IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2023 004999**

IN THE MATTER OF THE DEATH OF CHRISTOPHER KEISLER

RULING REGARDING USE OF SAPSE DOCUMENTS

BACKGROUND

1. On the morning of 7 September 2023, Christopher Keisler (hereinafter referred to as '**Chris**') was 44 years of age when he died following an incident involving the attendance of emergency services at his home in Point Cook, which was a supported residence funded under the auspices of the National Disability Insurance Scheme (**NDIS**).

2. Upon the arrival of emergency services personnel at his address, Chris appeared to be experiencing an incident of acute mental ill health, and to be highly agitated. With the assistance of police and paramedics, he was restrained and administered with sedating medications. Unexpectedly, and very sadly, Chris deteriorated and went into cardiac arrest *en route* to hospital, where he was pronounced deceased.

PROCEDURAL HISTORY

3. An initial directions hearing was held at the Coroners Court of Victoria (hereinafter '**Coroners Court**' or '**Court**') in relation to Chris's death on 28 September 2023 in accordance with '*Practice Direction 5 of 2020 - Directions Hearings in Mandatory Inquests*'.[1] Interested Parties in attendance included Ambulance Victoria (**AV**) and the Chief Commissioner of Police (**CCP**).

4. On 3 January 2024, the autopsy report of the Forensic Pathologist, Dr Michael Burke (**Dr Burke**), was finalised. The cause of Chris's death was formulated by Dr Burke as '*1 (a) drug induced hypoxic cardiac arrest; 1 (b) chemical sedation for acute psychosis in a man with schizophrenia'*.

[1] State Coroner Judge John Cain, *'Practice Direction 5 of 2020 - Directions Hearings in Mandatory Inquests*' dated 17 September 2020; available here.

5. On 8 April 2024, the Court asked AV for '*any reports of any internal reviews regarding the death of Christopher Keisler*'.[2]

6. On 15 May 2024, in response to this request, legal representatives for AV provided the Court with the following documents that pertained to its serious adverse patient safety event (**SAPSE**) review conducted following Chris's death:

    a) 'SAPSE review report: Review of an event meeting sentinel event criteria, Ambulance Victoria', inclusive of Parts A, B and C, signed off on 28 December 2023;

    b) 'SAPSE review report: Review of an event meeting sentinel event criteria, Ambulance Victoria', Part D (Recommendation Monitoring Report), signed off on 28 March 2024;

    c) Appendix 1 ('Linear Timeline') and Appendix 2 ('Cause and Effect'); and

    d) Patient Safety Incident Management Serious Adverse Patient Safety Event In-depth Case Review Report dated 11 September 2023.

7. For the purposes of the present Ruling, documents a) to d) above will be referred to collectively as '**SAPSE Documents**'.

8. AV submits that the SAPSE Documents fall into two categories. The first category is the SAPSE review report relating to Chris's death prepared pursuant to s 128T of the *Health Services Act 1988* (hereinafter '***Health Services Act***'), which is made up, collectively, of documents a) to c) in paragraph 6 of this Ruling. For the purposes of the present Ruling, I will refer to documents a) to c), as they relate to the SAPSE review report prepared following Chris's death, as the '**SAPSE Report**'.[3]

9. The second category of SAPSE Documents is referred to by AV as '**SAPSE Materials**'. In the present case, AV submits that the SAPSE Materials are made up of only one document, being the 'Patient Safety Incident Management Serious Adverse Patient Safety Event In-depth Case Review Report' dated 11 September 2023 and referred to at paragraph 6 (d) above.

10. The SAPSE Documents were provided to the Court on 15 May 2024 with the following email communication:

> *While we acknowledge AV is permitted to disclose this to the Coroner pursuant to section 128U(3) of the [Health Services Act 1988 (Vic)], we respectfully request the documents not be distributed further without prior notice from the*

[2] Email communication from Court to legal representatives for AV, 8 April 2024, 12:06pm, Court File.
[3] AV Submissions, para 2.2; Submissions of Counsel for AV, T-30, lines 17-26.

Court, as AV may wish to make submissions in that respect. Finally, we are instructed that AV has informed Mr Keisler's father of the SAPSE Review and indicated there is a copy of the review available to him if he so chooses.[4]

11. Following a request from the Court for AV to outline any claims as to public interest immunity (or any other claim) in relation to the use of the SAPSE Documents in the coronial proceedings and/or their inclusion in the coronial brief, on 28 June 2024, AV requested a redaction be made to one of the SAPSE Documents and noted it was *'otherwise happy with including the SAPSE Report and its respective attachments in the brief, but would ask that the usual non-publication order apply to the documents (and the brief)*'.[5]

12. However, on 2 July 2024, a legal representative for AV wrote to the Court and indicated that AV had withdrawn its instructions to consent to inclusion of the SAPSE Documents in the coronial brief and requested time to provide formal submissions for the Court's consideration.[6]

13. On 19 July 2024, legal representatives for AV wrote to the Court and, in detailed correspondence, requested a further 8 weeks to obtain advice and inform the Court as to AV's position regarding the SAPSE Documents.[7] This request was granted, with AV submissions due on 4 September 2024.[8]

14. Further requests for extension of time on behalf of AV were sought and granted, with AV ultimately providing a set of written submissions regarding the SAPSE Documents on 1 November 2024 (**AV Submissions**).[9] Therein, it was submitted that while AV does not consent to inclusion of the SAPSE Report in the coronial brief, it would consent to it being provided to Interested Parties '*subject to confidentiality and for background information only*'.[10]

15. Accordingly, on 8 November 2024, and to inform submissions, the Court circulated to Interested Parties: (i) the AV Submissions; (ii) SAPSE Documents; and (iii) a copy of the coronial brief. The Court provided an opportunity for Interested Parties to make any submissions, by 4 December 2024, in response to the AV Submissions.

16. Counsel for Chris's family filed submissions in response on 3 December 2024 (**Family Submissions**).

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[4] Email communication from legal representatives for AV to the Court, 15 May 2024, 2:47pm, Court File.
[5] Email communication from legal representatives for AV to the Court, 28 June 2024, 3:26pm, Court File.
[6] Email communication from legal representatives for AV to the Court, 2 July 2024, 3:13pm, Court File.
[7] Letter from legal representatives for AV to the Court dated 10 July 2024, Court File.
[8] Email communication from Court to legal representatives for AV, 15 July 2024, 1:55pm, Court File.
[9] Letter from legal representatives for AV to the Court dated 1 November 2024, Court File.
[10] AV Submissions, para 2.3(a).

17. A Court hearing was convened on 9 December 2024 at which oral submissions on use of the SAPSE Documents in coronial proceedings and their inclusion in the coronial brief were made by: (i) Counsel for AV; (ii) Counsel for Chris's Family; and (iii) Counsel Assisting the Coroner (**Counsel Assisting**).[11]

18. The Coronial Investigator, Chief Commissioner of Police, Forensicare and Safer Care Victoria attended the hearing remotely and did not seek to be heard on the issue.

19. I indicated at the close of the hearing that, rather than make an oral ruling on the application, I would consider the oral and written submissions filed in the matter, and issue a written ruling in due course.[12] The present document constitutes that ruling.

JURISDICTION

20. Chris's death was reported to the coroner because it appeared to be unexpected and because he appeared to be, immediately before death, a person in custody or care. His death is therefore reportable under both s 4(2)(a) and (c) of the *Coroners Act 2008* (hereinafter '***Coroners Act***').

21. Notably, Chris's death occurred one week after the commencement of Victoria's new *Mental Health and Wellbeing Act 2022* (hereinafter '***MHW Act***'). The precise nature of his being 'in custody' of police versus being 'in care' of AV paramedics under the *MHW Act*, or otherwise, is a matter that may require further clarification in these proceedings.

22. Regardless, pursuant to s 52(2)(b) of the *Coroners Act*, an inquest into his death is mandatory.

23. A coroner investigating such a death must find, if possible: (a) the identity of the deceased; and (b) the cause of death; and (c) the circumstances in which the death occurred (s 67 of the *Coroners Act*).

[11] *See* Transcript of Directions Hearing dated 9 December 2024 (**T**).
[12] T-60, lines 17-24.

LEGAL FRAMEWORK

I. Health Services Act

24. SAPSE reviews may be conducted under the *Health Services Act* where a SAPSE occurs. SAPSE reviews are defined in section 3(1) of the *Health Services Act* and governed by Division 8, Part 5A. Their scope is provided for in section 128O.

25. Section 3(1) of the *Health Services Act*, read together with Regulation 3B of the *Health Services (Quality and Safety) Regulations 2020*, defines a SAPSE as an event of a prescribed class or category that results in harm to one or more individuals. A prescribed class or category includes an event that: (a) occurred while the patient was receiving health services from a health service entity; and (b) in the reasonable opinion of a registered health practitioner, has resulted in, or is likely to result in, unintended or unexpected harm being suffered by the patient.

26. Section 128T provides for the content of SAPSE review reports, which must be prepared and produced for the health service entity which appointed the SAPSE review panel as soon as practicable after completing an investigation into a SAPSE.

27. Section 128U provides, with limited exceptions, that no person may be compelled to produce SAPSE review reports or related documents as defined in s 128U(1)(b), and that such reports/documents are not admissible in court.[13] However, under s 128U(3), a SAPSE review report may be produced to a Coroner and/or to the Coroners Court for an investigation or inquest.

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[13] **s128U - Confidentiality of SAPSE review documents and report**

(1) A person (other than under subsection (3) or in prescribed circumstances) must not be required to produce before any court or tribunal or any board, agency or other person—

(a) a report prepared under section 128T; or

(b) any document in the person's possession or under the person's control that is the original or a copy of a document that was—

(i) created for the sole purpose of providing information in the course of conducting a SAPSE review; and

(ii) provided in the course of conducting a SAPSE review by or on behalf of that person.

(2) Subject to subsection (3), the following is not admissible in any action or proceedings before any court or tribunal or any board, agency or other person—

(a) evidence of any other information or reports obtained by or in the possession of a serious adverse patient safety review panel in the course of conducting a SAPSE review;

(b) evidence of or about a document to which subsection (1) applies;

(c) a report prepared under section 128T.

(3) A report prepared under section 128T may be produced to a coroner or the Coroners Court (as appropriate) for the purposes of—

28. Section 128W provides that, other than in prescribed circumstances, a person cannot be compelled to disclose certain information regarding SAPSE processes.

II. *Coroners Act* and relevant case law

29. For the purposes of the present ruling, relevant provisions of the *Coroners Act* include:

    a) Section 7 (avoiding unnecessary duplication of inquiries and investigations);
    b) Section 8 (factors to consider for the purposes of the *Coroners Act*);
    c) Section 9 (fairness and efficiency of the coronial system);
    d) Section 42 (documents and prepared statements required by the Coroner);
    e) Section 55 (Coroners' powers at inquests); and
    f) Section 115 (access to documents).

30. *Priest v West* (2012) 40 VR 521 (***Priest v West***) is also relevant insofar as it enshrines the well-established principle that, in investigating a death, the coroner must pursue all reasonable lines of enquiry, be an active investigator and discover all they can about the circumstances surrounding the death (at [521], [525] and [560]).

SUBMISSIONS ON SAPSE DOCUMENTS

I. Ambulance Victoria (AV)

31. As noted above, AV draws a distinction in its submissions in relation to permitted uses of the two sets of SAPSE Documents, with the SAPSE Report treated differently to the SAPSE Materials. That distinction is a proper one having regard to s 128U of the *Health Services Act*, and is discussed further below.

32. AV's position is that it does '*not consent*' to the inclusion of the SAPSE Report in the coronial brief, and makes application that the Coroner refrain from: (i) including the SAPSE Report in the coronial brief; and/or (ii) admitting it into evidence in the inquest into Chris's death ('**Application**').[14]

33. AV submits that the SAPSE Materials are protected from being compelled to be produced to, and used by, the Coroner. Further, it submits that the SAPSE Materials were provided to the Court in error and seeks for them to be disregarded.

(a) an investigation under Division 1 of Part 4 of the **Coroners Act 2008**; or

(b) an inquest (within the meaning of the **Coroners Act 2008**) in respect of a death.

[14] Submissions of Counsel for AV; T-5, lines 12-15.

i. SAPSE Report

34. AV argues that the introduction of and requirement for SAPSE reviews and reports in Victoria (such as in a case where a patient dies when receiving health services from a health service entity, as Chris did) is a relatively new development in the health field.

35. The *Health Legislation Amendment (Quality and Safety) Bill 2021* was passed into law on 1 March 2022 to amend the *Health Services Act*. It provides for SAPSE reviews to be conducted to establish the relevant facts, identify factors that may have contributed to the SAPSE, and identify appropriate remedial measures to prevent similar events occurring in future and improve the quality and safety of the services.[15]

36. AV submits that the *Health Services Act* contains strict and specific protections of confidentiality and non-disclosure as a '*critical limb of the legislation*'.[16] The circumstances in which disclosure is permitted are tightly constrained and clearly prescribed. AV emphasises that the legislature considered this to be necessary to encourage full and frank participation and to ensure comprehensive consideration of risks and recommendations, without fear of repercussions.[17]

37. AV submits that, in the case of the SAPSE review related to Chris's episode of care, it has elected to exercise its 'discretion' under s 128U(3) of the *Health Services Act* to provide the SAPSE Report to the Court. AV accepts that '*access to the SAPSE Report may benefit the coronial process in this particular case*'. Similarly, AV would consent to the Coroner providing the SAPSE Report to the Interested Parties on the condition of confidentiality, for use as background information only, without its inclusion in the coronial brief, so that Interested Parties can '*have the benefit of the learnings from the report, without being able to rely on it directly*'.[18]

38. In circumstances in which a health service has already provided a SAPSE review report to the Coroner, AV concedes that, in light of s 128U(3) of the *Health Services Act*, '*it seems clear that in those situations where a SAPSE Report has been handed over there's no legislative restriction [as to] what the coroner can do with it',*[19] including admitting in into evidence at Inquest and including the document in the coronial brief. However, AV makes application to the Court <u>not</u> to take that course of action, on the basis of three (somewhat overlapping) arguments:

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[15] AV Submissions, para 3.1, referring to clause 5, s 128O. *See also* submissions of Counsel for AV; T-5, line 23 to T-6 line 31.
[16] Submissions of Counsel for AV; T-11 lines 17-18.
[17] AV Submissions, para 3.2.
[18] AV Submissions, para 3.3 and 3.4. As noted above, this occurred on 8 November 2024 for the purposes of allowing Interested Parties to make submissions on these issues.
[19] Submissions of Counsel for AV; T-18, lines 16-19.

a) **The forensic utility of SAPSE review reports in coronial proceedings is limited**, insofar as their reliability cannot be appropriately assessed by the Coroner in circumstances where, *inter alia*: (i) the legislation requires that the identities of the members of the SAPSE review panel and report authors not be referenced; (ii) persons contributing to a SAPSE review report cannot be compelled to give evidence about certain matters (such as whether or not they have provided information to a SAPSE review panel); and (iii) the information underlying the SAPSE review report cannot be disclosed and therefore reliably used as evidence at inquest;[20]

b) **There are procedural fairness issues associated with including the SAPSE Report in the coronial brief**, insofar as those who may be subject to adverse comment in the SAPSE Report will not have had the opportunity to test, and are prohibited from testing, the evidence upon which the SAPSE Report findings were based. AV submits that, accordingly, '*there is a risk that relying on the report is going to breach the obligation of the coroner to provide procedural fairness to those people who may be the subject of adverse comment in the SAPSE report*';[21] and

c) **Inclusion of the SAPSE Report in the coronial brief would undermine the purpose of the confidentiality provisions in the *Health Services Act,*** and '*will potentially have a chilling effect'* on health workers' forthright participation in SAPSE reviews and/or on the SAPSE review panel from making robust recommendations, which is antithetical to the Coroner's preventative role.[22] Further, it may expose healthcare workers to blame, or fuel a culture of blame,[23] which can '*lead staff to conceal poor outcomes and so allow system weaknesses to incubate and fester*'.[24]

39. AV argues that s 128U of the *Health Services Act* provides health services with the *discretion* to provide a SAPSE review report to a Coroner,[25] and it is not a document whose production can be compelled by the Court. Counsel for AV submits that, as a matter of statutory construction and in light of the Explanatory Memorandum relating to the *Health Services Act* amendments, a

[20] AV Submissions, para 3.5(a). *See also* submissions of Counsel for AV, T-19, line 15 to T-20, line 5.
[21] AV Submissions, para 3.5(b). *See also* submissions of Counsel for AV, T-20, lines 9-15.
[22] AV Submissions, para 3.5(c). *See also* submissions of Counsel for AV, T-24 line 13-14.
[23] *See* exchange with Counsel for AV at T-29 line 5 to T-30 line 2. *See also* T-53 line 15 to T-54 line 1.
[24] Submissions of Counsel for AV, T-25 lines 14-16, referring to '*Targeting Zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care*', January 2023, available here.
[25] Submissions of Counsel for AV, T-16 lines 16-29 quoting Explanatory Memorandum, Health Legislation Amendment (Quality and Safety) Bill 2021, p 9 which states, *'There is a limited exception providing that a SAPSE review report may, at the discretion of the relevant health service entity or health service entities, be provided to a coroner for the purpose of an investigation or an inquest in respect of a death.'* Accessible at: Health Legislation Amendment (Quality and Safety) Bill 2021.

Coroner's general powers in ss 42 and 55 of the *Coroners Act* (which relate, in part, to Coroners' powers to compel production of documents) should be read as subject to, and should yield to, the specific protections in s 128U of the *Health Services Act*.[26]

ii. SAPSE Materials

40. AV submits that Part 5A, Division 8 of the *Health Services Act* prohibits production to, and use by, the Coroner of the SAPSE Materials. The restrictions on disclosure and use of information and documents relate to:

    a) any documents created for the sole purpose of providing information in the course of conducting a SAPSE review; and

    b) any documents provided in the course of conducting a SAPSE review.[27]

41. AV notes that section s 128U(1)(b) mandates that a person must not be required to produce such documents before any court or tribunal or board, and that further, s 128U(2) provides that evidence of '*any other information or reports obtained by or in the possession of a [SAPSE] review panel in the course of conducting a SAPSE review'* is not admissible in any action or proceedings before any court or tribunal of board, agency or other person.

42. At the hearing on 9 December 2024, Counsel for AV, referring to s 128U, submitted that the sorts of documents that might be captured by s 128U(1)(b) would be '*notes, materials, drafts, file notes, summaries, opinions, expert reports, transcripts or recordings, all of those materials that are created for the sole purpose of a SAPSE review and provided to the SAPSE panel, all of those documents that underpin or feed the SAPSE report*'.[28]

43. The position of AV is that the Patient Safety Incident Management Serious Adverse Patient Safety Event In-depth Case Review Report, dated 11 September 2023, of some 29 pages (which is the only document it describes as 'SAPSE Materials') falls into either s 128U(1)(b) or s 128U(2) or both.[29]

[26] Submissions of Counsel for AV, T-14, lines 3-12. The four reasons provided in support can be found at T-14 line 13 to T-18, line 2.
[27] AV Submissions, para 4.1.
[28] Submissions of Counsel for AV, T-12 line 22 to T-13 line 2.
[29] No further details of this categorisation were provided on behalf of AV, which did not directly state or provide evidence that the document was either created for the sole purpose of providing information in the course of conducting a SAPSE review, or was provided in the course of conducting a SAPSE review, though this appears to be argued by implication.

44. AV submits that, in hindsight, having regard to Part 5A, Division 8, the SAPSE Materials should not have been provided to the Court, and AV seeks that they be disregarded and not relied upon in any way by the Court or otherwise used by Interested Parties.[30]

II. Submissions of Counsel Assisting the Coroner

45. Counsel Assisting the Coroner (**Counsel Assisting**) opposes the Application, submitting:

(i) the SAPSE Report (as distinct from the SAPSE Materials) is a compellable document;

(ii) such review documents are regularly included in coronial briefs and may later be the subject of submissions about weight and reliability; and

(iii) including a document in the coronial brief is not the same as accepting the contents of it.

46. Counsel Assisting argues that s 128U of the *Health Services Act* can be understood as a '*statutory secrecy provision*' that operates to limit the powers of other courts, tribunals and bodies to compel the production of information under the *Health Services Act*, save where s 128U(3) applies. Section 128U(3) preserves the power of the Coroners Court to receive a SAPSE review report for the purposes of an investigation or inquest; the power to compel production of such report then resides in the *Coroners Act* (as opposed to the *Health Services Act*).[31]

47. Counsel Assisting submits that the specific exemption for the Coroners Court alone to receive SAPSE review reports for the purposes of investigations or inquests was carved out by Parliament because such reports, which relate to serious adverse patient safety events, will likely pertain to matters over which the Coroners Court has jurisdiction. It necessarily follows that a SAPSE review report will potentially contain material that is relevant to the Coroner's functions, including in identifying relevant issues about the cause or circumstances of death, or identifying potential systems improvements. Use of a SAPSE review report by a Coroner is also consistent with the requirement in section 7 of the *Coroners Act* to avoid the duplication of investigations.

48. Counsel Assisting emphasises that the carve-out for the Coroner to receive SAPSE review reports in s 128U of the *Health Services Act* is clear on its face and that there is no need for recourse to extrinsic materials such as the Explanatory Memorandum to the *Health Legislation Amendment (Quality and Safety) Bill 2021* (**Amendment Bill**). However, to the extent that consideration of extrinsic materials is considered prudent, the Second Reading Speech to the

[30] AV Submissions, para 4.1-4.5. AV resiled from an earlier submission that the Court '*delete all records of SAPSE Materials*' (contained at AV Submissions para 4.5) – *see* submissions of Counsel for AV, T-30 line 27 to T-31 line 7.
[31] Submissions of Counsel Assisting, T-32, line 12 to T-35 line 8.

Amendment Bill is, according to Counsel Assisting, '*entirely consistent […] with a reading of the legislation that contemplates Parliament's intention that the only body which will get to see these reports, is the Coroners Court*'.[32]

49. In response to the assertion put forward by AV that the SAPSE Report ought not to be included in the coronial brief but rather be treated as '*background information*', Counsel Assisting notes the clear meaning of the terms 'investigation' and 'inquest' under the *Coroners Act* and submits that '*the words of the exemption in 128U(3) talk about it being produced for the purposes of an investigation or an inquest, and […] if it was going to say "just as background information" it would say so*'.[33]

50. Further, Counsel Assisting disagrees with the submission that inclusion of the SAPSE Report in the coronial brief and relying upon it as evidence would produce '*insurmountable natural justice barriers*',[34] as argued by AV (including where such report adversely impacts the interests of potential witnesses), noting that reliance on a SAPSE review report by a Coroner may in fact obviate the need for certain witnesses to be called where the outcome of the SAPSE review is accepted by relevant persons. Conversely, where the contents of a SAPSE review report are not accepted (for example in the case of an adverse comment regarding a clinician who disputes that comment or conclusion), the Court has available to it the '*tools to ensure that it gives any person who disagrees with the SAPSE report an appropriate opportunity to be heard*'.[35]

51. Further, in terms of the argument made by AV suggesting that SAPSE review reports are inherently unreliable from an evidentiary perspective due to the fact, *inter alia*, that the authors and participants are required to be anonymous, Counsel Assisting argues that '*one could ordinarily expect that a review conducted properly and to the high standards that the legislation contemplates and done in the way in which the legislation directs would be a document that would certainly have the faith of the health service that conducted it and would ordinarily be a document of high quality that the Coroners Court would be assisted by receiving*'.[36]

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[32] Submissions of Counsel Assisting, T-36, lines 4-10, discussing Victoria, *Parliamentary Debates*, Legislative Assembly, 1 December 202, p 4855 (Martin Foley MP). Accessible at: Legislative Assembly 2021-12-01.pdf and which reads '[*t*]*he protections for serious adverse patient safety event reviews will mean that working documents are exempt from Freedom of Information requests and are not admissible in court proceedings. However, a report from a serious adverse patient safety event review will be made available to the Coroners Court for the purposes of an investigation or inquest*'.

[33] Submissions of Counsel Assisting, T-36, lines 26-30.

[34] Submissions of Counsel Assisting, T-37, lines 15-17.

[35] Submissions of Counsel Assisting, T-39, lines 4-9 and 16-25.

[36] Submissions of Counsel Assisting, T-37 line 31 to T-38 line 7.

52. Finally, in relation to the argument that use of a SAPSE review report by the Coroners Court (via its inclusion in the coronial brief and/or treatment as evidence by a Coroner) may have a '*chilling effect*' on clinicians participating in SAPSE review processes, Counsel Assisting emphasises that '*in circumstances where Parliament has expressly contemplated that the Court can receive these reports as part of legislative change designed to encourage candour from hospitals and health services, the Court should be slow to accept the proposition that the Court receiving these reports and using them as Parliament intended is going to have a chilling effect*'.[37]

III. Submissions of Chris's Family

i. SAPSE Report

53. Chris's Senior Next of Kin (hereinafter '**the Family**') also opposes the Application. The Family submits that, in interpreting legislation, the Court must look first to the statutory text itself, with the statutory context and purpose being aids in this task. In considering the text of s 128U of the *Health Services Act*, the Family argues that it is clear that subsections (1) and (2) set out prohibitions on first, requiring production of a s 128T SAPSE review report and second, admitting a s 128T SAPSE review report into evidence in any proceeding. Each of those subsections is expressed to be subject to subsection (3).[38]

54. The Family notes that subsection (3) provides that a s 128T SAPSE review report may be produced to a Coroner for (a) an investigation or (b) an inquest. The Family argues that, contrary to AV's interpretation, the use of '*may'* in the exception in subsection (3) does not give to AV a discretion to determine whether it produces the SAPSE report to the coroner. It merely provides an exemption from the prohibitions set out in subsection (1) and (2). That exemption being clear, AV must then produce the SAPSE review report in response to any legal requirement by the Coroner to do so.[39]

55. The position advanced by the Family is that, given the SAPSE Report was produced to the Coroner, it may be used for the purposes of both an investigation and an inquest. The specific permission to use a SAPSE review report for the purposes of an Inquest makes clear that it may be included in the Inquest brief, relied upon in the course of Inquest and admitted into evidence.

[37] Submissions of Counsel Assisting, T-40 lines 11-20.
[38] Family Submissions, para 5.
[39] Family Submissions, para 7.

Had the legislature not intended this to be the case, it would not have included 'inquest' as a second sub-category of exemption.[40]

56. The Family submits that, while AV's submissions as to the weight and reliability of the SAPSE Report are acknowledged, they are not relevant to the question of statutory interpretation before the Court at this stage, arguing that: '*[t]he legislation is clear. The SAPSE [R]eport may be produced for the purposes of investigation and inquest. Submissions as to its reliability or weight may go to whether it should be admitted at inquest and, if so, what use should be made of it. They do not go to whether the report may be produced or included in the inquest brief*'.[41]

57. During the hearing on 9 December 2024, Counsel for the Family reiterated the submission that it is premature to make a ruling regarding the use of the SAPSE Report by excluding it from the coronial brief '*in circumstances where we haven't yet seen how anyone would want to use that report and that may very well depend on the evidence that emerges in the course of inquest or in the lead up to inquest, for example, if any of the parties or the court obtains expert evidence*'.[42]

58. Counsel for the Family also made several additional points on the potential value of Coroners using SAPSE review reports, including that they are usually prepared contemporaneously with the events under consideration at a much earlier point in time than when an Inquest is convened.[43]

59. The Family also submits that, where a SAPSE review report has failed to live up to its statutory purpose (in the sense of failing to genuinely engage with the issues related to the incident being reviewed or to identify relevant systems improvements), the Coroners Court may have an important role in assessing, through its use and consideration of such reports, whether the *Health Services Act* amendments as they relate to SAPSE reviews are working well, which is consistent with the Court's own prevention function. Use of SAPSE review reports may also obviate the need for coronial recommendations where systems improvements have been appropriately identified and acted upon by the relevant health service.[44]

ii. SAPSE Materials

60. In the same vein as Counsel Assisting, the Family does not dispute AV's submission that the SAPSE Materials cannot be compelled to be produced, or otherwise admitted into evidence. The

[40] Family Submissions, para 8.
[41] Family Submissions, para 9.
[42] Submissions of Counsel for the Family, T-44 lines 9-20.
[43] Submissions of Counsel for the Family, T-49 lines 12-23.
[44] Submissions of Counsel for the Family, T-50 lines 9 to T-51 line 3.

Family does note that the circumstances of the creation and provision of the SAPSE Materials is not clear on the face of AV's submission. However, on the assumption that the SAPSE Materials were created for the *sole purpose* of providing information in the SAPSE review and were provided in the course of the review, the Family accepts that the Court is not permitted to require production of the SAPSE Materials. Similarly, if the SAPSE Materials were obtained by the SAPSE review panel, it is not an admissible document.[45] The Family therefore accepts the characterisation of the SAPSE Materials put forward by AV in its submissions.

RULING

61. In ruling on the Application, I have considered applicable legislation (including Part 5A, Division 8 of the *Health Services Act*[46] and the relevant provision of the *Coroners Act*),[47] the written submissions of Interested Parties, and the oral submissions of Interested Parties and of Counsel Assisting made on 9 December 2024, and, broadly, the evidence as it as currently known regarding the cause and circumstances of Chris's death.

Relevance of the SAPSE Report

62. At the outset, I note that in the present case, AV provided the SAPSE Report to the Court voluntarily, without any process being initiated by the Court to compel it to do so under s 42 of the *Coroners Act*.[48]

63. AV concedes that, in light of s 128U(3) of the *Health Services Act*, '*it seems clear that in those situations where a SAPSE Report has been handed over there's no legislative restriction [as to] what the coroner can do with it',*[49] including admitting in into evidence at inquest and including the document in the coronial brief.[50]

64. The Application now made by AV, however, is that I refrain from including the SAPSE Report in the coronial brief and instead treat it as '*background material*'. When asked what status the SAPSE Report would have under the *Coroners Act* if so regarded, AV did not identify any

[45] Family Submissions, para 14. Counsel for the Family confirmed at the hearing on 9 December 2024 that the position of AV with respect to the SAPSE Materials is not disputed and that '*if as AV says they were produced for the purposes of the SAPSE report then we accept that position*' - T-43 lines 1-6.
[46] *Including in particular* ss 128N, 128O, 128Q, 128R, 128S, 128T, 128U, 128V, 128W, 128X and 128Y.
[47] *Including in particular* ss 1, 7, 8, 9, 42, 55, 69, 115.
[48] Section 42 of the *Coroners Act 2008* outlines a process for the Coroner to compel production of documents or prepared statements for the purposes of an investigation, often referred to as a 'Form 4', in reference to the corresponding form number in the schedule to the *Coroners Regulations 2019*.
[49] Submissions of Counsel for AV; T-18, lines 16-19.
[50] Indeed, the position initially advanced on behalf of AV was that it took no issue with the inclusion of the SAPSE Report in the coronial brief.

particular provision, but simply asserted that it ought not be regarded as evidence or included in the coronial brief, though ought to be provided to Interested Parties.[51]

65. Section 115 of the Coroners Act governs access to documents in coronial proceedings. Therein, the term 'coronial brief' is defined at section 115(7), which I will reproduce in full:

> *In this section, coronial brief means a brief of evidence that is prepared for a coronial investigation and contains the following (if available)—*
>
> *(a) a statement of identification by an appropriate person;*
>
> *(b) any reports given to a coroner as a result of a medical examination;*
>
> *(c) reports and statements that the coroner investigating the death or fire believes are relevant to a coronial investigation;*
>
> *(d) other evidentiary material that the coroner investigating the death or fire believes is relevant to the coronial investigation;*
>
> *(e) any material prescribed by the rules or the regulations.*[52] (emphasis added)

66. In circumstances in which AV has acknowledged that '*access to the SAPSE Report may benefit the coronial process in this particular case*' and that Interested Parties ought to have access so they can '*have the benefit of the learnings from the report'*,[53] it is safe, in my view, to consider that its relevance to the coronial investigation is common ground. Counsel Assisting and Counsel for the Family made extensive submissions on this front. Indeed, Counsel for AV also submitted this to be the case at the hearing of 9 December 2024, noting '*[w]e accept it is relevant, we accept it may be useful to the court in some way […]*'.[54]

67. Having perused the SAPSE Report and in light of the cause and circumstances of Chris's death, as they are currently understood, I have taken the view that the SAPSE Report is indeed highly relevant to the present coronial investigation. Without detailing the contents of the SAPSE Report in the present Ruling, I will simply note broadly that the opportunity to be apprised of what happened on 7 September 2023 from the review panel's perspective, how it happened, and

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[51] T-28 lines 10-16 at which Counsel for AV stated, when speaking of the SAPSE Report, '*It holds the status of background information, it holds the status of, when a coroner's investigator particularly, goes out and obtains evidence, not everything makes it onto the coronial brief so I would say it falls in that category of background information that can be used by parties to inform, but not evidence, not evidence of the truth of its contents*'.

[52] Section 115(7) *Coroners Act*. 'Inquest brief' is not defined in the Coroners Act but is a term that typically refers to a coronial brief that has been prepared for or is used in coronial proceedings in which an inquest is held.

[53] AV Submissions, para 3.3 and 3.4. As noted above, this occurred on 8 November 2024 for the purposes of allowing Interested Parties to make submissions on these issues.

[54] Submissions of Counsel for AV, T-55, lines 4-6.

what systems improvements could preclude similar events from recurring, has the potential to be helpful – deeply helpful – to the discharge, in accordance with the principles in *Priest v West*, of my statutory functions, including those under s 67(1) of the *Coroners Act* to make findings as to the cause and circumstances of death, where possible. It is also highly relevant to s 72 of the Act, which deals with the power to make recommendations.

68. Having established the relevance of the SAPSE Report to these proceedings, I consider that acceding to AV's request not to include the SAPSE Report in the coronial brief and/or not to admit it during the Inquest proceedings[55] is therefore untenable for the four reasons that follow.

(i) The notion of treating the SAPSE Report as mere '*background information*' lacks transparency and a proper legal basis

69. As noted above, AV has not identified how a document classified as *'background material'* would be categorised for the purposes of Court's legal framework, which envisages the inclusion in the coronial brief of reports and statements that the Coroner investigating the death or fire considers are relevant to a coronial investigation. The use of a coronial brief provides certainty and transparency for Interested Parties in the context of inquisitorial proceedings in which the Court may receive a volume of documents throughout the course of an investigation, and Interested Parties are entitled to receive any document considered relevant to the proceedings, and upon which the Coroner may rely in reaching a finding. This category of documents is reflected in the format of a coronial brief that may be provided to Interested Parties and other applicants with relevant standing,[56] usually subject to conditions under s 115(3).

70. The creation of a separate category of document that is relevant for consideration by the Coroner and for circulation to Interested Parties but which is *not* included in a coronial brief would create a situation of potential uncertainty for Interested Parties and others as to what has been relied upon by the Coroner in reaching findings or in making key decisions, for example on the scope of an investigation or Inquest.[57] It may also create uncertainty as to the status of any concessions offered by a health service on the basis of the contents of a SAPSE review report.

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[55] For completeness, I note that while these are two separate questions, the typical practice of the Coroners Court is to include relevant materials in a coronial brief prior to Inquest and to tender the brief in its entirety at the conclusion of the Inquest proceedings (subject to any objections of Interested Parties). Therefore, a document considered relevant for inclusion in a coronial brief will usually be admitted into evidence, but the weight given to that evidence will always be a matter of submissions in an individual case.

[56] In the context of an inquest, s 115(1)(b) *Coroners Act* provides specifically for this.

[57] The uncertainty as to the legal status accorded to such document may also arise where an Interested Party seeks judicial review of a determination made in the course of the coronial proceedings, and/or commences an appeal under Part 7 of the *Coroners Act*. It also gives rise to uncertainty as to the application of s115(3) of the *Coroners Act*.

71. The distinction between what goes into the coronial brief and what is excluded is predicated on relevance alone. It is common ground that the SAPSE Report in this case is relevant to the coronial investigation; as the Coroner with carriage of the investigation, I confirm this to be my view. Consequently, in accordance with s 115(7) of the *Coroners Act*, where a document is relevant to a coronial investigation, it ought to be included in the coronial brief.

72. The notion that relevant documents should be included in the coronial brief is also consistent with the *Health Services Act*. Rather than relegating SAPSE review reports to the uncertain status of '*background material*', which lacks transparency or foundation in the Court's legal framework, the specific permission in the *Health Services Act* to use the SAPSE review reports for the purposes of an Inquest and investigation makes clear that such report may be included in the coronial brief, in the usual manner, and used in the course of inquests or investigations where appropriate. The ultimate weight to be accorded to a SAPSE review report is a separate matter to which I will return.

(ii) **There is a clear carve-out and rationale for the Coroners Court to receive SAPSE review reports under s 128(U) of the *Health Services Act***

73. Section 128U(3) of the *Health Services Act* provides an exception to the prohibition on the compelled production of SAPSE review reports to courts, tribunals or any board, agency or other person set out in subsections (1) and (2). A report prepared under section 128T may be produced to a coroner or the Coroners Court (as appropriate) for the purposes of a) an investigation under Division 1 of Part 4 of the *Coroners Act*; or b) an Inquest (within the meaning of the *Coroners Act*) in respect of a death. I note that, while s 128U(3) of the *Health Services Act* refers to '*a coroner or the Coroners Court (as appropriate)*', s 89(3) of the *Coroners Act* somewhat obviates the need for this distinction.

74. In my view the extrinsic materials make it clear – and it is not disputed by AV – that the carve-out for the Coroners Court alone to receive SAPSE review reports for the purposes of investigations or Inquests was created by Parliament because such reports, which relate to serious adverse patient safety events (including deaths, which are required to be reported to the Coroner) have the potential to inform and assist the coronial investigation into the very same incident, and thus assist the Coroner in discharging their statutory functions.

75. It necessarily follows that a SAPSE review will have significant crossover with the Coroner's functions, including in identifying relevant issues about the cause or circumstances of death, or identifying potential systems improvements, as is the case in the present investigation. Given the

duty under s 7 of the *Coroners* Act to avoid unnecessary duplication of investigations – a SAPSE review being an example of a such a separate investigation – I consider this to be a further reason militating in favour of including the SAPSE Report in the coronial brief in the present case, particularly in circumstances where it is mandatory that I hold an Inquest.

76. In this connection, section 8 of the *Coroners Act* is also relevant. The potential additional burden placed on health workers of being required to participate in or contribute to not only a SAPSE review but also a coronial investigation, is also a relevant matter to consider when deciding whether, and how, to use a SAPSE review report. Such persons are '*affected by a death*' within the meaning of Section 8 of *the Coroners Act*. There have been a number of coronial matters in which witnesses who might otherwise have had to attend to give evidence about distressing matters have not needed to attend because of concessions made in the light of internal reviews. As noted above, I do not consider this can occur where a SAPSE review report is accorded an uncertain and ambiguous status, beyond the legal framework, as '*background material*'.

(iii) **That carve-out includes the power for the Coroner to use SAPSE review reports in coronial proceedings and to compel their production**

77. I note that the extrinsic materials to the *Health Services Act* amendments do not appear united on the issue of compellability of SAPSE review reports to the Coroner. The Explanatory Memorandum says the following in relation to section 128U:

> New section 128U provides that a SAPSE review report and any documents created for the purposes of a SAPSE review or during the course of that review are not required to be produced in legal proceedings, and are not admissible in any court, tribunal or other legal proceedings. There is a limited exception providing that a SAPSE review report may, at the discretion of the relevant health service entity or health service entities, be provided to a coroner for the purpose of an investigation or an inquest in respect of a death.

78. This suggests that it is for AV (or any other health service which has conducted a SAPSE review) rather than for the coroner to decide whether a SAPSE review report will be produced in any given instance. As I have noted, AV relies on the Explanatory Memorandum in submitting that it has a discretion whether to provide the SAPSE Report or not.

79. However, I consider that a plain reading of the legislation gives a different outcome. Subsection 128U(1) of the *Health Services Act* prohibits the compelled production of certain SAPSE documents and is specifically made subject to s 128U(3). That being the case, where a SAPSE review report is sought for the purposes of an investigation or inquest under the *Coroners Act*,

the Coroner may compel its production.[58] Had the SAPSE Report not been voluntarily produced to the Court by AV, it could have been made the subject of a Form 4. The power to compel production of the SAPSE Report resides not in the *Health Services Act* but in the *Coroners Act*, which provides for this possibility in s 42, in the case of investigations and Inquests, and s 55, in the case of Inquests alone. Section 128U(3) of the *Health Services Act* preserves the continued operation of the relevant provisions of the *Coroners Act*. It does not itself give a power.

80. The effect of this is that the use of the word '*may'* in the exception in subsection (3) does not give AV a discretion to determine whether it produces the SAPSE Report to the Coroner. It merely exempts the Coroner from the prohibitions set out in subsection (1) and (2). That exemption being clear, a health service must then produce a SAPSE review report to the Coroner or Coroners Court in response to a legal requirement by the Coroner to do so. The failure to do so may expose a health service to the penalty provisions under s 42 of the *Coroners Act*, and may in certain circumstances also have implications under s 103 of the *Coroners Act* (which governs contempt).

(iv) The three risks identified by AV of the Coroners Court using SAPSE review reports are not made out

81. The three issues advanced by AV to argue against inclusion of the SAPSE Report in the coronial brief and/or against its admission as evidence at inquest (contained above at paragraph 38) are, in my view, without basis. I will step through each argument in turn.

Does the use of SAPSE review reports create insurmountable procedural fairness issues?

82. It is indeed the case that the Court will need to carefully ensure that procedural fairness is afforded to any person or entity whose interests are or may be affected by the contents of a SAPSE review report, and to carefully assess any reliability issues given the authors and participants are anonymised, rather than demonstrating a blanket reliance on such report.

83. However, these are issues that can be accommodated and addressed during the proceedings (through hearing from those whose interests are affected) and, if the SAPSE review report is admitted into evidence, may later be the subject of submissions about weight and reliability. These considerations cannot of themselves deprive the SAPSE review report from its status as potential evidence or from its inclusion in the coronial brief pursuant to s 115(7) of the *Coroners Act*.

[58] The Second Reading Speech also supports this interpretation – *see above in this regard* paragraph 48, and footnote 32.

Are SAPSE review reports inherently unreliable from an evidentiary perspective?

84. I am troubled by AVs submission that the SAPSE Report contains information, including '*learnings*', that are conceded to be relevant to the Coroner and to Interested Parties but are simultaneously submitted to be inherently unreliable from an evidentiary perspective. The legislation includes clear requirements for the scope of SAPSE reviews, the personnel who may be involved on the panel (including, per s 128Q(2), that each member of a panel must have '*appropriate skills and experience to conduct a SAPSE review*'), and, per s128Q(1)(b), a prohibition on any person involved in the SAPSE itself being on the review panel.

85. Accordingly, while each report would need to be assessed on a case-by-case basis, it is untenable to suggest that SAPSE review reports are inherently unreliable from an evidentiary perspective, as a class of document, and ought not to be included in a coronial brief or be eligible to be admitted as evidence. If in a given case the Coroner had access to other evidence that was inconsistent with a SAPSE review report or which suggested that a review panel had reached incorrect conclusions, then in that case, the weight given to it would be reduced.

86. In the present case, there is nothing to suggest that the SAPSE Report prepared following Chris's death is inherently unreliable so as to warrant its omission from the coronial brief. On the face of it, it is a document that is relevant, is capable of assisting me and as such, it should be included in the coronial brief. Interested Parties will yet be afforded an opportunity to make submissions on the appropriate weight that ought to be accorded to the SAPSE Report, including (as the case may be) in light of any other evidence received in the course of the coronial proceedings that touches upon its subject matter.

Does the use of SAPSE review reports by a Coroner risk creating a 'chilling effect' on frank participation in SAPSE review processes?

87. I have given careful consideration to the submission of AV that use of the SAPSE Report would risk perpetuating a culture of blame in health services that is antithetical to the Court's prevention function, and may lead to a '*chilling effect*' on clinicians' participation in SAPSE reviews or production of frank SAPSE review reports. I agree that, as a Coroner exercising statutory functions in a jurisdiction geared towards improving prevention efforts and identifying systems improvements, it would not be appropriate to take any steps that would have such an effect.

88. However, I do not accept that use of a SAPSE review report by a Coroner in the course of an investigation or inquest would have such an effect. Indeed, amendments made to the *Health Services Act* in 2022 were accompanied by a new statutory duty of candour - the fundamental

purpose of which was to engender a culture of honesty and openness in health services and to improve the quality of health care, with a focus on safety and person-centeredness.

89. The SAPSE review reports, which are also required to be offered to family in line with this duty, form part of this cultural shift, balanced by strict protections precluding their production in legal proceedings other than those overseen by the Coroners Court. In amending the legislation as reflected in Part 5A Division 8 of the *Health Services Act*, Parliament has already contemplated the need for frankness on the part of participants as a precondition of quality SAPSE review processes and has provided for it through the existing protections in the legislation. I do not accept that the provision of a SAPSE review report to the Coroner will undermine that focus on frankness.

Conclusion regarding application

90. I accept that AV has made this application having given genuine and anxious consideration to the way in which SAPSE review reports may be disseminated and in circumstances where there has not yet been any judicial determination of the precise meaning and scope of section 128U(3) *Health Services Act*.

91. However, having considered AV's arguments, I do not accept them. Whilst it would never be proper for the Court to take inappropriate advantage of a mistake by an Interested Party who has provided documents which were in fact not compellable, that is not the situation here. The SAPSE Report and SAPSE Materials have been provided to the Court, and I am satisfied that the SAPSE Report is properly before me and could have been compelled if not provided voluntarily.

92. The Application made on behalf of Ambulance Victoria is therefore refused.

SAPSE Materials

93. I accept that if the SAPSE Materials constitute a document falling under s 128U(1)(b) *Health Services Act*, or s 128U(2), or both, they would be precluded from being included in the coronial brief or admitted into evidence for the purposes of the present coronial proceedings.

94. However, I do not consider that AV has established as a matter of evidence that the SAPSE Materials constitute a document falling under s 128U(1)(b) or s 128U(2) *Health Services Act*. No evidence has been provided to underpin AV's submission that the SAPSE Materials were either created for the sole purpose of providing information in the course of conducting a SAPSE review and provided in the course of conducting a SAPSE review (s128U(1)), or that the SAPSE

Materials constitute evidence of any other information or reports obtained by or in the possession of a SAPSE review panel in the course of conducting a SAPSE review (s128U(2)).

95. I consider, however, that AV advanced the submission in good faith that the document referred to as 'SAPSE Materials' falls under one or both of those provisions.

96. I will therefore not order its inclusion in the coronial brief at this stage, and shall not admit it into evidence in the present proceedings, without providing the opportunity for AV to make further submissions on the issue together with any relevant evidence in support of its contention that the document falls outside the scope of section 128U(3).

ORDERS AND DIRECTIONS

97. I order that the SAPSE Report, as described above at paragraph 8, be included in Version 2 of the coronial brief for **COR 2023 004999 - Christopher Keisler**. It will thereafter be eligible to be admitted into evidence during or at the conclusion of the inquest into the death of Christopher Keisler, as part of the coronial brief.

98. I further direct that AV provide any further submissions or evidence in relation to the use of the SAPSE Materials in these proceedings within 4 weeks of this Ruling being distributed to Interested Parties. Upon receipt of any further submissions or evidence on behalf of AV on this issue, I will make a determination in relation to use of the SAPSE Materials.

99. The coronial investigation into the death of Christopher Keisler, which has been in abeyance pending the ruling on the Application, is hereby recommenced.

100. I direct that a copy of this Ruling be distributed to Interested Parties and published on the Coroners Court website in accordance with the *Coroners Court Rules 2019*.

Signature:

Ingrid Giles
Coroner
Date: 14 March 2025