DISTRICT COURT OF QUEENSLAND

CITATION:	*Parsons v Ryan (State Coroner)* [2022] QDC 237
PARTIES:	**GARY PARSONS** (applicant) **V** **TERRY RYAN, STATE CORONER** (respondent) **AND** **ATTORNEY-GENERAL OF QUEENSLAND** (amicus curiae)
FILE NO/S:	2887/2021
DIVISION:	Civil
PROCEEDING:	Application
ORIGINATING COURT:	Brisbane District Court
DELIVERED ON:	4 November 2022
DELIVERED AT:	Brisbane
HEARING DATE:	18 and 19 July 2022, with further written submissions supplied on 2 August 2022 (applicant) and 8 August 2022 (amicus curiae)
JUDGE:	Prskalo A/DCJ
ORDER:	**Application dismissed**
CATCHWORDS:	MAGISTRATES – CORONERS – INQUESTS AND INQUIRIES – where there is an application for an order by the District Court under s 11A *Coroners Act 2003* that a death is a 'reportable death' on the basis that it meets the statutory definition of a 'health care related death' under s 10AA – where the application is refused on the basis that the objective requirements of s 10AA were not satisfied by the evidence.
LEGISLATION:	*Civil Liability Act 2003* (Qld) ss 22, 36 *Coroners Act 2003* (Qld) ss 3, 8, 10AA, 11, 11A, 27, 28, 30, Sch 2 *Human Rights Act 2019* (Qld)
CASES:	*Coal and Allied Operations Pty Ltd v Australian Industrial Relations Commission* (2000) 203 CLR 194 *Davies v Ryan, State Coroner* [2019] QCA 282

	The Queen v Australian Broadcasting Tribunal; Ex parte Hardiman (1980) 144 CLR 13
COUNSEL:	Self-represented applicant E J Cooper for the respondent
SOLICITORS:	Self-represented applicant Crown Law for the respondent

The Application

[1] Keiran Parsons was a 26-year-old man with a history of signet-ring cell carcinoma of the colon – a rare primary cause of colonic cancer particularly in a person of his youth. When he was diagnosed with the disease in late September 2011, he was suffering from advanced disease with a large obstructing and invasive cancer. He was treated with surgical excision and end-to-end anastomosis and referred to the Redcliffe Hospital for adjunctive chemotherapy. It appears that Keiran had only partially completed the course of chemotherapy, before opting to cease treatment due to side-effects. He was subsequently managed with supportive treatment and, eventually, palliation until he succumbed to his illness on 3 April 2013.[1]

[2] Keiran's father, Mr Gary Parsons is the applicant in this proceeding. His wife and Keiran's mother, Mrs Christine Parsons, was present at the hearing as a McKenzie friend.

History of the investigation

[3] By correspondence dated 18 September 2014, the applicant referred the death of his son to the Office of the State Coroner.[2] In essence the complaint, detailed in an 81-page document, alleged negligence by Queensland Health staff in failing to diagnose a preventable cancer. The applicant sought a full inquest and the establishment of an independent body to investigate all Queensland Health deaths.

[4] On 13 October 2014, the applicant was notified that the State Coroner had requested the Registrar to examine his concerns with a view to determining whether the death was reportable under the *Coroners Act 2003* (the Act) and, if so, the extent of coronial investigation required.

[5] As required under the Act, on 11 December 2014 an independent report was commissioned from Dr Hall, a senior Forensic Medical Officer with the Clinical Forensic Medicine Unit.

[6] Dr Hall reviewed 12 volumes of medical notes incorporating several thousand pages from the four hospitals concerned, as well as the GP records and the written concerns of Mr Parsons. Dr Hall could find no evidence to support a contention that this was a health care related death.[3]

[7] On 13 October 2015, the Judicial Registrar (and then Acting Coroner) determined that Keiran's death was not a reportable death. It was determined that Keiran had died of natural causes and further that the health care he received had not caused or

[1] Affidavit of BP – Exhibit BP-54 – Dr Hall's report at pp. 1, 22.
[2] As the Coroners Court of Queensland was then titled.
[3] Affidavit of BP – Exhibit BP-54 – Dr Hall's report at p. 23.

contributed to his death. Having made that determination, the Office of the State Coroner was prevented from undertaking any further investigation into Keiran's death.[4]

[8] As the death was determined not to be reportable, the coroner was not further required to consider whether to hold an inquest pursuant to section 28 of the Act.

[9] Under section 11A of the Act, a person dissatisfied with a coroner's decision about whether a death is reportable may apply for an order about whether it is a reportable death. Section 11A(2)(a) provides that, if the coroner is not the State Coroner, the application must be made to the State Coroner.

[10] In September 2020, the applicant sent a 637-page report to the State Coroner and others. The essence of the report was to lodge a formal appeal about the unsatisfactory manner in which the Office of the State Coroner had investigated his son's death. The report extensively documented Keiran's medical presentations, with particular emphasis on shortcomings and omissions in Dr Hall's report. The report otherwise raised broad-ranging complaints about failures in medical care and the subsequent deficits in the investigation of these failures by the Office of the State Coroner and other agencies.[5]

[11] Upon receipt, the State Coroner treated the September 2020 correspondence as a request under section 11A of the Act for a review of the decision that the death was not reportable.[6]

[12] While the State Coroner did not accept that the Clinical Forensic Medicine Unit was unable to provide independent advice to coroners, a decision was made to engage a colorectal surgeon.[7] Dr Allison was so engaged and provided his report to the State Coroner on 4 August 2021.[8] In summary, Dr Allison believed that treatment through the four hospitals was appropriate for each presentation.

[13] On 22 October 2021, the State Coroner determined that the death was not a reportable death and accordingly declined the application under section 11A of the Act.[9]

The originating application

[14] By originating application filed on 5 November 2021, the applicant seeks an order that the death of Keiran Parsons is a reportable death under section 10AA of the *Coroners Act 2003*, and any such further order as deemed appropriate.

[15] The jurisdiction of the District Court derives from section 11A, which provides that a person who is dissatisfied with the State Coroner's decision may apply for an order about whether it is a reportable death.

---

[4] Affidavit of BP – Exhibit BP-60.
[5] Affidavit of BP – Exhibit BP-61.
[6] Affidavit of BP – Exhibit BP-62.
[7] Affidavit of BP – Exhibit BP-72.
[8] Affidavit of BP – Exhibit BP-92.
[9] Affidavit of BP – Exhibit BP-92.

[16] In accordance with the principle in *The Queen v Australian Broadcasting Tribunal; Ex parte Hardiman*,[10] on 28 January 2022, the respondent State Coroner filed submissions that the respondent would abide by the order of the court.

[17] On 1 February 2022, Judge Muir granted the Attorney-General of the State of Queensland leave to appear as amicus curiae.

[18] While not expressly stated in the originating application, it is apparent that the applicant seeks not only an order that the death is a reportable death, but seeks an order that an inquest be held, amongst other orders.

[19] The Attorney-General[11] submits that the question of whether a death is deemed reportable is separate to the question of whether an inquest is to be held; the two concepts are not interchangeable under the Act.

Preliminary

[20] Pursuant to section 3(c), one of the objects of the Act is to establish the procedures for investigations, including by holding inquests, by coroners into particular deaths.

Investigations generally

[21] Section 11 of the Act outlines the types of deaths that may be investigated under the Act and the type of coroner who conducts the investigation. Section 11(2) provides:

> A coroner must, and may only, investigate a death if the coroner –
>
> (a) considers the death is a reportable death, whether or not the death was reported under section 7; and
> (b) is not aware that any other coroner is investigating the death.

[22] Section 11(3) provides a limited exception in that a coroner must investigate a death if the State Coroner directs the coroner to investigate the death.

[23] Pursuant to section 11(4) the State Coroner may direct a coroner to investigate a death if:

> (a) the State Coroner considers the death is a reportable death; or
> (b) the State Coroner has been directed by the Minister to have the death investigated, whether or not the death is a reportable death.

[24] In other words, the Minister can direct any death be investigated. The State Coroner can only direct that deaths he or she considers are reportable be investigated.[12]

[25] The power to investigate a death that is not reportable can only be exercised at the direction of the Minister. In this case, there being no direction by the Minister, the Coroners Court was precluded from investigating the death unless the death was determined to be reportable in accordance with the definition of that term in section 8 of the Act.

[26] Schedule 2 of the Act defines the term 'investigation' to include –

---

[10] (1980) 144 CLR 13.
[11] Appearing as amicus curiae.
[12] See the Explanatory Notes to the Coroners Bill 2002 at p. 14.

(a) a preliminary examination; and
(b) a preliminary investigation by a coroner to decide, for section 11(2)(a), whether a death is a reportable death; and
(c) the holding of an inquest.

Inquests and investigations

[27] Section 27 of the Act mandates that a coroner investigating a death must hold an inquest in certain circumstances. Section 28 provides that an inquest may be held into a reportable death if the coroner investigating the death is satisfied it is in the public interest to hold the inquest.

[28] Section 30 provides that a person may apply to the coroner investigating a person's death for an inquest to be held. If the coroner decides not to hold an inquest, the person may apply to the State Coroner for an inquest to be held. If the State Coroner decides not to hold an inquest, the person may apply to the District Court for an order that an inquest be held.

[29] In *Davies v Ryan, State Coroner*,[13] Holmes CJ observed that section 30(8) of the *Coroners Act 2003* required the learned District Court Judge, before exercising his or her discretion as to whether to order an inquest, to reach a state of satisfaction that it was in the public interest that an inquest be held. Holmes CJ held:

> "Guidance as how to characterise that decision-making process, and the nature of any appeal against it, is to be found in the High Court's decision in *Coal and Allied Operations Pty Ltd v Australian Industrial Relations Commission*. In that case, a member of the Industrial Relations Commission similarly had to reach a state of satisfaction as to a particular matter (that industrial action posed a threat to public welfare and the economy) before exercising his discretion to make orders. Considering the nature of an appeal from the decision, Gleeson CJ, Gaudron and Hayne JJ observed that it involved, in fact, two discretionary decisions. The achievement of the necessary state of satisfaction "involved a degree of subjectivity" and could be described, broadly, as a discretionary decision; the Commission member, having achieved that state of satisfaction, had then to make a further discretionary decision, as to whether to make an order."[14] (footnotes omitted)

[30] Sections 27, 28 and 30 are to be construed consistently with other provisions of the Act. The sections are only engaged, with limited exception, when a death is a reportable death.

[31] In this case, the Acting Coroner and the State Coroner treated the applicant's written requests as applications for an investigation under section 11A. The written requests also then sought, as they do now, that an inquest be held. The Acting Coroner and the State Coroner did not determine the matter under section 30 and nor were they required to.

The power of the court

[13] *Davies v Ryan State Coroner* [2019] QCA 282.
[14] *Davies v Ryan, State Coroner* [2019] QCA 282 at [3].

[32] The application under section 11A requires this court to determine, on the evidence before it, whether the death is reportable. That question is to be answered by applying the definitions in sections 8 and 10AA.

Reportable death

[33] Section 8 defines the term '*reportable death'*. Relevant to this hearing, a death is a reportable death if, pursuant to section 8(3)(d), the death was a 'health care related death'. That term is defined in section 10AA:

> (1) A person's death is a ***health care related death*** if, after the commencement, the person dies at any time after receiving health care that—
>
> (a) either—
>
> (i) caused or is likely to have caused the death; or
>
> (ii) contributed to or is likely to have contributed to the death; and
>
> (b) immediately before receiving the health care, an independent person would not have reasonably expected that the health care would cause or contribute to the person's death.
>
> (2) A person's death is also a ***health care related death*** if, after the commencement, the person dies at any time after health care was sought for the person and the health care, or a particular type of health care, failed to be provided to the person and—
>
> (a) the failure either—
>
> (i) caused or is likely to have caused the death; or
>
> (ii) contributed or is likely to have contributed to the death; and
>
> (b) when health care was sought, an independent person would not have reasonably expected that there would be a failure to provide health care, or the particular type of health care, that would cause or contribute to the person's death.
>
> (3) For this section—
>
> (a) health care contributes to a person's death if the person would not have died at the time of the person's death if the health care had not been provided; and
>
> (b) a failure to provide health care contributes to a person's death if the person would not have died at the time of the person's death if the health care had been provided.
>
> (4) For this section, a reference to an independent person is a reference to an independent person appropriately qualified in the relevant area or areas of health care who has had regard to all relevant matters including, for example, the following—
>
> (a) the deceased person's state of health as it was thought to be when the health care started or was sought;
>
> *Example of a person's state of health—*

an underlying disease, condition or injury and its natural progression

(b) the clinically accepted range of risk associated with the health care;

(c) the circumstances in which the health care was provided or sought.

Example for paragraph (c)—

It would be reasonably expected that a moribund elderly patient with other natural diseases would die following surgery for a ruptured aortic aneurysm.

(5) In this section—

commencement means the commencement of this section.

health care means—

(a) any health procedure; or

(b) any care, treatment, advice, service or goods provided for or purportedly for the benefit of human health.

The material

[34] The application was supported by a 160-page affidavit by the applicant (filed on 13 January 2022), which exhibited extensive material, in large part consisting of annotated medical records, correspondence and detailed submissions which had been made to the Coroners Court and other agencies. As well as detailing facts, the affidavit contains submissions primarily directed towards the deficiencies in the reports of Dr Hall and Dr Allison and related criticisms of the State Coroner for relying upon their opinions. Also in evidence was the applicant's 637-page September 2020 report.

[35] The applicant's concerns are broad ranging; the allegations are of negligence, falsification of records and incompetence within the Queensland Health system. There is, it is alleged, a lack of impartiality within the agencies tasked to oversee or investigate Queensland Health.

[36] At its most fundamental, the complaint was correctly identified by Dr Hall in his August 2015 report when he stated that the family:

> "….. had a number of concerns with Keiran's management but most of all were concerned that he had presented to a number of hospitals complaining of symptoms that may have heralded his carcinoma prior to the diagnosis being made, thus suggesting that there was a failure to diagnose his condition in months or even years prior such that his condition was potentially curable if diagnosis was made in a timely manner."[15]

[37] In the applicant's submission, the failure to provide care by Queensland Health caused or contributed to Keiran's death and the death was therefore a 'reportable death'.

[38] At page 636 of the September 2020 report, the applicant further submitted that there were many systemic issues that the State Coroner was obliged to act upon, and that

[15] Affidavit of BP – Exhibit BP-54 – Dr Hall's report at p. 1.

there may have been criminal acts committed along with major professional misconduct.

[39] In this proceeding, the Coroners Court filed 17 volumes of documents within their possession, totalling 3976 pages. That material consisted of correspondence, medical records and the applicant's reports.

[40] By an affidavit dated 13 January 2022, the applicant sought remedies beyond that stated in the originating application. The applicant seeks orders from the District Court that:

1. there be a totally independent investigation, not by Queensland Health and its own Clinical Forensic Medical Unit; and
2. that the State Coroner is not to be involved in the matter any further and that the Attorney-General be required to appoint a totally independent Coroner possibly from interstate to conduct and oversee the investigations and to carry out any Coronial Inquest.[16]

[41] In the affidavit, it is also alleged that the Acting Coroner breached section 30 of the *Coroners Act 2003*.[17]

[42] By that affidavit, it was also broadly argued that the applicant was denied procedural fairness and natural justice.[18] It was argued (in essence) that, because the State Coroner did not comment or answer every allegation in the 637-page report, the veracity of the Hall report could not be determined, and the State Coroner could not properly conclude that the report was factual. Matters were compounded when the State Coroner received the Allison Report, that doctor being unaware of the applicant's specific concerns, as well as being in possession of the Hall report.[19] It is submitted by the applicant that there is a very high public interest reason for an inquest to be held and an order made to that effect.[20]

Grounds of appeal

[43] On 1 February 2022, the applicant filed an outline of argument. In that document, the grounds of appeal were expressed in these terms:

1. The learned Queensland State Coroner applied the law erroneously in finding that the death of the deceased Keiran James Parsons was not a reportable death under the *State Coroners Act 2003*.
2. The learned Queensland State Coroner erred in not abiding by the principles of procedural fairness and natural justice in making a decision that the death was not a reportable death.
3. The learned Queensland State Coroner erred in not carrying out the requirements of the *State Coroners Act 2003* of a proper investigation into the death of the deceased Keiran James Parsons and that the State Coroner knows that Queensland Health Hospitals have a non-delegable duty of care.

---

[16] Affidavit of Gary Parsons sworn 13 January 2022 at [1118], p. 159.
[17] Affidavit of Gary Parsons sworn 13 January 2022 at [30], p. 5. This matter is addressed above at [14].
[18] Affidavit of Gary Parsons sworn 13 January 2022 at [1119] to [1124], p. 160.
[19] Affidavit of Gary Parsons sworn 13 January 2022 at [1102] to [1110], pp. 157, 158.
[20] Affidavit of Gary Parsons sworn 13 January 2022 at [1124] to [1125], p. 160.

4. The learned Queensland State Coroner disregarded many Queensland Health systemic issues of failure and negligence that should have been addressed as part of the deceased's Coronial Inquest.[21]

[44] In respect of ground 1, the applicant submitted that the State Coroner had a responsibility to conduct a proper investigation into the death of the deceased but delegated this responsibility to an Acting Coroner who then lawfully sought clinical advice to assist, but this advice was erroneous and untruthful. The Acting Coroner relied upon this advice to reach a decision that the death was not reportable.

[45] It was submitted that, by relying on the fallacious report of Dr Hall, both the State and Acting Coroners did not reasonably conclude, based on the documentary evidence, that Queensland Health's lack of care and treatment contributed to the death. There was evidence, it was submitted, that a lack of treatment and negligent conduct largely contributed to the death.

[46] In respect of ground 2, the applicant submitted that the State and Acting Coroners failed to follow principles of procedural fairness and natural justice in that they did not conduct any thorough or proper investigation into the death of the deceased. It was submitted that they failed to examine the documents and records thoroughly or at all and delegated their responsibilities solely to Dr Hall and later to Dr Allison.

[47] It was submitted that Dr Allison did not view the deceased's records but relied upon Dr Hall's report. It was submitted that Dr Allison's report was error riddled, shallow, and unreliable.

[48] It was argued that the State Coroner showed bias and unfairness in allowing Dr Allison to have access to Dr Hall's report but not access to the applicant's reports, in particular the 81-page report of 2014 and the 637-page report of 2020. Accordingly, Dr Allison did not address the specific concerns raised in the applicant's reports. Dr Hall was criticised for forwarding his report to Dr Allison, because that would not ensure that Dr Allison would come to his own conclusions and be truly independent.

[49] In the 637-page report, the applicant had set out the errors in Dr Hall's report. The State Coroner had been warned six times to use only a totally independent person to investigate the death. This was not done as evidenced by the Hall report. This, it was argued, was not procedurally fair and did not accord with natural justice.

[50] In relation to ground 3, the applicant argues that fundamentally the State and Acting Coroners relied upon two unreliable and possibly untruthful reports and did not conduct their own investigations.

[51] Ground 4 related to numerous complaints about systemic failures within Queensland Health which the State Coroner failed to address.

[52] It was sought that the District Court makes orders:

1. that a new and totally independent investigation be undertaken by a party or person that this court has the power to appoint and who is independent from the State Coroner and the Acting Coroner;

[21] Outline of Argument for the Applicant filed 1 February 2022, p. 1.

2. that the Queensland Health Clinical Forensic Medical Unit be disbarred from taking part in any such investigation and that possibly the State Coroner's Office no longer use this clinical forensic medical unit;
3. that a possible Queensland Coronial Inquest take place as to the full circumstances as to the treatment and care that the deceased received or did not receive based upon the findings of a totally independent investigation and that both the State Coroner and the Acting Coroner take no further part in this matter.[22]

[53] By written outline of submissions dated 2 August 2022, the applicant repeated core aspects of the matters outlined above. In addition, it was argued that:

1. While the State Coroner had the right to commission a doctor from the Queensland Health Clinical Forensic Medicine Unit and to commission Dr Allison for a secondary review, Dr Hall and Dr Allison were not 'independent'.
2. Dr Hall and Dr Allison had conflicts of interest. Dr Hall's conflict of interest was said to arise from his familiarity with Dr O'Loughlin. Dr Hall ought to have declared this conflict and stepped aside. Dr Allison's conflict of interest was said to arise from his association with Dr Hall.
3. Queensland Health had a non-delegable duty of care and the treatment provided fell below this standard of care. It was for the District Court to determine whether the treatment met the legal requirement and whether Queensland Health breached its duty of care. Sections 22 and 36 of the *Civil Liability Act 2003* were relied upon.
4. It was in the public interest for an inquest to be held.

[54] Beyond the above matters, the applicant made numerous other submissions.

[55] The District Court does not have the power to grant many of the remedies sought by the applicant. This judgment will be factually and legally confined to matters relevant to the court's exercise of power under section 11A of the *Coroners Act 2003*. The only question to be determined is whether the death is a reportable death as defined by the Act.

[56] The *Civil Liability Act* applies to civil claims for damages; the provisions of that act have no application or relevance to this hearing. See *Davis v Ryan, State Coroner* [2019] QCA 282 at [33] and [37].

The medical material and opinions

[57] Dr Hall reviewed 12 volumes of medical records incorporating several thousand pages from the four hospitals concerned as well as the GP records and the written concerns of Mr Parsons. Dr Hall restricted his investigation and opinion to the time frame during which Keiran had presented to hospitals with symptoms that could suggest colon carcinoma and therefore might represent a potential earlier window of opportunity to diagnose the cancer.[23]

[58] Dr Hall reviewed only the presentations which could in some way be attributable to an abdominal or indeed systemic condition, noting that Keiran was a young adult

[22] Outline of Argument for the Applicant filed 1 February 2022, pp. 4-5.
[23] Affidavit of BP – Exhibit BP-54 – Dr Hall's report at p. 1.

male involved in martial arts and sports and there had been occasions of interpersonal violence which caused him to present to hospital. By way of general comment, it appeared to treating practitioners at times that Keiran had a low threshold to pain. That this might have caused treating doctors at times to question the requirement for large and repeated doses of (particularly narcotic) analgesia is understandable and standard practice in most if not all hospitals. Dr Hall found no evidence that appropriate analgesia was withheld. Dr Hall agreed that on a number of occasions, during inpatient stays in particular, it was felt that there was a 'functional' or 'emotional' overlay to expressions of pain. However, this did not result in the withholding of appropriate treatment. There was also a history of mental health issues, including depression, and a number of presentations with visible evidence and history of self-harm. Dr Hall could find no evidence in presentations to hospitals by Keiran with respect to his abdominal complaints that he was treated any differently given documentation of his past mental health issues.[24]

[59] In Dr Hall's analysis, it was clear that, during the evolution of Keiran's symptoms, a colonoscopy was not only recommended but was booked and scheduled. In Dr Hall's opinion, in the setting of colorectal cancer, colonoscopy is viewed as the gold standard in diagnosis as it allows for direct visualisation and the ability to take tissue diagnosis prior to surgical and oncology planning.

[60] In Dr Hall's view, the period from 31 July to 25 August 2009 represented a period where there might have been a possibility to diagnose the cancer early.[25]

[61] The progress notes from an admission on 31 July 2009 at the TPCH document the past history of depression, a family history of Crohn's disease and the history of an uncle with bowel cancer. The plan was noted:

> Patient has private health cover and wants colonoscopy done as an outpatient privately. Already referred for colonoscopy and endoscopy by GP. Patient discharged to get scope done as arranged by GP.[26]

[62] During an emergency department admission on 25 August 2009, Keiran was advised to attend the colonoscopy / endoscopy appointment set for the following day.[27]

[63] The applicant has placed into contention the circumstances surrounding the cancellation of that procedure. The medical records simply state that the appointment was cancelled because Keiran did not wish to return to the hospital for the procedure. The procedure was cancelled.[28]

[64] While a CT scan and a laparoscopy were performed, in Dr Hall's opinion, colonoscopy was necessary to identify the cause of the rectal bleeding and pain as the laparoscopy did not provide convincing evidence of a cause. Dr Hall states that staff at TPCH correctly and appropriately encouraged Keiran to follow through with the colonoscopy.

---

[24] Affidavit of BP – Exhibit BP-54 – Dr Hall's report at p. 2.
[25] Affidavit of BP – Exhibit BP-54 – Dr Hall's report at p. 19.
[26] Affidavit of BP – Exhibit BP-85 at pp. 2182, 2183, 2186.
[27] Affidavit of BP – Exhibit BP-85 at p. 2213.
[28] Affidavit of BP – Exhibit BP-85 at p. 2214.

[65] Advice was given to return to Dr Franz's clinic to make alternative arrangements for further investigation. Bookings made for Dr Franz's clinic on 9 September and 7 October 2009 were cancelled by the patient.[29]

[66] Dr Hall's report documents the admission to the RBWH on 9 April 2010 following an assault. Dr O'Loughlin identified a thickening of the transverse colon in CT scans and arrangements were made for an inpatient colonoscopy, booked for 23 April 2010.

[67] On 19 April 2010 Keiran was discharged. Dr Hall notes that there is no documentation regarding the reasoning behind this decision however the discharge summary to the GP at the time stated that he was booked in for colonoscopy at 13:00 hours on 23 April 2010 and contained information regarding the bowel preparation compound.

[68] Dr Hall's report documents the admission to the RBWH on 22 April 2010. The previous CT scan was noted, as was the appointment for the colonoscopy the following day. On 23 April 2010, the colonoscopy was cancelled due to the X-ray appearance of faecal loading. In the ED notes, it was documented that the patient was given colonLYTELY (bowel preparation solution) throughout the early hours of the morning. At 19.15 hours it was documented that the patient wished to be discharged. The surgical team wished to keep him in over the weekend for observation given the history of rectal bleeding. Given that Keiran was deemed to have the capacity to make decisions he was allowed to self-discharge.[30]

[69] Keiran was booked for surgical outpatient review by Dr O'Loughlin on 27 May 2010 but failed to attend. Keiran attended the clinic on 10 June 2010 and, when he realised that this was the surgical review and not maxillofacial clinic (regarding his nasal fracture), he told the registrar that he elected to see a private gastroenterologist for scopes which were said to be booked privately for 22 June 2010.

[70] In Dr Hall's view, given the protracted history of abdominal complaints and the known aggressive nature of the disease, it is difficult to state with any degree of confidence the earliest time that Keiran's cancer might have been diagnosed by colonoscopy. It would be reasonable to state that it was present when he was admitted to the RBWH in April 2010 given the CT scan appearance in the area where his cancer was eventually found. This would make it most likely that the cancer was present when he was seen in Caboolture in February 2010. It would be reasonable to state that it was possibly present when Keiran was seen at the TPCH in July and August 2009.[31]

[71] Dr Hall believes that the admission to the RBWH was probably the crucial time that a diagnosis could have been made. There appeared to be a long delay where surgical staff seemed to be under the impression that the procedure would go ahead soon; however, it was revealed that the procedure was booked for 23 April 2010 and Keiran was discharged to have the scope done as an outpatient. Dr Hall considers this delay was probably the critical period when a diagnosis might have been made. The delay was not excessive and within the most urgent elective procedural time frame of 30 days.

---

[29] Affidavit of BP – Exhibit BP-85 at pp. 2214 and 2215.
[30] Affidavit of BP – Exhibit BP-54 – Dr Hall's report at p. 9.
[31] Affidavit of BP – Exhibit BP-54 – Dr Hall's report at p. 16.

[72] Dr Hall states that the delay was critical because he observed a pattern of behaviours which he believes were anxiety-based whereby Keiran would avoid medical appointments or procedures unless he felt acutely unwell. Dr Hall candidly states that, if a colonoscopy were arranged for this admission, Keiran would not have had time to dwell on the matter and one would expect there would have been more success in having the procedure done. Dr Hall is satisfied that the treating team took Keiran's symptoms seriously and were prepared to investigate appropriately with the only rate limiting step being the colonoscopy. Dr Hall is also satisfied that appropriate follow-up arrangements were made.[32]

[73] When Keiran was admitted to the RBWH on 22 April 2010, it seemed clear on admission that he had rectal bleeding. Keiran stated he had taken the bowel preparation solution for his procedure for the following day. It was given to him twice in the department and, although he did have some vomiting, it was recorded that it was reasonably well tolerated, and the vomiting settled with Maxolon. Dr Hall highlighted another area of concern in that Keiran had reported to treating doctors that he was allergic to colonoscopy preparation solution. However, this reaction did not occur during the presentation to the RBWH. Dr Hall noted a complaint of abdominal pain and vomiting which are likely to have been due to the effects (or side effects) of the solution. It seems clear to Dr Hall that this reaction was not well tolerated by Keiran and Dr Hall believes that this caused him to baulk at recommendations for colonoscopy based on his fear of the reaction to the bowel preparation solution.[33]

[74] Keiran was admitted to the short stay unit; an abdominal X-ray revealed faecal loading and he was given a fleet enema to begin clearing the bowel. His colonoscopy was cancelled for that day and plans were made to admit him for observation given the rectal bleeding and for re-scope. Dr Hall is of the opinion that the RBWH staff were intending to go ahead with the colonoscopy and had admitted him for adequate bowel preparation for that procedure on that occasion. Keiran self-discharged; as the attending doctor documented, he had the capacity to do so as an adult and therefore the autonomy to do so.

[75] In Dr Hall's opinion, the treatment provided to Keiran at the RBWH was appropriate and there was a clear intention to proceed with colonoscopy to determine a cause for his symptoms. Although it would have been preferrable for Keiran to undergo the treatment as an inpatient, he was booked for the procedure as an outpatient and well within prescribed timeframes. He was sensitive to the effects of the colonoscopy preparation solution and was not prepared to be admitted to hospital. He elected to discharge himself. He also elected to follow up his ongoing health care elsewhere, which he was entitled to do as he had no executive incapacity and could autonomously make his own health care decisions.[34]

[76] Dr Hall documents the admission to the Caboolture Hospital on 25 February 2011.[35] On 28 February 2011, nurses documented that Keiran told them that he was being discharged and requested a medical certificate. It was further documented that he left the ward without his certificate, medications and his belongings. Dr Hall notes that there is a great deal of dispute over this which was the subject of a complaint to the

[32] Affidavit of BP – Exhibit BP-54 – Dr Hall's report at p. 16.
[33] Affidavit of BP – Exhibit BP-54 – Dr Hall's report at p. 17.
[34] Affidavit of BP – Exhibit BP-54 – Dr Hall's report at p. 17.
[35] Affidavit of BP – Exhibit BP-54 – Dr Hall's report at pp. 10 and 17 – 18.

Director General of Health. As this was essentially one person's recall of events against another's, Dr Hall refrained from comment. Dr Hall does not believe that all that could have been done to investigate the abdominal pain and bleeding was done. For some reason the impetus was placed upon investigation of the limb spasms and little to the ongoing pain. Nonetheless, appointments made for 6 April, 13 April, 4 May, 10 May and 25 May were not kept. As these were all opportunities for discussion of ongoing abdominal pain and rectal bleeding, these were missed opportunities to advance forward. The decision not to attend these appointments was Keiran's decision and Dr Hall is satisfied that the Caboolture Hospital provided opportunities by continuing to rebook him despite cancellations and non-attendance.[36]

[77] Dr Hall addressed core aspects of the applicant's complaints. One complaint was that the hospitals failed to carry out CT scans on almost every occasion. Dr Hall counters that Keiran underwent a number of CT scans although some were without oral and IV contrast. Dr Hall states that CT scanning is a very limited two dimensional black and white radiological investigation which has proven to be of weak value in the diagnosis of bowel cancer. CT colonography with per rectal application of contrast and air is better however not well tolerated. It is also unable to offer the ability to biopsy and essentially requires the same preparation as a colonoscopy, making the latter procedure far superior in making the diagnosis.[37]

[78] Dr Hall states that Keiran was advised on numerous occasions to have colonoscopies. Dr Hall states:

> "[Keiran] repeatedly avoided the issue by telling doctors that he had booked the procedure privately, by cancelling appointments and by stating that he had allergy and anaphylaxis to the preparation solution which was not quite true."[38]

[79] Ultimately, Dr Hall was satisfied that all reasonable steps were taken to encourage Keiran to have the procedure done. Keiran exercised his capacity and his autonomy to refuse the investigation.

[80] In Dr Hall's opinion, there was no evidence of a failure to provide appropriate care.

[81] At the request of the Coroners Court, Dr Allison was asked to review the medical material. In summary, Dr Allison believes that the treatment provided at the four hospitals was appropriate for each presentation. In Dr Allison's opinion, this was a very aggressive cancer, and he believes it highly likely that it would have been fatal even if there had been a colonoscopy in April 2010, with a diagnosis made at that time.

The hearing

[82] The application was heard over two days on 18 and 19 July 2022. Four witnesses were called by the applicant and cross-examined, including the report writers, Dr Hall and Dr Allison. Dr Hall and Dr Allison maintained their opinions that the care and treatment provided was appropriate.

---

[36] Affidavit of BP – Exhibit BP-54 – Dr Hall's report at pp. 18, 19.
[37] Affidavit of BP – Exhibit BP-54 – Dr Hall's report at p. 20.
[38] Affidavit of BP – Exhibit BP-54 – Dr Hall's report at p. 20.

Dr Hall

[83] Dr Hall holds a Bachelor of Medicine, Bachelor of Surgery degree through the University of Queensland, and a postgraduate master's degree in clinical forensic medicine through Monash University. He has a Fellowship with the Australasian College of Legal Medicine and is also a founding Fellow of the Faculty of Clinical Forensic Medicine through the Royal College of Pathologists of Australasia. Dr Hall was employed by Queensland Health. Dr Hall's report was peer reviewed by Dr Adam Griffin.

[84] Dr Hall has worked in forensic medicine at the Clinical Forensic Medicine Unit in Brisbane since 2011. Prior to that, he worked in emergency departments in public and private hospitals. He had worked at the Emergency Department of the Greenslopes hospital from 1995 to 2001 and knew Dr Allison professionally from his time there.

[85] The Clinical Forensic Medicine Unit sat within the structure of Forensic and Scientific Services, independently from hospitals, which were under the umbrella of Hospital and Health Services or HHS.

[86] Dr Hall testified that, if it were accepted that the thickening in the bowel that was seen on CT scans at the Royal Brisbane Hospital may have been the cancer, the risk of ultimate death from the cancer would, at that time, have been extremely high.

[87] Dr Hall testified that, while the medical records at times stated that there might have been an emotional overlay or an exaggerated response, those comments did not, in his opinion, impact on management and analgesia was not withheld.

[88] In his view, the medical records did not disclose a preconceived diagnosis. Appropriate investigations were done each time, and there were recommendations each time for a colonoscopy. For various reasons, the colonoscopy was not done.

[89] Regarding the admission to the Prince Charles Hospital, Dr Hall did not consider that the doctor disregarded the family history provided which was that an uncle had bowel cancer and there was a family history of Crohn's disease. The plan and advice given was for a colonoscopy, but the hospital was told it was to be done privately.

[90] Dr Hall stated that in most situations colonoscopies are carried out as an outpatient, not as an inpatient. There were opportunities when Keiran was an inpatient that a colonoscopy could have been done. There had also been a number of times where Keiran said he wanted to have it done privately and not at that particular hospital.

[91] Dr Hall considered there was a difference between a duty of care and what the medical staff can do. With a consenting adult who has full capacity to make decisions, autonomy is probably the pinnacle of the human right that should be respected.

[92] Regarding the Royal Brisbane Hospital admission, it was clear to Dr Hall that it was the intent of Dr O'Loughlin and his team to go ahead with the colonoscopy.

[93] Dr Hall had previously met Dr O'Loughlin but had never worked with him before and had no personal relationship with him.

[94] During cross-examination, the applicant criticised Dr Hall for stating in his report that Dr O'Loughlin was very astute, although the applicant himself agreed that Dr

O'Loughlin was astute.[39] Dr Hall considered that Dr O'Loughlin was very astute because he had identified the thickening in scans and wanted to investigate it.

Dr Allison

[95] Dr Allison is a very senior colorectal surgeon. He has written medico legal reports on various matters over the last 10 years. He has not previously worked with the Coroners Court.

[96] Dr Allison agreed that he had been given Dr Hall's report but had not received material specifically on the applicant's concerns. Had those concerns been sent to him, he would have read them. His report was based on information from Dr Hall's report as well as, more accurately, the information provided in the hospital notes of the various admissions.

[97] Dr Allison stated that a CT scan was a poor test for colonic cancer. Dr Allison referred to multiple attempts to get Keiran to have a colonoscopy, which he refused.

[98] Regarding the admission to the RBWH, it was not inappropriate for the patient to be discharged to have an urgent category 1 colonoscopy, which is one within 30 days; that would not be unreasonable.

[99] During the admission, the X-ray showed faecal loading, which indicated that the bowel preparation had not worked. Pursuing a colonoscopy urgently at that time would be deemed to fail and a pathology would not be found if it were present.

[100] Dr Allison did not consider that there were any alternatives to bowel preparation which are reliable. An examination required the exploration of the whole colon and the colon mucosa, and enemas were not good enough for that.

[101] Dr Allison knew of Dr O'Loughlin, who was a very senior surgeon at the RBWH when Dr Allison worked there as an intern in 1990. Dr Allison had, however, never worked with or under Dr O'Loughlin.

Dr O'Loughlin

[102] Dr O'Loughlin is the Director of Surgery at the Royal Brisbane and Women's Hospital, but by profession is a general surgeon who has been practising as a consultant since 1985. He had reviewed the medical records from the RBWH and had read the records from the Prince Charles, Caboolture and Redcliffe hospitals. In his opinion, management had been appropriate in all instances.

[103] Dr O'Loughlin testified that signet cell histopathology tends to be associated with aggressive forms of cancer and, as a result, the prognosis is not good.

[104] The two CT scans at the Royal Brisbane Hospital did reveal a possible abnormality in the distal transverse colon or splenic flexure but these could have represented pathologies other than a bowel cancer; for example, inflammatory bowel disease such as Crohn's disease, which does tend to affect younger people more often than colorectal cancer. A lymphoma is another possibility, and in the context of the presentation, it could be consistent with haemorrhage in the wall of the colon due to blunt force trauma. So, there were a number of possible explanations. It might also

[39] Transcript – Day 2, p. 23, line 1.

have been completely benign. It might have represented an area of spasm in the colon, where the colon had simply contracted at the time the scan was done.

[105] With this admission, Dr O'Loughlin's assessment was in the context of Keiran being badly beaten; a vicious assault where he was kicked and assaulted whilst he was in the gutter.

[106] The importance of the initial CT scan was to exclude those major injuries, such as perforation of the bowel or an injury to one of the solid organs, namely, the liver, spleen, kidneys or pancreas, which usually then results in internal bleeding. The CT scan was reassuring because it did not show any evidence of those things. The only abnormality that Dr O'Loughlin thought might be present was the thickening of the bowel, perhaps from some haemorrhage in the wall of the bowel. When the pain hadn't settled after a couple of days, a repeat scan was requested to see whether there were any new findings. The scan remained unchanged. It was taken seriously, and the next step was to visualise the inside of the bowel by colonoscopy.

[107] An X-ray showed that there was still quite a lot of faecal loading in the colon. Dr O'Loughlin presumes that was why the colonoscopy was cancelled.

Independent persons

[108] The applicant argues that, because Dr Hall and Dr Allison professionally knew each other, and both professionally knew of Dr O'Loughlin, they were not 'independent'. This, it was submitted, was a conflict of interest that ought to have been disclosed, particularly by Dr Hall. This argument is rejected. A conclusion of that kind would be unreasonable and illogical, and I decline to reach it on that basis.

[109] During cross examination, the applicant elicited Dr O'Loughlin's opinion that treatment was appropriate across all presentations. Because section 10AA(2) is concerned with the 'expectation' of an independent person (and not the treating team), Dr O'Loughlin's opinion on the ultimate issue is not relevant to the determination which must be made under the section. This is consistent with the scheme of the Act and the State Coroner's guidelines which state:

> "Section 10AA imports a measure of objectivity into the concept of health care related death by making it clear that the assessment of whether the death was not reasonably expected is one of an independent appropriately qualified clinician apprised of all the circumstances of the matter, rather than the perceptions of those directly involved in the person's care."[40]

Is the death reportable

[110] It may be accepted that, because a colonoscopy was not performed at an earlier time, there was a loss of opportunity to detect the cancer at an earlier time. That fact is not in dispute as between the experts. But the fact that a colonoscopy was not performed at an earlier time does not mean that there was a failure of health care within the meaning of section 10AA(2).

[40] State Coroner's Guidelines 2013 Chapter 3 (Version 3, amended July 2019), p. 13.

[111] The hospital records, in evidence at the hearing, prove that from as early as July 2009, the recommended diagnostic course (by the Prince Charles Hospital at that time) was for further investigation with colonoscopy.

[112] Two highly qualified doctors are of the opinion that the treatment provided was appropriate at each presentation. Both Dr Hall and Dr Allison are independent persons in that they are appropriately qualified in the relevant area of health care and, in my view, have had regard to all relevant matters.

[113] The Acting Coroner and the State Coroner were required to discharge their function in accordance with the law. The power to investigate the death, and to hold an inquest, was constrained by the operation of section 10AA. There was not, on the material before the Coroners Court, evidence which satisfied the objective requirements of section 10AA(2)(a) and (b).

[114] Assuming that the character of an application under section 11A is analogous to an application under section 30, this court is required to reach a state of satisfaction, on the evidence before it, that the death is a reportable death.[41]

[115] For a death to be reportable as a health care related death, there must be evidence which satisfies the statutory requirement in section 10AA. There must be evidence of a failure to provide health care (or a particular type of health care) and evidence that the failure either caused or is likely to have caused the death or contributed or is likely to have contributed to the death. There must be evidence that an independent person would not have reasonably expected that there would be a failure to provide health care that would cause or contribute to the person's death.

[116] On the evidence before this court, an early diagnosis could only have been made by colonoscopy, which would allow for visualisation and biopsy of pathological changes in the bowel. That procedure was the recommended diagnostic plan from as early as July 2009, some two years prior to the diagnosis. There was not therefore a 'missed' diagnosis, in the sense that a diagnostic procedure that should have been recommended was not. For different reasons and at different times, performance of the procedure was frustrated. That fact does not amount to a failure to provide health care. The diagnostic plan remained in place.

[117] There is no factual foundation upon which this court could conclude that there was a failure to provide health care which caused or contributed to death (or was likely to have caused or contributed to death). As the statutory definition under section 10AA is not satisfied, this court cannot order that the death is reportable.

Human Rights Act

[118] To the extent that the provisions of the *Human Rights Act 2019* (Qld) apply, I am satisfied that the decision to not order the death reportable is compatible with human rights and satisfies any operative provision of the *Human Rights Act 2019*.

[119] The application is dismissed.

---

[41] See *Davis v Ryan, State Coroner* [2019] QCA 282 at [3].