SUPREME COURT OF VICTORIA
COURT OF APPEAL

S EAPCI 2022 0005

DOUGLAS EDWARD FARRAR Applicant

v

CORONERS COURT OF VICTORIA Respondent

JUDGES:	MACAULAY JA, LYONS and J FORREST AJJA
WHERE HELD:	Melbourne
DATE OF HEARING:	12 October 2022
DATE OF JUDGMENT:	11 November 2022
MEDIUM NEUTRAL CITATION:	[2022] VSCA 246
JUDGMENT APPEALED FROM:	[2021] VSC 842 (O'Meara J)

CORONERS COURT – Coroner – Determination by Coroner that death not a 'reportable death' – Appeal to single judge on question of law, pursuant to Part 7 of the *Coroners Act 2008*, dismissed – Nature of appeal to the Court of Appeal in light of Part 7 of the *Coroners Act 2008* – No error of the judge in concluding that the Coroner's determination that death was not a 'reportable death' (on basis that the determination was not against the evidence and the weight of evidence) – Nature of 'preliminary examination', *Coroners Act 2008* s 3(1) – No error of the judge in concluding that 'preliminary examination' did not require an examination of the body of the deceased – No requirement under the *Coroners Act 2008* that a coroner 'direct' a 'preliminary examination'.

Coroners Act 2008, ss 3, 4, 14, 15, 16, 17, 23, 24, 78, 87; *Coroners Court Rules 2019* rr 33 and 34; *Supreme Court Act 1986* s 14C.

R v Australian Broadcasting Tribunal; Ex parte Hardiman (1980) 144 CLR 13, *Kennedy v Shire of Campaspe* [2015] VSCA 47, *Li v So* [2021] VSCA 32, *Allesch v Maunz* (2000) 203 CLR 172 and *Freeman v Rabinov* [1981] VR 539 referred to.

Counsel

Applicant:	In person
Respondent:	Ms M Fitzgerald

Solicitors

Applicant:	
Respondent:	Ingrid Giles, Coroners Court of Victoria

MACAULAY JA
LYONS AJA
J FORREST AJA:

Introduction and summary

1 Mrs Audrey Farrar died at Myrtleford Lodge Aged Care ('**Myrtleford Lodge**') on 12 September 2021. She was 85 years old. The medical certificate of cause of death ('**MCCD**') stated that Alzheimer's dementia was the '[d]isease or condition directly leading to death'.

2 On 26 September 2021, the Coroner determined that the death of Mrs Farrar was not a 'reportable death' within the meaning of s 4 of the *Coroners Act 2008* (Vic) (the '**Determination**'). Mrs Farrar's son, Mr Douglas Farrar, appealed to a judge of the Trial Division under Part 7 of the *Coroners Act*, contending that the Determination involved an error of law. This was because, among other things, he argued that her death was a 'reportable death' under the *Coroners Act* and, further, the *Coroners Act* required an examination of Mrs Farrar's body as part of the 'preliminary examination' under the *Coroners Act*.

3 By reasons for judgment delivered on 17 December 2021 ('**Reasons**'),[1] a judge dismissed the appeal. In summary, the judge concluded that there was sufficient evidence to support the Determination that the death was not a 'reportable death'. He also concluded, contrary to Mr Farrar's submission, that the *Coroners Act* did not require that every 'preliminary examination' must involve an examination of the body or that the provision of the body was a necessary prerequisite for every 'preliminary examination'.

4 Mr Farrar now seeks leave to appeal to this Court from those Reasons.

5 The first proposed ground of appeal is that the judge erred by concluding that there was sufficient evidence to support the Determination that Mrs Farrar's death was not a 'reportable death' ('**proposed ground 1**'). Rather, Mr Farrar contends that the judge ought to have found that the Determination was 'manifestly unreasonable'[2] in light of the evidence and that Mrs Farrar's death was reportable under:

(1) section 4(2)(a) of the *Coroners Act* (because her death appears to have been 'unexpected' or 'unnatural'); or

(2) section 4(2)(b) of the *Coroners Act* (because her death occurred 'following a medical procedure where the death is or may be causally related to the medical procedure' and a registered medical practitioner would not, immediately before that procedure, 'have reasonably expected the death').

6 The second proposed ground of appeal is that there was a jurisdictional error in that the Coroner failed to use her powers to perform a thorough investigation into whether the

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1 *Farrar v Coroners Court of Victoria* [2021] VSC 842 ('Reasons').

2 Mr Farrar's expression 'manifestly unreasonable' was shorthand for being 'against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made the finding': see [26] below.

death was a 'reportable death' ('**proposed ground 2**'). It was unclear how this was a ground of appeal from the Reasons.

7 The third proposed ground of appeal related to the nature of a 'preliminary examination' under the *Coroners Act* ('**proposed ground 3**'). The principal proposed ground of appeal is that the judge erred in concluding that a 'preliminary examination' under the *Coroners Act* did not require the body of Mrs Farrar to be provided for the purposes of the Coroner determining whether her death was a 'reportable death'. Further, in the event that the *Coroners Act* did not require the body to be provided for the purposes of a 'preliminary examination', there was a related proposed ground as to whether a direction is required by a coroner to undertake a 'preliminary examination' (the '**direction issue**'). However, the direction issue was not the subject of argument before the judge and, thus, was not addressed in the Reasons.

8 For the reasons that follow, we have concluded that proposed grounds 1 and 2 have no real prospects of success. As to proposed ground 1, there is no arguable error by the judge as there was ample evidence to support the conclusion of the Coroner that the death of Mrs Farrar was not a 'reportable death'. As to proposed ground 2, it does not relate to the Reasons. In any event, we can see no failure on the part of the Coroner to perform a thorough investigation into whether Mrs Farrar's death was a 'reportable death' under the *Coroners Act*. As a result, leave to appeal is refused in relation to both of these grounds.

9 As to proposed ground 3, we have concluded that we should grant leave to appeal but would dismiss the appeal. This is because we have concluded that:

(1) there is no requirement that the body of the deceased be provided in order for there to be a 'preliminary examination' under the *Coroners Act*; and

(2) although the direction issue was not raised before the judge, we have concluded that no direction is required under the *Coroners Act* for a 'preliminary examination' to occur.

The relevant provisions of the Coroners Act

10 The definition of a 'reportable death' is contained in s 4(1) and (2) of the *Coroners Act* which provides:

> **Reportable death**
>
> (1) In this Act, a death of a person is a ***reportable death*** if—
>
> (a) the body is in Victoria; or
>
> (b) the death occurred in Victoria; or
>
> (c) the cause of the death occurred in Victoria; or
>
> (d) the person ordinarily resided in Victoria at the time of death—
>
> and the death was a death specified in subsection (2).

…

(2) For the purposes of subsection (1), the deaths are—

(a) a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; or

(b) a death that occurs—

(i) during a medical procedure; or

(ii) following a medical procedure where the death is or may be causally related to the medical procedure—

and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death;…

11 Under s 12(1) of the *Coroners Act*, a person who has 'reasonable grounds to believe that a reportable death has not been reported' must report it without delay, relevantly, to a coroner. A failure to do so may result in a penalty of 20 penalty units.

12 In the *Coroners Act* a 'medical procedure' is defined in s 3(1) as:

> …a procedure performed on a person by or under the general supervision of a registered medical practitioner and includes imaging, internal examination and surgical procedure;…

13 Part 4 of the *Coroners Act* is headed 'Investigation of deaths and fires' and Division 1 of that Part is headed 'Investigation of deaths'. Under s 14, a coroner has the power to investigate whether a death is a 'reportable death' if the death appears to have occurred within 100 years before the death was reported to a coroner. Section 14 relevantly provides:

(1) A coroner may investigate a death that is or may be a reportable death if the death appears to have occurred within 100 years before the death was reported to a coroner.

…

(3) A power under subsection (1) includes a power to investigate whether the death is a reportable death.

14 Further, s 15 deals with deaths a coroner must investigate. It relevantly provides:

Deaths a coroner must investigate

A coroner must investigate the death of a person if—

(a) it appears to the coroner that the death, or the cause of death, occurred in Victoria; and

(b) it appears to the coroner that the death is a reportable death; and

(c) it appears to the coroner that the death occurred within 50 years before the death was reported to a coroner; and

(d) an interstate coroner has not investigated, is not investigating, and does not intend to investigate, the death.

15 Among the investigations a coroner may instigate, one is a 'preliminary examination', relevantly defined in s 3(1) of the *Coroners Act* as follows:[3]

> ***preliminary examination*** in relation to a body means any of the following procedures—
>
> (a) a visual examination of the body (including a dental examination);
>
> (b) the collection and review of information, including personal and health information relating to the deceased person or the death of the person;
>
> (c) the taking of samples of bodily fluid including blood, urine, saliva and mucus samples from the body (which may require an incision to be made) and the testing of those samples;…

16 Section 23 of the *Coroners Act* provides:

> **Preliminary examinations**
>
> (1) The purpose of a preliminary examination is to assist the coroner in the performance of his or her functions in respect of a death.
>
> (2) A coroner may provide a body to a medical investigator to enable a preliminary examination to be performed on the body.
>
> (3) The provision of the body authorises the conduct of the preliminary examination.
>
> (4) If a medical investigator who performs a preliminary examination reports to the coroner that, in the medical investigator's opinion, the body is, or is likely to be, Aboriginal ancestral remains, the coroner must notify the Aboriginal Heritage Council of that report.

17 Mr Farrar relied upon r 33(1) of the *Coroners Court Rules 2019* (Vic) (the '**Coroners Rules**') before the judge:

> **Preliminary examinations**
>
> (1) If a coroner has provided a body to a medical investigator to enable a preliminary examination to be performed on the body under section 23(2) of the [*Coroners Act*], the medical investigator must provide a report to a coroner on the preliminary examination in accordance with this Rule.

[3] Emphasis added (underlining).

18 Rule 33(2) of the Coroners Rules provides what must be contained in the report to the coroner on a 'preliminary examination' in accordance with r 33(1). Rule 33(3) provides in substance that, unless a coroner otherwise orders, such a report is confidential and must only be provided to the Coroners Court.

19 Further, s 17 of the *Coroners Act* provides that certain reportable deaths do not require an investigation to be continued. It relevantly provides:

> **Certain reportable deaths do not require investigation**
>
> (1) A coroner is not required to continue an investigation into a reportable death if—
>
> (a) the coroner determines that the death was not a death referred to in section 4(2)(a) (other than a death that appears to have been unexpected); and
>
> (ab) the coroner determines that the death is not a death referred to in section 4(2)(b), (c), (d), (e), (f), (g) or (j); and
>
> (b) a medical investigator conducts a medical examination on the deceased person and provides a report to the coroner that includes an opinion that the death was due to natural causes; and
>
> (d) the coroner determines that the death is not a reviewable death.
>
> (2) If a coroner determines under this section not to continue an investigation, the principal registrar must notify the Registrar of Births, Deaths and Marriages, without delay, of the prescribed particulars.

20 Section 16 concerns a determination by a coroner that a reported death is not a 'reportable death'. It relevantly provides:

> **Determination by coroner that reported death not a reportable death**
>
> (1) A coroner may determine that a death that was reported to the coroner as a reportable death is not a reportable death.
>
> …
>
> (2) If a coroner determines that a death is not a reportable death under subsection (1) or (1A), the coroner must give written notice of the coroner's determination to the person who reported the death.
>
> (3) If a coroner determines that a death is not a reportable death, the coroner must discontinue the investigation into the death. …

21 Further, in his amended written case, Mr Farrar referred to s 24 of the *Coroners Act*, which provides:

> **Identification directions**
>
> A coroner may direct a medical investigator to perform any procedure on a body (including the removal of tissue but not including a

preliminary examination) for the purposes of identifying the deceased person.

22 He also referred to r 34 of the Coroners Rules, which provides that '[a] direction made by a coroner under section 24 of the [*Coroners Act*] must be in Form 7'.

23 Other provisions in Division 1 of Part 4 of the *Coroners Act* oblige a coroner to direct certain matters. For example, s 25 relevantly provides:

> **Autopsies**
>
> (1) The purpose of an autopsy is to assist a coroner to perform his or her functions in respect of a death.
>
> (2) A coroner must direct a medical investigator to perform an autopsy on a body under the control of the coroner if the coroner believes that –
>
> (a) the autopsy is necessary for the investigation of the death; and
>
> (b) it is appropriate to give the direction.

24 Section 26 of the *Coroners Act* provides for a coroner to take reasonable steps to notify the senior next of kin of the deceased of a direction given under s 25(2), and a process for objections to the direction and determination of any objections. Rule 36(1) of the Coroners Rules provides that a direction under s 25 must be in Form 9.

25 As to the nature of an appeal from a determination made under s 16 of the *Coroners Act* to a judge of the Supreme Court, s 78 in Part 7 of the *Coroners Act* provides:

> **Appeal in relation to determination that death not a reportable death**
>
> (1) If a coroner determines under section 16(1) or (1A) that a death is not a reportable death, the person who reported the death may appeal against the coroner's determination to the Trial Division of the Supreme Court constituted by a single judge.
>
> (2) Subject to section 86, an appeal under this section must be made within 28 days after the day on which the determination of the coroner is made.

26 Further, s 87(1) provides that an appeal to the Supreme Court under Part 7 is an appeal on a question of law. Pertinent to proposed ground 1, s 87(1A) of the *Coroners Act* provides:

> (1A) 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.

The evidence relating to Mrs Farrar's death

27 The Reasons set out the facts leading to the death of Mrs Farrar. We did not understand Mr Farrar to dispute those facts in this application, although he contended there were relevant additional facts.

28 In late 2015 or early 2016, Mrs Farrar was diagnosed with Alzheimer's disease. At some point, Mr Farrar became her carer. In about June 2018, in light of friction between Mr Farrar and his sisters relating to the care of their mother, the Office of the Public Advocate ('**OPA**') was appointed as a limited Guardian in relation to Mrs Farrar, including a power to make medical decisions.

29 In about April 2019, Mrs Farrar became a resident of Myrtleford Lodge. It is evident from documents in evidence before the judge that Myrtleford Lodge is an aged care facility operated by Bentley Wood Health & Aged Care ('**Bentley Wood**').

30 On 24 August 2021, Dr James Wei attended upon Mrs Farrar at Myrtleford Lodge. Dr Wei's notes prepared at 8:54 am and at 12:35 pm:

(1) record that Mrs Farrar had 'advanced dementia', that she was 'full assist', 'non mobile' and 'non-verbal';

(2) record that Mrs Farrar had 'seizure activity?' of about eight minutes that morning, potentially due to mass lesion, stroke or other pathology;

(3) record that, in light of Mrs Farrar's advanced dementia, Dr Wei determined that 'CPR' (Cardiopulmonary Resuscitation), 'ICU' (Intensive Care Unit) and 'HDU' (High Dependency Unit) level care 'is futile';

(4) refer to prescribing Rivotril and Midazolam;

(5) refer to a plan which anticipated the prospect of further seizures and specifically state that Mrs Farrar was 'not for transfer' to an acute care hospital but was to receive '[p]alliative/comfort measures'; and

(6) record that Dr Wei communicated the substance of this plan with Mr James Doran of the OPA who was 'happy' with it.

31 On 7 September 2021, Dr Wei saw Mrs Farrar again. His notes record that there was nausea and vomiting and that Mrs Farrar was treated with Maxolon (an antiemetic) and Ondansetron.

32 On 8 September 2021 (8:49 pm), the nursing notes record that staff at Myrtleford Lodge had observed a decline in Mrs Farrar's health 'over the last three days'. On 9 September 2021 (12:20 pm), the nursing notes record that the family were notified of Mrs Farrar's deterioration and advised to attend Myrtleford Lodge if they wished to.

33 On 9 September 2021 (about 12:48 pm), Dr Simon Shute examined Mrs Farrar. His notes record:

(1) that Mrs Farrar was not eating and had minimal fluid intake but she had not vomited that day;

(2) that Dr Shute had seen an email from the OPA;

(3) under the heading 'Management':

> dtr present - discussed appears in end stage of dementia, likley [sic] to dehydrate and pass away. goal [o]f care is palliate any distress
>
> Brother attending shortly, will check if he in agreement [sic] for that

and;

(4) that Dr Shute had had a 'lengthy' discussion with Mr Farrar in which Mr Farrar informed Dr Shute that his father had −

> died demntia/hspital/had morphoie and maxolonmade him stiff. ventilated concerns. Inteersted in autopsy as to whyshe vomtied - i [Dr Shute] said I would not be requesting an autopsy [sic].

34 Mrs Farrar passed away on 12 September 2021. The nursing notes record that one of Mrs Farrar's daughters spent most of the day with her mother.

35 On that day, Dr Shute signed the medical certificate of cause of death (i.e. the MCCD) to the effect that he had examined Mrs Farrar's body, that 'alzheimer's dementia' had directly led to Mrs Farrar's death and, in his opinion, the death was not a 'reportable death' under the *Coroners Act*. The MCCD noted that Dr Shute 'referenced the cause of death' with Mrs Farrar's 'complete medical history'.

36 In the following days, Mr Farrar sent emails dated 13, 15, 21 and 27 September 2021 to the Coroners Court advising that he considered his mother's death required investigation. By an email dated 13 September 2021, Mr Farrar:

(1) suggested 'something untoward has taken place' in relation to his mother's death;

(2) stated that there had been a 'long history of abuse from the medical profession directed at Audrey Farrar' including in 2016 while Mrs Farrar was in the care of Northeast Health Wangaratta; and

(3) concluded that his mother's 'vomiting and death was out of the ordinary and unexpected' given that he had been told after a recent hospital visit that 'all test [sic] were normal and Mum was healthy'.

37 By an email dated 15 September 2021, Mr Farrar referred to:

(1) his belief that 'we have a brutal and murderous system in some institutions' for the care of 'unwanted disabled' persons;

(2) the circumstances in which his father died in about September 2015, which included vomiting shortly before his death;

(3) the 'unbelievable coincidence' that his mother also vomited shortly before her death and the fact that she was then prescribed Maxolon. Mr Farrar continued that the '[m]edical profession … know elderly women … and mind altering drugs [like Maxolon] don't mix';

(4) the fact that Mrs Farrar was later given morphine and a benzodiazepine (Midazolam) to control spasms on 11 September 2021; and

(5) his suggestion that the combination of drugs given to his mother was 'dangerous' and was 'poison' and questioning why they were so freely used in nursing homes.

38 In an email dated 21 September 2021, Mr Farrar:

(1) reiterated his belief that his mother was poisoned;

(2) referred again to the circumstances of his father's death;

(3) expressed his view that medical records are often not a true representation of the facts and that the medical profession has a 'dark side'; and

(4) referred in detail to evidence given at, and findings of, the Royal Commission into Aged Care Quality and Safety (the '**Aged Care Royal Commission**'), including in relation to restrictive practices in the medical profession.

39 In that email, Mr Farrar also expressed the view that he had been trying to stop the 'abuse' of Mrs Farrar as a result of medical treatment over a number of years but had been unsuccessful. In support of this view, he referred to:

(1) the treatment of Mrs Farrar's hip fracture in 2016;

(2) the treatment for redness in her groin in December 2019 with a cream which Mr Farrar considered resulted in an irregular heartbeat;

(3) the failure to record apparent irregularities in the urine testing of Mrs Farrar at the 'nursing home' (which we understand to be a reference to Myrtleford Lodge);

(4) the fact that, to his observation, his mother returned from hospital to Myrtleford Lodge in May 2021 at which time Mr Farrar and his sister 'saw how mentally improved Mum was';

(5) his observation that some of the symptoms Mrs Farrar suffered from were similar to those Mr Farrar's father had suffered from; and

(6) his belief that there had been medication provided to Mrs Farrar after entering Myrtleford Lodge which produced side effects including 'mysterious sedation'.

40 The email concluded:

> Audrey Farrar has been hard to kill, reminiscent of the sickening abuse of Alwyn Farrar who was also hard to kill. … Just like the thousands of submissions sent to Aged Care Royal Commission, Alwyn and Audrey Farrar have discovered why the medical profession likes to lock people in institutions … I suspect the abusers were too cocky and just to stick it up everyone, they killed Mum the same way as Dad, possibly a lack of oxygen from a drug

> interfering with her lungs, but that is your job, I have no idea.
>
> What may be very difficult is if respiratory depression caused by drugs such as a Benzodiazepine and morphine was the cause of Mum's deterioration then it was very smart to make sure these drugs were in Mum's system at death.

41 By an email dated 27 September 2021, after the Determination was made on 26 September 2021, Mr Farrar referred to ss 4(2), 15, 16 and 17 of the *Coroners Act*. He asserted that Mrs Farrar's death was a 'reportable death' within s 4(2) given that it was unexpected and followed a medical procedure. He referred to the fact that Myrtleford Lodge made no attempt to inform the family that Mrs Farrar was even sick, let alone that she may die. We note that this seems inconsistent with the nursing notes of 9 September 2021 and the note recording the discussion between Dr Shute and Mr Farrar referred to above.

42 On 14 September 2021, Mr Farrar's sister, Ms Julie Deretic, sent an email to the Coroners Court (the '**Deretic email**') stating that Mr Farrar had asked for an investigation 'for no reason at all'. The email notes she and her sisters 'do not want to go through all this again with autopsy's [sic] and deal with this stress all over again. We all sisters want to bury our mother and grieve accordingly and to move on with our grieving'.

43 By email dated 23 September 2021, Mr Doran of the OPA wrote to the Coroners Court (the '**Doran email**'):

(1) referring to various aspects of Mrs Farrar's medical history;

(2) referring to discussions with Dr Wei concerning Mrs Farrar's care, most recently on 24 August 2021, and confirming the substance of Dr Wei's note of that conversation summarised above;

(3) expressing his view that Mrs Farrar appeared to have died from dementia related decline and that her death was generally anticipated; and

(4) expressing the view that Mr Farrar's request for an investigation into his mother's death is consistent with Mr Farrar's 'longstanding and deep mistrust of conventional medicine and care services'.

44 Although not explicitly referred to by the judge, there was evidence before him to the effect that:

(1) when concerns of care are raised by family members of a deceased, it is the practice of the Coroners Court for a pathologist from the Victorian Institute of Forensic Medicine (who is also a registered medical practitioner) to assesses any medical or other records held; and

(2) following this initial review and assessment, the pathologist will present this case for directions at a Coroner's Duty Meeting.

45 Consistent with this practice, after Mr Farrar raised his concerns by his emails to the Coroner, Dr Melanie Archer, pathologist, reviewed the MCCD and the medical records

of Mrs Farrar from Myrtleford Lodge (which total about 65 pages and consist of documents from external health service suppliers and internal forms completed by staff, including the opinions of Drs Wei and Shute). Dr Archer then completed a Preliminary Examination Form dated 22 September 2021 (the '**PEF**').[4]

46 The PEF refers to the MCCD and the medical records, in particular the notes dated 24 August, 7 September and 9 September 2021 referred to above (and the drugs referred to in them). The PEF also refers to the fact that Mr Farrar alleged that his mother's death was suspicious and had similarities with the death of his father. The PEF refers to his allegations that Mrs Farrar had been 'abused by the medical profession' (and his description of the medical system/profession as 'murderous'), that she was 'poisoned' and that she 'was treated for non-existent diseases'. It also noted that Mr Farrar and at least one of his sisters were in conflict.

47 In the PEF, Dr Archer concluded:

> Case is not reportable
>
> - the cause of death is appropriate, and there are no suspicious features.
> - the deceased was given standard palliative drugs for explainable end stage dementia symptoms, in a manner that was well documented by the GP, and had OPA oversight.
> - the deceased was treated for standard comorbidities with clear diagnostic criteria, and the drugs for these conditions do not cause dementia.

48 Dr Archer was subsequently given access to further records from Myrtleford Lodge in relation to Mrs Farrar, including a running record of typed nursing notes, referred to as the Bentley Wood records. These records comprised approximately 137 pages. In an email dated 23 September 2021 to the Coroner, Dr Archer 'confirm[ed] that my original advice remains unchanged, and I do not have anything to add'.

49 There was evidence before the judge that, subsequently, Dr Archer and the Coroner discussed Mrs Farrar's case and the PEF at a Coroner's Duty Meeting. On 26 September 2021, the Coroner made the Determination that the death of Mrs Farrar was not a 'reportable death'. The Determination was made pursuant to s 16(1) of the *Coroners Act*. As a consequence of the Determination, the investigation into the death of Mrs Farrar was formally discontinued pursuant to s 16(3) of the *Coroners Act*.

50 The Determination (the heading of which refers to s 16 of the *Coroners Act*) relevantly provides:

> I, Sarah Gebert, Coroner, having investigated the death of:
>
> [Mrs Farrar]
>
> reported by –

[4] Reasons, [18] state the date as 23 September 2021.

[Mr Farrar]

determine the death is not a reportable death pursuant to the *Coroners Act 2008* (**the Act**) for the reasons set out below:

1. Audrey Farrar, aged 85, died on 12 September 2021 under palliation for end stage dementia at Myrtleford Lodge Aged Care where she resided.

2. Douglas Farrar (**the Applicant**) has alleged, amongst other things, that his mother had been poisoned and this has been his view for a number of years and, that there was medical mismanagement by health practitioners who had been involved in her care, also over a number of years.

3. In contrast by email to the Court dated 14 September 2021, the Applicants' sisters (there are four) requested that any coronial investigation be stopped and wrote:

My brother has asked for this investigation for no reason at all. A death is hard enough when losing a parent but when someone is delaying our grieving and not able to move forward to burying our beautiful mother which maybe 1 or 2 weeks time who knows as can't even put a date on this.

If you look back in your files 6 years ago our father Kevin Alwyn Edward Farrar had passed away with Alzheimer's and was in a nursing home for many years. My brother accused the nursing home of poisoning him over all those years and wrote letters daily to VCAT, and Northeast Health Wangaratta and threats.

On our father passing away, ….[the death] was under investigation and an autopsy was performed. My brother was not happy with this and unbeknown to us another one performed. Nothing come out of these autopsy's then he tried for a 3rd one but dad finally was sent back to us.

Our father was laid to rest 3 weeks after his death ……

….. Now our mother passed away on Sunday also with Alzheimer's but in a different nursing home.

The same is now been duplicated, that he states the nursing home had poisoned our mother also. We do not want to go through all this again with autopsy's and deal with this stress all over again.

We all sisters want to bury our mother and grieve accordingly and to move on with our grieving.

4. I was further advised that the Public Advocate had been limited guardian for Mrs Farrar since 12 June 2018 until the time of her death. There had been some reduction in authorities to remove 'Accommodation' and 'Access to Services' once she moved to live in Myrtleford Aged Care but 'Access to Persons' and 'Medical Treatment' decision making authorities were retained throughout.

5. James Doran, Office of Public Advocate (OPA) advised the Court by email dated 24 September 2021 that their office was aware of the views held by the Applicant in relation to his mother's care. He noted that Mrs Farrar appeared to have died from dementia related decline and her death was generally

anticipated. Mr Doran said that discussion between himself and her general practitioner (GP), Dr James Wei, around her care had taken place, most recently on 24 August 2021, at which time Dr Wei was clear that she was not a candidate for CPR or other assertive intervention and in the case of an event or other significant decline, her care was to be provided at Myrtleford Lodge and would focus on palliation and comfort measures only.

6. Following Mrs Farrar's death I note that GP Dr Simon Shute completed a medical cause of death certificate (**MCCD**) in relation to the death documenting the cause as 'Alzheimer's Dementia'.

7. As a result of the request by the Applicant for an investigation into Mrs Farrar's death, Dr Melanie Archer, pathologist, Victorian Institute Forensic Medicine (VIFM), reviewed the records obtained from Myrtleford Lodge Aged Care and advised that there are no medical reasons to suggest that the death is a reportable death. In addition, the medical history is consistent with the MCCD completed by the doctor, the cause of death is appropriate, and there are no suspicious features. Dr Archer noted that Mrs Farrar was given standard palliative drugs for explainable end stage dementia symptoms, in a manner that was well documented by the GP, and had OPA oversight. In addition that Mrs Farrar was treated for standard comorbidities with clear diagnostic criteria, and the drugs for these conditions do not cause dementia.

8. With respect to the value of conducting any medical examinations on the Deceased, Dr Archer considered that there was no utility in performing an external examination, an internal examination (full autopsy), toxicology testing or any other testing within VIFM's scope. She noted that a forensic pathologist would not be in a position to address concerns of care, and also that the findings of these examinations would confirm what is already known, and facts not in dispute. In addition, any toxicology testing would likely detect the palliative drugs midazolam and morphine, as well as antiemetics maxolon (metoclopramide) and ondansetron, rather than clarify any decisions related to their provision. The external examination and radiology would also not reveal any features of interest given that there are no allegations of inflicted injury.

9. I note there are no circumstances in relation to the death which would otherwise make it reportable under section 4(2) of the Act.

10. A coroner may only investigate those deaths that are reportable under the Act, and of those deaths are limited to an examination of matters that are significantly proximate, and causative, or contributory, to the death.

11. Having considered all of the above matters, there is no basis for me to conclude that the death of Mrs Farrar is reportable under the Act.

12. In reaching this decision I have had regard to all of the above matters, my review of the MCCD, records obtained from Myrtleford Lodge Aged Care and the following documents provided by the Applicant:

- Email to CAE dated 13 and 21 September 2021 (request for investigation);

- Submission dated 10 September 2021 to the Disability Royal Commission;

- Submission dated 16 July 2021 to the Disability Royal Commission; and

- Undated document comprising pages 39 pages including: document headed 'Age Care Royal Commission'; email dated 16 November 2018; email dated 2 October 2018; email dated 15 April 2016; email dated 18 April 2016; Submission dated 22 January 2020; Disability Royal Commission dated 24 May 2021; Submission dated 22 January 2020; Disability Royal Commission dated 25 August 2021 and Disability Royal Commission dated 28 May 2021.

Accordingly –

Pursuant to section 16(3) of the **Coroners Act 2008, I** discontinue the investigation into the death.

[Coroner Gebert's Signature]

Date: 26 September 2021

51 Thus, the Coroner, clearly aware of Mr Farrar's contentions, determined that there was 'no basis … to conclude that the death of Mrs Farrar is reportable under the [*Coroners Act*]'. She did so in the context of noting that there were no circumstances in relation to Mrs Farrar's death which would otherwise make it a 'reportable death' under s 4(2) of the *Coroners Act*.

The appeal to the judge

52 On 21 October 2021, Mr Farrar issued a notice of appeal to a single judge of this Court under s 78 of the *Coroners Act*. The appeal was heard before the judge on 7 and 10 December 2021. Mr Farrar appeared in person. The Coroner was represented by counsel who took the *Hardiman* position to assist the Court and otherwise to abide by the Court's decision.[5]

53 The judge identified three grounds of appeal. This first ground of appeal related to s 4(2)(a) of the *Coroners Act*, namely that:

(1) the Coroner's reasons failed to properly take into account the definition of 'unexpected' and 'unnatural' in the definition of 'reportable death' in s 4(2)(a) of the *Coroners Act*;

(2) on the weight of the evidence, Mrs Farrar's death was 'unexpected' and 'unnatural' with the result that it was a 'reportable death' and required coronial investigation; and

(3) the Coroner had taken into account irrelevant considerations when considering the Deretic email, the Doran email and the PEF.

[5] *R v Australian Broadcasting Tribunal; Ex parte Hardiman* (1980) 144 CLR 13; [1980] HCA 13 ('*Hardiman*'). As occurred before the judge, to assist the Court counsel for the Coroner provided written submissions as to the primary facts and the law without advancing argument in a tendentious manner.

54 The judge noted that, as to the weight of the evidence, Mr Farrar relied upon evidence before the Coroner that it was rare for his mother to vomit and that her death was unexpected given her history, including her release from hospital in May 2021.[6]

55 The judge rejected this ground on the basis that:

(1) the Coroner expressly had regard to s 4(2) of the *Coroners Act* and did not approach the question of whether the death appeared to be a 'reportable death' from a wrong perspective;[7]

(2) although Mr Farrar held certain concerns about his mother's treatment, deterioration and death, the substance of these concerns was conveyed to each of Dr Archer and the Coroner and were taken into account by the Coroner in making the Determination;[8]

(3) Mr Farrar's concerns could not be conclusive of whether the death was a 'reportable death' which was to be determined by the Coroner in light of the whole of the evidence; [9]

(4) it was appropriate for the Coroner to have regard to the Deretic email, the Doran email and the PEF in making the Determination;[10]

(5) based on the whole of the evidence:

(a) there was ample evidence in support of the Determination that Mrs Farrar's death was not a 'reportable death': indeed there 'could be no suggestion' that the Coroner's finding was against the evidence and the weight of evidence to such an extent that no reasonable coroner could have made it;[11]

(b) it was open to conclude that the cause of Mrs Farrar's death was Alzheimer's dementia; [12] and

(6) there was an emerging prospect and risk of death from late August 2021 based upon the 24 August 2021 notes, including the communications with the OPA.[13]

56 The second ground of appeal related to s 4(2)(b) of the *Coroners Act*, namely that:

(1) the Determination did not properly take into account s 4(2)(b) of the *Coroners Act*; and

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6 Reasons, [36]–[37].
7 Reasons, [47]–[50].
8 Reasons, [42], [47], [74]–[76].
9 Reasons, [66].
10 Reasons, [45], [72]–[73].
11 Reasons, [51], [67]–[68], [74].
12 Reasons, [52]–[54].
13 Reasons, [55]–[63].

(2) the administration of Maxolon on 7 September 2021 amounted to a 'medical procedure' that may be causally linked with Mrs Farrar's death.[14]

57 The judge rejected this ground. This was because, consistent with his conclusions summarised at [54] above, he did not accept that the Coroner overlooked any part of the definition of 'reportable death' or of the relevant circumstances relating to the death of Mrs Farrar.[15] Indeed, the judge concluded that, assuming the administration of Maxolon was a 'medical procedure' for the purpose of s 4(2)(b) of the *Coroners Act*, the only medical opinions before the Coroner did not support the view that the administration of this drug, or any other 'medical procedure', may have caused the death of Mrs Farrar.[16]

58 The third ground of appeal was to the effect that the Coroner erred in considering that Dr Archer had conducted a proper 'preliminary examination', because Mrs Farrar's body had not been provided to Dr Archer.[17] The judge rejected the third ground on the basis that the terms of ss 23 and 3(1) of the *Coroners Act* and r 33 of the Coroners Rules did not require that a 'preliminary examination' involve an examination of the body.[18]

The application for leave to appeal to this Court

59 By an amended application for leave to appeal dated 27 July 2022 ('**amended application**'), Mr Farrar now seeks leave to appeal to this Court from that Decision. Once again, in this Court, Mr Farrar appeared without legal representation. The Coroner was represented by counsel who again took the *Hardiman* position to assist the Court and otherwise to abide by the Court's decision.[19]

60 Under s 14C of the *Supreme Court Act 1986* (Vic), the Court of Appeal 'may' grant an application for leave 'only if it is satisfied that the appeal has a real prospect of success' i.e. 'a "real" as opposed to a "fanciful" chance of success'.[20] Even if this Court is satisfied that the appeal has real prospects of success, this Court may nevertheless exercise its discretion to refuse leave to appeal.[21]

61 As to the basis upon which this Court should now determine these applications, counsel for the Coroner contended that Mr Farrar was limited to raising errors of law in the Reasons of the judge. This was no doubt based, in part, upon the limited nature of the appeal from a determination of a coroner in s 87 of the *Coroners Act*. However, that section applies to an appeal to a single judge of the Supreme Court under Part 7 of the *Coroners Act*. Part 7 of the Act does not by its terms govern an appeal to this Court.

62 An appeal to this Court is an appeal by way of rehearing, the character or nature of which is influenced by the statutory context in which the matter under appeal arose. Subject to this qualification, on such an appeal the Court's role is to determine whether the decision of the primary judge was or was not correct, on the evidence and the law

14 Reasons, [78].
15 Reasons, [79].
16 Reasons, [81].
17 Reasons, [84].
18 Reasons, [85]–[87].
19 *Hardiman* (1980) 144 CLR 13.
20 *Kennedy v Shire of Campaspe* [2015] VSCA 47, [12] (Whelan and Ferguson JJA).
21 Ibid, [5].

as it stood at the time of the original decision. In so doing, the Court will confine its attention to the alleged errors of fact or law specified in the grounds of appeal, rather than conduct a general review of the decision below or consider all of the evidence afresh.[22] For this case relating to the *Coroners Act*, this Court is concerned with whether the judge was in error in deciding the question or questions of law raised before him, noting that one such error (based on s 87(1A) of the *Coroners Act* and forming part of proposed ground 1) related to '[a]n appeal on a question of law…on the grounds that the finding [of the Coroner] is against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made the finding'.

63 The amended application contains three proposed grounds of appeal:

> 1. My ground of appeal is that the facts manifestly demonstrate that Audrey Farrar's death was reportable and a major error has occurred in both the Coroners Court's and [the judge's] decisions. …
>
> 2. My ground of appeal is that there has been a major jurisdictional error in that the coroner has failed to use her powers to perform a thorough investigation. …
>
> 3. My ground of appeal is about a question of law in relation to preliminary examinations. …
>
> …
>
> (c) The question is; … does the law stipulate that in order for a 'preliminary examination' to take place a direction must be given or a body must be provided to a medical investigator … ?

64 As mentioned above, the issue relating to the need for a direction was not raised in the appeal before the judge. However, the amended application provides at [6](b)3.(c):

> The question is; did Justice O'Meara make an error, does the law stipulate that in order for a 'preliminary examination' to take place a direction must be given or a body must be provided to a medical investigator, and it is outside the law otherwise?

65 We shall deal with this issue further when addressing proposed ground 3 below.

Proposed ground 1

66 As set out above, proposed ground 1 is whether the judge erred by concluding that there was sufficient evidence to support the Determination that Mrs Farrar's death was not reportable and, rather, ought to have found that the Determination was manifestly unreasonable in light of the evidence and that Mrs Farrar's death was reportable:

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[22] *Li v So* [2021] VSCA 32, [34] (Tate, Emerton and Sifris JJA); *Allesch v Maunz* (2000) 203 CLR 172, 180 [23] (Gaudron, McHugh, Gummow and Hayne JJ); [2000] HCA 40. See also *Freeman v Rabinov* [1981] VR 539, 548 (Lush J, Murray and King JJ agreeing).

(1) under s 4(2)(a) of the *Coroners Act* because it 'appears to have been unexpected, unnatural … or to have resulted, directly or indirectly, from an accident or injury'; or

(2) under s 4(2)(b) of the *Coroners Act* as it occurred 'following a medical procedure … and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death…'.

67 To obtain leave to appeal on this ground Mr Farrar must demonstrate reasonable prospects for an argument that, on the weight of the evidence, no reasonable coroner could have arrived at the Determination. After reviewing all of the evidence, the judge found it was 'well open' to the Coroner to draw the conclusions that she drew.[23] On an appeal, Mr Farrar would have to persuade the Court that on the law and the facts the decision of the judge was incorrect in this regard.

68 Mr Farrar's amended written case in support of the proposed grounds of appeal was difficult to follow. In respect of proposed ground 1, Mr Farrar refers to:

(1) evidence given at the Aged Care Royal Commission;

(2) why two sets of records relating to Mrs Farrar were sent to the Coroner on 16 and 23 September 2021 when there was only one request;

(3) his belief that there were different opinions about the cause of Mrs Farrar's death because 'one doctor treating [her] in the last months did not think Alzheimer's was causing the shaking or vomiting which may have led to her death, and yet a different doctor decided Alzheimer's was the cause of death' and that 'the coroner also knew that Douglas Farrar thought Alzheimer's wasn't the cause'; and

(4) his belief that there is no interest by coroners in investigating the deaths of the 'elderly disabled' such as his parents. By way of example, Mr Farrar relied upon the fact that Dr Archer believed any medical examinations would not be worthwhile 'despite me [Mr Farrar] providing much information in relation to my poisoning allegation, and Mum's susceptibility to drug damage as written in the medical records'.

69 In his amended written case Mr Farrar stated:

> 16. The information I provided to the coroner was about Mum's long history of abuse from the medical profession and others, about the damaging drug history (prescribed by doctors), about the ***unnatural*** results of prescription medication, about my attempts to keep Mum away from the medical profession and the results of ***medical procedures*** when she was locked in the nursing home. All related to section 4 (2) of the Act; ***unnatural and following a medical procedure***.
>
> …

[23] Reasons, [68].

> 19. From my emails to the coroner dated 13 and 15 September 2021 … "*Audrey Farrar's vomiting and death was out of the ordinary and* ***unexpected****, we were told after a recent hospital visit that all test were normal and Mum was healthy*" Is where I inform the coroner about ***unexpected*** and I go into much more detail about vomiting in the transcript of proceedings with Justice O'Meara. The coroner had access to the nursing home records to confirm when Mum vomited and whether it was a common occurrence. …
>
> 20. There is no evidence from the nursing home that they expected Audrey Farrar to die any time soon, the reverse is the case … The guardian James Doran had only seem Mum once back in 2019 and all his information since has come from the nursing home, an opinion from him that Mum was expected to die soon is at odds with the nursing home. …

70 In short, we can see no error in the Reasons of the judge. While Mr Farrar asserted that the weight of evidence was to the effect that Mrs Farrar's death was a 'reportable death' under either s 4(2)(a) or s 4(2)(b) of the *Coroners Act*, it was plainly open to any reasonable coroner, on the weight of evidence, to come to the conclusion that Mrs Farrar's death was not a 'reportable death' under either of those subsections.

71 As to s 4(2)(a),[24] there was no material or evidence before the Coroner to suggest that the death of Mrs Farrar was 'unexpected' or 'unnatural', save for the assertions of Mr Farrar. The medical evidence of Dr Wei and Dr Shute was to the effect that Mrs Farrar had advanced dementia and required full assistance for all aspects of her care. Dr Wei's medical opinion in August 2021 was that, in all of the circumstances, Mrs Farrar was not for transfer to an acute medical facility but was to be treated with '[p]alliative/comfort measures'. Although it may not have been legally necessary to obtain his consent, Mr Doran agreed with this course.

72 The medical evidence of Dr Shute of his observation of Mrs Farrar on 9 September 2021 is consistent with Dr Wei's conclusions. For completeness, we do not consider that the nursing notes of 8 September 2021, which record a deterioration of Mrs Farrar's condition 'over the past three days' are inconsistent with the observations of each of Dr Wei and Dr Shute regarding Mrs Farrar's overall condition.

73 Further, the MCCD completed by Dr Shute stated that the cause of death was '[A]lzheimer's dementia'.

74 There is also Dr Archer's expert opinion in the PEF, namely that the '[c]ase is not reportable…the cause of death is appropriate, and there are no suspicious features.' This was confirmed by Dr Archer's subsequent email to the Coroner dated 23 September 2021 in which Dr Archer affirmed her original advice in the PEF. These conclusions were reached after:

(1) taking into account the concerns of Mr Farrar as to the cause of his mother's death; and

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[24] A death that appears to be 'unexpected' or 'unnatural'.

(2) reviewing all the medical records of Mrs Farrar from the Myrtleford Lodge received in the two batches as described above (in particular, the notes of 24 August, 7 September and 9 September 2021).

75 As to any assertion that Mrs Farrar was treated with drugs which somehow caused her death or caused it to be 'unnatural' or 'unexpected', there is the opinion of Dr Archer in the PEF (confirmed in her subsequent email to the Coroner) that:

(1) Mrs Farrar was given standard palliative drugs for explainable end-stage dementia symptoms;

(2) Mrs Farrar was treated for standard comorbidities with clear diagnostic criteria; and

(3) the drugs given to Mrs Farrar for these conditions do not cause dementia.

76 In all these circumstances, we can see no proper basis to conclude that it appeared that Mrs Farrar's death was 'unexpected' or 'unnatural'. The contrary is true. Further and relatedly, in light of the condition of Mrs Farrar from late August 2021, her death was not 'unexpected' or 'unnatural' from that time. We refer to our summary in [70] to [73] above. In this regard, we agree with the conclusion of the judge that from late August 2021 there was an emerging prospect and risk of death.

77 We consider that this part of proposed ground 1 has no real prospects of success.

78 As to s 4(2)(b),[25] we consider that the weight of evidence supported the conclusion that Mrs Farrar's death:

(1) did not occur 'following a medical procedure where the death is or may be causally related to the medical procedure' in circumstances such that

(2) 'a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death'.

79 First, assuming:

(1) the administration of a drug intravenously or via injection is a 'medical procedure' under the *Coroners Act*; and

(2) the injection of Maxolon on or about 7 September 2021 was the relevant 'medical procedure',

we agree with the conclusion of the judge that the medical opinions (of Dr Shute and of Dr Archer) before the Coroner did not support the view that the injection of Maxolon or any other 'medical procedure' may have caused the death of Mrs Farrar.[26] To the

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25 A death that occurs 'following a medical procedure where the death is or may be causally related to the medical procedure…and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death…'.

26 Reasons, [81].

contrary, those opinions only support the conclusion that the cause of death was advanced Alzheimer's disease.

80 For completeness, we consider that the administration of a drug by needle (including intravenous drip) may well fall within the definition of a 'medical procedure' under the *Coroners Act*. However, because of our view of the facts in this case it is unnecessary to decide this question to dispose of this part of proposed ground 1.

81 Second, in our view, the medical evidence does not support the conclusion that 'a registered medical practitioner would not, immediately before [the administration of Maxolon], have reasonably expected the death.' The weight of evidence is clearly to the contrary. We refer to our conclusions in [76] above.

82 In all these circumstances, we consider that this part of proposed ground 1 also has no real prospects of success.

83 There are three additional comments we wish to make in light of Mr Farrar's submissions. First, we can see no relevance in reaching our conclusions above that the records of Mrs Farrar were sent in two batches at different times. What is relevant is that Dr Archer had all those records and had regard to them in reaching her conclusions. Second, as is evident from the above, we can see no material difference between the opinions of Dr Wei or of Dr Shute, or indeed of Dr Archer, as to Mrs Farrar's cause of death.

84 Third, there is no evidence to support the assertion that '[t]here is no interest' by coroners in investigating deaths. To the contrary, Dr Archer reviewed all the medical records and other records provided to her, and prepared the PEF and her subsequent email dated 23 September 2021 in order to assist the Coroner in deciding if Mrs Farrar's death was a 'reportable death' under the *Coroners Act*. The Determination, and the process undertaken to arrive at it, reveals that the Coroner paid proper attention to Mr Farrar's concerns, and gathered and considered the necessary information to investigate whether Mrs Farrar's death was a 'reportable death'.

85 For completeness, we agree with the views of the judge that it was appropriate for the Coroner to have regard to the Deretic email, the Doran email and the PEF in making the Determination. This is because each of those documents contained information that was relevant to the Coroner's determination of whether Mrs Farrar's death was a 'reportable death'. In the case of the PEF, in our view, the Coroner was entitled to have regard to the expert opinion contained in the PEF, even if Dr Archer's investigation did not constitute a 'preliminary examination' under the *Coroners Act*. However, for the reasons set out in proposed ground 3, we consider that the nature of Dr Archer's examination falls within the definition of 'preliminary examination'.

Proposed ground 2

86 As set out above, we understand proposed ground 2 to be that there was a jurisdictional error in that the Coroner failed to use her powers to perform a thorough investigation into whether the death was a 'reportable death'.

87 In respect of proposed ground 2, in his amended written case, Mr Farrar states that 'this part is about the coroners [sic] failure to exercise her powers or misusing her powers'. Many of the same matters referred to in relation to proposed ground 1 are relied upon for proposed ground 2. Other matters relied upon seem to relate more to proposed ground 3.

88 In his amended written case, Mr Farrar then asserts that 'a minimal investigation would have at least help [sic] rule in or out my poisoning allegations'. It continues:

> 25 No investigations took place, it appears the coroner, despite her enormous powers, and certainly had jurisdiction to investigate Audrey Farrar's death, chose not to. The coroner failed to make an obvious inquiry about a critical issue and that the failure to consider the matters I raised about medication constituted a constructive failure by the Coroner to exercise the investigative jurisdiction conferred on her. …
>
> …
>
> 29 What more can I say, **a failure to conduct a sufficiently thorough investigation may constitute jurisdictional error in the form of a constructive failure by the coroner to exercise her jurisdiction.**

89 This issue was not directly raised before the judge. Further, and relatedly, as is evident from the previous paragraph, Mr Farrar seeks to challenge the Determination of the Coroner, not the Reasons of the judge. Thus, proposed ground 2 does not raise any error arising from the decision of the judge. As a result, we would refuse leave to appeal on proposed ground 2.

90 We would add the following: we can see no basis to conclude that the Coroner did not conduct a sufficiently thorough investigation in this case. Rather, through Dr Archer, and by gathering and analysing the information referred to in the Determination, the Coroner conducted a real and proper investigation into whether Mrs Farrar's death was a 'reportable death'. We have set out the steps taken and conclusions reached by Dr Archer above. It would appear that Dr Archer's investigation and conclusions were then discussed with the Coroner at a Coroner's Duty Meeting, prior to the Determination being made. The Determination discloses that the Coroner had regard to the following relevant material:

(1) the PEF;

(2) the correspondence from Mr Farrar including voluminous attachments;

(3) the MCCD;

(4) the Deretic email; and

(5) the Doran email.

91 Thus, it is evident that each of Dr Archer and the Coroner also had regard to Mr Farrar's concerns about the cause of his mother's death in reaching their conclusions. In our

view, further investigations were not required to 'rule in or out [Mr Farrar's] poisoning allegations'.

92 To be clear, in reaching our conclusion on this proposed ground, we have taken the view that there is no obligation on a coroner under the *Coroners Act* to examine a body in order to determine whether a death is a 'reportable death' under s 4(2) of the *Coroners Act*. We shall deal with this more fully in relation to proposed ground 3.

Proposed ground 3

93 As set out above, we consider that the third proposed ground of appeal relates to the nature of a 'preliminary examination' under the *Coroners Act*, namely:

(1) whether the judge erred in concluding that a 'preliminary examination' under the *Coroners Act* did not require the body of Mrs Farrar to be provided for the purposes of the Coroner determining whether her death was a 'reportable death'; and

(2) in the event that the *Coroners Act* does not require the body to be provided for the purposes of a 'preliminary examination', whether a direction is required by a coroner to undertake a 'preliminary examination'.

94 Mr Farrar's amended written case appears to raise the question whether the investigation in fact conducted in relation to the death of Mrs Farrar was a 'preliminary examination' under the *Coroners Act*. It relevantly stated:

> No direction for a preliminary examination, no body provided, therefore no authorisation to perform a preliminary examination. Dr Archer saw no point in investigating Audrey Farrar's death and her preliminary examination is not legal and has no relevance to the coroners determination.

95 The Coroner proceeded on the basis that Dr Archer had conducted a 'preliminary examination' in relation to the death of Mrs Farrar. It was in this context that Mr Farrar contended before the judge that a 'preliminary examination' must involve an examination of the body of the deceased.

96 In short, like the judge, we do not accept that a 'preliminary examination' under the *Coroners Act* requires an examination of the body of the deceased. In reaching this conclusion, we have had regard to the structure and provisions of the *Coroners Act*.

97 First, as noted above, Division 1 of Part 4 of the *Coroners Act* is headed 'Investigation of deaths'. First, under s 14 of the *Coroners Act*, a coroner has the power to investigate:

(1) a death that is or may be a 'reportable death' if the death occurred within 100 years of the date it was reported to a coroner (s 14(1)); and

(2) whether the death is a 'reportable death' (s 14(3)).

98 Second, s 15 of the *Coroners Act* sets out the deaths that a coroner must investigate. That relevantly includes, in s 15(b), a death that appears to a coroner to be a 'reportable death'.

99 Third, as to the nature of the investigations a coroner may instigate under Division 1 of Part 4, s 23(1) of the *Coroners Act* provides that '[t]he purpose of a preliminary examination is to assist the coroner in the performance of his or her functions in respect of a death'. The scope of the purpose of a 'preliminary examination' is not limited to investigative functions under s 15 but includes the investigative functions under s 14 of the *Coroners Act*.

100 Fourth, s 23 of the *Coroners Act* does not mandate that a 'preliminary examination' must involve a physical examination of the body of the deceased. To the contrary, s 23(2) provides that a coroner 'may provide a body to a medical investigator to enable a preliminary examination to be performed on the body'.[27] That language is permissive.

101 So too, the definition of 'preliminary examination' in s 3(1) of the *Coroners Act* does not mandate that a 'preliminary examination' must involve a physical examination of the body of the deceased. To the contrary, its terms set out in a series of subsections the different procedures, any of which qualify as a 'preliminary examination'. These include:

> (a) a visual examination of the body (including a dental examination);
>
> (b) the collection and review of information, including personal and health information relating to the deceased person or the death of the person;
>
> (c) the taking of samples of bodily fluid including blood, urine, saliva and mucus samples from the body (which may require an incision to be made) and the testing of those samples; …

102 Thus, the kind of investigative procedure conducted by Dr Archer on behalf of the Coroner would fall within the definition of 'preliminary examination' in (b) above. In this regard, we note that the judge concluded paragraph (b) of the definition of 'preliminary examination' 'amply describes the "procedure" undertaken by Dr Archer in the present instance and … she completed the "preliminary examination" form and provided it to the Coroner as requested'.[28]

103 We agree with this conclusion of the judge. Based upon s 23(2) and the definition of 'preliminary examination' under the *Coroners Act*, we can see no requirement under the *Coroners Act* for a 'preliminary examination' to involve a physical examination of the body of the deceased.

104 Mr Farrar also relied upon r 33(1) of the Coroners Rules before the judge. However, that rule only applies '[i]f a coroner has provided a body to a medical investigator to enable a preliminary examination to be performed on the body under section 23(2) of the [*Coroners Act*]…'.[29] As a result, this rule confirms our view that a 'preliminary examination' under the *Coroners Act* does not require or mandate an examination of the body of the deceased.

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27 Emphasis added.
28 Reasons, [88].
29 Emphasis added.

105 In the course of oral argument, Mr Farrar referred to apparent inconsistencies between the publicly available materials published by the Coroners Court in relation to preliminary examinations and the provisions of the *Coroners Act*. In our view, it is not necessary to review the publicly available material prepared by the Coroners Court. This is because, in reaching our conclusions, we have applied the relevant provisions of the *Coroners Act*.

106 As to the direction issue,[30] we repeat that this issue was not raised before the judge. As a result, it is not properly the subject of grounds of appeal from the Reasons.

107 However, we have concluded that we can see nothing in the *Coroners Act*, in particular in Division 1 of Part 4 relating to 'Investigation of deaths' which would require a direction by a coroner for a 'preliminary examination', relevantly, where the 'preliminary examination' involves the collection and review of information. Mr Farrar was unable to point us to any such provision. This is in the context of s 23(1) which provides that the purpose of a 'preliminary examination' is to assist a coroner 'in the performance of his or her functions in respect of a death'.

108 Our view in this regard is confirmed by other sections in the same Division of the *Coroners Act* which expressly provide that a direction may or must be given. By way of example, as set out above:

(1) sections 24 and 25 of the *Coroners Act* respectively provide the circumstances in which a coroner may or must provide a direction before certain procedures can be undertaken for the purpose of a coroner undertaking his or her functions; and

(2) in either of those events, rr 34 and 36 of the Coroners Rules respectively prescribe the Form any such direction must take.

109 These express provisions, which provide a 'direction' and the Form thereof, reinforce our view that a 'preliminary examination' under s 23 of the *Coroners Act* does not impose a requirement for a formal direction by a coroner for every 'preliminary examination', particularly where no examination of the body or taking of samples is involved.

110 For completeness, we do not consider that s 23(3) of the *Coroners Act* (which provides that the 'provision of the body authorises the conduct of the preliminary examination') supports a construction of the *Coroners Act* that imposes a requirement that either the body be provided or that a formal direction be given by a coroner for *every* 'preliminary examination'. Rather, we consider that this provision is a machinery provision in relation to preliminary examinations which involve an examination of, or taking samples from, the body of the deceased.

111 As a result, we will grant leave to appeal in relation to proposed ground 3 but will dismiss the appeal.

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30 See above, [7].

112 There is one final matter to address. At the commencement of the oral address, the Coroner sought leave to rely upon an affidavit of Dr Archer affirmed 27 September 2022. Counsel submitted that this affidavit may be of assistance to the Court in the event that leave to appeal were granted. That affidavit addressed, in substance, two matters, namely, some matters discussed between Dr Archer and the Coroner, presumably at the Coroner's Duty Meeting in relation to the Determination, and the utility of obtaining bodily samples. Mr Farrar objected to the admission of that additional affidavit into evidence. In light of the conclusions we have reached in relation to the proposed grounds of appeal, we do not grant leave to the Coroner to rely upon this affidavit.
