which should have 'at least' included observation; and

(f) he failed to resolve the difference of opinion between himself and RN Hills about Veronica's need for hospitalisation, and this did not reflect well on Veronica's care.

269 A majority of the Medical Conclave concluded the medical assessment and treatment by Dr Runacres was inadequate (although there was a minority view to the contrary).

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230 Coroner's Report, 191–2 [536].

270 Some members of the Medical Conclave concluded that, on the history of her 40.7 kg weight and vomiting alone, she should have been transferred to hospital at the time of her RMA. Other members opined that, given the information available to Dr Runacres, it was not unreasonable for him to not transfer her. This latter view assumed access to specialist medical support and the ability to monitor a patient closely.

271 In light of the matters set out above, the Coroner was satisfied that:[231]

(a) Dr Runacres' RMA was not comprehensive and his records of it were inadequate;

(b) Dr Runacres provided no plan for Veronica's ongoing management and ought to have done so; and

(c) Veronica was unwell at the time of her RMA and her presentation warranted transfer to hospital.

Recording of the physical assessment notes in Veronica's JCare file

272 It is within the context of the observations and findings set out in the foregoing paragraphs that the Coroner made his finding at [528][232] which is subject to appeal:

> On the basis of the evidence canvassed above, I find that a physical examination of Veronica was not conducted on 31 December 2019, although three examinations were recorded as having been undertaken in the MAF and Initial Appointment notes by Dr Runacres.

273 The evidence to which the Coroner referred is set out below.

(a) In Veronica's MAF and Initial Appointment Notes, Dr Runacres recorded Veronica's heart had no murmur, her chest was clear with good air entry to the base of the lungs, and her abdomen was soft and tender.[233] These annotations

231 Coroner's Report, 193 [539].
232 Also recorded as Item 21 in Appendix B of the Coroner's Report.
233 As set out at [159] above.

reflect an alteration to the Initial Appointment Notes pre-populated template so Dr Runacres must have entered them himself.[234]

(b) The evidence of RN Hills and Dr Runacres was that these observations are undertaken by the doctor and not a nurse.[235]

(c) RN Hills unequivocally stated that Dr Runacres did not conduct any physical examination of Veronica whilst in her presence.[236]

(d) Dr Runacres' evidence was that even though he had no independent recollection of Veronica's RMA, he was adamant that he does not make up data.[237] He said that because he had to enter the relevant notations into the form, this fortified him in his belief that he conducted the physical assessments.

(e) Dr Runacres conceded that he did not take care to ensure his notes in Veronica's JCare file were accurate.[238]

274 Counsel for Dr Runacres also submitted that RN Hills' evidence should not be accepted because she did not know what 'SNT' or 'HSDNM' meant.[239] The Coroner did not accept that RN Hills could not give evidence regarding the physical examination simply because she did not understand the abbreviations. He said that she was honest enough to concede she was not familiar with the acronyms and when giving evidence she was able to describe how each examination would be performed.

275 Given the Coroner's overarching view of the credibility of RN Hills when compared to the credibility and reliability of Dr Runacres' evidence in a contest of evidence, this finding was open to him.

276 The finding at [527] uses the same phraseology of 'not open' in respect of the finding that the examinations, including an abdominal examination of the patient when lying

234 Coroner's Report, 186 [521].
235 Coroner's Report, 186 [522].
236 Coroner's Report, 186 [522].
237 Coroner's Report, 186–7 [524].
238 Coroner's Report, 186 [524] citing Inquest Transcript, 985, 997. See also Inquest Transcript, 1020.
239 Coroner's Report, 186 [523], citing Inquest Transcript, 675–6. I discuss the acronyms at [159] above.

down, could have occurred at any location between 5:21:47pm when Veronica left the reception centre corridor and 5:22pm when Dr Runacres first opened the JCare file in the clinical room. In my view, this is soundly based. I reiterate my comments at [172]–[174] in respect of 'not open' as a choice of wording.

Conclusion as to Grounds 2 and 3

277 Considering the matters set out above, I am not satisfied that the Coroner erred in law in the manner in which he weighed all of the available evidence in finding at [528] of the Coroner's Report that the appellant did not physically examine Veronica on 31 December 2019. This finding was not 'against the evidence and the weight of the evidence' to such an extent that no coroner could have made it and the evidence relied upon was competent according to the *Briginshaw* standard.

278 It was submitted on behalf of Dr Runacres that it was inherently unlikely that no physical examination took place given the gravity of the allegation and the fact that there were notations in the medical notes, and no explanation or reason had been advanced as to why the appellant would have failed to conduct the examination and falsified the records to make it appear that he had done so.

279 I am not satisfied that the Coroner's conclusion to the requisite standard was not made out. His view of the reliability and veracity of Dr Runacres' evidence, as discussed above, was scathing. Where there was a different version of the evidence given by RN Hills on key matters, he preferred her evidence and found her to be a witness of truth.

280 The Coroner was required to make findings as to the circumstances of Veronica's death in a context where the evidence was hotly disputed. He carefully resolved inconsistencies by weighing the evidence in accordance with their cogency and credibility. For example, while contemporaneously created documentary evidence is usually seen as probative, the Coroner appropriately reduced his reliance on Dr Runacres' notes due to the clear evidence, including Dr Runacres' own admissions, that they were unreliable. The Coroner also made nuanced assessments as to the

credibility of witnesses. Where inconsistencies were raised — such as in relation to the argument that RN Hills had a personal motivation to negatively portray Dr Runacres — he scrutinised them appropriately in order to arrive at a reasoned conclusion.

281 It was also submitted that the Coroner did not appropriately weigh the countervailing evidence due to the lack of a motive or reason being advanced to explain why the appellant would have failed to conduct an examination and contemporaneously falsify records to make it appear that he had done so.

282 I am not satisfied that there is any substance to this criticism. Motive is not a necessary precondition to making such a finding. Insofar as this submission is intended to identify any logical inconsistency of the finding, given the overwhelming adverse view the Coroner took of the appellant's evidence, his significant lack of care in his record keeping, and his dismissive explanations (such as 'no one reads the record anyway', 'I don't weigh these people' and the categorisation of someone withdrawing from opioids as not being sick), the weight of the evidence indicates to me that there is no illogicality or unreality in this conclusion despite the gravity and of the implications of the finding. Further, the notion that the Coroner was required to develop a motive in order to explain his findings as to Dr Runacres' actions in my view is to require more from him than what the civil standard of 'balance of probabilities' requires.

283 Relatedly, as to the consideration of the presumption of innocence, I note that the role of the Coroner is not to accord guilt or fault but to make statutory findings as to the circumstances of the death. In making his statutory findings, the Coroner must be satisfied on the balance of probabilities on the evidence to support his findings. The Coroner was well aware of the gravity of the implications of his findings in respect of the appellant and recognised the heightened level of persuasion be adopted.

284 I am not persuaded that the finding was against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made it. On the contrary, in my view, the weight of the evidence was in favour of the finding and it

was entirely reasonable for the Coroner to reach it notwithstanding the evidence to the contrary. Further, I would also not be persuaded that his finding lacks an 'evident and intelligible justification' in accordance with *Li* — his reasoning is entirely intelligible and his justification for his findings is evident across the Report.

285 Grounds 2 and 3 are not made out.

GROUNDS 4 AND 5: RECORDING VERONICA'S WEIGHT

286 Grounds 4 and 5 (and corresponding Questions 4 and 5) relate to the finding at [520] of the Coroner's Report that the weight recorded for Veronica's MAF was inaccurate.

287 Paragraph [520] states:

> On the basis of Dr Baber's evidence, I find that Veronica weighed around 33kg at the time of her reception medical assessment and that the weight recorded by Dr Runacres in the MAF was inaccurate.[240]

288 In addition, and the further paragraph at [696] is relevant (footnotes omitted):

> Dr Runacres said that he did not take care to ensure that these notes were accurate because he did not believe that other staff would ever look at them. He left notes in error on Veronica's file, often failing to update pre-populated material. He also recorded an inaccurate weight in Veronica's MAF and recorded physical examinations that were not performed. Some of these errors were critical in Veronica's care – particularly the incorrect recording of her weight – as they were relied upon by Dr Brown.

289 The grounds allege that the Coroner's finding in relation to Veronica's weight ought not stand because:

(a) the Coroner failed to apply the *Briginshaw* standard, weighing all available evidence and bearing in mind the gravity of the finding and the inherent unlikelihood of the conduct found; and/or

(b) the finding is against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made it.

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240 Grounds 4 and 5 relate to this finding.

290 The grounds of appeal require consideration of whether there was sufficient evidence to form the basis that the weight recorded was inaccurate. This challenges the inference based on the evidence of Dr Baber, that Veronica weighed around 33 kg at the time of her RMA.

291 At the outset, I note that the appellant has framed the finding at [520] as a finding that Dr Runacres *recorded* Veronica's weight *inaccurately*, the emphasis being on the action of recording. However, on my reading of [520], the Coroner actually found that the *weight* recorded was inaccurate, the emphasis being on the weight itself, rather than the action of recording it. Therefore, the finding is not one which directly alleges fraudulent behaviour.

292 What is put by the appellant is that, having accepted the evidence that Veronica was not weighed, and that the entry as to weight in the MAF was done by Dr Runacres' hand, it must have been done fraudulently.

293 I am not convinced that the implication of fraud is the only conclusion from that finding. The use of the term fraud connotes illegality which is not the task of the Coroner to determine and, in my view, he did not do so. This finding at [520] is to be distinguished from the Draft Findings which are framed in much stronger language.[241] The finding equally implies a lack of care or diligence, particularly so in light of the finding at [540] of the Coroner's Report that Dr Runacres' medical assessment and treatment departed from reasonable standards of care and diligence expected in medical practice.

Record of Veronica's weight in the MAF

294 Dr Runacres recorded Veronica's weight as 40.7 kg on 31 December 2019. There was a factual dispute as to whether this weight recorded by him was the result of weighing her during the RMA.

241 See especially Draft Key Findings, [14]–[17] enclosed in Court Book, 11200.

295 Veronica's weight was recorded as one of five 'vital signs' in the MAF.[242] These entries were not pre-populated and it was not disputed that the first four of these vital observations were performed by RN Hills and recorded by Dr Runacres.[243]

296 The Coroner noted there was no other evidence that another person was present who could have or did weigh Veronica other than Dr Runacres or RN Hills.

Evidence of Veronica's weight at the time of her passing

297 On admission to the Victorian Institute of Forensic Medicine ('VIFM') mortuary on 2 January 2020, Veronica weighed 33 kg.

298 The discrepancy of 7.7 kg between the recorded weight in the MAF and that recorded by VIFM is a considerable one, equivalent to 19% of Veronica's body weight. The Coroner observed that the discrepancy was not one 'convincingly explained by the presence or absence of clothing or different calibrated scales — either singly or in combination'.[244] The evidence from Dr Baber was that no weight loss which would 'register in terms of kilograms' would occur post mortem[245] and it would not be possible for a living person to lose 7.7 kg (or even 5 kg) in body weight in 36 hours. The Coroner accepted Dr Baber's evidence on this point.[246]

299 The Coroner noted the importance of accurately measuring and recording a prisoner's weight and other physical observations at the time of the RMA as the MAF with these observations and measurements become part of the prisoner's electronic JCare file.[247] This was important, the Coroner commented, because the file is reviewed by subsequent medical officers and clinicians as a marker against which to assess the person's clinical presentation. Dr Brown was to review the file the next day before she made further decisions about Veronica's care and treatment.[248] Assessment and treatment will be viewed by the clinician in the light of physical vulnerability,

242 The other four entries were blood pressure, heart rate, temperature and respiratory rate.
243 Coroner's Report, 151 [426].
244 Coroner's Report, 184 [517].
245 Coroner's Report, 184 [517] citing Inquest Transcript, 2055.
246 Coroner's Report, 184 [517] citing Inquest Transcript, 2055, 2079.
247 Coroner's Report, 183 [513]–[514].
248 Coroner's Report, 183 [514] fn 730 citing Inquest Transcript, 718.

especially where a person is underweight and undernourished. As noted by the Coroner, 'the usefulness of a prisoner's previous records to the clinician when making baseline comparisons is inextricably linked to their accuracy.'[249]

Other evidence regarding Veronica's weight

300 The relevant evidence and submissions which must be weighed in this regard are as follows:

(a) Dr Runacres had no general recollection of Veronica's RMA;

(b) Dr Runacres had no memory of Veronica being weighed but he nonetheless said she was weighed because a weight was recorded in the MAF, and that he 'does not make up numbers';[250]

(c) Dr Runacres suggested that there were scales in one of the clinical rooms or in the hallway;

(d) it was Dr Runacres' evidence that it was RN Hills' responsibility, as the nurse assisting him, to weigh patients. He said he does not weigh 'these people';[251]

(e) RN Hills' evidence was that she could not recall a time in 60 to 70 shifts that there were entries in the medical record without a corresponding examination;

(f) apart from Dr Runacres' notes, there was no other objective evidence about Veronica's weight at the time of her reception at DPFC;

(g) the Coroner did not address the evidence that Veronica could have lost 5 kg of fluid from her stomach or bladder which Dr Baber said was 'incredibly hypothetical' and 'not very likely'[252] and there was no further expert evidence on the point;

249 Coroner's Report, 184 [514].
250 Coroner's Report, 184 [518] citing Inquest Transcript, 1079.
251 Coroner's Report, 185 [518] citing Inquest Transcript, 1082.
252 Inquest Transcript, 2079.

(h) the CCTV footage did not capture all of Veronica's movements during her stay at DPFC;

(i) Dr Runacres' counsel submitted that Veronica could have been weighed before the RMA and in the absence of RN Hills;

(j) the evidence of RN Hills was that Veronica was not weighed;

(k) RN Hills had independent recall of the RMA and was unequivocal that Veronica was never weighed;

(l) RN Hills said there was no discussion between her and Dr Runacres about estimating Veronica's weight;

(m) she discounted the possibility that Veronica was weighed when she was not present;

(n) the evidence of Dr Baber, who performed the autopsy on Veronica on 6 January 2020, reported her body weight at 33 kg, describing her as cachectic[253] and with a BMI calculated to be 12.9. Veronica's BMI was described as being indicative of a person who is 'grossly underweight' and undernourished;[254]

(o) Dr Baber was questioned about how the deceased are weighed on receipt at the VIFM mortuary and the likelihood of significant weight loss in the approximate 36 hours period prior to or shortly after passing. Dr Baber's opinion was that no weight loss that would 'register in terms of kilograms' would occur post mortem and it would not be possible for an individual to lose 7.7 kg or 5 kg in body weight in 36 hours of life;[255] and

(p) Dr Baber confirmed that Veronica's malnutrition was apparent shortly before she passed because she was 'incredibly thin'[256] and that her malnutrition was

253 Cachectic refers to a person who has cachexia, which is a medical term for someone who appears very malnourished looking.
254 Coroner's Report, 67–8 [195].
255 Coroner's Report, 70–1 [205] citing Inquest Transcript, 2055, 2079.
256 Coroner's Report, 71 [206] citing Inquest Transcript, 2077.

the most significant causative factor in Veronica's passing because it would be unlikely for an otherwise healthy individual — that is, one not affected by the long term effects of malnutrition — to have passed if they were in the position Veronica was in in the last two or three days of life.[257]

Conclusion as to Grounds 4 and 5

301 As noted at [287] above, the Coroner found on the basis of Dr Baber's evidence that Veronica weighed around 33 kg at the time of the RMA and that the weight recorded by Dr Runacres in the MAF was inaccurate.

302 Despite not being briefed with all of the information which was available to the Coroner, the Medical Conclave also formed a negative view of the appellant's assessment and care, including record keeping.[258]

303 Evidence of others as to her physical appearance corroborated that Veronica was exceptionally or incredibly thin.[259]

304 The Coroner found that there were many errors in Veronica's medical file. As the Coroner noted, some of these errors, including as to her weight, were 'critical' in her care.[260]

305 I am not satisfied that the conclusions drawn from the evidence available were wrongly formed. Where there was no direct evidence, the evidence was capable and supportive of the inferences the Coroner drew.

306 The finding that Veronica weighed 'around 33kg' at the time of her RMA was a finding open to him on the evidence of Dr Baber. The degree of weight loss over 36 hours raised is highly unlikely, thus does not weigh against the finding that weight on reception could logically or medically have been 7 kg more. The submission that the Coroner failed to engage with the submission that Veronia could have lost fluid

257 Coroner's Report, 71 [208] citing Inquest Transcript, 2076–7.
258 Discussed at [149], [193], [268]–[270] above.
259 Coroner's Report, 71 [206] citing Inquest Transcript, 2077 (Dr Baber). See also Coroner's Report, 181–2 [506]–[507].
260 Coroner's Report, 241 [696].

(as opposed to body weight) is an ambitious one, both as a matter of evidence and of logic.

307 Where there was a conflict of evidence between RN Hills and Dr Runacres, the Coroner preferred the evidence of RN Hills. It is trite that a Coroner, upon hearing evidence *viva voce*, is entitled to reach a view as to the credibility of witness testimony. He was in the best position to make an assessment having observed the witnesses in person, both by reference to their demeanour and through analysis of internal and external inconsistencies. I reiterate my views at [279]–[280] above.

308 No direct evidence was given of anyone else who could or would have weighed Veronica.

309 The Coroner based his finding primarily on the cogent evidence of Dr Baber. Where he was required to draw inferences, he carefully weighed the evidence with reference to its credibility and consistency with the other evidence which was available to him. In doing so, he satisfied the demands of the *Briginshaw* standard.

310 As to the inference that the appellant thus must have falsified the medical record, as noted at [291]–[293] above, that is not the finding the Coroner in fact made. He said that the *weight* recorded was inaccurate. He was satisfied that she was not weighed during the RMA, as he similarly found that no physical examination took place. In finding these facts, he was persuaded by the weight of the evidence. This included the evidence of RN Hills and the rejection of the appellant's version of events where there was a conflict of direct evidence, and taking into account corroborated testimony.

311 That there was a medical record entry (be it a pre-populated one or not) of itself does not prove the examination, including weighing of Veronica *in fact* took place, especially where the person who made the notes cannot recall what in fact occurred (even after a review of CCTV footage) and there being clear evidence that the records were inaccurate.

312 The CCTV footage is equivocal without audio. It must be considered in the context of the competing other testimonies.

313 Whilst it was theoretically possible that Veronica was weighed (and other physical examinations took place) and that her weight was in fact 40.7 kg, the only evidence which would tend to prove that fact was the medical record entries. In the context of the medical record being woefully inaccurate and the evidence of the appellant that at least in some respects he thought 'no one would read it anyway', the veracity and evidentiary worth of the medical record entries is very limited and very much open to doubt. The reliability of a contemporaneously made written record can be diminished by evidence of its inaccuracy and error. The authenticity and reliability of the written record was undermined by the lack of care by the appellant in the entries made by him in Veronica's medical record.

314 As I have found in respect of Grounds 2 and 3, I find that, consistently with the *Briginshaw* standard, the Coroner weighed the evidence carefully in accordance with its cogency, and inferences were guided by corroborating evidence. The Coroner carefully chose his wording so as to emphasise that the weight recorded by Dr Runacres was inaccurate, rather than making any specific finding as to fraudulent or dishonest behaviour. It is equally open to infer a lack of care or diligence on the part of the appellant.

315 I am also satisfied that the weight of the evidence before the Coroner was in favour of his ultimate finding — thus it cannot be described as 'against the evidence and the weight of the evidence' to such an extent that no reasonable coroner would have made it. As with the finding at [528], his Report reveals an evident and intelligible justification for his finding.

316 Grounds 4 and 5 fail.

GROUND 6: SETTING IN MOTION A 'CHAIN OF EVENTS'

Conduct of Veronica's RMA

317 After canvassing the facts and circumstances of Veronica's assessment and care in the RMA process commencing at [419] of the Coroner's Report, the Coroner then concludes (footnote omitted):

> [539] In light of the above, I am satisfied that:
>
> 539.1 Dr Runacres' reception medical assessment was not comprehensive and his records of it were inadequate;
>
> 539.2 Dr Runacres provided no plan for Veronica's ongoing management and ought to have done so;
>
> 539.3 Veronica was unwell at the time of the reception medical assessment and her presentation warranted transfer to hospital.
>
> [540] I find that Dr Runacres' medical assessment and treatment of Veronica on 31 December 2019 was inadequate. Dr Runacres' failure to physically examine Veronica, plan her ongoing care and maintain accurate records are significant departures from reasonable standards of care and diligence expected in medical practice.

318 What follows is the paragraph challenged as the third finding under review in this appeal, being at [541] of the Coroner's Report where the Coroner says (footnote omitted):

> Dr Runacres was the health professional responsible for identifying at reception whether Veronica was fit to be held in an unobserved cell. The reception medical assessment is intended to be a comprehensive health assessment and offered the best opportunity in the prison reception process for the extent of Veronica's unwellness to be identified, recorded, treated and escalated. Dr Runacres' failure to properly utilise this opportunity set in motion a chain of events in which her medical treatment and care was inadequate in an ongoing way.

319 The statement is followed by the following finding at [542]:

> I find that Veronica should have been transferred to hospital at the time of her reception to DPFC, and that CV and CCA staff continually failed to transfer her to hospital thereafter, and this ongoing failure causally contributed to her death.

320 Given all that came before, the observation at [541] was a fair one and clearly open to the Coroner to form that view.

Does [541] amount to a finding?

321 As noted at [14] above, a Coroners Act appeal is limited to the statutory findings of a coroner and there is no such right of appeal against a coroner's comments or recommendations in respect of a death.

322 'Finding' is not defined in the Coroners Act and there been no jurisprudential analysis of what constitutes a 'finding' made under s 67(1), as distinct to a comment or recommendation made under ss 67(3) and 72(2) respectively. Nor is there any guidance as to the proper characterisation of statements made which do not fit in any of these categories.

323 The Coroner made a large number of observations and formed conclusions preparatory to his statutory findings made in accordance with s 67 of the Coroners Act.[261] These included the specific findings against the appellant in this proceeding. The Coroner also made referrals and notifications in respect of certain individuals to the relevant professional regulatory bodies[262] and, in accordance with s 72(2) of the Coroners Act, he made a large number of associated recommendations connected with Veronica's passing.[263]

324 In my view, in its context, the statement at [541] is a preliminary causative conclusion on the evidence which forms part of the continuum of analysis which underpins the ultimate finding at [542]. As such, it is not itself an appealable finding for the purposes of the Coroners Act. I am fortified by the following factors:

(a) the statement at [541] immediately follows the finding at [540] and precedes the finding at [542]. It refers to subject matter in both of those findings and presents as a summary of the evidence and previous findings in the Report which leads to the ultimate statutory finding at [542]. This is a pattern of reasoning reflected in the Coroner's Report where the Coroner states his satisfaction as to certain

261 The findings are found throughout the Coroner's Report and are consolidated in Appendix B.

262 Coroner's Report, 301–303 [871]–[877]. These were to the Victorian Legal Services Board and Victorian Legal Services Commissioner, the Australian Health Practitioner Regulation Agency and the Director of Public Prosecutions.

263 Collated in Coroner's Report, Appendix C.

matters which then leads him to a statutory finding. For example, [539] (which sets out various deficiencies in Dr Runacres' RMA) is a preliminary conclusion upon which the finding at [540] (that Dr Runacres' medical assessment and treatment of Veronica was inadequate) is based;

(b) the statement at [541] does not contain the expression 'I find', which is the nomenclature adopted by the Coroner for every other finding in the Report. The same approach is adopted for recommendations. The Coroner's comments are included at [879]–[881] of the Report; and

(c) the statement at [541] is not included in Appendix B, which is the section of the Report in which 'all' of the Coroner's findings appear.[264]

325 However, even if it is properly to be characterised as a finding, it is not one which is 'against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made it' nor lacks an evident and intelligible justification:

(a) the first two sentences of [541] are uncontroversial and wholly supported by the evidence;

(b) the observation that Dr Runacres failed to 'properly utilise' the RMA is supported by the weight of the evidence as to his inadequate treatment, care and record keeping in respect of Veronica, including the evidence (canvassed above) which led to the Coroner's findings at [528] and [520]; and

(c) the fact that Dr Runacres' failure 'set in motion' a 'chain of events in which her medical treatment and care was inadequate in an ongoing way' is a rearticulation of the importance of the RMA in determining a prisoner's ongoing care in the prison healthcare system — both of which in this case were found to be inadequate. It also reflects the finding that Dr Runacres' records were inadequate in important respects and were relied on by subsequent

264 Coroner's Report, 304 [878].

medical officers and prison staff. It is also consistent with the finding at [542] that Dr Runacres should have transferred Veronica to hospital at the time of her RMA, and at [831] that Veronica's death was preventable.

326 I note that in oral submissions, counsel for the appellant conceded that Dr Runacres' RMA may be said to have a causal relationship with Veronica's death in a 'mechanical' sense (as opposed to a 'fault' or liability sense).[265] This concession is telling. Indeed, the Coroner did not, and cannot, make findings of legal liability or guilt. I take the Coroner's statement as to causation in this instance as referring to the factual causal connection between the RMA and subsequent inadequate care which was open to him to make.

327 Ground 6 fails.

CONCLUSION

328 For the reasons I have set out, I have determined that there is no legal error in the findings under challenge.

329 The task of the Court on an appeal brought under s 87 of the Coroners Act is a supervisory one. It is not an appeal on the merits. The applicant must identify a question of law sufficient to warrant intervention by the Court.

330 An appeal on a question of law includes an appeal on the grounds that the finding is against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made it. It also includes an error with respect to the evidential standard which the Coroner applied to the evidence.

331 As previously set out, the Coroner's investigation covered many topics and his Report traversed many matters. The medical care of Veronica, whilst a subset of the areas which were the subject of the investigation, was a crucial part of the Coroner's investigation.

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265 Trial Transcript, 11.

332 Dr Runacres does not seek to review all of the findings adverse to him. In making the case for the unreasonableness of the Coroner's Findings as to Veronica's medical care insofar as Dr Runacres was involved, the focus was on the CCTV footage and the evidence which formed the temporally limited time frame between her arrival at DPFC at 4:35pm on 31 December 2019 and the end of Dr Runacres' shift.

333 To focus on this portion of the time in which Veronica was in custody at DPFC is understandable from his perspective. There is logic to the argument that he was not responsible for her care after he left the premises.

334 However that was not sufficient in the view of the Coroner to avoid part of the responsibility for the assessment and care of Veronica. Rather, as he plainly stated, the RMA is key to setting up the care for a prisoner. Tardiness, inaccuracy or failure to undertake this task in accordance with the standard expected is justly criticised.

335 Findings of the Coroner in respect of other medical staff who interacted (or failed to interact) with Veronica after this time were also the subject of adverse findings and observations.

336 I have reviewed the whole of the Coroner's Report and the documents and transcript which formed the materials in the Court Book. There is a difficulty in properly determining a claim of unreasonableness of a finding in the limited and isolated way in which it was emphasised before me on behalf of the appellant. Whilst not every matter the Coroner considered in his investigation is relevant to the role played by Dr Runacres, the context as a whole is important. To focus on the three paragraphs which are raised in the appeal in isolation from the whole of the relevant evidence and the reasoning which led to those conclusions would be inappropriate.

337 It would equally be an inappropriate assessment of the evidence to look only at parts of the CCTV footage in isolation from the Coroner's observation and findings as to credit and his conclusions as to who he found to be witnesses of truth. The consideration of all of the evidence and the weight given to particular parts in isolation and in combination is the task for the Coroner.

338 The position of the Coroner, who had the benefit of seeing and hearing all of the witnesses in person (and not just a transcript of their oral evidence as was before me) and the ability to make an assessment of the veracity of their evidence and their demeanour, cannot be underplayed.

339 The Coroner's Report dealt with the claim of inconsistency in respect of RN Hills' evidence. He explained his view of those matters raised with him. The matters were not ignored, they were just not accepted on the balance of probabilities that that evidence outweighed the contrary evidence. It was open to the Coroner to form the view of the evidence that he did.

340 Just because there is an inconsistency in the evidence, or that there is a dispute as to the facts and events does not amount to lack of reliability to the requisite degree. The appellant's challenge to the Coroner's assessment of the evidence does not argue that there was no evidence upon which the Coroner could form the view that he did. The submission is that the conclusion was 'against the evidence and the weight of the evidence' to the extent that no reasonable coroner could have formed the view that he did. That there may be some other theoretical explanation or version of the facts of itself is not enough. The bar is a high one.

341 I acknowledge that the implications of the Coroner's Findings are adverse to the applicant. That said, I am not satisfied that the only inference which can be drawn from the lack of satisfaction that Veronica was weighed is not fraud, but a lack of care or diligence. In respect of the physical examinations, a similar observation can be made.

342 The Coroner having correctly identified the *Briginshaw* test, acknowledging the significance of the impact of an adverse finding on the character, reputation or employment prospects of an individual and the presumption of innocence, weighed the evidence and formed his conclusions. It is not the role of this Court to substitute its own view or stand in the shoes of the Coroner, but to examine the material before the Coroner and determine whether it was open to him to form the conclusions he did

on evidence which was sufficiently clear and cogent and not based on inexact proofs, indefinite testimony or indirect inferences.

343 Having reviewed the Inquest Transcript, the relevant statements of the witnesses, the CCTV footage to which I was referred, and the submissions of the relevant participants both before the Coroner and before me, and applying the legal principles by which I am bound, I am not persuaded that the Coroner erred in his findings against Dr Runacres.

344 On the question of whether the 'finding' at [541], that Dr Runacres set in motion a chain of events in which Veronica's medical treatment and care was inadequate in an ongoing way, was a statutory finding or (an unappealable) comment or other kind of observation, I am of the view that it was a causative conclusion which is not itself a finding, but part of the Coroner's reasoning in respect of the flawed course of conduct in Veronica's assessment and inadequate medical treatment. It is clearly an adverse statement but is equally one that was open to the Coroner. He had the benefit of hearing the continuum of evidence from Veronica's reception to her death, and the aftermath. The finding which follows from this observation is that at Item 23 of Appendix B and found at [542] in the body of the Coroner's Report. It is preceded by the finding at Item 22 of Appendix B, found at [540] of the body of the Coroner's Report. There are numerous conclusions on the evidence which are just that and do not form a formal statutory finding in their own right.[266]

345 For the foregoing reasons, I am not satisfied that there is any basis to overturn the challenged findings in respect of the appellant.

346 The appeal is dismissed.

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[266] For example, the conclusory statement at [539] of the Coroner's Report where the Coroner states that he is satisfied of certain deficiencies in Dr Runacres' treatment and care of Veronica upon which the finding at [540] (which is Appendix B Item 22) that Dr Runacres' medical assessment and treatment of Veronica was inadequate.

CERTIFICATE

I certify that this and the 93 preceding pages are a true copy of the reasons for judgment of Quigley J of the Supreme Court of Victoria delivered on 11 June 2024.

DATED this eleventh day of June 2024.

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Associate